Media Release
Association for Savings and Investment South Africa (ASISA)
10 May 2022

Life insurers uncover record numbers of fraudulent and dishonest claims in 2021

South African life insurers detected 4 287 fraudulent and dishonest claims worth R787.6 million across all lines of risk business in 2021. This is a significant increase from 2020, when 3 186 cases of fraudulent and dishonest claims to a value of R587.3 million were uncovered.

The fraudulent and dishonest claims statistics for 2021, released this week by the Association for Savings and Investment South Africa (ASISA), show that funeral insurance once again attracted the highest incidence of fraud and dishonesty, followed by death cover, disability cover, hospital cash plans and retrenchment benefit cover.

Megan Govender, convenor of the ASISA Forensics Standing Committee, attributes the surge in exposed fraudulent and dishonest claims to the deployment of sophisticated detection mechanisms by the long-term insurance industry to stop fraud and dishonesty.

He says the R787.6 million in fraudulent and dishonest claims detected in 2021 may seem like a negligible amount when compared to the R608 billion in claims and benefit payments made to honest policyholders and their beneficiaries in 2021 – the highest ever paid in a single year. However, adds Govender, if left unchecked fraud and dishonesty would have the biggest impact on honest policyholders who would ultimately have to pay higher premiums to make up for untenable claims rates.

He explains that the long-term insurance industry is therefore constantly innovating preventative measures to combat insurance fraud, including the use of artificial intelligence, data sharing for early detection of trends and an increased focus on field investigations.

"In 2020, the lengthy COVID-19 lockdown prevented our forensic investigators from physically going out into the field, which plays an important part in uncovering syndicate operations and taking a closer look at other criminal activities such as suspicious unnatural deaths," says Govender. "However, by 2021 our field investigations were largely back to normal, and the success rate is reflected in these statistics."

Govender warns those contemplating a crime to gain access to an insurance pay-out that the chances of being caught are extremely high with the consequence most likely a lengthy prison sentence or a hefty fine. Last year's Rosemary Ndlovu case, for example, resulted in a sentence of six life imprisonment terms for the former police officer who had several family members murdered so that she could benefit from the funeral insurance pay-out. Similarly, a pastor and his wife in the Western Cape received lengthy prison sentences last year for taking out life insurance policies on church members with the intention of having them murdered by a hitman for the death benefits.

Govender says while these high-profile cases have focused the spotlight on criminality in the funeral insurance and death claims space, dishonest disability (including critical illness)

claims are also not uncommon. While the case numbers are typically lower, the value of fraudulent and dishonest disability claims thwarted in 2021 exceeds the value of funeral insurance claims by a significant margin. The total value of fraudulent and dishonest disability claims detected in 2021 was R195.9 million, compared to R128.2 million for funeral claims.

Examples of fraudulent disability claims detected in 2021

- **Claiming for HIV with someone else's blood**

A disability claim was submitted by a nurse under her severe illness benefit, alleging that she had suffered a needle stick injury at work which resulted in her being exposed to and infected with HIV. She supported the claim with a test result that confirmed her status as HIV positive even though antiretrovirals had been administered immediately after the alleged exposure.

The life insurance company's forensic department investigated the claim and found several inconsistencies and no records of the client being treated for HIV. The nurse was requested to undergo further testing with an independent laboratory. This resulted in her admitting that she was not HIV positive and that she had used the blood of an infected person to submit her claim.

The life insurer reported the fraudulent claim to the police and the nurse received a five-year jail sentence, suspended for five years, and a R10 000 fine or six months imprisonment. The investigation resulted in the prevention of a R1 million fraudulent claim pay-out.

- **Taking cover on an already disabled person**

An ASISA member received a claim for sudden severe dementia against a disability and severe illness policy only one month after the policy had been taken out. The claim was submitted by the policyholder's brother who had a power of attorney.

A forensic investigation revealed that the policyholder had suffered a severe stroke before the policy was taken out and was unable to communicate. All signatures on the policy had been forged. The claim was declined, preventing fraud worth R8.7 million.

Fraudulent and dishonest claims in numbers

- **Funeral claims**

Life insurers detected dishonesty or criminal intent in 3 268 funeral claims worth R128.2 million last year.

Govender points out that unlike the year before when fraud was the biggest concern in the funeral insurance space, in 2021 misrepresentation and material non-disclosure cases formed the bulk of the dishonest claims. Misrepresentation and non-disclosure refer to policyholders not disclosing or misrepresenting material information to a life insurer that could materially affect the terms of the policy.

He explains that 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, misrepresentation in this space most commonly concerns the relationship that the policyholder has with the person whose life is being insured.

Funeral cover is designed to enable people to cover themselves as well as their extended families. However, when a policyholder includes his best friend and the friend's family under the policy claiming that he is a brother, this is considered misrepresentation.

	2021		2020	
	Cases	**Value**	**Cases**	**Value**
Funeral Claims	**3 268**	**R128.2 million**	**2 282**	**R80.8 million**
Misrepresentation/ Material Non-Disclosure	2 232	R78.8 million	863	R34.1 million
Fraudulent Documentation	964	R44.6 million	1 383	R44.4 million
Syndicate Involvement	68	R4.6 million	28	R2 million
Beneficiary Involvement in death	4	R0.2 million	8	R0.4 million

Death claims

Govender points out that while there was a welcome decline in misrepresentation and material non-disclosure in the death claims space last year, there was a significant increase in fraudulent death claims.

He believes that the COVID-19 pandemic has highlighted the importance of being able to protect your family financially with a death benefit, which has probably resulted in greater policyholder honesty when taking out life cover. In the six months from 1 April to 30 September last year, South African life insurers reported a 53% surge in death claims when compared to the same period in pre-COVID 2019. The Rand value of these claims increased by 127%.

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."

	2021		2020	
	Cases	**Value**	**Cases**	**Value**
Death Claims	**452**	**R460.4 million**	**388**	**R264.3 million**
Misrepresentation/Material Non-Disclosure	305	R238.4 million	340	R166.9 million
Fraudulent Documentation	146	R222 million	41	R95.1 million
Syndicate Involvement	0	0	7	R2.2 million
Beneficiary Involvement in death	0	0	0	0
Adviser/Broker Involvement	1	R20 000	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 2021. Out of the 352 irregular claims detected, 333 were rejected due to misrepresentation or material non-disclosure.

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."

	2021		2020	
	Cases	**Value**	**Cases**	**Value**
Disability Claims	**352**	**R195.9 million**	**325**	**R233.6 million**
Misrepresentation/Material Non-Disclosure	333	R167.9 million	306	R220.4 million
Fraudulent Documentation	19	R28 million	19	R13.2 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Hospital cash plans

The number of dishonest claims against hospital cash plans increased in 2021 when compared to the previous year, but there was a significant decrease 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 forces life insurers to apply heightened vigilance when processing claims to ensure the financial viability of these products.

	2021		2020	
	Cases	**Value**	**Cases**	**Value**
Hospital Cash Plan Claims	**204**	**R2.1 million**	**141**	**R6.7 million**
Misrepresentation/Material Non-Disclosure	185	R1.6 million	127	R6 million
Fraudulent Documentation	11	R0.4 million	9	R0.6 million
Syndicate Involvement	8	R0.1 million	5	R87 931
Adviser/Broker Involvement	0	0	0	0

Retrenchment benefit claims

Govender explains that the dishonest and fraudulent retrenchment claims will continue to decline as very few life insurers still offer this cover.

	2021		2020	
	Cases	**Value**	**Cases**	**Value**
Retrenchment Benefit Claims	**11**	**R976 193**	**50**	**R1.9 million**
Misrepresentation/Material Non-Disclosure	9	R913 241	31	R0.8 million
Fraudulent Documentation	2	R62 952	19	R1.1 million
Syndicate Involvement	0	0	0	0
Adviser/Broker Involvement	0	0	0	0

Fraudulent and dishonest claims across the provinces

Govender reports that the bulk of fraudulent and dishonest claims were uncovered in KwaZulu-Natal (KZN) and the Eastern Cape, followed by Gauteng and the Northern Cape.

PROVINCE	SUB-TOTAL	PERCENTAGE
KZN	998	23%
Eastern Cape	972	23%
Gauteng	682	16%
Northern Cape	566	13%
Western Cape	308	7%
North West	308	7%
Free State	220	5%
Limpopo	72	2%
Mpumalanga	70	2%
Unallocated	91	2%
TOTAL	**4 287**	**100%**

Ends

To set up interviews please contact:
Lucienne Fild
Independent Communications Consultant
082 567 1533
lucienne@fild.co

Issued on behalf of:
Megan Govender
Convenor of the Forensics Standing Committee
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.