Media Release
Association for Savings and Investment South Africa (ASISA)
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Life insurers report significant increases in funeral insurance fraud for 2020

South African life insurers reported a 12% increase in fraudulent and dishonest claims across all lines of risk business in 2020 when compared to 2019. The 2020 fraudulent and dishonest claims statistics, released this week by the Association for Savings and Investment South Africa (ASISA), show that last year 3 186 cases of fraudulent and dishonest claims to a value of R587.3 million were recorded, compared to 2 837 fraudulent and dishonest claims in 2019 valued at R537.1 million.

The highest incidence of fraud and dishonesty last year took place in the funeral insurance space, where a total of 2 282 claims were found to be fraudulent or dishonest.

Commenting on the statistics, Megan Govender, convenor of the ASISA Forensics Standing Committee, says the increase in fraudulent and dishonest claims is not surprising since tough economic conditions make it more tempting for dishonest policyholders and syndicates to try their luck in the hope of scoring sizeable insurance pay-outs.

Govender says while funeral insurance has always been seen as a soft target for fraudsters, the Covid-19 pandemic has made it worse. He says desperation due to job losses is driving more people to resort to crime while the pandemic has also resulted in a significant increase in deaths, which makes it easier to source dead bodies from flooded mortuaries for fraudulent claims.

"Since funeral insurance 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, criminals and dishonest individuals most commonly try their luck in this space."

Examples of fraud involving funeral policies

Govender says there have been several shocking incidents in recent months that illustrate just how far some people will go to access a funeral policy pay-out illegally.

- **The "hit and run" crime**

Funeral policies impose a waiting of period of between 6 and 12 months on deaths due to natural causes to prevent people from only taking out a policy once they are sick and know that they are probably going to die.

Govender says he has come across cases where families were so desperate for pay-outs from funeral policies that they orchestrated unnatural deaths after their family members had died from natural causes within the waiting period. One family collected the body from the mortuary before the death was registered. The body was then purposefully placed in the road where it could be hit by a car. The family reported a hit and run accident and submitted a claim.

- **Buying dead bodies**

Govender says fraud in the funeral insurance space often involves mortuary employees who sell dead bodies to syndicates who then use these bodies to claim against policies that were fraudulently taken out some months earlier.

"If funeral cover is taken out on someone who does not exist by submitting fraudulent documentation, the criminal will have to commit a further crime by either buying a dead body or murdering someone to enable them to claim. Buying an unclaimed dead body is usually the easier option."

- **Exploiting addicts from poor communities**

Govender says the life industry has picked up on a syndicate that targets drug addicts and alcoholics from impoverished communities and under the pretext of a job offer obtains their personal details, including banking details. These details are then used to submit fraudulent funeral policy applications.

Govender says in one case the syndicate then tried to murder the victim. The victim managed to escape, and the syndicate then moved to plan B of buying a dead body and submitting a claim. The claim was marked suspicious by the life company's claims department and submitted to the forensic department for further investigation. Investigators found that the person whose life was insured was in fact still alive. Govender says the same syndicate has also been responsible for other fraud cases and suspicious deaths.

Protecting honest policyholders

Govender says while fraudulent and dishonest claims seem like a drop in the ocean when compared to honest claims paid, life insurers must vigorously counter fraudulent and dishonest claims to prevent them from leading to untenable claims rates that would ultimately result in higher premiums for honest policyholders. He points out that while life insurers are frequently accused of trying to avoid paying claims, the numbers tell a different story.

Policyholders and beneficiaries received claims and benefit payments worth R522.7 billion from South African life insurers in 2020. The life industry recorded 434 216 legitimate death claims in 2020, of which more than half were for funeral policies (266 321). Last year 2 282 claims against funeral policies were found to be fraudulent or dishonest.

Govender warns those contemplating a dishonest or fraudulent claim that life insurers have put in place extremely sophisticated fraud detection mechanisms using artificial intelligence and data. "The chances of being caught are extremely high and the consequence is likely to be a lengthy prison sentence," says Govender.

Funeral claims

Life insurers detected fraud, dishonesty, or criminal intent in 2 282 funeral claims worth R80.8 million last year. Govender points out that there was a significant increase in fraud last year, with the value of fraudulent claims up by R16.6 million.

	2020		2019	
	Cases	**Value**	**Cases**	**Value**
Funeral Claims	**2 282**	**R80.8 million**	**1 783**	**R54.2 million**
Misrepresentation/ Material Non-Disclosure	863	R34.1 million	666	R25.6 million
Fraudulent Documentation	1 383	R44.4 million	1 095	R27.8 million
Syndicate Involvement	28	R2 million	20	R0.8 million
Beneficiary Involvement in death	8	R0.4 million	1	R0.02 million
Adviser/Broker Involvement	0	0	1	R0.02 million

Death claims

Govender says considering the 27% increase in death claims last year because of the Covid-19 pandemic, it is not surprising that there was an increase in misrepresentation and material non-disclosure cases from 276 to 340. Misrepresentation and non-disclosure refer to policyholders not disclosing or misrepresenting material information to a life insurer about a medical or lifestyle condition to secure lower premiums or to obtain cover without exclusions.

Govender says misrepresenting material information or not disclosing important information such as any lifestyle or health related detail that could materially affect the terms of the policy, is incredibly short-sighted. "When claims are declined as a result, this is likely to have devastating financial consequences for those financially dependent on a policyholder."

Govender points out that 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. "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."

	2020		2019	
	Cases	**Value**	**Cases**	**Value**
Death Claims	**388**	**R264.3 million**	**346**	**R271.4 million**
Misrepresentation/ Material Non-Disclosure	340	R166.9 million	276	R175.5 million
Fraudulent Documentation	41	R95.1 million	62	R93.3 million
Syndicate Involvement	7	R2.2 million	7	R0.1 million
Beneficiary Involvement in death	0	0	1	R2.5 million
Adviser/Broker Involvement	0	0	0	0

Disability claims

Misrepresentation and material non-disclosure with the aim of misleading insurers was once again the number one reason for disability claims being declined in 2020. Out of the 325 irregular claims detected, 306 were rejected due to misrepresentation or material non-disclosure.

Govender notes that there has been a significant drop in cases involving misrepresentation and non-disclosure, which is good news. He comments that over the past four years misrepresentation and non-disclosure for disability claims had more than halved from 757 in 2017 to 306 in 2020.

	2020		2019	
	Cases	**Value**	**Cases**	**Value**
Disability Claims	**325**	**R233.6 million**	**447**	**R208.7 million**
Misrepresentation/ Material Non-Disclosure	306	R220.4 million	437	R219.6 million
Fraudulent Documentation	19	R13.2 million	10	R10.2 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Hospital cash plans

Dishonest claims against hospital cash plans continued their downward trend in 2020, but there was a significant increase last year in the value of these claims.

Govender 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 forced life insurers to apply heightened vigilance when processing claims to ensure the financial viability of these products.

	2020		2019	
	Cases	**Value**	**Cases**	**Value**
Hospital Cash Plan Claims	**141**	**R6.7 million**	**192**	**R1.3 million**
Misrepresentation/ Material Non-Disclosure	127	R6 million	191	R1.3 million
Fraudulent Documentation	9	R0.6 million	0	0
Syndicate Involvement	5	R87 931	1	R0.02 million
Adviser/Broker Involvement	0	0	0	0

Retrenchment benefit claims

Govender says considering the high number of retrenchments last year, the drop in dishonest and fraudulent retrenchment claims was surprising. Life insurers declined only 31 claims due to misrepresentation and non-disclosure and 19 due to fraudulent documentation.

	2020		2019	
	Cases	**Value**	**Cases**	**Value**
Retrenchment Claims	**50**	**R1.9 million**	**69**	**R1.5 million**
Misrepresentation/ Material Non-Disclosure	31	R0.8 million	61	R1.2 million
Fraudulent Documentation	19	R1.1 million	8	R0.3 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Fraudulent and dishonest claims across the provinces

Govender reports that 31% of all fraudulent and dishonest claims was detected in KwaZulu-Natal, followed by the Eastern Cape with 16% and Gauteng with 15%.

PROVINCE	SUB-TOTAL	PERCENTAGE
KZN	975	31%
Eastern Cape	522	16%
Gauteng	482	15%
Northern Cape	316	10%
Western Cape	211	7%
North West	200	6%
Free State	159	5%
Limpopo	89	3%
Mpumalanga	73	2%
Unallocated	159	5%
TOTAL	**3 186**	**100%**

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.