Media Release
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Life insurers report a marked reduction in irregular claims for 2019

South African life insurers detected 2 837 fraudulent and dishonest claims to the value of R537.1 million last year.

The 2019 fraudulent and dishonest claims statistics, released this week by the Association for Savings and Investment South Africa (ASISA), show a marked reduction in both the number of irregular claims detected as well as in the value of these claims.

According to Megan Govender, convenor of the ASISA Forensics Standing Committee, the number of claims identified as either fraudulent or dishonest in 2019 dropped by 20% from the 3 708 detected in 2018. He adds that the value of the irregular claims in 2019 was less than half the R1.13 billion recorded in 2018.

Govender describes the drop in fraudulent and dishonest claims as good news for both consumers as well as for the life industry.

He says when consumers take out a long-term insurance policy, they do so to protect themselves and their families against the financial risk of a life event like death or disability. It is the duty of the life insurer to assess the risk of such a life event happening based on the information received from the person applying for cover as well as the prevailing claims rates. "Insurers are expected to put a fair price on this risk protection in the form a premium. If we do nothing to counter fraudulent and dishonest claims, honest policyholders will ultimately end up footing the bill through higher premiums driven by untenable claims rates."

Govender points out that while life insurers are frequently accused of trying to avoid paying claims, the numbers tell a different story. In 2019, life insurers paid 99% of claims made against fully underwritten individual life policies alone, to a value of R16.7 billion. He adds that in the first half of this year, life insurers also paid claims and benefit payments of R230 billion to policyholders and their beneficiaries.

According to Govender, the highest incidence of fraud and dishonesty for 2019 took place in the funeral insurance space. "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. This makes it tempting for criminals and dishonest individuals to try and access pay outs via dishonest or criminal means."

Funeral claims

Life insurers detected fraud, dishonesty or criminal intent in 1 783 funeral claims worth R54.2 million last year. Govender points out that while there was a marginal reduction in the number of cases detected the value of the claims dropped by more than two thirds from R176.4 million in 2018 to R54.2 million in 2019.

	2019		2018	
	Cases	**Value**	**Cases**	**Value**
Funeral Claims	**1 783**	**R54.2 million**	**1 915**	**R176.4 million**
Misrepresentation/ Material Non-Disclosure	666	R25.6 million	625	R25 million
Fraudulent Documentation	1 095	R27.8 million	1 127	R147.5 million
Syndicate Involvement	20	R0.8 million	156	R3.5 million
Beneficiary Involvement in death	1	R0.02 million	7	R0.4 million
Adviser/Broker Involvement	1	R0.02 million	0	0

Death claims

Life insurers reported a significant drop in both the number of irregular death claims as well as the value of the claims submitted last year. In 2019, 346 cases worth R271.4 million were detected, compared to 698 cases to a value of R417.3 million in 2018.

Govender says while the significant reduction in fraudulent death claims is good news for the life industry, the increase from 195 to 276 in misrepresentation and material non-disclosure cases is concerning. 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 and 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."

	2019		2018	
	Cases	**Value**	**Cases**	**Value**
Death Claims	**346**	**R271.4 million**	**698**	**R417.3 million**
Misrepresentation/ Material Non-Disclosure	276	R175.5 million	195	R237.8 million
Fraudulent Documentation	62	R93.3 million	481	R171.7 million
Syndicate Involvement	7	R0.1 million	7	R3.6 million
Beneficiary Involvement in death	1	R2.5 million	0	0
Adviser/Broker Involvement	0	0	15	R4.2 million

Disability claims

Misrepresentation and material non-disclosure with the aim to mislead insurers was once again the number one reason for disability claims being declined in 2019. Out of the 447 irregular claims detected, 437 were rejected due to misrepresentation or material non-disclosure.

Govender comments that the value of these claims had, however, more than halved in 2019 when compared to 2018.

	2019		2018	
	Cases	**Value**	**Cases**	**Value**
Disability Claims	**447**	**R208.7 million**	**530**	**R463.9 million**
Misrepresentation/ Material Non-Disclosure	437	R219.6 million	463	R433.5 million
Fraudulent Documentation	10	R10.2 million	16	R30.4 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Hospital cash plans

Dishonest claims against hospital cash plans dropped significantly in 2019, both in numbers and in value. Govender attributes the decline to increased vigilance by life insurers in

recent years, after fraud and dishonest claims threatened to spiral out of control. While in 2010 some 649 dishonest claims against hospital cash plans worth R12.6 million were foiled, only 192 cases worth R1.3 million were uncovered in 2019.

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.

	2019		2018	
	Cases	**Value**	**Cases**	**Value**
Hospital Cash Plan Claims	**192**	**R1.3 million**	**519**	**R3.2 million**
Misrepresentation/ Material Non-Disclosure	191	R1.3 million	517	R3.1 million
Fraudulent Documentation	0	0	0	0
Syndicate Involvement	1	R0.02 million	2	R0.1 million
Adviser/Broker Involvement	0	0	0	0

Retrenchment benefit claims

Dishonest and fraudulent retrenchment claims recorded a slight increase from 46 in 2018 to 69 in 2019. Life insurers declined 61 claims due to misrepresentation and non-disclosure and eight due to fraudulent documentation.

	2019		2018	
	Cases	**Value**	**Cases**	**Value**
Retrenchment Claims	**69**	**R1.5 million**	**46**	**R1.4 million**
Misrepresentation/ Material Non-Disclosure	61	R1.2 million	39	R1.2 million
Fraudulent Documentation	8	R0.3 million	7	R0.2 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Fraudulent and dishonest claims across the provinces

Govender reports that 33% of all fraudulent and dishonest claims were detected in KwaZulu-Natal, followed by the Eastern Cape with 18% and Gauteng with 13%.

PROVINCE	SUB-TOTAL	PERCENTAGE
KZN	948	33%
Eastern Cape	506	18%
Gauteng	382	13%
Western Cape	225	8%
Northern Cape	159	6%
North West	110	4%
Free State	102	4%
Mpumalanga	84	3%
Limpopo	77	3%
Unallocated	244	8%
TOTAL	**2 837**	**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.