ANTI - FRAUD POLICY

AVIVA LIFE INSURANCE COMPANY INDIA LIMITED
October 2016

POLICY OWNER	**CHIEF COMPLIANCE OFFICER, VIJAYALAKSHMI NATARAJAN**
VERSION CONTROL	**Ver. 3.0/AFP/10212016**

TABLE OF CONTENTS

1. INTRODUCTION

Aviva India has a “Zero Tolerance” approach to fraudulent acts. Aviva India strives to maintain the highest standards of governance, personal and corporate ethics, compliance with all laws and regulations. Aviva India values integrity and honesty while dealing with all employees, customers, suppliers and other stakeholders.

Aviva India is committed to support government, law enforcement and international bodies to combat financial crime. Anti – Fraud policy will be made available for public viewing on all Aviva India Website.

2. OBJECTIVE

In order to adequately protect the organisation from the financial and reputational risks posed by insurance and other frauds, framework has been put in place to identify, measure, manage, monitor and report occurrence of frauds in the company.

3. SCOPE

The framework applies to any fraud or suspected fraud in Aviva India, involving employees (including contractual employees) as well as shareholders, customers, insurance agents, corporate agents or any third party / intermediaries who have a business relationship with Aviva India.

4. REGULATION

The Insurance Development and Regulatory Authority of India (IRDAI), vide its circular IRDA/SDD/MISC/CIR/009/01/2013 dated 21st January 2013, called upon all insurers in India to recognize and assess the implication of fraud as a risk management measure and to put in place an effective and comprehensive policy to deal with fraud.

The Guidelines mandate insurance companies to put in place, as part of their corporate governance structure:

- fraud detection and mitigation measures; and
- submit periodic reports to the Authority in the formats prescribed herein (FMR – 1 and FMR – 2)

All insurers are required to ensure that the risk management function is organized in such a way that the insurer is able to monitor all the risks across all lines of business on a continuing basis and to initiate measures to address them suitably.

5. FRAUD CATEGORIES AND DEFINITION

Fraud in insurance is an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties. This may, for example, be achieved by means of:

- misappropriating assets
- deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurer’s status;
- abusing responsibility, a position of trust or a fiduciary relationship

Broadly, Insurance frauds can be categorized into following:

a) **Policyholder Fraud and / or claims fraud –** Fraud against the insurer in the purchase and / or execution of an insurance product, including fraud at the time of making a claim.

b) **Intermediary fraud –** Fraud perpetuated by an Insurance agent / Corporate Agent / Intermediary / Third Party Administrators (TPAs) against the insurer and / or policyholders.

c) **Internal Fraud –** Fraud / mis-appropriation against the insurer by its Director, Manager and / or any other or staff member (by whatever name called).

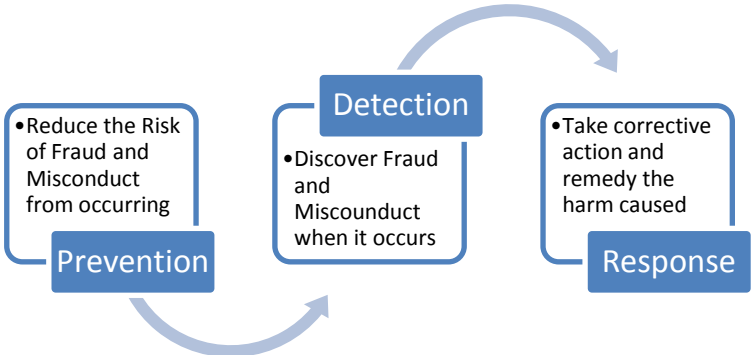
d) **Third Party Fraud –** Fraud committed by third parties against the Insurer and the general public which primarily includes activities such as issue of fake / forged policies and cover notes in the name of the Insurer.

For actions constituting fraud, please refer Appendix A and detailed classification of Policyholder / Intermediary/ Internal Fraud, please refer Appendix B.

6. FRAUD RISK MANAGEMENT FRAMEWORK

Aviva India fraud risk management framework will include identifying, measuring, managing, monitoring, and reporting of fraud risks.

Fig : Fraud Risk Management Framework



6.1. Fraud Management Strategy

Fraud Management Strategy will focus on fraud prevention and to be proactive in our approach towards mitigating fraud risk. Key components of an effective strategy to mitigate fraud risk are set out below –

- **Risk Identification –** Execution of a fraud risk assessment to understand Aviva India's inherent fraud risks**.**
- **Prevention –** Implementation of risk based, proportionate fraud prevention controls.
- **Detection –** Implementation of risk based, proportionate fraud detection controls
- **Investigation –** Design and implementation of a Fraud Response Plan (FRP) which sets out amongst other things responsibility for different types of fraud investigations (internal, claims, underwriting and etc.).
- **Reporting and Recording –** Implementation of documented fraud reporting requirements which are transparent and accurately reflect fraud data in Aviva India.
- **Management Information –** Production of relevant management information to enable effective understanding and oversight.
- **Roles and Responsibilities –** Documentation and implementation of a Fraud Target Operating Model in order to have clear roles and responsibilities related to a fraud risk management programme across the 3 lines of defence.

6.2. Fraud Detection

Detection is the proactive and reactive identification of fraud. Aviva has a detection programme to monitor activities where fraud risk has been identified through the risk assessment process or through Risk Control Unit (RCU).

Fraud detection is carried out through data mining, policy document scrutiny, screening of employees, due diligence of vendor / third party / advisors, exception reporting, red flag monitoring, quality assurance, internal audit, risk monitoring, training and awareness, transaction monitoring, information sharing.

6.3. Fraud Prevention

Fraud prevention involves identifying the root cause of an inherent fraud risk through risk assessment and implementing effective controls to stop fraud before it happens.
Following will form the basis for a proactive fraud prevention strategy

- **Risk Assessment –** The completion of a comprehensive risk assessment to initially identify the inherent fraud risks in Aviva India. Risk assessment in Aviva India will be carried out through the Risk Control Self Assessment (RCSA) framework. Continous monitoring of identified risks will be carried out as per the prescribed methodology.
- **Risk Based Approach –** Implement risk based approach to fraud prevention.
- **Application of Controls –** Where inherent fraud risks have been identified, Aviva India should assess whether resources are sufficient and implemented controls are effective in preventing fraud or whether residual risks are present and require additional or more enhanced controls to achieve a robust control environment.
  - **Training and Awareness –** Annual Financial crime training and assessment to be conducted for all employees as per stipulated timelines. -

  Awareness amongst employees to be created through regular mailers, e-education series, messages from the leadership, etc. Point number 9 (Page Number – 7) details about the training and awareness programme.
- **Deterrence –** Framework and action grids have been created and communicated to employees through a formal channel to create awareness on Aviva's response to fraud. Identified instances may be used as deterrent. 'Tone from the top' clearly states that Aviva has a zero tolerance approach to fraud and those found to have engaged in fraud will be disciplined and may be referred for prosecution.
- **Management Information –** Management information will be used as a fraud prevention tool e.g. training completion rates, high percentage of fraud in a particular category, region etc.
- **Independent Review of Control Effectiveness –** Independent audits are carried out by second line and third line of defence to provide an assessment of design and control effectiveness (As per their annual review plan / adhoc review).
- **Due diligence / Pre-employment Screening and Vetting –** Documented empanelment process is in place for employees, insurance agents, corporate agents, intermediaries, third party which is carried out before concluding the relationship.
  Implementation of a Whistle Blower policy - A Whistle blower policy is in place to enable confidential reporting of fraud suspicions. For more details, refer to point no. 6.5.1 (page no 6).

6.4. Fraud Response Plan

Aviva India has a documented Fraud Response Plan (FRP). FRP sets out a detailed plan and investigation procedure which covers internal reporting process, investigation responsibilities, whistle blowing charter, feedback mechanism, disciplinary actions, reporting and recording etc.

6.5. Reporting and Recording

6.5.1. Internal Reporting and Recording

Aviva India has defined internal reporting and recording procedures. Employees should report known or suspected violations of policies through **Right Call / Whistleblower.** Right Call is a

completely independent malpractice reporting service that allows reporting concerns confidentially via email, internet or telephone. Right Call is available seven days a week, twenty-four hours a day. This is a free 24 hour service which operates 7 days a week offering the facility to report in the local language. Fraud events are reported and presented at Board Audit Committee / Risk Management Committee which is held at quarterly frequency. The report details statistics of fraud cases, summary on key cases identified during the quarter, loss amount, resolution and action etc. Additionally information is uploaded on the system – case management tool to which our shareholders (Group Investigation and Forensic Audit) have an access. Fraud loss events are updated in OPERA on quarterly basis.

Contact information

Call at: 0008004401286

EMAIL: transparency@avivaindia.com, rightcall@expolink.co.uk

WEBSITE: http://iconnect.avivaindia.com, www.expolink.co.uk/rightcall

6.5.2. External Reporting

The Company submits annual report on various fraudulent cases to IRDAI in forms FMR 1 and FMR 2 as required by the regulator providing details of:

- Outstanding fraud cases and
- Closed fraud cases

Regulator requires the report to be filled every year within 30 days of the close of financial year.

6.6. Internal Accountability, Responsibility, Expertise and Resourcing

Aviva has a defined three lines of defence fraud risk management programme clear lines of internal accountability and responsibility have been laid out in FCTOM and roles and responsibility document.

The 'three lines of defence model is structured as follows.

- **First Line of Defence –** Primary responsibility for the implementation and practice of fraud risk management, including core risk management principles of risk identification, measurement, management, monitoring & reporting rests with 1st line of defence.
- **Second line of Defence –** The Compliance and Risk function are second line of defence. Who are responsible for reviewing and challenging the completeness and accuracy of the first line's risk identification, measurement, management, monitoring and reporting.
- **Third line of Defence –** Internal Audit (IA) is the 3rd line of defence. IA is responsible for independent assessment on the effectiveness of the fraud controls framework design and operation is also responsible for reporting findings and concerns to group and Aviva's audit and risk committees.

7. Information sharing and Co-ordination with Law Enforcement Agencies

Aviva is committed to provide the necessary support & information on fraud as required through Life and General councils and co-ordinate with law enforcement agencies for exchange of information. Necessary information on Frauds, can be shared amongst all insurers through respective Councils / Forums. Requirements of dealing with law enforcement agencies have been broadly categorized in following two categories:-

- Coordination for frauds detected by the Company and frauds reported to the Company by Authority.

- Coordination for policy related information sought by a Statutory Authority like CBI / Income Tax etc.

As per the new regulations issued by IRDAI for Appointment of Insurance agents, 2015 (dated 16-Mar-15) the designated officer has to update to other Insurance companies regarding the action taken (only termination) on the agents, list of terminated agents needs to updated on the blacklisted agents portal of IRDAI.

8. Fraud monitoring Functions

Activities for fraud monitoring are collectively held by second and third line of defence with clear set out responsibilities. Fraud prevention and detection is carried out by the Risk and Compliance team. Investigations and reporting undertaken by the Internal Audit team.

SPOC of every department needs to interact directly with the fraud monitoring function and report suspicious activities within their departments or identified during their anti-fraud procedures. Any employee, intermediary or supplier can whistle blow to the Fraud Monitoring Function. The Fraud Monitoring function (FMF) is committed to independently investigate such allegations in confidentiality.

9. Training and Awareness

Financial crime training to all employees is provided at the time of joining through induction programme. All employees need to undergo and ensure timely completion of mandatory annual training on Financial Crime which includes components, such as Anti Money Laundering (AML), Anti-Bribery and Corruption (ABC), Central Monitoring, Gift & Hospitality (G&H) and Market Abuse. To ascertain the successful training completion, assessment is conducted.

In addition, role specific training will include:

- Providing enhanced training to employees with specific roles which may present a higher risk or hold the responsibility of ensuring implementation and effectiveness of financial crime controls.
- Tailored to higher risk roles held by employees;
- Including red flags for potential indicators of financial crime.
- Key components of financial crime laws and regulations e.g. Elements of financial crimes, requirement for financial institutions to implement financial crime prevention programmes consistent with applicable local laws, Politically Exposed Persons (“PEPs”) and other higher risk financial crime issues;
- Applicable local legal and regulatory requirements for the recognition and reporting of suspicious transactions, cash transactions exceeding local thresholds and sanctions reporting; and
- Escalation protocols.

Awareness amongst employees may be created through regular mailers, e-education series, messages from the leadership etc.

10. Disciplinary Action Plan

All employees and agents of Aviva whether active or not can attract an action against any fraud event. There is a defined action grid on the basis of which action will be taken on the employee.

11. Glossary

As per the IRDAI, points included in the framework of the policy are included wholly or partly in the mentioned paragraphs.

- **Procedure for Fraud Monitoring –** Risk Identification point in Point number 6.1 and Risk Assessment point in Point number 6.2 (Page Number – 4) describes the process for identification of potential areas of fraud.
- **Identify Potential Areas of Fraud –** Appendix – A (Page Number – 8) gives the illustrative list of potential areas of fraud.
- **Co-ordination with Law Enforcement Agencies –** Explained in Point number 7 (Page Number – 6) Information sharing and co-ordination with law enforcement agencies.
- **Framework for Exchange of Information –** Explained in Point number 7 (Page Number – 6) Information sharing and co-ordination with law enforcement agencies.
- **Due Diligence –** Explained in Point number 6.2 (Page Number – 5) Due diligence / Pre-employment Screening and Vetting
- **Regular Communication Channels –** Explained in Management information point in Point Number 6.1 (Page Number – 4). Implementation of a Whistle Blower policy point in Point Number 6.2 (Page Number – 5).
- **Fraud Monitoring Function –** Explained in Point Number - 8
- **Reports to the Authority –** Covers in Point Number 6.5.2 (Page Number – 5) External Reporting
- **Preventive Mechanism –** Covers in Introduction paragraph (Page Number – 3) and Point Number 6.2 (Page Number – 4) Fraud Prevention.
- **Insurer's to Ensure Compliance –** Point 6.5.2, Application of Controls point of Point Number 6.2 (Page Number -5)

12. Appendix

Appendix – A : Actions Constituting Fraud

Based on the nature, size and distribution of business, following is the illustrative list of potential fraud areas:

- Forgery or alteration of any document relating to the Company's insurance policies or insured parties.
- Forgery or alteration of checks, bank drafts, or any other financial documents.
- Fraudulent alteration, addition or removal of information on the Company's management information systems.
- Any dishonest or fraudulent act or attempted act by employees of the Company
- Misappropriation of funds, securities, supplies, or other assets
- Impropriety in the handling or reporting of money or financial transactions
- Disclosing confidential and proprietary information to outside parties
- Destruction, removal, or inappropriate use of records, furniture, fixtures, and equipment; and/or
- Fraudulent financial reporting
- Stealing cheques
- Inflating expenses claims/over billing
- Paying false (or inflated) invoices, either self-prepared or obtained through collusion with suppliers
- Permitting special prices or privileges to customers, or granting business to favoured suppliers, for kickbacks/favours
- Forging signatures
- Removing money from customer accounts

- Selling insurer's assets at below their true value in return for payment
- Reporting and claiming of fictitious damage/loss
- Medical claims fraud
- Fraudulent Death Claims
- Signature Forgery
- Misselling which has resulted in Refund of premium or fund value including rebating the customer
- Split of policies: Multiple policies of the same product category sold to the same customer with same beneficiary and term and conditions (within 60 days)
- Policy document submitted for nonexistent customers / person was dead before policy was issued
- Same address proof/ telephone number for multiple unrelated customers
- OSV done for forged documents
- Posting of renewal premium into new business or in other policy or Churning of policies basis customer complaint
- Fraudulently surrender of existing policy of customer by advisor/SM
- Influencing the doctor to conceal information/ alternatively coercing the doctor to submit report without conducting tests or sending a dummy person to attend medicals
- Premium diversion-intermediary takes the premium from the purchaser and does not pass it to the insurer
- Inflates the premium, passing on the correct amount to the insurer and keeping the difference
- Disclosing to other persons the confidential or private business activities of the Company.
- Accepting or seeking anything of material value from applicants, beneficiaries,
- The improper withholding of any money or premiums paid on an insurance policy, if the insurance contracted for is not ultimately provided.
- Any false statement made to law enforcement agencies, prosecutors or the insurance departments of any state.
- Any similar or related irregularity.

Detailed department wise Fraud Procedures to mitigate the above fraud areas are documented in the Fraud Procedural Manual

Appendix – B

Some of the examples of fraudlent acts / omissions include, but are not limited to the following:

Policyholder Fraud and/or claims fraud – Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim:

- Claims fraud - death, critical illness, waiver, Private Medical Insurance or Permanent Health Insurance claim is fraudulently made against the policy. For example, a death claim when the event has not happened, fraudulent non-disclosure / misrepresentation. Staging the occurrence of incidents
- Medical claims fraud
- Underwriting fraud - where a policyholder or applicant either deliberately misrepresents or deliberately fails to disclose material facts at policy inception (that would materially impact either the terms & conditions applied to a policy of insurance, or the issue/renewal decision itself) for financial gain.
- Assignment fraud -when an insured or owner takes possession of the issued policy, s/he will transfer ownership, or "assign" the policy for value to a person or entity with no insurable interest in the continuation of the insured person's life.

- Trustee fraud - Fraud by trustees or potential beneficiaries of defined benefits pensions schemes. Also includes exaggerated deductible expenses.

Intermediary fraud – Fraud perpetuated by an Insurance agent/ Corporate Agent/ Intermediary/ Third Party Administrators (TPAs) against the insurer and/or policyholders:

- Broker / Agent fraud - fraud or manipulation of records by a general insurance intermediary, agent or broker resulting in a loss to the Company or our policyholders. For example, Manipulation of systems, Non submission of premiums, Overcharging customers
- Policy related fraud - any attempt to obtain payment from a policy to which the recipient is not entitled where there is no suspicion that this is by a member of staff, intermediary or supplier.
- Premium Diversion – Where intermediary takes the premium from the purchaser and does not pass it to the insurer
- Inflates the premium, passing on the correct amount to the insurer and keeping the difference
- Commission Fraud – Insuring non-existent policy holders while paying a first premium to the insurer, collecting commission and annulling the insurance by ceasing further premium payments.

Internal Fraud – Fraud/miss-appropriation against the insurer by its Director, Manager and/or any other or staff member (by whatever name called):

- Misappropriating funds
- Stealing cheques
- Overriding decline decisions to open accounts of family and friends
- Forging signatures
- Forging documents
- Permitting special privileges / kick backs to customer etc.