



# Verification of Insurance Claims

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## Introduction

Reputation and customer trust are important to the insurance industry as well as to individual insurance companies as they help maintain their edge in the highly competitive insurance business. These assets could however be destroyed overnight by corruption and fraudulent practices, hurting not only the insurance companies but also the practitioners in the industry. It is therefore imperative for insurance companies and the practitioners to uphold an ethical business culture and adopt good practices in conducting business.

The handling of fraudulent claims is an area of major concern in the insurance sector because it may involve colluding staff in the insurance companies and could result in higher premium costs to the policyholders which in turn will adversely affect business.

This document aims to provide a checklist of good practices so that risks of corruption and fraudulent practices can be identified and reduced. It focuses on insurance claims assessment which is prone to abuse and corruption. Individual insurance companies may make adaptations to the recommended practices and procedures to suit their own operational needs.

## Prevention of Bribery Ordinance (Laws of Hong Kong Cap. 201)

Section 9 of the Prevention of Bribery Ordinance sanctions corruption offences in the private sector. In essence, it is an offence for an agent or employee to solicit or accept an advantage, without the permission of his principal (e.g. the company he works for or his employer), as an inducement to, or reward for, his doing or forbearing to do any act in relation to his principal's affairs. Any person who offers an advantage to an agent is also guilty of an offence.

The key components of Section 9 and other relevant Sections of the Prevention of Bribery Ordinance are detailed below for easy reference. Any person who requires an interpretation of the Prevention of Bribery Ordinance provisions should seek professional legal advice.

### ***Principal***

In the context of this document, a principal is the “employer”. The “employer” means the company itself, including authorized persons acting on its behalf.

### ***Agent***

An agent is a person acting for, or employed by, the principal. Any director or employee acting for an insurance company is an agent of the company.

### ***Advantage***

Advantage refers to anything that is of value such as money, gift, commission, employment, service or favour, etc. Entertainment, which is defined as food or drink provided for immediate consumption on the occasion, is not an advantage.

### ***Principal's Permission***

It is lawful for an agent to accept an advantage in relation to his official duties with his principal's permission. The permission must be given by the recipient's principal, and NOT the offeror's principal. In any case where an advantage has been accepted without prior permission, the agent must apply for his principal's approval as soon as possible afterwards.

### ***Deception by Using Receipts, Accounts or Other Documents***

Any agent who, with an intent to deceive his principal, uses any receipt, account or other document which contains any statement which is misleading or false or defective in any material particular and in respect of which the principal is interested, shall be guilty of an offence.

### ***Custom Constitutes No Defence***

It is not a defence to claim that an advantage accepted or offered is customary in any profession, trade, vocation or calling.

### ***Verbal Agreement Counts***

The offeror and the recipient of a bribe are liable to prosecution if a verbal agreement on a corrupt arrangement is reached, notwithstanding the act of bribery has not been carried out.

### ***Penalty***

A person convicted of an offence under Section 9 of the Prevention of Bribery Ordinance is subject to a maximum penalty of seven years' imprisonment and a fine of HK\$500,000.

## Related Laws

Apart from the Prevention of Bribery Ordinance, insurance companies should take note of other relevant ordinances and regulations; including the Insurance Companies Ordinance, the Employment Ordinance, the Personal Data (Privacy) Ordinance, and the Inland Revenue Ordinance, etc. (Please visit website <http://www.legislation.gov.hk> for details of the above ordinances.)

## Introduction

Commitment to lawful and ethical practices is the key to good governance in running a business. It is important for insurance companies to issue a Code of Conduct to staff or guidelines to their agents, stating the company's commitment to ethical and lawful practices, and setting out the proper practices and standards required of them. The Code and guidelines can help deter corruption and malpractice such as fraud, build the company's reputation, as well as enhance the trust of customers and business associates.

In appointing service contractors (e.g. loss adjustors, investigation agencies, health care management service contractors), insurance companies could require them to issue a similar Code of Conduct or guidelines to their employees and agents.

## Code of Conduct

The Code should include the following key elements (a sample code is obtainable from the Advisory Services Group (p. 25) upon request):

- a statement of commitment to ethical practices;
- rules governing acceptance of advantage and entertainment;
- requirements to avoid and declare any conflict of interest when performing official duties (e.g. when processing claims applications) and the procedures for handling such declarations;
- requirements to protect confidential and commercially sensitive information obtained through work;
- requirements to report breaches of the Code and other matters of concern to the company; and
- obligation to comply with all relevant laws and regulations.

Further elaboration of some provisions in the Code is provided below.

## Corporate Commitment

The Code should include a statement of commitment that the company:

- accepts integrity, accountability and fair competition as the company's business conduct;
- adopts a "zero tolerance" attitude against corruption and fraud;
- demands a high standard of business ethics from all staff members and expects all service contractors and business associates to conform to the standard; and
- seeks to provide an efficient and courteous customer service.

## Acceptance of Advantage

Offers of gifts in money or in kind may be bribes in disguise and acceptance may compromise one's position in conducting business. For example, the staff handling claims applications may be offered gifts by claimants in return for favours in claims settlement.

With reference to Section 9 of the Prevention of Bribery Ordinance, insurance companies should have a policy prohibiting employees from accepting advantages which include any gift, loan, commission, employment, contract, services etc., from persons with whom they have official dealings. If employees are allowed to accept token gifts, the permissible value and the circumstances under which they are offered should be specified.

## Acceptance of Entertainment

Entertainment itself is not a bribe in law, but extravagant or frequent entertainment offered to the staff by business associates may be a calculated act to "sweeten" them in order to build up a store of goodwill for future demands of favours (e.g. in appointment of service contractors or assessment of claims applications). There should be guidelines advising the staff to avoid accepting offers of entertainment that are lavish or frequent.

## Conflict of Interest

A conflict of interest arises when the private interest of the staff member competes with the interest of the company. Staff should be advised to **avoid any actual or perceived conflict of interest** and to **make a declaration** to their supervisors when such a situation arises.

### *Examples of Conflict of Interest*

It would be helpful to staff if examples of conflict of interest are provided in the Code of Conduct. The following are some examples of conflict of interest situations that may arise in the process of claims assessment:

- A claims application under consideration is submitted by a claimant who is a close friend or relative of the staff member responsible for the assessment.
- A staff member invests in the business of an investigative agency which provides service to the insurance company.
- A candidate under consideration in a recruitment exercise is a relative of the staff member responsible for recruitment.
- A staff member responsible for appointing the motor repair service contractor for the insured vehicles engages the selected motor repair shop to provide him with free repair service or a discounted fee for his own car.

## Handling of Confidential Information

Staff may have access to confidential or sensitive information such as information relating to the company's business and customers' personal data.

### *Information Systems Security*

To protect the interest of the company and to prevent abuse, the classification of information should be made known to all staff. Restriction on access to confidential information should be clearly defined. While individual staff should be held responsible for the protection of the confidential information in their possession, the management should ensure that there are adequate safeguards to protect data integrity in computer systems and sufficient physical security in the office. (More information is available in the **Best Practice Module on Information Systems Security** (p. 25).)

## Investment Restrictions

There should be clear guidelines governing investments by staff, e.g. a staff member should be prohibited from dealing directly or indirectly in the company's shares or other shares of any listed company when he is in possession of information obtained as a result of his employment by or his connection with, that company or its Group, and the information is not generally available to the shareholders of the company or the public.

## Effective Enforcement

To effectively enforce the Code of Conduct, the company should ensure that it is:

- issued with the full support of the management;
- incorporated in the company's staff handbook for issue upon appointment and ***strictly enforced***;
- promoted through ***continuous capacity building workshops*** to foster good practices;
- ***communicated to service contractors, customers and business associates*** to ensure that they are aware of the company policy and the ethical standards expected of staff; and
- ***updated*** as necessary.

## Introduction

Claims management is the core operation of an insurance business. Claims fraud may be committed by policyholders when applying for compensation and corruption arises if the fraud is condoned by compromised or colluding staff of the insurance company. Claims fraud may also involve third parties in the settlement of a claim. For example, a garage operator inflates the repair cost of a motor vehicle for a client, or a medical practitioner assists a patient in making false claims for medical services that have not been provided.

## Ways of Claims Fraud

Claims fraud may be made in the following ways:

- (i) Where there is no damage or loss: Reporting of fictitious damage or loss (e.g. loss of personal property during an insured trip).
- (ii) Where there is damage or loss:
  - *Misrepresenting the damage or loss in order to bring it under a policy's coverage (e.g. a non-works related injury claimed under a workers compensation policy);*
  - *Exaggerating the damage or loss covered by a policy (e.g. damages caused by a car accident);and*
  - *Staging the occurrence of incidents causing damage or loss covered by a policy (e.g. a staged car accident).*

The modus operandi of claims fraud uncovered in recent years is illustrated in the following examples of cases which are associated with claims under various kinds of insurance policies.

### *Personal Accident Insurance*

A personal accident policy includes a schedule of benefits payable as a result of accident. These include death compensation and monetary benefits for physical damages such as the loss of one's eyes or limbs, etc. A sample case is described as follows:

#### *The Eye Injury Case*

- The mastermind of the scam took out insurance policies with various insurance companies, using the names of persons under his control. The mastermind then recruited a number of Mainland residents who, with the corrupt assistance of medical practitioners, agreed to inflict injury to their eyes for the purpose of making false claims under the insurance policies. In return, these residents were each offered monetary rewards. They filed false claims with 16 insurance companies involving a total compensation of \$23 million.

### *Life Insurance*

A life insurance policy provides for payment of a sum of money upon the death of the insured. Apart from the death benefit, life insurance nowadays also includes different kinds of benefits such as waiver of premium or cash benefits that can be used for investment or savings. A sample case is described as follows:

#### *Bogus Death Claim*

- The fraudster took out a life insurance policy with an insurance company in the name of the insured, who was a Mainland resident, at an insured sum of \$700,000. He claimed that he was the insured's brother and the sole beneficiary of the policy.
- One month after taking out the policy, the fraudster claimed that the insured was struck dead by a thunderbolt and furnished to the insurance company a number of bogus documents to prove his claims. Investigation revealed that the alleged death did not actually take place and the insured was still alive, residing in a village in the Mainland.

### ***Motor Vehicle Insurance***

A motor vehicle insurance policy covers the policyholder against accidental loss of, or damage to, his motor vehicle, up to either its market value (i.e. what the vehicle is worth just before the damage occurs) or the agreed value (i.e. the value agreed with the insurance company when the policy is taken out). It also covers the policyholder against any damage that he may cause to someone else's car or property. A sample case is described as follows:

#### ***Staged Car Accidents***

- A syndicate, involving garage operators, mechanics, drivers etc., staged a series of traffic accidents in order to swindle nearly 30 fraudulent motor insurance claims, involving a total compensation of \$2.4 million and 11 insurance companies.
- The syndicate deliberately crashed the insured motor vehicles and falsely made accident reports to the Police in order to make insurance claims for damages sustained by the motor vehicles.

### ***Medical Insurance***

A medical insurance policy indemnifies the financial loss of the insured as a result of treatment of an injury, sickness or disease. Injury means bodily injury to the insured, and sickness or disease means a physical condition marked by a pathological deviation from the normal healthy state. A sample case is described as follows:

#### ***False Medical Certificates Scam***

- A former insurance agent recruited family members and friends as alleged patients, and conspired with a doctor and a bonesetter to issue bogus medical certificates which served to falsely represent to various insurance companies that these persons had received the treatment for bodily injuries and had paid medical expenses. The doctor and bonesetter were rewarded between \$150 and \$400 for each certificate issued. The scam involved more than 20 persons. A number of insurance companies were deceived into paying out about \$200,000 in medical benefits.

### ***Workers Compensation Insurance***

Workers compensation insurance protects employees who are injured on the job. The injured employee is paid medical expenses, lost wages and other expenses while recovering from injury.

### *Fake Claims*

Some dishonest employees may knowingly make bogus claims under the compensation insurance policies. Some scams may also involve unscrupulous medical practitioners. The following are examples of how the fake claims work:

- ***Un-related injuries:*** A dishonest worker gets injured off-duty but claims that he is hurt while working so as to claim medical expenses under the workers compensation policy.
- ***Inflated injuries:*** A dishonest worker suffers a fairly minor injury on-duty but insists that he is seriously injured and cannot go to work. As the degree of seriousness of some injuries (such as pain caused by a twisted back) may not be easily attested by doctors, the scam enables the worker to stay off the job longer and get more compensation.
- ***Faked injuries:*** Some dishonest workers claim to have suffered injuries which are hard to disprove (e.g. soft-tissue muscle injuries).
- ***Old injuries:*** A dishonest worker with an old injury (e.g. a damaged knee) claims that he has just got hurt on-duty and asks for compensation under the workers compensation policy.
- ***Inflated medical bills:*** The scams involve unscrupulous and colluding medical practitioners who have overstated the seriousness of the injuries and then the bills resulting in the insurance companies having to pay for expensive and unnecessary treatments or tests, or even for treatment that has never taken place.

## Introduction

For the sake of enhancing marketing and customer service, underwriting insurance policies is now often done in ways convenient to customers (e.g. customers need not be seen by the underwriting agent). The development of new technology (e.g. insurance policies taken out on the Internet) also makes it more difficult to verify a claim by conventional means (e.g. checking the insured person's signature). While all these developments may result in higher risk of corruption and fraud, such risk can be mitigated by adoption of adequate and effective preventive measures.

## Company Policy and Guidelines

Insurance companies should make known to all staff the **company policy** that activities of fraudulent insurance claims will not be tolerated.

To ensure consistency in practice, the claims staff should be issued with **clear guidelines** on the handling of insurance claims, covering the procedures for the receipt of applications, allocation of cases, verification of claims and supporting documents, conduct of supervisory checks, claims approval and settlement of payment.

The role and responsibility of each level of the processing staff and the authority for approving certain transactions (e.g. outsourcing of services) should be specified in the guidelines. As verification of claims could be complicated and labour intensive, insurance companies could also consider allocating sufficient resources to handle claims as vigilant verification efforts could help detect and deter fraudulent insurance claims.

## Checks and Balances

A claims verification system should have the following **checks and balances**:

- **assign randomly** new claims applications to the staff for processing;
- establish a **fire-wall** between the Agency Department and the Claims Department to prevent the staff of the former department exerting undue influence on the staff of the latter (e.g. urging the latter to expedite or approve claims applications from agents with whom they are familiar);

- **segregate** the claims processing **duties** as far as practicable;
- designate **approval authorities** at the right level to approve claims of specified financial limits;
- maintain separate **lists of approved service providers** for the provision of professional services (e.g. loss adjustors or health care managers);
- require the claims staff to **keep proper records** on the processing of claims for random supervisory checks;
- conduct risk-based **independent audit checks** on completed cases;
- issue **clear instructions** and **guidelines** for compliance by the claims staff; and
- remind the claims staff to **make a declaration of conflict of interest** regarding their relationship with the claimants whose applications are being assessed.

## Notification to Customers

To deter fraudulent claims, insurance companies should draw their customers' attention to the following when a policy is taken out or a claim is made:

- the duty for them to **make disclosures** in accordance with the policy terms when a policy is taken out, failing which they would be liable to non-payment when compensation is claimed;
- the duty for them to **report claims timely**;
- the duty for them to **assist the investigation of claims** by providing the necessary documents and information;
- the insurance company has the **right to inspect and assess** the extent of the damage prior to any repair work;
- the insurance company's **policy to report fraud claims** to the law enforcement authorities; and
- the **consequences of false claims**, e.g. liable to prosecution and/or non-payment of compensation.

## Claims Verification Procedures

To ensure the procedures for claims verification have adequate control, the insurance companies should:

### Checking Documents

- develop a **checklist** for completion by the claims handlers to ensure that all supporting documents have been submitted by the insured;
- require the claims handlers to **check the authenticity** of the documents submitted, particularly those issued by the overseas authorities or organizations, and to analyse the documents submitted with the underwriting papers to **confirm** that there is **no non-disclosure clause** when the policy was taken out.

### Checking Internal Database

- establish an **internal database** containing intelligence or information of any individuals or companies who have a history of dubious/suspicious claims; and require the claim handlers to make checks against the database to identify any potential fraud cases.

### Red Flags

- require the claims handlers to make an **assessment of the fraud risk** of the claim (the “Guidance Paper on Preventing, Detecting and Remediating Fraud in Insurance”, published by the International Association of Insurance Supervisors, provides **useful lists of the warning signs or fraud indicators (i.e. the red flags)** to assist the claims handlers in detecting potential fraud cases. The Annex lists some of these red flags).

### Peer Reviews

- require the claims handlers to **seek the advice** of their supervisors **in case of doubt**.

## Additional Control

On identifying suspicious claims, insurance companies could adopt the following additional control measures:

### Checking External Sources

- Fraudsters may target different insurance companies and submit fraudulent claims to them at the same time. The **sharing of information** about suspicious claims amongst the insurance companies therefore could effectively help the detection

of these claims. This may be achieved through **timely communication** with other insurance companies about the suspicious claims (e.g. by checking with other insurance companies to see if the claimant has taken out similar insurance policies with them).

- To facilitate sharing of information, a consensus agreement can be reached with other insurance companies so that the parties concerned can, within the limits of the privacy law, entertain requests from peer companies for checking suspicious claims.

### **Interviewing Claimants**

- **Interviews** with the claimants or witnesses **by the professional interviewers** could help obtain more information about the incidents and the particulars of the claimant (such as his health condition, financial position, employment records, and the amount of coverage in other policies taken out, etc.). Such interview records should be properly documented.

### **Investigation**

- It is advisable to obtain expert opinion on the loss or damage reported by the claimant and to engage a professional investigation agency for further investigation of suspicious cases (e.g. to confirm the incident or to check with an overseas hospital).

## **Claims Approval and Settlement**

Claims exceeding specified financial limits should be reviewed and approved by designated staff at the appropriate level.

Payment should be made to the claimant by cheque or credited to the claimant's bank account.

## **Reporting to Law Enforcement Agencies**

If fraudulent claims are identified, insurance companies should have a **policy for prompt reporting to the law enforcement agencies**. This can help deter fraudsters from committing further fraud.

## Management Monitoring

An effective management monitoring system could help deter and detect malpractice. Insurance companies may use a computer to generate **periodic management information reports**, such as reports showing the claims history of individual claimants, the claims processed or approved by individual claims handlers and the loss of business referrals from individual agents, etc. Irregularities detected should be investigated.

## Internal Audit

Cases processed by the claims staff should be subject to risk-based internal audit checks. The **internal audit function** should be performed **by an independent party** not involved in the day-to-day claims processing activities, and the audit findings reported to a management board or committee.

## Information Updating

Claims frauds could take many forms and are difficult to detect. Insurance companies should therefore **collect updated information** on fraud cases and **be alert to their trends** in the industry. The information could be used to evaluate periodically the effectiveness of the procedures and control measures to see if changes are necessary.

## Introduction

Sometimes, verification of claims may require input from experts in various fields (e.g. legal or medical practitioners, loss adjustors, motor repairers, or health care management personnel, etc.). Insurance companies which do not have the relevant expertise in-house, may have to outsource the required services to service providers.

It is important for insurance companies to have an efficient and competitive mechanism for the selection of service providers and to ensure that the confidentiality of information will not be compromised during the outsourcing process.

## Compiling Lists of Service Providers

Insurance companies should engage quality service providers with a good reputation. Compilation of approved lists of service providers enables insurance companies to deal only with reliable service providers and helps reduce the time and labour in sourcing the suitable service providers on each occasion.

In compiling the approved list, the following safeguards are recommended:

- **Criteria** for inclusion of service providers should be **pre-determined** for different types of services.
- Nominations of service providers by staff or business associates based on personal knowledge should **not be exempted from assessment** against the pre-determined criteria.
- The shortlist should be **reviewed** by a designated staff member and **approved by a more senior staff member or a panel** if resources permit.
- **Separate approved** lists of service providers should be kept for different types of services.
- The approved lists should be **properly managed and periodically updated** with a view to admitting new comers and removing inactive or under-performed service providers, taking into account the views of the claims staff.

## Inviting Quotations

The following arrangements help minimize the risk of manipulation in inviting bids from the service providers.

- The listed service providers should always be invited to bid on a ***fair share principle***, i.e. the listed should be given a fair chance to bid, such as by rotation. Any deviation should be justified and approved by a designated authority.
- ***Supervisory*** staff should conduct ***random checks*** to see if the same few service providers are repeatedly selected for bidding which is unfair to the others.
- The ***minimum number of service providers*** to be invited for quotation in respect of different values of contracts and the approval authority should be specified. Justifications for the use of single quotation should be properly documented and approved.
- All quotations should be ***protected from tampering or leakage before the closing time***. For this reason, verbal quotations should be recorded or confirmed in writing.
- A designated fax machine installed in a secluded area or a computer terminal with password control should be used for receiving quotations by fax. All written quotations should be kept securely by an assigned staff member not involved in the quotation process to enhance checks and balances.
- Quotations should only be opened ***after the deadline***.
- ***A summary of the bidders' names*** and their ***price offers*** should be made to provide for audit trail if the quotations are to be disposed of after the exercise.
- To prevent false quotations, a supervisor may randomly call the bidders invited to ***confirm the genuineness of the quotations*** received or contact the invited service providers who have failed to respond to see if they have actually been invited to bid.

## Evaluation of Quotations

To ensure fair and objective evaluation of bids, the following measures are recommended:

- Quotations should be assessed by ***an assigned staff member*** or ***a panel*** if resources permit, taking into account the value of the service contract.

- If price is not the only consideration, quotations should be assessed in accordance with **pre-determined criteria** (e.g. price, service providers' track record, service delivery efficiency and after-sale service). Justifications for departure from the assessment criteria should be endorsed by senior staff and documented.
- For high value purchases where price is not the only consideration, a **marking scheme** with weightings for the respective pre-determined criteria could be used for evaluation.

## Term Contracts

If frequent and repeated use of certain services is necessary, insurance companies may appoint, through competitive means, term service providers for a fixed period (say two years) to cater for the need. This could also save the time and resources spent on quotation exercises.

## Performance Appraisal

To ensure those service providers whose performance is sub-standard would not be corruptly tolerated, there should be a system to assess their performance, taking into account users' feedback and any complaints from clients. A disciplinary system should be in place to sanction poor performers (e.g. issue of warnings or suspension from invitation to bid).

## Other Measures

The following additional measures are recommended for the overall improvement in the engagement of service providers:

- The staff responsible for the process should always be required or reminded to **declare conflict of interest** at the start of a quotation exercise.
- **Management reports** showing the volume of business given to each service provider should be generated periodically for review to facilitate detection of irregularities (e.g. favouritism to a particular service provider).

- **Manuals** covering the policy and procedures for engagement of service providers should be compiled for issue to staff.
- The management should issue a letter to the term or major service contractors informing them of the company's policy that staff are not allowed to accept advantage except token gifts. This could help dispel any doubt of the service providers and deter offers of unauthorized commissions and rebates to the company's staff.
- The contract signed with the appointed service providers should contain **clauses on protection of confidential information** obtained during the course of business with the company and on **prohibition of offers or acceptance of advantage** by their employees.

## Introduction

Fraud against a company may be committed by a corrupt staff member on his own or in collusion with others who may or may not be the company's staff. Other than financial losses, internal fraud could pose serious risk to an insurance company's reputation. Adoption of good governance and effective internal control is therefore important in preventing fraud and unethical practices in the company.

This chapter provides a checklist of measures which could help insurance companies enhance governance and internal control in management.

## Good Governance & Ethical Practices

Insurance companies should announce their commitment to good governance and ethical practices. Good governance requires **commitment from the top management** to put ethics into practice in the company and to lead by example. If the company has an ethical culture which forms the basis upon which the staff conduct business, the company's image can be enhanced, the overall efficiency improved and the customers' trust fostered. This in turn will boost the company's competitive edge and profitability.

## Internal Control Systems

Insurance companies should identify their claims processing procedures that are vulnerable to internal fraud, and introduce appropriate measures to mitigate the risks. The following are key considerations in the setting up of internal control systems:

### *Laying Down Clear Policy and Procedures*

- Lay down in guidelines and instructions the **policies and procedures** for processing claims applications and dealing with customers, etc.
- Ensure the company's policies and preventive measures are understood by the claims staff through **regular briefing or training**.
- **Review the policies and procedures** regularly, taking into account the recent trend in the nature of fraud cases.
- Ensure customers, service providers and business associates are well aware of **the company's** policies and business culture.

### ***Defining Staff Responsibilities***

- ***Define clearly the role and responsibility*** of each level of the claims staff to enhance accountability.
- ***Specify clearly the authorities*** for approving claims and payments.
- Allow ***discretion*** to be exercised only by staff ***at the appropriate level*** and with the required experience or expertise.

### ***Segregating Duties and Functions***

- ***Segregate the key duties and functions*** as far as resources permit to enhance checks and balances.
- ***Rotate the duties*** of staff in sensitive positions (e.g. those responsible for approval of claims).

### ***Safeguarding Sensitive Information***

- Properly ***classify and physically secure sensitive and confidential information*** such as the claimant's personal particulars or medical history.
- Adopt measures to ***prevent unauthorized access*** to sensitive or confidential information stored in computer systems.
- Assign a staff member to make ***surprise checks on compliance*** with the security measures and to report to the management in case of non-compliance.

### ***Initiating Effective Supervision***

- Require supervisors at different levels to conduct ***supervisory checks*** on the claims processed to detect and deter undue delay or other irregularities.

### ***Maintaining Proper Documentation***

- Require staff to ***maintain proper and accurate records*** of the claims process to enhance accountability and to facilitate audit trail.

### ***Producing Management Information Reports***

- Require the staff responsible for processing claims to produce ***regular management information reports*** such as useful data on claims applications, the amount of claims approved, and the number of cases refused and still on-going.

### ***Establishing Channels for Complaints and Feedback***

- Establish and publicize the ***channels for complaints or feedback*** from staff and customers.
- ***Handle complaints promptly*** to show the management's determination to address the problems identified.
- ***Conduct exit interviews with departing staff*** who may provide useful information for detecting fraud and other malpractice.

### ***Reporting Suspicious Fraud***

- Establish a ***confidential reporting mechanism*** for staff to report irregularities and fraud to a designated senior staff member.
- Draw up a clear ***policy and the procedures for reporting suspicions of fraud*** to the appropriate law enforcement agencies.

### ***Organizing Capacity Building Workshops***

- Organize ***induction training and on-going capacity building workshops for staff***, covering the relevant laws, the company's anti-fraud policies and procedures with examples of fraud cases and the fraud detection methods, etc.

### ***Performing Internal Audits***

- Carry out ***risk-based internal audits*** on completed claims cases to detect and deter irregularities.
- Ensure the ***internal audit function is independent*** from the day-to-day claims processing activities and the findings are reported direct to the board of directors or a designated committee.

## **Signs of Warning**

Insurance companies should raise staff awareness of the potential risk of fraud and provide them with guidance on the identification of the risk indicators. The following are some signs of possible irregularities or fraud which may warrant management attention.

### ***Staff Behaviour at Work***

- Staff insisting on handling particular cases and resisting re-assignment of duties.
- Staff resisting to their work being reviewed by an independent party.
- Staff failing to maintain proper records as required.
- Staff habitually deviating from the laid-down procedures or a supervisor frequently exercising discretion to override controls with various excuses.
- Staff habitually providing excuses for an under-performed service provider and refrain from taking disciplinary action, even though they are reminded or instructed to do so.

### ***Staff Behaviour in Private***

- Staff having an extravagant lifestyle not commensurate with their income.
- Sudden change of lifestyle or spending habit.
- Too cosy a relationship with the service providers, e.g. taking pleasure trips in private with the employees of the service providers.
- Acceptance of frequent or lavish entertainment from the service providers, such as meals, visits to night clubs, karaoke bars, or massage parlours.
- Easily irritated by or overly defensive to simple enquiry about work or conduct.
- Signs of depression, stress or tenseness.
- Signs of financial distress or indebtedness, e.g. calls or fax messages from a debt-collection agency or frequent borrowing from colleagues.

## ADVISORY SERVICES GROUP

Apart from this Best Practice booklet, a series of Best Practice Modules on systems such as procurement, staff administration, letting and administration of contracts are available for reference. They can be obtained from the **Advisory Services Group** of the Corruption Prevention Department of ICAC which provides free, confidential, and tailor-made corruption prevention advice to private organizations on request. For further information, please contact the Group at telephone no. **2526 6363** or fax no. **2522 0505** or email address at **[asg@cpd.icac.org.hk](mailto:asg@cpd.icac.org.hk)**.

## Claims Fraud Indicators

The following are some warning signs or indicators (non-exhaustive) of possible irregularities or conditions conducive to corruption or fraud. The existence of these signs alerts insurance companies of possible fraudulent practices but does not necessarily imply that the parties deploying such measures are fraudsters. In handling claims, insurance companies should be looking out for these warning indicators, particularly when more than one occur, for the purpose of early detection of fraud and safeguarding their interests.

### *Claimants' Behaviour*

- A claimant, when making a claim, is exceptionally demanding or insistent on quick settlement.
- A claimant makes overly frequent enquiries about the progress of his claim application.
- A claimant is unwilling to co-operate during a reconstruction of the event or gives evasive answers.
- A claimant handles all enquiries verbally and avoids written communication.
- A claimant refuses to let his family members, friends or neighbours provide the necessary information in support of his claims.
- A claimant has checked the insurance coverage shortly before the incident which leads to the claim.
- A claimant has several insurance policies with the same insured coverage.
- A claimant has been denied insurance before and has not mentioned this when taking out for the insurance policy.
- A claimant frequently makes claims.
- A claimant is difficult to contact, e.g. only uses post office box address or communicates with the insurance company through a third party.

### *Documents Produced*

- A claimant is unable to provide documentary evidence for the loss claimed.
- The documents produced are unreadable flimsies.
- The original documents or receipts in support of the claim are missing and only copies are provided.

- Brand new receipts are provided in support of dated incidents or products bought a long time ago.
- The documents produced show different kinds of ink, handwriting or typewriting.
- The documents produced contain alterations or misspelled legal or medical terms.
- The receipts or invoices produced are printed on plain paper rather than paper with a letterhead.
- The dates on the documents are dubious (e.g. the date falls on a public holiday).
- The receipts provided are from companies that do not exist or have ceased operation.
- The receipts produced are in consecutive numbering with dates wide apart
- The receipts or invoices issued by different organisations are of the same paper size, e.g. A4 size.

### *Characteristics of Claimed Losses*

- The claim is filed either shortly after the policy coverage becomes effective or shortly after the coverage has been extended.
- The loss taking place overseas has not been reported at the place where it occurred.
- There are inconsistencies between the insured amounts and the characteristics (e.g. age and profession) or the life style of the insured.
- The claimed loss is just below a threshold that will trigger additional checks by the insurance company.
- A claim payment exceeds the daily income of the claimant before the accident.

### *Property Claims*

- The loss claimed misfits the claimant's characteristics, such as standard of residence, occupation, income and lifestyle.
- According to the claimant, the insured claims are new items which are over-insured.
- No police report has been made in respect of the claimed loss.
- The claimant is unable to describe the loss in detail.
- The damaged items cannot be produced for examination by the loss adjustor.

### *Claims Involving Vehicles*

- The claimant was involved in the claimed accidents before, with similar circumstances.
- There are inconsistencies in the claimant's account (e.g. who was driving and what was the final destination).
- After an accident with substantial damage, no calls were made to the police or ambulance service.
- There are substantial similarities in the reported injuries, including the medical reports or car repair shop reports.
- The actual damage does not tally with the claimed injuries (e.g. little physical damage resulting in severe personal injuries).
- The injuries claimed, such as headaches, are difficult to be objectively observed or assessed.
- There are no marks at the location of the claimed accident.
- The accident took place at a deserted location, without any witness.
- The claimant's employment records are dubious.
- There is suspicious inconsistency between the age or social position of the insured and the type of the damaged car.

### *Life Insurance Claims*

- The insured dies abroad and the cause of death is suspicious.
- A claim arises shortly after the effective date of the policy.
- The policy provisions or the beneficiary are changed just before the death.
- There is inconsistency between the insured amount and the standard of living of the insured.
- The insured amount is just below the limit that would trigger a more detailed examination of the application.
- Death certificate is not available or not certified by the local authority.
- Hasty burial or cremation of body.
- Multiple policies in force with one or more companies or increased benefits just prior to claim.
- Lapsed policy was reinstated just prior to claim.

### *Healthcare Claims*

- There are conflicting medical opinions from the medical professionals engaged for providing a second opinion.
- The medical treatment provided to the claimant is inconsistent with the reported diagnosis.
- The treatment dates appeared on public holidays or on days that medical facilities would not normally be available.
- Claims of illness the seriousness of which is difficult to access, such as psychiatric disorder.
- The claimant later claimed to have develop additional injuries allegedly to be related to the initial injury or illness when it appears the claim will be rejected.
- The medical terminology on the documents produced is misspelled or misused.
- The claimant changes the consulting physicians frequently.
- The attending physician (a general practitioner) is not in the same geographic region where the claimant resides and is not the claimant's family doctor.
- The attending physician's specialty is not related to the claimed illness.



## Corruption Prevention Department

Independent Commission Against Corruption

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