ANTI - FRAUD POLICY MANUAL

شركة الخزنة للتأمين ش.م.ع.

Al Khazna Insurance Company P.S.C.

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Anti-Fraud Manual

1. Definitions

1.1. The term "Companies" in this manual is intended to include:
Insurance and reinsurance companies and insurance related service providers including insurance brokerages, insurance agencies, reinsurance brokerages, and reinsurance agencies.

1.2. Insurance Fraud is defined as an act or omission of an act intended to gain dishonest or unlawful advantage for the party committing the fraud or for other parties. This may, for example, be achieved by means of:

- Misappropriating assets.
- Deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to a financial decision, transaction or perception of the insurer's status.
- Abusing authority, a position of trust or a fiduciary relationship.

2. Scope and Exemptions

2.1. This code applies to insurance and reinsurance companies, and insurance related service providers including insurance brokerages, insurance agencies, reinsurance brokerages, and reinsurance agencies.

2.2. Companies can be subjected to multiple forms of fraudulent activities from inside or outside the company. However, most of these activities fall under three overarching categories:

- Internal fraud: fraud perpetrated by company's employee.
- Intermediary fraud: fraud by insurance services providers against the companies or policyholders.
- Policyholder fraud: fraud committed in the purchase or execution of an insurance product to obtain an illegitimate coverage or payment.

3. Anti-fraud Standards

3.1. Internal Fraud

3.1.1. Detection

3.1.2.2. Internal fraud can be committed by the company board members, management, and staff in any of the business activities of the company. Fraud can

be detected in overall business practices as well as personal conduct or attitude. Typical internal fraud indicators are provided in Table I.

3.1.2. Measure

Companies should define clear and well documented policies and procedures to measure internal fraud. The implementation and efficiency of these procedures should be verified by internal auditors yearly and report regarding fraud occurrence, trends and Mitigation efficiency should be submitted to the board of directors.

3.1.3. Mitigation

3.1.3.1. Companies should define transparent and comprehensive policies when dealing with internal fraud, highlighting in particular:

a) The role of the board, management and staff when dealing with the internal fraud.
b) The enforcement measures to be taken against fraudsters.
c) The relevant law enforcement authorities' notification procedure.

3.1.3.2 Companies should restrict the access to cash and electronic transfers by:

a) Setting up physical and procedural security measures over the availability and use of cash, assets and information systems.
b) Arranging for cash and electronic transfers to be dealt with by more than one person.

3.1.3.3. Companies should enforce strict information technology rules, including but not limited to:

a) Restricting the physical access to computer server rooms.
b) Monitoring access rights to networks.
c) Limiting and monitoring remote accesses to networks.
d) Controlling and renewing network password on a regular basis.
e) Implementing network security and auditing trail.

3.1.3.4. Companies should, prior to hiring permanent or temporary personnel, thoroughly screen and perform background checks to ensure the integrity and the proper moral values of potential recruits.

3.1.3.5. Companies should promote a culture of integrity and accountability within their organizations, e.g., by developing an internal ethical behavior manual that promotes proper conduct and good values.

a) Job description should be defined clearly across the organization, detailing roles and responsibilities of management and staff.
b) Functions that might be susceptible to conflict of interest should be separated.
c) Vacations and job rotations for management and staff in key sensitive positions should be mandatory.

3.1.3.6. Companies should maintain comprehensive and complete personnel records for a sufficient amount of time after the personnel's departure.

3.1.4. Monitoring

3.1.4.1. Companies should enforce thorough management and staff supervision policies, particularly for key positions within the organization.

3.1.4.2. Sensitive activities should be subject to the dual verification principle, i.e., be submitted for verification by another staff member from a different department within the organization.

3.2. Service provider fraud

3.2.1. Detection

3.2.1.1. Since they handle most market-facing activities (e.g., distribution and claims settlement), insurance services providers are at the heart of the relationship with the policyholder. Consequently, insurers should enhance close collaboration with insurance service providers to detect and combat internal and policyholder fraud at their level, while monitoring the insurance service providers themselves for the insurance service provider

3.2.1.2. Typical insurance services provider fraud includes:

a) Withholding premiums collected by policyholders until a claim is reported
b) Insuring fictional policyholders while paying a first premium, collecting the commission and ceasing the insurance.
c) Conspiring with policyholders to commit fraud.

Typical insurance service provider fraud indicators are provided in Table II

3.2.2. Measurement

3.2.2.1. Insurers' internal auditors should assess the fraud risk of all contracted insurance service providers on an annual basis in a report to be submitted to the board of directors. In particular, this report should contain for each insurance service provider:

a) A review of the business (e.g., volume, nature of transactions, trends, etc.) of the insurance service providers.
b) An assessment of the risk level, trend, and occurrence of fraud (if any).
c) An overview of the insurance service provider's key processes which represent the highest risk of fraud.
d) A profile of staff members handling key market-facing activities, e.g., sales and claims managers.

3.2.3. Mitigation

3.2.3.1. Insurers should take the necessary fraud risk mitigation measures to select and deal with reputable insurance service providers. These measures include but are not limited to:

a) Enforcing a well-defined and documented screening procedure for the appointment of new insurance service providers. Such a procedure should require applicants to disclose all relevant information about their business and contain steps to:
    i. Evaluate the references and reputation of potential new insurance service providers.
    ii. Assess their financial situation and solvency.
b) Setting fraud management agreements with each contracted insurance service provider. Such agreements should:
    i. Require the insurance service provider to comply with the insurer's anti-fraud policies, procedures and controls.
    ii. Stress the enforcing sanctions in case of non- compliance.

3.2.3.2. To minimize the risk of fraud, insurers should:

a) Avoid paying a commission before the first premium is collected.

b) Avoid paying commissions beyond a certain percentage of premiums paid

c) Keep parts of the commission in a temporary deposit account when dealing with unknown or new insurance service providers.

d) Send policies and renewal documents directly to policyholders.

e) Request from insurance service providers not to accept cash payments of premiums.

3.2.4. Monitoring

3.2.4.1. Insurers should define appropriate indicators to flag insurance service providers with higher risk of fraud.

3.3. Policyholder Fraud

3.3.1. Detection

3.3.1.1. Policyholder fraud is committed by policyholders and/or third parties mainly at the policy setup and claims management stages of the client relationship.

Consequently, companies should design and implement procedures to combat the main types of policyholder fraud, which include but are not limited to:

a) At the policy setup stage: withholding or providing incorrect personal or background information.
b) At the claims filing stage:
   i. Submitting claims for fictitious damage or loss.
   ii. Misrepresenting facts to include the claim in the coverage.
   iii. Overstating cost of damage.

Typical policyholder fraud indicators are provided in Table III.

3.3.2. Measurement

3.3.2.1. Companies should maintain detailed records of occurrence of policyholder fraud. These records should detail at a minimum:

a) The type of fraud

b) The technique and/or technology used to commit the fraud.

c) The weaknesses in internal control procedures and deficiencies in processes

d) The fraudsters' profiles and backgrounds.

e) The amount of the fraud.

3.3.2.2. Internal auditors (or fraud function officer if existent) should prepare and submit to the board of directors on a yearly basis, comprehensive reports detailing fraud occurrence, description, trends, and an assessment of the efficiency of anti-policyholder fraud measures.

3.3.3. Mitigation

3.3.3.1. Companies should design their policies to minimize the occurrence of fraud. Based on internal auditors' yearly reports and under the supervision of the board directors, senior managers should implement new anti-fraud measures, procedures and policies and improve existing ones.

3.3.3.2. Companies should clearly define and document client filtering policies and set, for each insurance business class and product, the conditions required to accept new clients. These conditions should be subject to the board of directors' approval, and reviewed on an annual basis.

3.3.3.3. Companies should define for each insurance product clear and comprehensive claims assessment procedures, detailing in particular the steps to verify the claim's facts and validity and to check for fraud indicators (see Table III).

3.3.3.4. Companies should inform policyholders about their anti-fraud policies and the consequences of providing false or inaccurate information. Furthermore, an information section can be included in the text of the policy itself to ensure policyholders read and agree to the measures in place.

3.3.3.5. Since insurance business development and customer relationship requirements can conflict with fraud minimizing requirements, targets, customer satisfaction, and fraud detection. Consequently, operational and fraud reduction targets should be combined and approved by the board of directors on annual basis.

3.3.4. Monitoring

3.3.4.1. Companies must establish, for each business class and product, appropriate policyholder fraud indicators, trigger levels, and responses.

Table I: Typical Internal Fraud Indicators	
Business practices and conditions	
Governance and Organization Structure	• Single individual or group of individuals acting together drives operations and/or financial decisions. • Company's strategy changes suddenly. • Organizational structure is complex. • Executive directors are numerous. • Directors, managers, members of staff, external business and contractors have conflict of interest. • Commission structures are unusual.
Operational Management	• Training programs are weak. • Transaction time, place and parties are unusual. • Activities are inconsistent with the insurer's stated policy. • Management turnover is high. • Staff turnover is high in financial and/or accounting departments. • Obsoleteness or lack of procedural manuals. • Documentation for transactions, processes or expenses is limited. • Tasks and transactions are complex and require special skills.
Accounting and Finance	• Assets are restructured without justification. • Accounting procedures are weak. • Financial results and ratios are uncorrelated. • Share value changes without explanation. • Costs rise unjustifiably or are high compared to competitors. • Financial issues emerge.
Internal Controls	• Internal control structure is weak.
Internal Audit	• Information from prior audits is insufficient. • Internal audits are weak or non-existing.
Information Technology	• Data and asset security. • System is weak.
Complaints	• Number of complaints received from external parties is high.

Conduct	
Governance and Management Matters	• Board of directors emphasize unduly on meeting earing projections. • Board of directors and management take undue risks. • Board, managers, or members of staff have insufficient levels of income to meet personal debts or financial losses. • Board, managers, or members of staff appear to be living beyond their means. • Board, managers, or members of staff change lifestyles suddenly. • Boards, managers, or members of staff display marked personality changes or intense family pressure. • Board managers or members of staff have a feeling of unfair treatment. • Board mangers or members of staff display extreme greed for personal gain. • Board members and managers incur significant increase of expenses. • Board of director and/or management provide unsatisfactory answers to the supervisor's or auditor's questions • Directors and/ or management have poor reputation in the business community • Boards of directors and/or management display overly aggressive attitude toward financial reporting • Boards of directors and/ or management place undue pressure on the auditors • Board of directors and/ or management do not comply with laws and regulations • Board of directors and/ or management display dominant management style, discouraging critical or challenging views from others such as members of staff
Working Environment	• Morale is low within the insurer or within certain departments of the insurer. • Relationships at work are inappropriate or acting of individuals is unusual. • Earning ability is lower than that of other comparable insurers. • Company faces adverse legal conditions. • Managers or members of staff work late, are reluctant to take vacations and display signs of stress.
Operational Management	• Staff recruiting processes contain problem • Management fails to follow proper policies and procedures in making accounting estimates • Processing of payments is done at odd times (e.g., late in the day, after business hours, etc.) • Insiders reduce holdings of insurer's stock

Table II: Typical Insurance Service Provider Fraud Indicators	
Business practices and conditions	
Finance	• Intermediary is in financial distress.
Portfolio	• Portfolio is small but has high insured amounts. • Number of insurance policies, where the commission is higher than the first premium. • Portfolio contains an arrear of premium payments. • Portfolio displays high amount of claims fraud or a disproportionate number of high risk insured individuals, (e.g., elderly people).
Operations	• Intermediary operates outside the region of the policyholder. • Intermediary asks for an immediate or in advance payment of commission. • Intermediary asks the policyholder to make payments via the intermediary himself which is an unusual business practice. • Intermediary receives premiums and pays commissions that are above or below the industry norm for type of policy. • Intermediary has a relatively high claims ratio. • Intermediary has an exceptional increase in production without apparent reason. • Intermediary has a high level of early cancellations. • Intermediary has a high number of unsettled claims. • Intermediary insists on using certain loss adjusters and/ or contractors for repairs. • Intermediary changes control or ownership frequently.
Conduct	• Intermediary has a personal or a close relationship with the client. • Intermediary changes name and address frequently. • Intermediary has a number of complaints or regulatory inquiries.

Table III: Typical policyholder Fraud Indicators	
Business practices and conditions	
General Indicators	
Claimant's Behavior	
General Conduct	• Claimant doesn't do anything to prevent or limit the damage • Claimant provides evasive answers and does not cooperate during a reconstruction • Claimant hides details of claim to other people (e.g.., family, Friends, neighbors, etc.)' • Claimant handles business in person or by phone, while avoiding written communication • Claimant displays detailed knowledge about insurance terms and claims processes • Claimant checks the insurance coverage shortly before the claimed event • Claimant modifies address bank or telephone details shortly before a claim is made • Claimant insists on using certain contractors, engineers, or medical practitioners without a convincing reason • Claimant avoids giving information concerning denial of previous insurance when applying for a new insurance
Coverage	• Policyholder possesses several policies with the same insured object and coverage • Policyholder changes insurers frequently • Policyholder insists on changing terms and conditions • Claimant does remarkable filing of the claim (e.g., claimant seeks help of a lawyer or other professional advice in reporting the claim)
Payment	• Claimant requests that payment is made is cash • Claimant requests that payment is made into different accounts • Claimant requests that payment is made to a third party • Claimant insists that the payment exceeds the value of the damaged goods

Speed of Settlement	• Claimant insists on quick settlement of claims. • Claimant threatens to bring in a lawyer if the claim is not settled swiftly • Claimant enquires frequently about the progress of the claim

Claimant's Characteristics	
Background Information	• Claimant provides vague information regarding identity of policyholder and/ or beneficiary. • Claimant uses a post office box or hotel as an address, moves repeatedly. Gives false addresses or has non-matching telephone numbers. • Claimant refuses the disclosure of claims history with other insurer.
Personal Financial Situation	• Claimant has an usual and/ or difficult occupational situation (e.g., unemployed, self- employed, frustrated with job, facing disciplinary action, seasonal worker, or in an industry experiencing downsizing and lay-offs). • Claimant is experiencing a bad financial situation. • Claimant faces a difficult family situation (e.g., divorce). • Claimant has a relationship with known fraudsters or criminals. • Claimant has a history in bad claims. • Insurer is experiencing difficulties reaching the claimant • Claimant lives in a known fraud area.
Documents	
Forms	• Application forms are incomplete and/ or unsigned. • Claim forms are incomplete and/ or unsigned. • Claim forms are modified frequently. • Application form and the inception date of the cover are different. • Application form and claim form are inconsistent.
Receipts and Reports	• Minor losses are sufficiently documented while major ones are not • Documents/ receipts are unspecific, modified, or unreadable • Original documents/ receipts are missing: only copies are provided. • Receipts are new (e.g., not wrinkled, clean for old events or products • Receipts contain different handwritings. • Documents display odd dates (e.g., during holidays, after business

	hours etc.). • Doubtful receipts are provided, from companies that do not exist, have ceased operations, or are insolvent. • Doubtful receipts are provided, with differing dates but with successive numbering. • Foreign receipts contain unspecified currency.

Claims' Characteristics	
Submission of claim	• Claims are submitted by a third party without proper power of attorney • High claims are submitted frequently • Claims submitted display prevailing connections
Timing of Claims	• Claim is filed in one of the following cases: - Shortly after coverage becomes effective. - Just before cover ceases. - Shortly after the cover has been increased or the contract provision are changed. - Loss occurs in the period of provisional cover
Size of Claim	• Loss is actually far higher than first reported • Loss claimed is just below the threshold that causes additional checks by the insurer. • Amounts insured and the characteristics (e.g., age, profession) or life style of the policyholder are inconsistent.
Indicators specific to business Classes	
Property claims (including disaster fraud)	
General Property Losses and Claims	• Losses and the characteristics (e.g., residence, occupation, income, lifestyle, etc.) of the policyholder are inconsistent. • Claimed losses and the finding in the police report are inconsistent. • Damaged items cannot be/ are not examined by loss adjusters. • Destroyed items are in bad shape. • Large amount of cash is stolen
Fire	• Fire affects a single property or building without affecting others. • Policyholder, family and pet are absent during a fire. • Items of sentimental value (e.g., photograph albums) or family heirlooms are not lost or damaged during fire.

	• Absence of physical evidence of the place where heavy items were located (eg. indentations in the carpet from furniture). • There are multiple sources of fire. • Origin of fire is unknown. • There is no evidence of burglary in case of arson. • Building is unoccupied and without surveillance at the time of fire. • Building is disconnected from public utilities at the time of fire. • Fire is not detected by fire alarm. • Fire alarm is switched off coincidently. • Fire alarm is switched on, but blocked by objects. • Fire is detected shortly after people leave the building.
Car Theft	• Vehicle has unusual registration number. • Vehicle has been registered very recently. • Vehicle is stolen just after the end of the "new-value period" • Registration certificate is inside the vehicle or is lost before the theft. • Vehicle keys are not the original ones. • Vehicle alarm is switched on but does not work. • Stolen vehicle is recovered completely undamaged. • Stolen vehicle is recovered with valuables / documents. • Age or social position of the insured and the make and model of the vehicle are inconsistent.
Car Accidents	• Car damage and/ or injuries are exaggerated, claims are fabricated or accident is staged. • Circumstances of accident are identical as a previous claim or with the same lawyer. • Blame on the accident is accepted too easily. • Police and/ or emergency services are not contacted immediately after an accident with substantial damage. • Claim for recovery damage is not made immediately after an accident with substantial damage. • Relationship exist between the people involved (e.g., between passengers of different vehicles, between patient and doctor, etc.). • One of the individuals involved has a rental car. • Driver of the rental car accepts blame easily. • Eye witness is very cooperative. • One of the vehicles involved in the accident is old and the other is new. • Severe damage occurs without a collision (e.g., swerving). • Both people involved are foreigners from the same country. • Claim involves victims with no own damage insurance and/or one who would be at risk if found at fault. • Testimonies are very similar or strikingly different after an

	accident. • Reported injuries are remarkably similar. • Damage does not match the injuries (e.g., little physical damage but severe personal injuries). • Inconsistencies in the damage of the cars involved (e.g., one with minor damages, the other with severe damages). • Injuries are difficult to observe objectively (e.g. Headaches or whiplash). • Marks at the location of the absent or difficult to find. • Accident occurs in a deserted location.
Claimants Conduct & Employment Information	• Losses are described vaguely. • Claim is filed with delay. • Items are over-insured substantially • Claimant gives very detailed description of the property or a detailed photo report at the preliminary stages of the claim. • Lists of property in the claimant's and the loss adjuster's reports are in the same order • Items insured are new according to the claimant's. • Inconsistencies exist in the claimant's account • Claimant' does not want the claim handler to contact his employer directly. • Claimant's employment information is suspicious. • Claimant's started his employment shortly before the accident occurred.
Police Reports	• Police report is not provided when expected. • Discrepancies exist between insurance the claimed losses and the findings in the police report.
Travel	
Timing	• Loss is reported a long time after trip. • Mismatch exists between insurance term and holiday period. • Beneficiary's name and account number are inconsistent.
Life	
Policyholder Information and conduct	• Relationship between the policyholder, the insured and the payer of the premiums is unclear. • Policyholder or beneficiary owns several policies with different addresses. • Policyholder accepts unfavorable conditions. • Insured amount and standard of living of the policyholder are

	inconsistent.
Payments and beneficiaries	• Payments are requested to be made to others rather than the policyholder or the beneficiary. • Premium is paid in cash. • Premium is made in foreign currencies or from a foreign bank account. • Payment is made to unrelated third parties. • Policyholder and beneficiary have a significant age difference. • Beneficiaries of policy are frequently changed • Beneficiary's name and account number are inconsistent.
Cancellation of policy	• Request for cancellation of policy or refund of premiums are made shortly after the cooling off period. • Request for cancellation is not signed or signed by an unauthorized third party.
Time and place of death or claim	• Claim of suicide or a criminal offence is made shortly after inception of the policy. • Change of policy provisions or beneficiary is made just before death or disability. • Insured is claimed dead while aboard. • Disability claim is made just after a premium default.
Missing Death Information	• Body of deceased is missing or unidentified. • Original death certificate is unavailable. • Cause of death or disability is suspicious.
Transport	
Operations	• Weighbridge is no calibrated. • Goods are delivered after theft. • Drivers are paid per trip. • Documents are handled without sufficient supervision (e.g., in hotels, restaurants). • Goods are transported to a destination that does not have a market or proper processing facilities. • Goods are repacked to larger volume entities. • Goods destined to developing countries are over evaluated.

Inconsistencies	• Inconsistencies exist between insured volume/weight and the real weight. • Inconsistencies exist between the insured volume/weight and the type of goods. • Inconsistencies exist between the insured amount and market prices.
Related Parties	• Parties involved have a bad reputation in the business. • Endorser is different from claimant. • Intermediaries are non- cooperative.

Healthcare	
Conduct of Claimant	• Physicians are changed frequently. • Claimant has multiple disability policies. • Claimant claims a disability and is involved in active employment or in a physical sport or hobby. • Claimant develops additional injuries allegedly related to the initial injury or illness when it appears that the claim will be terminated. • Claimant's illness or injury occurs shortly before an employment problem (e.g., disciplinary action, demotion, layoff, strike, termination or downsizing). • Claimant visiting more than two medical providers of the same case.