

**Media Release**  
**Association for Savings and Investment South Africa (ASISA)**  
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### **Life insurers stop record number of fraudulent and dishonest claims**

South African life insurers last year detected a record number of 4 826 attempts by policyholders and beneficiaries to access policy benefits through fraudulent and dishonest means.

Peter Dempsey, deputy CEO of ASISA, says the foiled claims would have cost the industry R824.2-million in 2009 had they gone undetected.

Statistics relating to fraudulent and dishonest policy claims are gathered by ASISA on an annual basis. Dempsey says life companies share fraud statistics and information with each other with the aim of detecting trends and syndicate activity as early as possible.

Dempsey says a combination of reasons led to the 2009 statistics being significantly higher than in any other year since the industry started gathering fraudulent and dishonest claims statistics in 2003.

“We know that during times of economic hardship more people try and access policy benefits through dishonest means. While we certainly believe that this was a contributing factor last year, the industry has also significantly improved its fraud detection measures and reporting mechanisms over the years. As a result ASISA received the most comprehensive set of reports yet from member companies last year.”

Dempsey adds that for the first time life companies also submitted data for health business and hospital claims, as well as retrenchment claims. For these reasons, he says, there is little value in comparing last year’s fraudulent and dishonest claims statistics to previous years.

Dempsey explains that if life companies do not try and prevent claims fraud, the claims experience of life companies would increase substantially and ultimately force companies to recover these losses from customers through increased premiums.

He adds, however, that by far the majority of claims submitted to life companies are honest and legitimate and are therefore honoured by life companies. The life industry paid out benefits of more than R175.6-billion in 2009 to consumers as a result of death and disability claims, maturity pay-outs and pension, annuity and other payments.

The highest number of fraudulent and dishonest claims were submitted in Kwa-Zulu Natal (40%), followed by Gauteng (22%) and then the Eastern Cape (15%).

### **Death and funeral policy claims**

Dempsey says the death and funeral insurance category experienced the highest number of fraudulent and dishonest claims last year. Life companies reported 3 579 cases to the value of R443.8-million.

The majority of cases were due to misrepresentation and material non-disclosure, as well as the submission of fraudulent documentation. Syndicate involvement, beneficiary involvement in the death of the policyholder, and adviser and broker involvement also contributed to the statistics, but to a much lesser extent, says Dempsey.

- **Misrepresentation and material non-disclosure**

Misrepresentation and material non-disclosure in this category resulted in 1 648 claims to the value of R352-million being rejected as dishonest in 2009. Misrepresentation and material non-disclosure do not involve the criminal intent that comes with fraud and are therefore classified as dishonest claims.

Misrepresentation occurs when policyholders deliberately provide misleading information to a life insurer, because they know that if the insurer was made aware of the full risk, they would in all likelihood be required to pay a higher premium.

A pilot, for example, would be guilty of misrepresentation if he declares that he flies only 100 hours a year, when he really spends more than 400 hours a year in the air. A pilot who flies less hours represents a lower risk to the life company and therefore qualifies for lower rates. You are also misrepresenting information to your life insurer if you add someone else's child to a funeral policy, pretending that it is your own child.

Material non-disclosure refers to the deliberate failure of policyholders to disclose information about a medical or lifestyle condition, which is material to the assessment of the risk to be insured. An example of material non-disclosure is when an applicant for life cover omits to mention that she recently enrolled as a student helicopter pilot.

- **Fraudulent documentation**

Dempsey says companies also reported a high incidence of fraudulent documentation being submitted in an attempt to gain access to death or funeral policy benefits. Last year life companies reported 1 238 cases to the value of R74-million.

"A number of these cases involved falsified death certificates. We have also come across cases where the date of death was changed to fall outside of the waiting period of the policy. In one case the beneficiary used an unclaimed body at the mortuary and presented the deceased as someone covered by the policy."

### **Disability policy Claims**

According to Dempsey, 813 cases of misrepresentation and material non-disclosure were detected in the disability claims category to a value of R360.8-million. Fraudulent documentation was submitted in 22 cases involving cover of R9.9-million.

Dempsey says during tough economic times some consumers resort to fraud to access their disability cover.

"We have come across policyholders who misrepresent material information such as their income with the aim of claiming more money in disability than they had actually been earning while able to work. There have also been cases where policyholders took out disability or income protection cover while already suffering from the condition they would later claim for."

### **Health Business and Hospital Claims**

Dempsey warned consumers that life companies have caught on to policyholders who have themselves admitted to hospital without a valid medical condition for the sake of claiming from their hospital cash plans.



Life companies rejected 404 claims worth R9.6-million last year in the health business and hospital claims category.

Dempsey says in one case a policyholder was found to have six hospital cash plans with different life companies, claiming from all of them after submitting fraudulent documentation claiming to have spent time in hospital.

**Retrenchment claims**

Dempsey says given the wave of retrenchments that hit South Africa last year, it is surprising that only eight fraudulent and dishonest retrenchment policy claims to a value of R172 684 were submitted.

**Fraudulent and dishonest policy claims statistics for 2009**

Category	Number of cases	Rand value
<b>Death and Funeral Claims</b>	<b>3 579</b>	<b>443 766 560</b>
Misrepresentation/Material non-disclosure	1648	352 231 922
Fraudulent documentation	1238	74 240 673
Syndicate involvement	150	3 830 043
Beneficiary involvement in death	460	5 959 581
Advisor involvement	25	1 197 899
Broker involvement	58	6 306 442
<b>Disability Claims</b>	<b>835</b>	<b>370 692 310</b>
Misrepresentation/Material non-disclosure	813	360 804 243
Fraudulent documentation	22	9 888 067
<b>Health Business and Hospital Claims</b>	<b>404</b>	<b>9 603 892</b>
Misrepresentation/Material non-disclosure	390	9 331 632
Fraudulent documentation	14	272 260
<b>Retrenchment Claims</b>	<b>8</b>	<b>172 684</b>
Misrepresentation/Material non-disclosure	2	107 300
Fraudulent documentation	6	65 384
<b>TOTAL</b>	<b>4 826</b>	<b>824 235 446</b>

**Ends**

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ASISA represents the majority of South Africa's asset managers, collective investment scheme management companies, linked investment service providers, multi-managers, and life insurance companies. ASISA was formed in 2008 by members of the Association of Collective Investments (ACI), the Investment Management Association of South Africa (IMASA), the Linked Investment Service Providers Association (LISPA) and the Life Offices' Association (LOA).