Media Release
Association for Savings and Investment South Africa (ASISA)
9 December 2019

Life insurers report fewer cases of non-disclosure, but rampant fraud proves a challenge for funeral insurance

South African life insurers detected 3 708 fraudulent and dishonest claims to the value of R1.06 billion in 2018.

The 2018 fraudulent and dishonest claims statistics, released this week by the Association for Savings and Investment South Africa (ASISA), show that the total number of irregular claims was lower in 2018 than in 2017, but the claims value remained almost the same. In 2017, life insurers detected 5 026 fraudulent and dishonest claims worth R1.13 billion.

Donovan Herman, convenor of the ASISA Claims Standing Committee, says life insurers owe it to honest policyholders to protect the integrity of the long-term insurance model by preventing fraud and dishonesty. "If we allow fraudulent and dishonest claims, honest policyholders will ultimately end up footing the bill through higher premiums driven by untenable claims rates."

He says while life insurers are frequently accused by the public of trying to avoid paying claims, the numbers tell a different story. In 2018, life insurers paid 99.3% of claims made against fully underwritten individual life policies alone, to a value of R15.1 billion.

Herman notes that there has been a significant decrease in misrepresentation and non-disclosure across all long-term insurance categories from 2017 to 2018. "This indicates to us that policyholders are becoming more aware of the potentially devastating financial consequences of not honestly disclosing important information that could materially affect the terms of the policy."

Misrepresentation occurs when a policyholder deliberately provides misleading information to a life insurer, while material non-disclosure refers to the failure of policyholders to disclose important information about a medical condition or lifestyle.

According to Herman, most of the fraudulent activity in 2018 took place in the funeral insurance space. Reports from the forensic departments of life insurers show that the buying and renting of dead bodies for the purpose of obtaining fraudulent death certificates is a popular modus operandi.

Below follows a summary of irregular claims detected for different types of long-term insurance cover.

Funeral claims

Life insurers rejected 1 915 funeral claims worth R176.4 million in 2018, of which 1 127 were found to involve fraudulent documentation. Another 156 fraudulent claims showed

syndicate involvement and in seven cases beneficiaries were found to have caused the death of the policyholder.

Herman says funeral policies do not require blood tests and medical examinations and are designed to pay out quickly and without hassle when an insured family member dies.

"Unfortunately, this makes it tempting for criminals and dishonest individuals to take out funeral cover for people who do not exist with the intention of later submitting claims using death certificates issued for dead bodies rented or bought for the purpose of committing fraud."

	2018		2017	
	Cases	**Value**	**Cases**	**Value**
Funeral Claims	**1 915**	**R176.4 million**	**1 025**	**R34.9 million**
Misrepresentation/Material Non-Disclosure	625	R25 million	755	R23.7 million
Fraudulent Documentation	1 127	R147.5 million	232	R5 million
Syndicate Involvement	156	R3.5 million	28	R0.5 million
Beneficiary Involvement in death	7	R0.4 million	10	R5.7 million
Adviser/Broker Involvement	0	0	0	0

Death claims

In 2018, long-term insurers declined 698 irregular death claims worth R417.3 million. Fraud was detected in 481 cases, while seven cases involved syndicate fraud and another 15 dishonesty by financial advisers. A further 195 claims were declined due to misrepresentation and/or material non-disclosure.

Herman says the significant drop in cases involving misrepresentation and non-disclosure from 316 in 2017 to 195 in 2018 is good news.

Policy applicants are compelled by law to honestly disclose all information likely to influence the judgment of the insurer when determining appropriate policy terms and premiums. Information generally regarded as material includes medical history, state of health, family history, and lifestyle. Herman explains that only when all the facts are disclosed honestly by the applicant is the insurer able to set premiums that are appropriate for a certain level of risk, thereby ensuring that every person pays a fair premium without subsidising someone less healthy.

	2018		2017	
	Cases	**Value**	**Cases**	**Value**
Death Claims	**698**	**R417.3 million**	**2 111**	**R564.2 million**
Misrepresentation/Material Non-Disclosure	195	R237.8 million	316	R253.3 million
Fraudulent Documentation	481	R171.7 million	1 784	R307.8 million
Syndicate Involvement	7	R3.6 million	7	R0.8 million
Beneficiary Involvement in death	0	0	1	R2 million
Adviser/Broker Involvement	15	R4.2 million	3	R0.2 million

Disability claims

Misrepresentation and material non-disclosure by policyholders was by far the biggest reason for disability claims being declined in 2018. Out of the 530 claims not paid, 463 were rejected due to misrepresentation or material non-disclosure. In 2017, however, some 775 claims worth R516.5 million were rejected.

Herman says some policyholders do not disclose existing health conditions with the aim of securing lower premiums. "This is very short sighted since the life insurer is likely to uncover deliberate attempts to hide material information, which will lead to claims being declined."

	2018		2017	
	Cases	**Value**	**Cases**	**Value**
Disability Claims	**530**	**R463.9 million**	**775**	**R516.5 million**
Misrepresentation/Material Non-Disclosure	463	R433.5 million	757	R486.8 million
Fraudulent Documentation	16	R30.4 million	17	R29.5 million
Syndicate Involvement	0	0	1	R0.27 million
Adviser/Broker Involvement	0	0	0	0

Hospital cash plans

Fraudulent and dishonest claims against hospital cash plans continued to show a decline in 2018. A total of 519 claims worth R3.2 million was declined compared to 2017 when 989 claims worth R6.1 million were rejected.

Herman says hospital cash plans are easy to understand products designed to help consumers cope with unexpected expenses as a result of being admitted to hospital. He adds that unfortunately, as is the case with funeral insurance products, the simplicity of these products often leaves them wide open to abuse.

This forces life insurers to implement tough measures to ensure the financial viability of these products, says Herman.

	2018		2017	
	Cases	**Value**	**Cases**	**Value**
Hospital Cash Plan Claims	**519**	**R3.2 million**	**989**	**R6.1 million**
Misrepresentation/Material Non-Disclosure	517	R3.1 million	971	R5.8 million
Fraudulent Documentation	0	0	8	R0.1 million
Syndicate Involvement	2	R0.1 million	10	R0.2 million
Adviser/Broker Involvement	0	0	0	0

Retrenchment benefit claims

Dishonest and fraudulent retrenchment claims decreased from 126 in 2017 to 46 in 2018. Life insurers declined 39 claims due to misrepresentation and non-disclosure and 7 due to fraud.

	2018		2017	
	Cases	**Value**	**Cases**	**Value**
Retrenchment Claims	**46**	**R1.4 million**	**126**	**3.6 million**
Misrepresentation/Material Non-Disclosure	39	R1.2 million	113	2.7 million
Fraudulent Documentation	7	R0.2 million	13	R0.9 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Most dishonest provinces

Herman reports that 35% of all fraudulent and dishonest claims were detected in KwaZulu-Natal, followed by the Eastern Cape with 18% and Gauteng with 17%. The Western Cape was responsible for 9% of claims declined due to fraud and dishonesty. All the other provinces were responsible for 5% or less.

Ends

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The Association for Savings and Investment South Africa (ASISA)

ASISA represents the majority of South Africa's asset managers, collective investment scheme management companies, linked investment service providers, multi-managers, and life insurance companies.