Insurance Regulatory and Development Authority of India (Insurance Fraud Monitoring Framework) Guidelines, 2024

In exercise of power enshrined under Section 34 of Insurance Act, 1938, Section 14(1) of Insurance Regulatory and Development Authority Act 1999, Regulation 12 of the Insurance Regulatory and Development Authority of India (Corporate Governance for Insurers) Regulations, 2024 read with Master Circular on Corporate Governance for Insurers, 2024, these Guidelines are issued to provide regulatory framework on measures to be taken by Insurers and Distribution Channels to address and manage risks emanating from fraud.

1. Short Title, Applicability and Commencement

1.1. These Guidelines may be called the Insurance Regulatory and Development Authority of India (Insurance Fraud Monitoring Framework) Guidelines, 2024

1.2. These guidelines shall be applicable to all insurers and distribution channels unless otherwise specified

1.3. These guidelines shall come into force from XXXXXXXXXXXXX

2. Objective

To establish a comprehensive framework to identify, assess, and mitigate fraud risks effectively across the insurance industry. This includes setting clear standards for fraud detection and prevention, ensuring robust internal controls, and promoting transparency in reporting and investigations. The guidelines aim to enhance the sector's resilience against fraud, foster a culture of integrity, protect policyholders' interests, safeguard financial stability and maintain public trust.

3. Definitions

3.1. "Insurance Fraud" shall mean an act or omission intended to gain advantage through dishonest or unlawful means for a party committing the fraud or for other related parties; including but not limited to:

- Misappropriating assets;

- Deliberately misrepresenting, concealing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the parties to contract of insurance;
- Abusing responsibility, position of trust or a fiduciary relationship.

3.2 Red Flag Indicator (RFI) means a possible warning sign, that points to a potential fraud and may require further investigation or analysis of a fact, event, statement, or claim, either alone or with other indicators.

3.3 Cyber or New Age Fraud means fraud carried out using digital or new age technologies by any person with malicious intent by exploiting vulnerabilities in systems, processes or people, resulting into insurance fraud, thereby posing significant risks to the security and integrity of data, systems, processes, financial transactions, and customer trust.

3.4 Distribution Channels means the distribution channels as defined under para 7 (8) of IRDAI (Protection of Policyholders' Interests and Allied Matters of Insurers) Regulations, 2024.

3.5 Words and expressions used and not defined in these guidelines but defined in the Insurance Act, 1938 (4 of 1938), Insurance Regulatory and Development Authority Act, 1999 (41 of 1999) shall have the meanings respectively assigned to them in those Acts, Rules, Regulations, Guidelines issued under those Acts, as the case may be.

4. Classification of Frauds

4.1. Fraud comes in many forms and can manifest in various ways. It may be a plain opportunistic act committed by a single individual, such as misrepresenting policy features, falsifying documents, submitting false claims or siphoning of money. Alternatively, it can be a sophisticated and elaborate scheme involving a large number of people, possibly including employees of the insurer / distribution channel and/or external parties. These complex operations often involve coordinated efforts to deceive and exploit the insurance system, making detection and prevention significantly more challenging. Whether simple or complex, fraud poses a serious threat to the integrity and financial stability of the insurance

industry. Understanding the varied nature of fraud is essential to effectively combat it.

4.2. Fraud may be broadly classified into the following categories:

4.2.1. **Internal Fraud:** Fraud against the insurer, policyholders, customers or beneficiaries by internal staff, including employees, senior management, or board members, either alone or in collusion with others, with an intent to defraud or deceive. It may, inter alia include misappropriating funds or assets, theft of official data, privileged abuse / unauthorized privilege access to critical assets, forgery or alteration of documents, colluding with fraudulent claimants and concealment of fraudulent activities.

4.2.2. **Distribution Channel Fraud:** Fraud against the insurer, policyholders, customers or beneficiaries by distribution channels, either alone or in collusion with others, with an intent to defraud or deceive. It may, inter alia include misrepresentation of policy features, premium siphoning and embezzlement or withholding premiums, forgery of documents and records, fabrication / falsification of information, documents and records, willful and dishonest non-disclosure/concealment of material facts, impersonation and collusion, inflation of claims and insuring or attempting to insure non-existent persons, offering insurance from fake entities through online and digital mode.

4.2.3. **Policyholder Fraud and/or Claims Fraud:** Fraud against the insurer, by a person either alone or in collusion with others, in obtaining coverage or payment during the purchase, servicing, surrender, or claim of an insurance policy, with an intent to defraud or deceive. It may, inter alia include, material misrepresentation and non-disclosure, fabricating documents and records/signature, forgery and impersonation.

4.2.4. **External Fraud:** Fraud, other than Internal fraud, distribution channels Fraud and Policyholder and/or Claims Fraud, against the insurer, by external parties' / service providers / vendors etc. It may, inter alia include creating fake reports to support fraudulent claims, premium siphoning and embezzlement, gaining unauthorized access to insurer's resources, inflating repair costs or billing for services not rendered after an insured event, performing unnecessary medical procedures to bill insurers and selling fake insurance policies or coverage.

5. Risk Governance Framework

It is imperative to establish a structured and proactive approach for managing fraud risk. Robust policies and procedures must be in place to identify potential fraud early, respond swiftly to fraudulent activities, implement effective controls, and ensure ongoing monitoring and review to minimize financial losses and reputational damage.

The Fraud Risk Governance Framework serves as an essential supporting structure by which the board ensures accountability and transparency in managing fraud risk. It enhances the insurer's ability to safeguard assets, maintain regulatory compliance, and uphold trust among policyholders and stakeholders.

It is also necessary to have in place a well-documented policy to effectively implement fraud risk management strategy in order to proactively address potential fraud, and support the organization's long-term stability and success.

5.1. The monitoring and risk management of fraud shall be owned by Chairperson and Managing Directors/Chief Executive Officers (CMD/CEOs), Risk Management Committee and Audit Committee of the Board of the insurer.

5.2. Every insurer shall have in place appropriate fraud risk governance framework to deter, prevent, detect, monitor and mitigate insurance frauds. The governance framework shall include:

5.3. **Anti-Fraud Policy**

5.3.1. Insurer shall put in place a Board approved Anti-Fraud Policy which shall include the procedures, processes and safeguards to be built in by the Insurer to deter, prevent, detect, monitor, investigate, and report fraud. Such policy shall target for zero tolerance for fraud and shall:

a) consider its business size and risk profile, unique nature, scale, complexity, overall business strategy, products, distributions channels, technology infrastructure, etc.

b) establish essential checks and controls to ensure early identification and mitigation of fraud risks

c) establish suitable mechanism including nodal point(s) / designate officer(s) for reporting incidents of fraud to Law Enforcement Agencies

(LEA), proper coordination to meet the requirements of the LEAs and follow up with the LEAs and/or court for final disposal of fraud cases.

d) establish appropriate mechanism for disciplinary action in case of fraud or non-compliance to the fraud risk governance framework
e) include adequate fraud detection measures in case online platforms are used for solicitation, servicing and claim settlement of insurance policies
f) ensure that the appropriate and adequate resources are provided to the Fraud Monitoring Unit to carry out its functions effectively.
g) ensure that people alleged/involved of fraud shall not continue in sensitive posts
h) define responsibilities, delegation of authorities for all relevant functions and levels to prevent, detect, monitor, investigate, and report fraud.
i) Consider other relevant areas as outlined in Annexure 1.

5.3.2. The insurer shall review the Anti-Fraud Policy regularly, at least annually, based on risk exposure, operational experience and emerging trends.

5.4. **Fraud Monitoring Committee**: Every insurer shall establish a Fraud Monitoring Committee (FMC) to oversee fraud deterrence, prevention, detection, monitoring, investigation, and reporting activities.

5.4.1. **Structure of Fraud Monitoring Committee:** The FMC shall be headed by a KMP and shall include senior representatives from relevant departments, such as underwriting, claims, legal or any other department as the committee may deem necessary. The FMC may establish subcommittees or task forces for its effective functioning.

5.4.2. **Functions of Fraud Monitoring Committee**: The functions of the FMC shall inter alia include:

a) Recommending appropriate measures on fraud risk management to various functions and regularly update based on experiences.
b) facilitating effective management, oversight and execution of the insurer's fraud risk management and control processes

c) ensure prompt responses to instances or suspicions of fraud relating to various departments
d) effective implementation of fraud risk governance framework across all applicable functions of the insurer, service providers, vendors and distribution channels as applicable.
e) taking appropriate actions against the fraud perpetrators (internal / distribution channels/external fraud as applicable).
f) monitoring and evaluating the insurer's fraud prevention efforts to identify areas for improvement and adaptation.
g) conduct of customer awareness programs and periodic training programs for employees and distribution channels at all levels to educate them about fraud risks and preventive measures.

5.4.3. **Reporting Requirements:** The FMC shall submit quarterly reports to the RMC on its activities, findings, and recommendations including analysis on the number of fraud cases detected, investigated, and prevented, as well as the financial impact of fraud on the insurer. FMC shall submit report of the annual review of the frauds before the Board of Directors through RMC. In case of all internal frauds, FMC shall also report to the Audit Committee, in addition to the RMC.

5.5. **Fraud Monitoring Unit:** Every insurer shall establish an independent Fraud Monitoring Unit (FMU), separate from internal audit, which will support FMC in discharging its functions and shall be responsible for implementing measures for fraud deterrence, prevention, detection, monitoring, investigation, and reporting.

The functions of the FMU, in addition to supporting FMC, shall inter alia include:

a) effective implementation of measures suggested by FMC
b) monitoring insurance claims, policy applications, and other transactions, as appropriate, for RFIs or signs of fraudulent activity and investigation of RFIs.

c) investigations, evidence gathering, and collaboration with relevant departments for investigation. Conflicts of interest shall be identified and avoided throughout the investigation process.
d) timely reporting of identified fraud cases to FMC as per the established procedure of the insurer
e) maintaining transactional-wise details of each and every fraud including action taken
f) collaborating with industry peers / bodies, law enforcement agencies and regulatory bodies to pursue cases of fraud and share information / intelligence on known fraud schemes and perpetrators.

5.6. **Risk Identification and Measurement:** Insurers shall put in place appropriate measures to identify and assess fraud risks. It shall inter alia include:

5.6.1. **Annual Comprehensive Risk Assessment:** Insurers shall conduct and submit to Board, an Annual Comprehensive Risk Assessment to identify potential vulnerabilities across business lines and activities for fraud, using past experiences, emerging trends & Red Flag Indicators (RFIs), etc.

5.6.2. **Red Flag Indicators for fraud detection:** Based on the lines of business, activities, past experience, trends etc, Insurers shall identify Red Flag Indicators (RFIs), as applicable, for detection of frauds and incorporate them appropriately in their operations. Such RFIs shall be reviewed regularly for their continued relevance and effectiveness in detecting fraud. For examples of RFIs, please refer to https://www.iaisweb.org/uploads/2022/01/Application_paper_on_fraud_in_insurance.pdf.pdf

5.7. **Risk Control and mitigation:** In order to ensure the fraud risks identified as part of the Annual Comprehensive Risk Assessment are mitigated, Insurers shall have in place appropriate measures to deter, prevent, monitor, investigate, and report fraud with respect to the following:

5.7.1. **Internal Fraud:** To mitigate internal fraud, insurers shall implement measures such as prudent HR practices (background checks and reference verification during recruitment, job rotation policies), regular

training to employees on fraud awareness, secure and confidential whistle-blower mechanism for reporting frauds, segregation of duties, maker checker process and strict access controls with respect to critical transactions and sensitive systems, etc.

5.7.2. **Distribution Channel Fraud:** To mitigate Distribution Channel fraud, every insurer shall adopt measures such as fit and proper standards for distribution channels including background checks for any adverse records, adherence to insurer's fraud management controls as applicable, documented procedures for change in policyholder's personal information, robust system for tracking and analyzing customer complaints against distribution channels, scrutiny of distribution channels in case of high policy turnover rates or unusual patterns of policy cancellations and reissuances, regular reconciliation between intermediary records with insurer database, etc.

5.7.3. **Policyholders or Claims Fraud:** To mitigate policyholder or claims fraud, insurers shall implement measures such as robust client acceptance policy, embedding safeguards throughout the product life cycle, educating policyholders and the general public about the consequences of insurance fraud, robust underwriting processes to assess the risk profile of policyholders accurately, appropriate controls throughout the claims management process to detect and prevent fraudulent claims, deploying advanced technologies to identify patterns and anomalies indicative of fraudulent behaviour, etc.

5.7.4. **External Fraud**: To mitigate external fraud insurers shall implement, among others, measures such as periodic due diligence on vendors' / service providers, regular audit and review of the performance of vendors / service providers in implementing contractual clauses and service level agreements, etc.

6. Risk Monitoring and Review

6.1. Every insurer shall establish and maintain an "Incident Database" of relevant parties who have been convicted of fraud or have attempted to defraud the insurer or policyholder.

6.2. An insurer shall:

a) monitor the performance and trend of business brought in by distribution channels.

b) carry out periodic fraud-sensitive audits to ensure compliance with its policies and procedures regarding insurance fraud risk.

c) continuously monitor vendor activities to ensure compliance with fraud prevention measures and contractual obligations.

d) monitor customer grievances, complaints, etc. to detect and prevent frauds.

7. Cyber or New Age Fraud

7.1. Cyber fraud can have far-reaching consequences, including identity impersonation, financial frauds, reputational damage etc. Personal information such as KYC details, financial details, and medical records are highly coveted by cybercriminals, who exploit vulnerabilities in security defences to gain unauthorized access to these sensitive data available with insurers or distribution channels. In order to prevent such frauds, Insurer shall:

7.1.1. establish robust cybersecurity framework and implement appropriate controls to strengthen their defences against evolving cyber frauds or threats.

7.1.2. ensure that the systems or processes used for fraud risk identification, detection, prevention, mitigation, monitoring such as Incident Database, measures to verify customer information before accepting proposal to prevent identity frauds, risk posed by different distribution channels, enhanced verification mechanisms for certain areas with high incidence of frauds, access rights to employees or vendors as per principle of least privilege etc. are continuously monitored and strengthened.

7.1.3. deploy specialised and competent team with relevant risk or technological expertise for managing cyber fraud risks emanating from various lines of insurance business.

8. Insurance Information Bureau (IIB)

8.1. Data analytics plays a crucial role today in enabling organisations to detect, predict, and mitigate frauds. By leveraging advanced techniques organisations can stay ahead of fraud risks and protect their assets.

8.2. In order to ensure that the data available with insurers is effectively utilized to prevent frauds in insurance sector, an appropriate Fraud Monitoring Technological Framework cutting across all line of insurance business at IIB shall be utilized. As insurers are both data providers to IIB and beneficiaries of the aforementioned framework, all insurers shall participate in IIB's fraud monitoring mechanism to help the industry combat fraud and protect policyholders and all stakeholders.

8.3. The common platform at IIB containing the industry-wide database on suspected and reported fraudulent activities within the insurance industry shall facilitate timely threat intelligence sharing across insurance sector. For the platform to be effective, suitable mechanism for identifying policyholders irrespective of insurer, such as a unique identifier, shall be adopted.

8.4. IIB shall maintain a caution repository concerning blacklisted agents, distribution channels, hospitals, TPAs, etc. in order to safeguard the integrity of the insurance market by preventing the involvement of those with a record of fraudulent activities.

9. Framework for Reinsurance

9.1. Reinsurers can reduce their exposure to fraudulent claims from ceding insurers and reinsurance intermediaries by understanding the fraud risk management systems the counterparties have in place. Accordingly, these guidelines apply mutatis mutandis in case of Reinsurers.

9.2. The Insurers shall accord special attention to reinsurance transactions in fraud monitoring activities.

9.2.1. Insurer shall put in place systems and processes to verify the authenticity of all reinsurance transactions, especially those involving multiple intermediaries or cross-border placements. Insurer shall take extra care with transactions involving intermediaries that are not part of their regular list or when the cover is obtained from reinsurers whose credit rating is below the benchmark or does not meet the acceptance limits specified in their reinsurance policy.

9.2.2. Insurer shall mandatorily seek direct confirmation from the reinsurer immediately after placement or premium remittance, verifying the acceptance of terms and risks as outlined in the slip received from any intermediary. Where placement is through a distribution channel, insurer

shall also obtain direct confirmation from the reinsurer on receipt of the premium.

9.3. Robust controls, verification processes, and periodic audits shall be conducted to mitigate risks associated with reinsurance fraud.

10. Framework for Distribution Channels

Distribution channels are integral to the insurance business, serving as key facilitators between insurers and policyholders. They handle a range of responsibilities, from distributing and servicing of insurance products to managing client relationships, making them a significant stakeholder in fraud risk management. To ensure a comprehensive approach to fraud prevention, it is essential that distribution channels also establish an appropriate fraud risk monitoring framework commensurate with their business size and risk profile.

10.1 Intermediary and Insurance Intermediary (except for individuals)

10.1.1 As a part of corporate governance, Intermediaries and Insurance Intermediaries shall recognise and understand fraud risk to their organization, including potential types and impact of frauds and take steps to minimize their vulnerability to Frauds.

10.1.2 Intermediaries and Insurance Intermediaries shall put in place internal policies, procedures and controls to deter, prevent, detect, report and remedy frauds. Types of frauds mentioned under para 4 and red flag indicators shall be taken into account, as applicable, while forming such policies. Internal policies shall at the minimum cover:

- Education, awareness and training to employees
- Internal reporting structure for frauds
- Procedure for reporting Frauds to Law Enforcement Agencies (LEAs), proper coordination to meet the requirements of the LEAs and follow up with LEAs and/or court for final disposal of fraud cases
- Due diligence procedures for appointing employees / sales persons
- Whistle Blower Policy
- Internal procedures to detect, prevent and mitigate frauds

- Investigation

10.1.3 Whenever there is a suspicion of Fraud which may also impact the Insurer, the same shall be brought to the notice of Insurer.

10.1.4 Responsibility for ensuring that Intermediaries and insurance intermediaries have adequate fraud risk management ultimately lies with the Board and Senior Management of the intermediary.

10.2 **Distribution Channels other than Intermediary and Insurance Intermediary:**

10.2.1 Distribution Channels (other than Intermediary and Insurance Intermediary) shall comply with the insurer's anti-fraud policies, procedures and controls.

10.2.2 Whenever there is a suspicion of Fraud which may also impact the Insurer, the same shall be brought to the notice of Insurer.

11 Training, Education and Awareness

Training, education, and awareness are vital for strengthening fraud prevention efforts.

11.1 Insurers shall conduct regular fraud awareness programs to educate policyholders and the general public about the risk of fraud and offer advice on how to prevent and protect against it.

11.2 Insurers shall conduct regular training programs for employees including board members and senior management, intermediaries, and agents on fraud risk management. The type of training shall correspond with the business process in which the person is engaged.

12 Reporting

12.1 Insurers shall report incidents of fraud to Law Enforcement Agencies and/or other relevant agencies subject to applicable laws

12.2 Insurers shall file annual returns with Authority in forms FMR-1 placed in Annexure III within 30 days of close of the financial year.

12.3 In the event of fraud committed by distribution channels registered by IRDAI, the insurer shall promptly escalate and report the matter to IRDAI without delay.

Annexures

Annexure-I - Anti-Fraud Policy

1. Introduction
   a. Anti-Fraud Mission Statement

   A mission statement will indicate the insurer's level of tolerance to fraud and provide direction to the anti-fraud plan.

   b. Anti-Fraud Goals

   Anti-fraud goals can indicate the insurer's quantitative risk tolerance limits on fraud and its priorities (Deterrence, Loss minimization, Objective claims handling, etc)

2. Definitions
   This shall include:
   a. 'fraudulent insurance act / suspected insurance fraud / attempted insurance fraud', classification of fraud and other relevant terms as defined in these guidelines
   b. other definitions of key terms used in the insurer's Anti-Fraud Plan

3. Prevention, Detection and Investigation of Insurance Fraud
   This shall include:
   a. a description of the insurer's fraud prevention, detection, and investigation procedures for each category of fraud (Internal Fraud, Intermediary Fraud, Policyholder / Claims Fraud and External Fraud)
   b. a detailed list with brief explanations of the red flags / fraud indicators for each line of business that the insurer uses to detect instances or suspicion of fraud
   c. A description of the insurer's fraud investigation process, including evidence collection, documentation methods for suspected frauds, internal timelines from fraud detection to investigation and report submission
   d. a description of the procedures for hiring / contracting external fraud investigators including required qualification, experience, etc
   e. a description of the insurer's procedures for reporting insurance fraud to appropriate law enforcement agencies including the official(s) responsible to report fraud and timelines for reporting, following up, etc.
   f. a description of the insurer's due diligence procedures while appointing / on boarding / hiring personnel (management and staff)/ insurance agent/ intermediary/ third party service provider
   g. a description of the insurer's fraud detection methodology, technology and systems including automated red flags, predictive modelling etc
   h. a description of audit or review process to identify "missed" insurance fraud detection opportunities
   i. a description of the insurer's whistle blower protection policy

4. Education and Awareness
   This shall include:

a. A description of the insurer's external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.
b. A description of the insurer's internal awareness/antifraud education and training initiatives of any personnel involved in antifraud related efforts including employees and distribution channels. The description shall include topics covered, method of training and exam / quiz, frequency and minimum number of training hours provided, etc.

5. Primary Contact

Contact information of the official(s) responsible for oversight and implementation of the Insurer's anti-fraud plan

Annexure II

Fraud Monitoring Reports

FMR – 1

Fraud Monitoring Report

Name of the Insurer:

Part I

Frauds Outstanding- Business segment wise :

Sl. No.	Category of Fraud (LoB wise)	Unresolved Cases at the beginning of the year		New cases detected during the year		Cases closed during the year		Unresolved Cases at the end of the year	
		No.	Amount involved (` lakh)	No.	Amount involved (` lakh)	No.	Amount involved (` lakh)	No.	Amount involved (` lakh)
	Internal Fraud								
	Distribution Channel Fraud								
	Policyholder and/or Claims Fraud								
	External Fraud								
	Total								

**Irrespective of the category of fraud, details of Cyber / New Age Fraud shall be reported separately containing brief description / details like nature of data used to carry out fraud, modus operandi, financial impact etc.*

Part II – Age-wise analysis of unresolved cases

Sl. No.	Unresolved Cases at the end of the year (age-wise)	No.	Amount involved (` lakh)
1	30-60 days		
2	60 – 180 days		
3	180 – 360 days		
4	More than 360 days		
	Total		

Part III

Cases Reported to Law Enforcement Agencies

Sl. No.	Description	Unresolved Cases at the beginning of the year		New cases reported during the year		Cases closed during the year		Unresolved cases at the end of the year	
		No.	` lakh	No.	` lakh	No.	` lakh	No.	` lakh
	Cases reported to Police								
	Cases reported to CBI								
	Cases reported to Other agencies (specify)								
	Total								

* Business segments shall be as indicated under IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations 2024

CERTIFICATION

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date: Signed/-
Place: Name of the Chief Executive Officer of the Insurer

 # Closure of Fraud Cases:

For reporting purposes, only in the following instances of fraud cases can be considered as closed:

1. The fraud cases pending with CBI/Police/Court are finally disposed of.
2. The examination of staff accountability has been completed
3. The amount of fraud has been recovered or written off.
4. The insurer has reviewed the systems and procedures, identified the causative factors and plugged the lacunae and the fact of which has been taken note of by the appropriate authority of the insurer (Board / Audit Committee of the Board)
5. Insurers are allowed, for limited statistical / reporting purposes, to close those fraud cases, where:

    a. The investigation is on or challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police, or
    b. The trial in the courts, after filing of charge sheet / challan by CBI / Police, has not started, or is in progress.

Insurers shall also pursue vigorously with CBI for final disposal of pending fraud cases especially where the insurers have completed the staff side action. Similarly, insurers may vigorously follow up with the police authorities and/or court for final disposal of fraud cases and / or court for final disposal of fraud cases.