Media Release
Association for Savings and Investment South Africa (ASISA)
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Life insurers report a strong increase in dishonest claims

Life insurance companies uncovered 5 466 fraudulent and dishonest insurance claims in 2012 to a value of R669.9 million. This marks an increase in cases of 157 from 2011, when the value of fraudulent and dishonest claims detected was R599.7 million.

Claims fraud statistics released by the Association for Savings and Investment South Africa (ASISA) this week show that the majority of irregular claims detected involved dishonesty through misrepresentation and material non-disclosure rather than the criminal intent of fraud.

Dishonest claims

Peter Dempsey, deputy CEO of ASISA, says the number of death, funeral, disability, health and hospital as well as retrenchment claims deemed dishonest as a result of either misrepresentation or material non-disclosure by policyholders increased to 4 939 in 2012 from 4 675 in 2011. The value of these claims went up from R463.5 million in 2011 to R620.1 million in 2012.

Misrepresentation occurs when a policyholder deliberately provides misleading information to a life insurer.

Dempsey says a number of life insurers reported cases where policyholders added children that were not their own to a funeral policy to take advantage of the free benefit for children. This is considered misrepresentation. “Since this is a growing trend life insurers are increasingly asking policyholders to submit proof that they are either the biological parents or legal guardians of children listed on their funeral policies.”

Material non-disclosure refers to the failure of policyholders to disclose important information about a medical or lifestyle condition.

Dempsey explains that policyholders are legally obliged 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 by a life insurer includes medical history, state of health, family medical history, life style and financial status.

Dempsey says unfortunately dishonesty tends to increase in times of financial hardship. “There will be policyholders who will try to keep their premiums to a minimum by not disclosing all risks and get as much as possible from their cover without having to pay for it. This is, however, not in their long-term interest. It is much better to be completely honest and pay the appropriate premium than to run the risk of having a claim declined when you die or become disabled.”

He points out that the statistics for fraudulent and dishonest insurance claims show that the majority of dishonest and fraudulent claims are detected.

“Dishonest policyholders risk losing their cover and fraudsters may end up doing jail time.”

Fraudulent documentation and syndicates

Dempsey says life insurers have seen a drastic decline in the submission of fraudulent documentation across all insurance categories.

Last year a total of 264 claims involving fraudulent documentation were submitted to a value of R31.4 million. In 2011 the total number was 455 to a value of R125.1 million.

In 2012 life insurers dealt with 243 death and funeral claims worth benefits of R29.2 million involving fraudulent documentation. In 2011 the number of cases detected stood at 419 to a whopping value of R112.6 million.

Last year only two cases of fraudulent documentation were detected for disability claims (eight in 2011), 18 for health and hospital insurance claims (27 in 2011) and one for retrenchment cover (one in 2011).

Dempsey says although the number of fraudulent claims involving syndicates increased from 154 in 2011 to 198 in 2012, the amount involved more than halved from R6.8 million in 2011 to R2.7 million in 2012.

He says the decline in claims involving fraudulent documentation and the value of claims as a result of syndicate activity is very good news for the life industry and its policyholders.

"In 2010 the life industry experienced a massive increase in fraudulent claims, probably because life companies are often seen as soft targets by criminals hoping to access benefits through fraudulent means. Life companies have, however, put sophisticated fraud detection mechanisms in place to allow for early detection and clearly this is starting to deliver the desired results."

He explains that life companies also share fraud statistics and information with each other with the aim of detecting trends and syndicate activity as early as possible. For this reason statistics relating to fraudulent and dishonest policy claims are gathered by ASISA on an annual basis.

Legitimate claims

Dempsey points out that by far the majority of claims submitted to life companies are honest and legitimate and therefore honoured.

In 2012, the life industry paid out more than R263.2 billion in benefits to policyholders, beneficiaries, and pension fund members as a result of death and disability claims, maturity pay-outs and pension, annuity and other payments.

He explains that while the R669.9 million not paid out due to fraud and dishonesty seems almost insignificant when seen against the R263.2 billion in benefit payments, it is important that the life industry fights claims fraud.

"If left to escalate, fraud and dishonesty would over time substantially increase the claims experience of life companies and ultimately force companies to recover these losses from customers through increased premiums."

Fraudulent and dishonest policy claims statistics for 2012, compared to 2011

	2012		2011	
	Cases	Rand Value	Cases	Rand Value
Death & Funeral Claims	**4534**	**310.8 million**	**4237**	**318.8 million**
Misrepresentation/Material Non-Disclosure	4044	273.9 million	3681	195.3 million
Fraudulent Documentation	243	29.2 million	419	112.6 million
Syndicate Involvement	184	2.6 million	118	6.7 million
Beneficiary Involvement in Death	57	2.4 million	10	1.2 million

Adviser Involvement	6	2.7million	3	0.2 million
Broker Involvement	0	0	6	3 million

Disability Claims	**551**	**355.1 million**	**504**	**276.7 million**
Misrepresentation/Material Non-Disclosure	547	342.4 million	496	264.3 million
Fraudulent Documentation	2	2 million	8	12.4 million
Adviser/Broker Involvement	2	10.6 million		

Health Business & Hospital Claims	**375**	**3.8 million**	**549**	**4 million**
Misrepresentation/Material Non-Disclosure	343	3.7 million	488	3.8 million
Fraudulent Documentation	18	0.1 million	27	0.07 million
Syndicate Involvement	14	0.03 million	34	0.09 million

Retrenchment Claims	**6**	**0.2 million**	**13**	**0.2 million**
Misrepresentation/Material Non-Disclosure	5	0.2 million	10	0.2 million
Fraudulent Documentation	1	0.02 million	1	0.02 million
Syndicate Involvement	0	0	2	0.01 million

Total		**669.9 million**		**599.7 million**

Figures have been rounded up.

Ends

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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. These members hold assets under management of more than R4-trillion.