

## Media Release

Association for Savings and Investment South Africa (ASISA)

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### Hospital cash plans fight increasing claims fraud

South African life insurers managed to prevent 5 792 cases of claims fraud during 2010. Had these attempts not been foiled, the life industry would have lost over R638-million to fraud.

Peter Dempsey, deputy CEO of the Association for Savings and Investment South Africa (ASISA), says while there had been a slight decrease in 2010 in the total value of the attempted claims fraud from 2009, the number of cases had increased substantially by 1 204 from the 4 588 cases recorded in 2009\*.

“The rise in the number of claims fraud cases detected can be attributed to the increasingly sophisticated fraud detection mechanisms applied by many of the forensic departments of the long-term insurance companies. But it does also indicate that for many policyholders and beneficiaries who are struggling financially, fraud is seen as the easy way out.”

Dempsey warns that in cases where fraudulent intent is evident, criminal charges are laid by life insurers and perpetrators may face jail time. Dishonest policyholders and beneficiaries who fail to disclose important information when taking out policies may find themselves without cover in their biggest time of need.

Dempsey points out, however, that by far the majority of claims submitted to life companies is honest and legitimate and therefore honoured. The life industry paid out benefits of more than R190-billion in 2010 to consumers as a result of death and disability claims, maturity pay-outs and pension, annuity and other payments.

“While the R638-million almost seems insignificant when seen against the R190-billion in benefit payments, it is important that the life industry fights claims fraud. Unbridled fraud would substantially increase the claims experience of life companies and ultimately force companies to recover these losses from customers through increased premiums.”

Dempsey adds that while the R638-million represents fraud detected, there are bound to be cases that did not appear on the radar screens of the forensic departments. While it is impossible to estimate how much, Dempsey says it is a given that millions are lost to fraud and dishonesty each year.

He explains that life companies share fraud statistics and information with each other with the aim of detecting trends and syndicate activity as early as possible. For this reason statistics relating to fraudulent and dishonest policy claims are gathered by ASISA on an annual basis.

The highest number of fraudulent and dishonest claims was submitted in Kwa-Zulu Natal (24%), followed by Gauteng (19%), the Western Cape (18%) and the Eastern Cape (15%). Dempsey notes that this is the first time that the Western Cape features in the top three, having pushed the Eastern Cape down to fourth position.

### Health business and hospital claims

According to Dempsey, a worrying trend is the substantial increase in fraudulent health business and hospital claims from 404 cases (to the value of R9.6-million) in 2009 to 649 cases (R12.6-million) in 2010. ASISA started collecting data for health business and hospital claims fraud in 2009, which means that this is the first time a comparison can be made.

Hospital cash plans pay policyholders a daily cash benefit for each day spent in hospital. This amount is paid irrespective of medical aid payments or sick leave available to the person hospitalised.

“Hospital cash plans offer good value for money and help alleviate the financial burden of having to take time off work if you are self-employed or having to hire help if you are a stay-at-home parent,” says Dempsey.

“Unfortunately, however, we have seen a consistent increase in fraudulent claims where doctor and hospital administrator collusion is helping dishonest policyholders make claims they are not entitled to.”

Dempsey says life insurers have come across cases where patients being treated for minor conditions are kept in hospital for much longer than needed, enabling them to claim from a number of hospital cash plans with several different insurers.

“While some of these cases were spurred by desperation where the money was needed to repay debt, in many other cases the goal was blatant self enrichment. Life insurers are currently pursuing criminal cases against two female policyholders accused of fraudulently claiming from their hospital cash plans.”

### **Death and funeral claims**

The death and funeral claims category continued to experience the highest number of fraudulent and dishonest claims in 2010. Life companies foiled 4 636 cases to the value of R321.7-million.

Dempsey comments that while the number of cases in 2010 was much higher than in 2009 when 3 579 cases were recorded, the fraud amount is substantially lower by R122.1-million.

The bulk of the cases was due to misrepresentation and material non-disclosure. 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 far lesser extent, says Dempsey.

“In fact, brokers and advisers were responsible for only 24 fraudulent and dishonest claims. Since the introduction of the FAIS Act and subsequently the FAIS examinations, we have seen a steady reduction in fraud involving brokers and advisers. The death and funeral claims category is the only one where there has still been some involvement - all the other categories show no cases involving intermediaries.”

- **Misrepresentation and material non-disclosure**

Misrepresentation and material non-disclosure resulted in 4 101 death and funeral claims to the value of R292.5-million being rejected as dishonest in 2010. This represents the bulk of the cases in this category. In 2009, however, misrepresentation and non-disclosure was present in only 1 648 cases, but to a value of R352.2-million.

Misrepresentation and material non-disclosure cases 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 is made aware of the full risk, they would in all likelihood be required to pay a higher premium.

A car sales person would, for example, be guilty of misrepresentation if he fails to declare that he also participates in motor racing on most weekends. A car sales person represents a lower risk to the life company than a racing driver and would therefore qualify 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 is also an avid mountain climber.

Dempsey points out that misrepresentation and non-disclosure almost always have serious consequences for policyholders and their beneficiaries. “While withholding important information may result in lower premiums or in cover without exclusions, the life insurer is entitled to declare the policy void if at claims stage it is discovered that critical information was not disclosed.”

- **Fraudulent documentation**

Dempsey says in 412 cases worth R23.3-million, fraudulent documentation had been submitted in an attempt to gain access to death or funeral policy benefits. In 2009, this figure was much higher at 1238 cases worth R74.2-million.

Fraudulent death certificates are the most common fraudulent documentation submitted.

“We also come across cases where the date of death has been changed to fall outside the waiting period of the policy. More ruthless beneficiaries have been caught presenting unclaimed bodies at mortuaries as the deceased covered by the policy.”

#### Disability policy claims

According to Dempsey, 490 cases of misrepresentation and material non-disclosure were detected in the disability claims category to a value of R302.1-million. Fraudulent documentation was submitted in only 4 cases involving cover of R1.4-million. A total of 494 dishonest and fraudulent disability claims cases to a value of R303.5-million were uncovered.

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

“In extreme cases, policyholders harm themselves to qualify for a legitimate disability payout. But most commonly, policyholders take out disability or income protection cover while already suffering from the condition they would later claim for. Others 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.”

#### Retrenchment claims

Dempsey says given the more than one million job losses in South African since the start of the financial crisis in 2008, it is surprising that only 13 fraudulent and dishonest retrenchment policy claims to a value of R531 567 were detected. In 2009 only eight such claims to a value of R172 684 were recorded.

#### Fraudulent and dishonest policy claims statistics for 2010, compared to 2009

Category	2010		2009	
	Number of cases	Rand value	Number of cases	Rand value
Death and Funeral Claims	4 636	R321.7-million	3 579	R443.8-million
Misrepresentation/Material non-disclosure	4 101	R292.5-million	1 648	R352.2-million
Fraudulent documentation	412	R23.3-million	1 238	R74.2-million

Category	2010		2009	
	Number of cases	Rand value	Number of cases	Rand value
Syndicate involvement	36	R1.5-million	150	R3.8-million
Beneficiary involvement in death	63	R1.7-million	460	R6-million
Adviser involvement	14	R2.4-million	25	R1.2-million
Broker involvement	10	R0.3-million	58	R6.3-million
Disability Claims	494	R303.5-million	597	R240.8-million
Misrepresentation/Material non-disclosure	490	R302.1-million	575	R230.9-million
Fraudulent documentation	4	R1.4-million	22	R9.9-million
Health Business and Hospital Claims	649	R12.6-million	404	R9.6-million
Misrepresentation/Material non-disclosure	604	R10.7-million	390	R9.3-million
Fraudulent documentation	41	R1.9-million	14	R0.3-million
Syndicate involvement	4	R17 300	0	0
Retrenchment Claims	13	R0.5-million	8	R0.2-million
Misrepresentation/Material non-disclosure	7	R0.3-million	2	R0.1-million
Fraudulent documentation	6	R0.2-million	6	R65 384
<b>TOTAL</b>	<b>5 792</b>	<b>R638.3-million</b>	<b>4 588</b>	<b>R694.3-million</b>

*Figures have been rounded up.*

**Ends**

**\* Note to Editors:** Reference is made to the adjusted 2009 claims fraud statistics, which are marginally lower than initially reported. The adjustment was made after it emerged that one insurer had included cases that fell outside of the reporting spectrum.

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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).