The Fight against Fraud in Life Assurance

(A Lacuna in the Insurance Industry)

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A dissertation submitted in partial fulfilment of the requirements of the Degree of Bachelor of Commerce (Honours) in Insurance at the University of Malta

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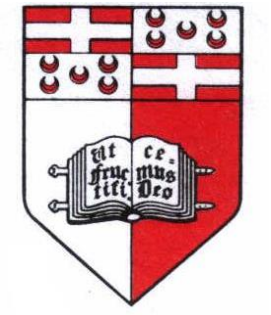

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Declaration

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I, hereby declare that I am the legitimate author of the authentic dissertation and that the context is the result of my own study and personal research except where acknowledged and referenced. No portion of this work has been previously submitted to this or any other University for another degree.

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Abstract

Fraud is a significant problem in life assurance causing policy holders and insurance companies to suffer. Most of the time, this involves fabrication of events by dishonest policyholders, misrepresentation and money laundering. Life Assurance companies have to compensate for the losses incurred by fraud by setting higher premiums and at times they are left with a lesser amount in their profit and loss scenario.

In this study different types of fraud in life assurance protection and savings policies were identified and real-world cases were reported. Various stakeholders in this problem of life assurance fraud were consulted in interviews and discussions followed on the adequacy of the law, the mechanisms that are in place to fight against fraud, recommendations and the levels of co-operations between all parties. Moreover, questionnaires were also distributed to the general public and the degree of consistency to the responses given by the experts was analysed.

An evaluation of the present situation of fraud in life assurance and of the future tendencies is part of the thesis conclusion. A prototype of an analytical system that can help insurers to recognise possible fraudsters based on the data collected from the questionnaires was also presented. The study concludes with other recommendations that can effectively supress fraud.

Acknowledgements

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ABI	Association of British Insurers
FIAU	Financial Intelligence Analysis Unit
FPO	Financial Planning Officer
FSA	Financial Services Authority
IAIS	International Association of Insurance Supervisors
IFB	Insurance Fraud Bureau
IFED	Insurance Fraud Enforcement Department
IFR	Insurance fraud Register
MIA	Malta Insurance Association
MFSA	Malta Financial Services Authority
MLRO	Money Laundering Reporting Officer
NICB	The National Insurance Crime Bureau
SAR	Suspicious Activity Report
STR	Suspicious Transaction Report
UREC	University Research Ethics Committee

1. Introduction

"All glory comes from daring to begin."

Eugene F. Ware (1841 - 1911)

1.1 Background

The negative effect on loss ratios is well documented. Fraud is nowadays on every firm's agenda across all sections of the economy and insurance is no different in this respect. It is a fact that some level of fraud in the insurance sector is inevitable. A survey conducted by Ernst and Young (EY, 2012) in the period 2010 to 2011 explained that insurance fraud is parametrically an acceptable factor to a certain extent and this can be explained by the law of diminishing returns. At some point, this implies that the cost of putting fraud to an end will exceed the amount that can be saved. The problem arises when it is beyond reasonable limits.

The National Insurance Crime Bureau (NICB) calls fraud the "second most costly white-collar crime in America behind tax evasion." (NICB, 2010) This negative consequence is being felt throughout the whole sector of insurance, be it underwriters, brokers and claims handlers. The frequencies of fraudulent insurance claims have more than doubled over the last five years. According to an ABI report, in the year 2011 there were 2,670 fraudulent insurance claims every week. (ABI, 2012b)

There are various types of insurance fraud in all areas of insurance. A substantial percentage of the total amount of fraudulent claims occurs in the life assurance sector.

1.2 Aims

The main aim of this thesis is to analyse in perspective the problem of insurance fraud, particularly in life assurance. In this dissertation we deal with the two aspects of life assurance, namely the protection and investment aspects. In the area of protection, the focus is on life and loan protection policies against which faking of death or identity are common fraudulent activities whereas in the area of investment there are the savings and investments policies against which money laundering is a common fraudulent activity. The idea is to identify what tools are being used to lessen the problem of insurance fraud in these two aspects of life assurance. An additional element of this study is to identify the people that are most prone to commit fraud.

Figure 1.1 shows the most common forms of insurance products that are flagged as suspicious activities. According to this report the most vulnerable area in insurance fraud is that of money laundering with 64.04% of the findings while suspicious activities in mortgage loan fraud caters for 0.4% of all activities.

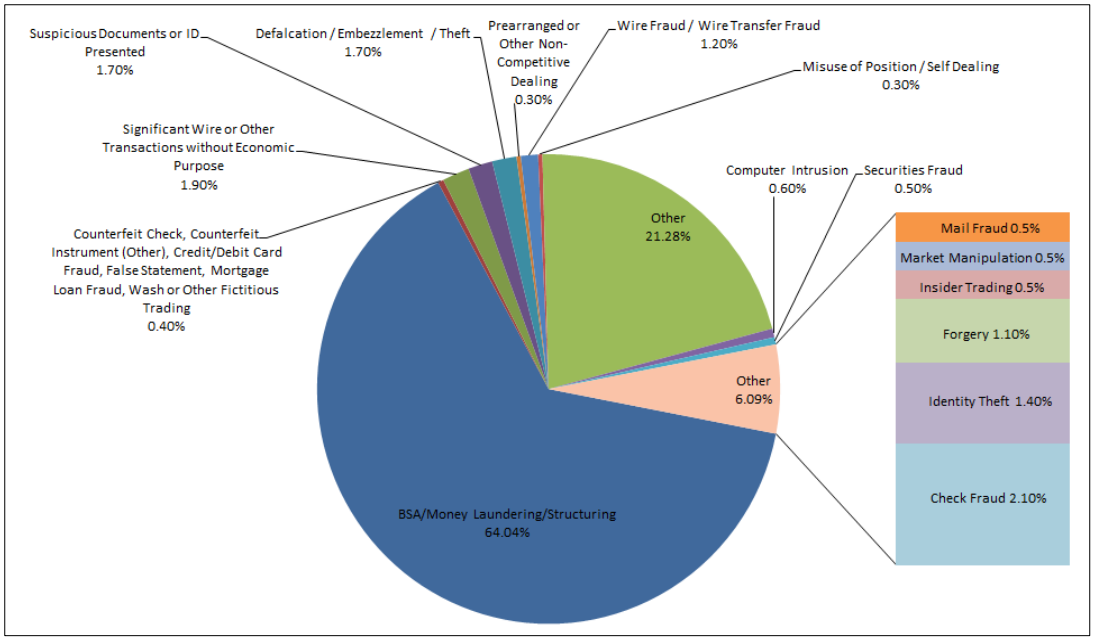

Figure 1.1 Characterizations of suspicious activities identified in Suspicious Activity Reports (SARs) for segments of the insurance industry (based on activities) filed by insurance companies between 2007 and 2008 Source: (Network, 2010, p. 25)

1.3 Objectives

The ways and means that are currently in place to fight against fraud in life assurance are debatable and are not sufficient to work effectively. This can be shown in Table 1.1 in which the Association of British Insurers (ABI) recorded the number of fraud cases in both the Investments and Life Insurance products. The number of fraud cases for each year hint that the tools available are not adequate to fight proactively against fraud so as to avoid the fraud cases before they happen. It is therefore one of the author's objectives to identify the weaknesses in these mechanisms and develop other means that can.

Type	Number of fraud cases
Investments	
2006	381
2007	376
2008	213
2009	256
2010	222
2011	172
Life	
2006	754
2007	660
2008	347
2009	346
2010	660
2011	599

Table 1.1 Number of fraud cases in product types: Investments and Life. Adapted from: (Logan, 2012)

In addition to this, other objectives follow:

- Analyse the perception of the general public towards fraud in life assurance.
- Study the responses of the general public to fraudsters' actions in case scenarios.
- Investigate the adequacy of the laws in place to fight against fraud in life assurance.
- Conduct an interview with the Financial Intelligence Analysis (FIAU) unit that is responsible for investigating money laundering and terrorism in Malta.
- Conduct an interview with the Economic Crimes Unit in the Malta Police Force that is responsible for investigating financial fraud.
- Conduct interviews with life assurance companies that sell life assurance policies.

- Discuss the degree of consistency of the perceptions of the general public vis-à-vis the perception of the experts.
- Identify clusters of people from the general public that are more prone to commit fraud.
- Provide the underwriter with a system that would be able to check whether a prospective policyholder lies in one of those clusters.
- Analyse the future trends of fraud in life assurance.
- Recommend effective techniques to fight against fraud.

1.4 Document structure

The rest of the dissertation is divided as follows:

- The second chapter gives an overview of the areas researched that were relevant to the goal of the thesis.
- In the third chapter, the mixed research method used in this dissertation is described together with the different qualitative and quantitative techniques.
- The fourth chapter presents the analysis and the results obtained through the research methods used.
- In chapter five a conclusion together with a set of recommendations and a discussion concludes this dissertation.

2. Literature Review

"Literature adds to reality, it does not simply describe it."

C.S. Lewis (1898-1963)

2.1 Insurance

Life is full of risks. Some of these risks can be prevented, others can be minimized and yet more are completely unforeseeable. People have sought security since the beginning of human civilisation. "The roots of insurance can be traced back to Babylonia, over four thousand years ago when traders developed markets to insure the goods on their caravans against loss on the hazardous trade routes." (Brown & Gottlieb, 2007, p. 1) As society developed, the urge for insurance increased.

"Insurance is an effective tool to mitigate financial risk." (Wang, 2005) It is based on the concept of risk transfer mechanism. By definition it is a contract between two parties, known as the insurer and the insured, where the insurer promises to pay the other party (the insured) financial losses subject to monetary compensation known as the premium. Insurance does not eliminate risk but it spreads the loss over a large number of people who insure themselves over the particular risk. The main principle of insurance is the spread of risk to a pool. It is this pooling of risk that enables an insurance company to operate profitably while at the same time being able to pay for claims that will or may arise during the period of insurance.

2.2 Life assurance: an overview

As Benjamin Franklin once said, nothing is certain but death and taxes. There is no exact way of predicting when one is to die. People need to be financially prepared otherwise their dependents' financial security could be at risk.

Life assurance is the simplest, most popular and most cost-effective way of protecting one's own family or mortgage in the event of one's death. Not only can life assurance benefit one's family in the event of death, but it can also benefit one as an investment.

A life assurance contract is defined as:

> *"…an agreement in which an insurer agrees, for a consideration, to pay to or for the account of the insured a sum of money or other consideration, whether by way of indemnity against loss, damage or liability or otherwise, on the happening of a specified event with respect to which there is an element of uncertainty as to when or whether it will take place." (Justice, 1998, p. 3)*

A life assurance contract must have three contracting bodies; the insurer, an insured, and a beneficiary. The beneficiary can either be the insured itself, in which case the life assurance would be taken on his own life or else as desired by the policy holders. For instance it includes;

- Spouse's life
- Life of children
- Employer and employee
- Creditor and debtor
- Business Partners

2.3 Types and uses

Various forms of life contracts exist; some provide indemnification on death whereas others provide a return on either the investment if the latter turned out to work efficiently, or else the policyholder managed to survive up to a pre-defined age. The market offers a wide variety of life insurance products, each one having different terms and conditions of cover. Each type of product is designed accordingly to meet the specific demands or needs of customers. ”They are available from a range of providers including insurance companies and insurance brokers, banks and building societies, internet providers and even large supermarkets.” (Monestos, 2010)

A life assurance policy can be attributed to either protection or savings as shown in figure 2.1.

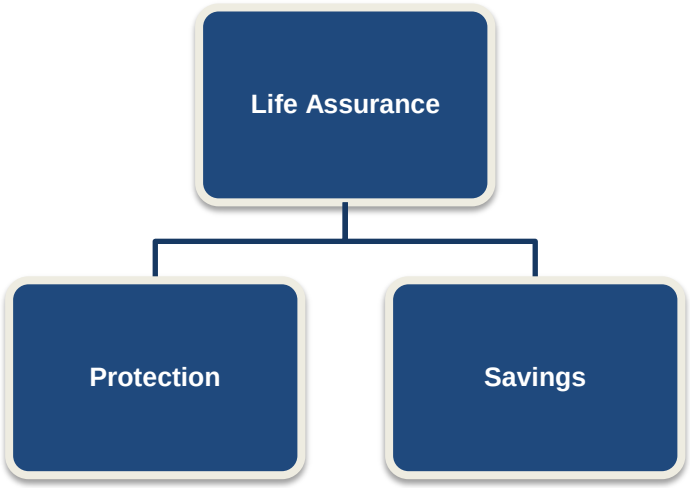

Figure 2.1 The two main types of life assurance policies; protection and savings policies.

In the protection sub-division the main types of policies are for life and loan protection. In Malta these are the most common policies that are sold. One main reason for this is that all of the banks in Malta are obliged to request for a life assurance policy as collateral when they issue a loan for a large amount of money. The savings and investments aspects of life

assurance allow the policyholder to save for the future. Policies can be invested in various funds according to the policyholder's desire.

2.4 Principles of insurance

Two principles need to be adhered to in order for a life assurance contract to be valid. These principles are Utmost Good Faith and Insurable Interest.

2.4.1 Insurable interest

Insurable interest is a requirement for the conclusion of a life assurance contract in which the client must prove interest in the life sought to be insured including legal and financial relationships. It is this principle of insurable interest which provides the right to be insured. Insurable interest refers to the pecuniary that a policy holder must have in the thing being insured.

> *"Subject to the interest being lawful, the agreement by an insurer to enter into a contract of life assurance over the life of a person other than the policyholder shall be sufficient evidence of the fact that the assured has an insurable interest in the life of the life assured." (Malta – Act No. XI of 2005 – Clause 1712B)*

In the absence of Insurable Interest the contract will be considered as void. In the notable case of Worthington v. Curtis (Cleveland Moak, 1877):

> *"The lack of Insurable Interest is a defence which a life assurance company may plead in resisting a claim, but if it chose to waive that defence it might do so and the rights under the policy would be determined as though the statute did not exist"*

Unlike other non-life assurance contracts, in life assurance, insurable interest need to be present at the time when the policy is being formulized (at inception) and not at the time of loss. (G. Monsour, Jr., 2011)

The Life Assurance Act (1774)[1] prohibits:

> *"…the making of any life policy on the life or life's of any person, or any other event or events whatsoever, wherein the person or persons for whose use benefit or on whose account such policy or policies shall be made, shall have no interest or by the way of gambling or wagering"*

2.4.2 Utmost good faith

Contracts of insurance are described as contracts of utmost good faith, also known as Uberrimae Fidei. (Stempel, 2007)

The material facts lie solely within the exclusive knowledge of one party and failure to disclose these facts renders the contract voidable at the option of the insurer. (Chen-Wishart, 2012) The duty to inform the insured of all the terms of the contract is similarly of the insurer. In the case Malhi vs. Abbey Life Insurance Co Ltd., the insurer repudiated the claim on the original policy, stating that they were not originally informed of the insured's alcoholism and prior case of malaria. (MacDonald Eggers & Foss, 1998)

The law imposes the duty of Utmost Good Faith on every proposer as the insured is the only one who knows about the self's personal facts on health, occupation and leisure time.

[1] The official text of the Life Assurance Act 1774 is found online in the UK Status Law Database (http://www.legislation.gov.uk/)

Therefore the proposer needs to submit a correct disclosure of all material facts, since insurers place a great reliance on this information in order to issue the requested policy.

It should also be noted that the insured must make full disclosure even if not specifically asked for the information. As stated in the case Rozanes vs. Bowen (1928)[2]:

> *"It has been for centuries in England the law in connection with insurance of all sorts, that as the underwriter knows nothing and the man who comes to ask him to ensure knows everything, it is the duty of the assured, the man who desires to have a policy, to make a full disclosure to the underwriters, without being asked of all the material circumstances… That is expressed by saying that it is a contract of Utmost Good Faith"*

2.5 Insurance Fraud

Insurance fraud is one of the main economic problems that every life assurance company has to face from time to time.

According to Derrig (2002, p. 273):

> *"Insurance fraud is a criminal act, provable beyond a reasonable doubt that violates statutes, making the wilful act of obtaining money or value from an insurer under false pretences or material misrepresentation a crime."*[3]

2.5.1 History

Insurance fraud has been in existence since the commencement of the industry's operations dating to the 17th Century. Fraud attracted little attention until the 1980s when the insurance industry had to increase their premiums to compensate for the losses paid for claims. This

[2] Full details of the case in: Rozanes v. Bowen, (1928), 32 L.I.L.R. 98
[3] Derrig cited (Derrig & Krauss, 1994)

led to a situation where insurance companies could no longer ignore unnecessary expenses. In the 1990s the problem was felt more, due to the increasing number of serious and more complex fraud cases that were harder to discover. Today, the problem is still on the increase. Some insurers believe that it is too expensive and infeasible to detect fraud and accept to pay out claims instead of investing in effective anti-fraud mechanism systems. Others prefer to accept a pre-defined amount of claims (irrelevant of the legitimacy of the claims) as part of the standard cost for the running of the business.

A report (ABI, 2012a) issued by the ABI in September 2012 states that approximately fifteen claims per hour are being reported as fraudulent claims in the United Kingdom. In 2011, another £983 million was reported as fraudulent claims, a 7% increase from the previous year. As a result the ABI has found out that fraudulent claims are costing insurance companies £1.5 million a year which in turn results in adding another 5% to the premiums paid by honest customers.

Nearly one in four Americans said that it is acceptable to defraud insurers, according to a 2003 Accenture survey (CIFA, 2005) while insurers estimate that as much as one third of the claims paid are questionable. (Stokes, 2012)

Such losses will surely weaken an insurer's financial position and will lessen its ability in offering competitive rates. Moreover it will underestimate the reputable of a company which in turn will lower the profit side of the company.

2.5.2 Insurance fraud model

Various models have been developed to explain why fraud occurs, including insurance fraud. One of the famous models is Dr. Cressey's fraud triangle which despite being developed in 1950 is still very relevant today. The triangle depicted in figure 2.2 describes the three key factors that need to be present for fraud to occur (Tuke, 2012).

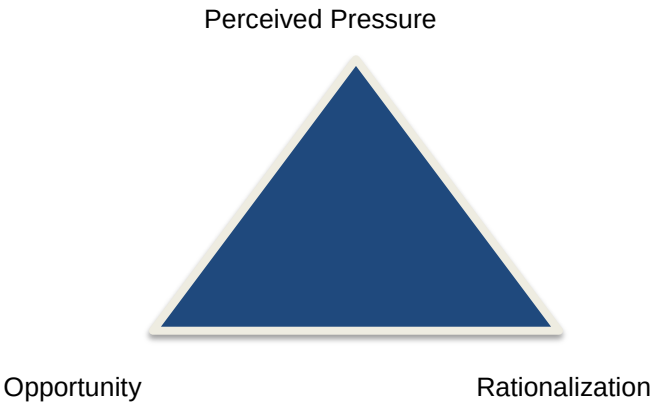

Figure 2.2 Donald Cressey's fraud triangle. Adapted from Tuke (2012).

- *Perceiving an opportunity* - Primarily, fraudsters require an opportunity to commit fraud. It is more likely that they act when the likelihood of being caught is small. Insurers should therefore have mechanisms to proactively disallow fraud from occurring, proper policies, procedures and fraud detection methods.
- *Perceived pressure* - Motivation to commit fraud may be for various reasons. The main motivators are related to financial problems and pressure to meet surreal personal or business objectives. The insurers must look for the potential for these reasons to exist and therefore would be pro-actively fighting against fraud before it could happen.
- *Rationalization* is the unconscious defence mechanism used by a fraudster to persuade the self that something that is otherwise known as being wrong is actually acceptable. (IAIS, 2011)

2.6 Life assurance fraud

Fraud can exist in various types and areas of insurance. However a considerable percentage of the total fraudulent claims occur in the life assurance sector. In 2011 ABI has registered 599 fraudulent cases in life while another 172 were registered in investments. (ABI) Last year, South African life insurers also registered a record number of 4,514 attempts by policyholders and beneficiaries to claim policy benefits through fraudulent or dishonest means. (Kamhunga, 2010) These facts demonstrate the gravity and the high relevancy of the problem of life assurance fraud. Approximately 8% of life insurance companies apply for reinsurance so that the lower the risk of becoming insolvent due to the high possibility that exist in policyholders defrauding them. (Young, 2011)

2.6.1 Types of life assurance fraud

Life assurance fraud can occur in various forms including:

- **Misrepresentation** - this can take place in two forms. Innocent misrepresentation is related to inaccurate statements made by a client to the underwriter without any fraudulent intention. Fraudulent misrepresentations refer to false statements that are made with the intent to deceive the insurer or else these are made recklessly without any regard for truth. (Kutty, 2008) Misrepresentation and material non-disclosure rendered 1,648 claims (amounting to R352 million) dishonest in 2009. (ASISA, 2010) (Hamilton, 2009)
- **Fraudulent documentation** - 1,238 cases (amounting to R74 million) of fraudulent documentation sent to the insurers with the attempt to receive death/funeral policy benefits were also reported (ASISA, 2010):

> *"A number of these cases involved falsified death certificates. We have also come across cases where the date of death was changed to fall outside of the waiting period of the policy. In one case the beneficiary used an unclaimed body at the mortuary and presented the deceased as someone covered by the policy."*

- **Murder for profit** - This involves the killing (or arranging for the killing) of a person in order to claim money. It is often the case that the murderer may make the event look like it was an accident or a random killing. The death and funeral insurance categories experienced the highest number of fraudulent and dishonest claims in 2009. Life companies reported 3,266 cases costing R364.9 million (in Rand currency). (ASISA, 2010)
- **Money laundering** - Applications constitute the second largest risk exposure after claims. Saving policies are more attributed to money laundering when compared to protection. This is so because the nature of the policies that are available under the savings domain makes them more vulnerable and easier for customers to engage in money laundering activities. Unfortunately insurance is susceptible to money laundering and life insurance is not an exception. This is true since most insurance business is channelled through intermediaries resultantly make it vulnerable to money-laundering activities. Another way of how money laundering can take place in life assurance policy is through early policy redemption. (Robinson, 2007)

2.6.2 Cases

Various types of cases exist in life assurance. A typical life assurance fraud case lies in that of John Darwin. Darwin decided to disappear in his canoe in the sea outside his country after having to pay a sum of £240,000 in mortgages. Darwin together with his wife planned to defraud the life insurance policy for a lovely return of £680,000 after which the couple was seen as prospective buyers looking for a new property in Panama. (Daily Mail, 2011)

Another fraudulent life assurance case was held in South Africa where a couple fabricated a false birth certificate and years later claimed out for benefits. The couple had borrowed a female body from a mortuary for the funeral to take place. (BBC, 2012)

In another account, Helen Golay and Olga Rutterschmidt were also involved in fraud. This is one of the most extreme and most disturbing cases of a life insurance scam to date. These senior citizens decided to become friends with two homeless men, take out 15 life insurance policies in their names, and then have them killed to get the $3 million in insurance money. Joel Zellmer was also accused of murdering his step daughter to collect money from insurance. (Hannan, 2010)

Seven persons were charged with mail fraud, money laundering and asset forfeiture. (Investigation, 2012) The accused persons had allegedly used their position for receiving commission by selling life insurance policies based on false information; specifically, the applicant's net worth and annual income.

2.6.3 Ways to combat fraud

The fight against fraud in life assurance is a combined effort including different stakeholders such as the insurance companies, government and police:

> *"Whosoever, with intent to obtain for himself or for any other person the payment of any money due under any insurance against risks, or any other undue benefit, destroys, disperses or deteriorates, by any means whatsoever, things belonging to him, shall, on conviction, be liable to imprisonment for a term from seven months to two years, and, where he succeeds in his intent, from nine months to three years." (Justice, 1854, p. 117)*

In an empirical test on the attitude towards fraud from insurance customers, set up by Tennyson 1997, it was concluded that a customer's attitude would be influenced by two main factors; the ethical and social environment of people. In this test it was expressed that usually fraud is commenced by individuals who have negative perception on insurance institutions. In another survey set out by the International Association of Insurance Supervisors (IAIS), public attitude was discussed in the light that it cannot let the public think that fraud was an acceptable action. Instead awareness and education must be the main tools in changing clients' mentality.

2.6.4 Tools and mechanisms used

The Insurance Fraud Bureau (IFB) aids insurers in detecting and preventing cross-industry fraud. Insurance Fraud Enforcement Department (IFED) is another important unit that has dedicated specialist police units that can identify and prosecute fraudsters. A recent weapon for combating insurance fraud is the Insurance fraud Register (IFR) which was launched on 13 September 2012. This register combines all the data of fraudsters and the IFR will then enable insurers to eliminate fraudsters who have committed fraud (of any type) with other insurers in the past. Such information will enable insurers to make a good evaluation in the underwriting of insurance and when processing claims. The Financial Services Authority's (FSA) perspective view on insurance fraud was that by working in affiliation with stakeholders, government, law enforcement, client itself and most importantly with insurance firms. (Robinson, 2007) (Davies, 2012) It is also required that insurers put in place fraud investigation teams with the right expertise and credentials that work hand in hand with law enforcement agencies to eliminate fraudulent claims. It is also important for the industry to build a shared or centralized database to share information related to frauds. (Young, 2011) Nowadays all the major insurers in the United Kingdom employ their own experienced fraud investigators and most use advanced data analytics that help them in identifying transactions and patterns that look unusual and merit closer attention. Moreover there are well established systems that allow collaboration between insurers in their attempt to combat

fraud at a sector level, rather than simply at an individual company level (KPMG, 2012). Another important milestone in fraud detection includes the whistle blower hotlines. These provide the means for people to report suspected fraudulent behaviour. This mechanism is highly effective in detecting fraud at an initial stage. Apart from technology it is also important to ensure having basic controls in place, especially those highlighted in the internal audit reviews. Audits can help identify any red flags that indicate identity theft. (KPMG, 2012)

Thus the need for sophisticated mechanisms to be in place is of inevitable importance. On deploying these types of mechanisms, insurers also need to keep in mind that fraudsters are becoming more aware and knowledgeable of technology in general and fraud detection systems. This in turn is making it much more difficult for insurance companies to detect fraud. The FSA's financial crime outcome was that customers are much more equipped nowadays to protect themselves from financial crimes. Therefore it is an on-going battle as fraudsters are continually looking for new ways of how to defraud insurance companies.

2.7 Conclusion

In this chapter we have given an overview of life assurance including the types and uses, the principles of insurance that relate to life assurance, the life insurance fraud model that we are adopting in this thesis, types of life assurance fraud cases including real-world cases and current ways and means to fight fraud. We will now describe the methodology used for this study in the following chapter.

3. Methodology

"Research is to see what everybody else has seen, and to think what nobody else has thought."

Albert Szent-Gyorgyi (1893-1986)

3.1 Introduction

Research is defined as a systematised effort to gain new knowledge.[4] The term *research* refers to the systematic and objective addressing of the problem, proposing the hypothesis, collecting the facts or data, analysing the facts and making conclusions in the form of solutions or generalisations (Kothari, 2004). Researchers make use of a mixture of quantitative and qualitative concepts to understand the world fully.

The purpose of this study is to analyse, in perspective, the problem of life assurance fraud. Research is conducted to identify the group of people that are most likely to commit fraud. Academics and professionals in the insurance academia and industry are consulted to give their own views.

The main aims in this chapter are to give a description of the qualitative and quantitative approaches that can be used, to give an explanation on the sampling approach, to describe the approaches that were used for this particular research and the procedure used in collecting the data.

[4] Definition was taken from (Redman & Mory, 1923).

3.2 Quantitative research

Quantitative research is generally attributed to the positivist paradigm. According to Cohen it is described as “social research that employs empirical methods and empirical statements.” Cohen stated that an empirical statement is defined as a descriptive statement about what “is” the case in the “real world” rather than what “ought” to be the case (Cohen & Manion, 1980).

3.2.1 Quantitative research techniques

There are various techniques that fall under the quantitative research paradigm. Two of these used are the interview and the questionnaire. Despite the fact that interviews are generally associated with qualitative methods due to the verbal communication that takes place, they also demonstrate quantitative data extracted from the interviewees’ opinions (Trochim, 2006).

Questionnaires are used to gather characteristic information of a large population that is of interest based on a study in which a smaller group of participants represent the whole of the population. The questionnaire is a technique that is used to collect data based on people's opinions usually by asking them how much they agree or disagree with a statement provided. The questionnaire would also require some questions to be answered by ticking the appropriate box. Respondents are also provided with questions that would ask for their own personal opinions. This allows the researcher to separate participants into different clusters (Hannan, 2007).

Quantitative research reduces measurements to numbers. The use of rating scales is commonly used. An example is the five-point agreement scale as shown in table 3.1.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Table 3.1 The five-point agreement scale.

A statement is provided in the questionnaire and the respondent replies with one of numbers in the five aforementioned categories. The researcher can then calculate the average based on the number of respondents (Johnson & Christensen, 2012).

3.3 Qualitative research

A qualitative approach is used to study the empirical world from the perspective of the subject, not the researcher (Duffy, 1987). Benoliel expanded on this aspect and described qualitative research as:

> *"...modes of systematic enquiry concerned with understanding human beings and the nature of their transactions with themselves and with their surroundings" (Benoliel, 1984, p. 3).*

Qualitative research is based on the examination of human choice and behaviour as it occurs naturally. Investigating the experience of participants is also referred to as the humanism approach. The researcher must not intervene in this natural flow of behaviour. The behaviour is studied holistically and naturalistically. The purpose here is to understand and interpret social interactions (Johnson & Christensen, 2012).

Data is usually expressed in the form of words after observations, in-depth interviews and group discussions have been conducted. These events may be recorded and are

subsequently transcribed into words and eventually analysed using qualitative techniques. The researcher is allowed to write relevant insights and thoughts, identify general categories and recurring themes (Xavier, 2012).

3.3.1 Interviews

Interviews can take the form of both individual interviews more known as one-to-one interviews and group interviews. Data that is produced during the interview can be recorded in a wide variety of ways including stenography, audio recording, video-recording or written notes. In interviews, there is generally a questioner and one or more interviewees. The main aim in the interview is to retrieve the ideas of the interviewees about the phenomenon of interest (Trochim, 2006).

3.3.2 Focus groups

A focus group is according to Lederman citing Thomas *et al*:

> "…a technique involving the use of in-depth group interviews in which participants are selected because they are a purposive, although not necessarily representative, sampling of a specific population, this group being 'focused' on a given topic". *(Thomas, et al., 1995, p. 206)*

Focus groups are useful for providing information about a range of ideas and feelings that individuals have about certain issues, as well as highlighting the differences in perspectives between different groups of individuals (Du Plessis & Du Rand, 2012).

3.3.3 Case studies

A case study is a research technique that is used to investigate a phenomenon within its real-life context. It is a technique for conducting research that involves an empirical investigation of a “particular contemporary phenomenon within its real life context using multiple sources of evidence” (Yin, 1984). The researcher is allowed to represent a generalization of the research problem in the case study method that is, in itself, an intensive study of a specific individual, group or context. Freud drew up several case studies of individuals to form the basis for the theory of psychoanalysis. In the case study method, data can be collected from a combination of sources such as focus groups, in-depth interviews and documents and are, therefore, considered as multi-perspective analyses (Anyanwu, 2009).

3.3.4 Sampling in quantitative and qualitative research

In both methods of research, the main aim of sampling is to draw a representative sample of the population. The results from the research study can then be generalized back to the whole of the population. The determination of the size of the sample is determined by the optimum number necessary to be able to generalise, or make valid inferences about the population. Increasing the sample size would result in a random sampling error but since the sampling error is inversely proportional to the square root of the sample size there is little to gain in using very large sample sizes. The sample size also depends upon the parameters such as rarity of the event and others (Marshall, 1996).

The most common approach is to take a random sample from the population where all members of the population have an equal choice of being selected. This approach is usually inappropriate to qualitative research and is not the most effective way of developing an

understanding of complex human behaviour issues. The reasons (Marshall, 1996) are various:

1. Samples for qualitative analysis are usually small leading to a large sampling error making the usage of biases inevitable.
2. For true random sampling, the characteristics of the population should be known; a rare possibility in complex qualitative studies.
3. There is no evidence that core characteristics of qualitative investigation such as values, beliefs and attitudes of members of the population are normally distributed.
4. Choosing people at random would be analogous to asking a passer-by how to repair a computer. Asking the computer technician would be more productive.

There are mainly three approaches to selecting a sample. Convenience sample refers to choosing the most accessible subjects. This would often result in the least costs but is criticized for credibility. The most common approach is, therefore, the judgment sample where the research selects the sample based on the researcher's practical knowledge, the available literature, evidence and other sources. Subjects may be able to recommend other prospective candidates (snowball sample). It is important to consider subjects who agree and who disagree (conforming and disconfirming samples). The last approach is the theoretical sample in which interpretative theories are extracted from the emerging data and a new sample is selected to elaborate on this theory (Marshall, 1996).

3.4 Methodology used in this study

The usage of surveys in this research study was an important technique for data collection. The term survey "is commonly applied to research methodology designed to collect data from a specific population or a sample from that population and typically utilizes a questionnaire or an interview as the survey –instrument" (Robson, 1993).

This study used a descriptive mixed-method research design using questionnaires and focused interviews. A questionnaire (see Appendix B) was designed to assess the perceptions, beliefs and attitudes of participants towards life insurance fraud. It was ensured that the included questions were easily comprehensible, straight-forward and left room for subjectivity where subjects were asked for the opinion on the causes of fraud, the genders and ages of fraudsters using quantitative techniques. The questionnaire also included a case study that described a case of insurance fraud using a real-world example that could happen in very normal families. The subjects could then give their own opinion in a ten-point Likert Scale. This was preferred to the five-point agreement scale, as the ambiguity in the wider scale could help with reducing the error. In the case study given, a scenario was placed in which participants had to express their attitudes towards a described social situation.

Focused interviews were also conducted where the pre-chosen experts could provide academic or profession-based opinions and views on the subject matter. These experts were contacted beforehand and a scheduled interview with each of them was conducted. Responses through emails were also received.

3.4.1 The use of multiple methods in research methodology

In order to ensure that the problem domain in this research study was fully understood, use was made of a combination of qualitative and quantitative concepts. This was possible through the use of triangulation which allows researchers to collect both quantitative and qualitative data through the use of primary and secondary sources (Bolton, 2005). The employment of different methods of observation allows one to view the problem domain from different aspects of empirical reality. This helps to alleviate the weaknesses, biases and errors that are caused by using only one method as different types of data provide cross-data validity checks. Triangulation is not aimed mainly at validation but also at deepening and widening one's understanding (Holborn, 2004).

Figure 3.1 depicts the concept of the mixed research method that is composed of both qualitative and quantitative concepts.

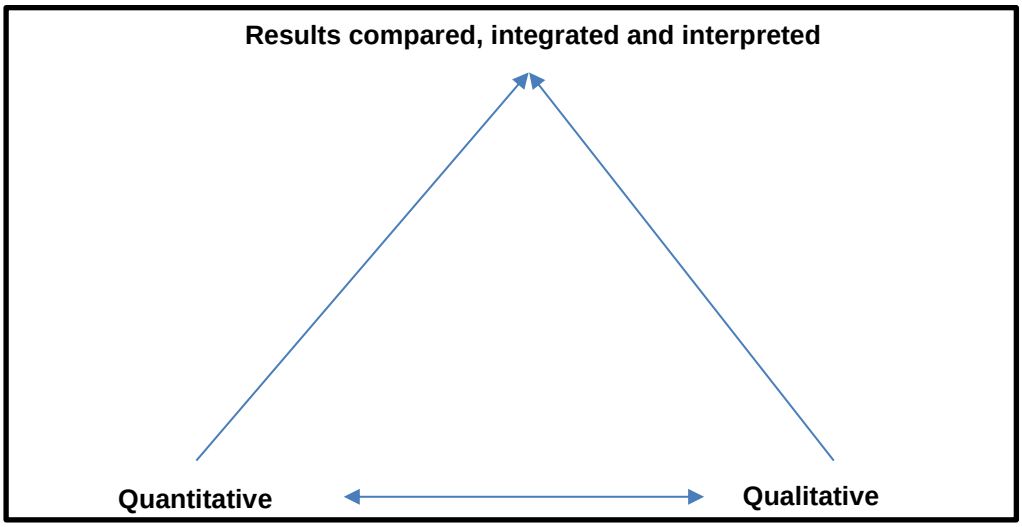

Figure 3.1 Triangulation research method – A mixture of qualitative and quantitative concepts. Adapted from: (Friedman, et al., 2002)

3.5 Data collection

Data was collected in the forms of recorded interviews, transcribed interviews and filled-in questionnaires. Interviews were recorded and transcribed (see Appendix D) after consent was sought from the interviewee. In the case where consent was denied a customized questionnaire was created for the specific interviewee instead of conducting the recorded interview. Moreover, the interviewee could freely terminate the interview at any point in time without an explanation or a justification. The questionnaires that were distributed to the general public did not collect data that could hint or indicate the identity of the participants.

3.6 Limitations

The minimum sample size n for a particular population using the normal approximation to the binomial distribution (Bittner, 2007) is defined as (Morris, 2008) :

$$n = \frac{z^2 pq}{E^2}$$

The variables:

z is the level of confidence. Typical value is 1.96

p and q are the population proportions. Typical value for each of them is 0.5

E is the margin of error. Typical value is 0.03.

Setting the variables to their typical values would imply a sample size of 1,068 subjects. Since time was a limitation in this research study, it was decided to decrease the sample size for the public's questionnaire to 150 subjects. This would result in E, the margin of error, to become 0.08 or 8%. This decision was also supported by the fact that the Maltese population is relatively small having only 416,110 as its population [5] and therefore relatively less people would be willing to participate in the survey.

3.7 Pilot study

The questionnaires that were distributed to the general public were iteratively refined so as to ensure that the questions that were included were easily comprehensible by all. It was ensured that the questionnaires did not take more time than necessary so as not to inconvenience the participants. This pilot study was conducted with an individual who is not familiar with the insurance domain. Copies of the questionnaires before and after the pilot study are found in Appendix B.

[5] The population size as at 2011 as indicated by the National Statistics Office. Retrieved from: (NSO, 2012)

In a second pilot study, the interviews that were addressed to the life assurance companies and concerning bodies were rehearsed with an expert in the field. Corrections were made during these iterations so as to ensure that the questions were asked to the most adequate interviewees. Copies of the interviews before and after the pilot study are found in Appendix C.

3.8 Ethical considerations

All ethical considerations were followed throughout this research study. A proposal form (Appendix E) addressed to the University Research Ethics Committee (UREC) was duly filled, signed by the research supervisor, Mr. Andre Farrugia, and handed in to the faculty committee before data collection could commence.

A letter of informed consent was forwarded to all participants (see Appendix A). It was ensured that the personal data that was collected was relevant to the purpose of the research study and correct. Personal data was not disclosed to third parties to ensure confidentiality (Malta, 2003).

3.9 Conclusion

In this chapter, research methods and techniques that were useful to carry out research investigation were identified. The reader was also introduced to the different methods that the author had adopted in this study including the sampling approaches that were considered.

4. Analysis and Results

"Curiosity begins as an act of tearing to pieces or analysis."

Samuel Alexander (1859-1938)

4.1 Introduction

In this chapter the scope is to analyse the various perceptions, beliefs and attitudes of both the general public as well as of the other stakeholders, including experts in the field. As described in chapter 3, this study is based on a descriptive mixed-method research design consisting of questionnaires and focused interviews as shown in figure 4.1.

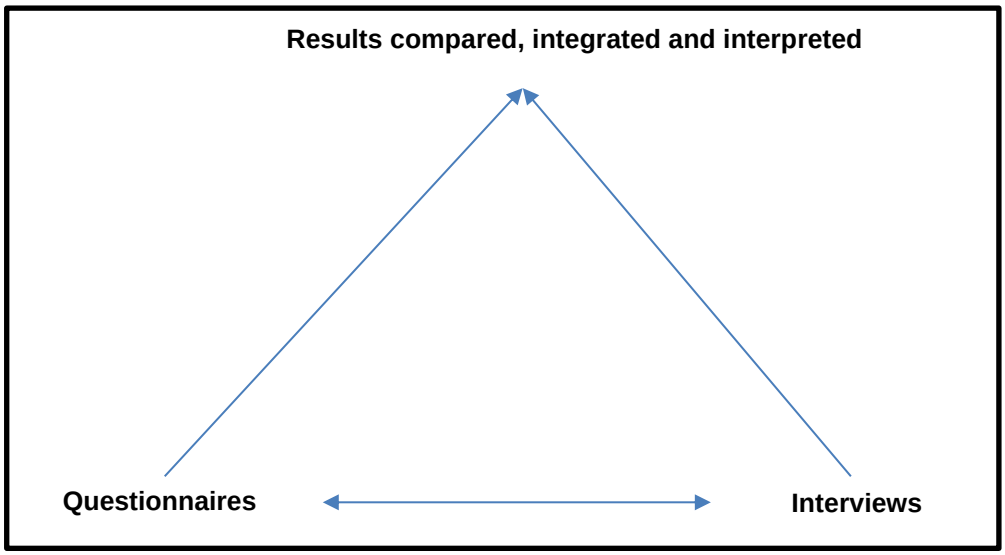

Figure 4.1 Triangulation research method – A mixture of qualitative and quantitative concepts. Adapted from: (Friedman, et al., 2002)

Comparing the results obtained from the qualitative and quantitative paradigms in this study has resulted in a degree of inconsistency. The following is a detailed overview of the results and findings obtained through quantitative and qualitative analysis.

4.2 Qualitative analysis

In this study, qualitative analysis takes the form of interviews. Interviews were carried out to a pre-selected group of professionals. In order to fulfil the aim of analysing the problem of insurance fraud under the two aspects of life insurance; savings and protection, various interviews were conducted with professionals who have different roles in the insurance market. These included professions such as companies' directors, chief executive officers, underwriter officers, chief underwriting officers, compliance officers, money laundering reporting officers and police. This was done to gather holistic information from the various sources and to check what insurance companies, police and other related bodies are doing to detect, prevent and suppress fraudulent life assurance claims.

Figure 4.2 The flow of escalations that should take place whenever insurance companies are confronted with a fraudulent life assurance case.

Figure 4.2 depicts the process that insurance companies go through when they are faced with a suspicious claim. Whenever insurance companies suspect that the proposal form/claim is of a fraudulent nature, the case is forwarded to the FIAU for money laundering purposes. If these Suspicious Transaction Reports (STRs) result positively they will be forwarded to the Police for further investigation and court judgments. On the other hand, with respect to protection's fraudulent claims, insurance companies conduct an internal find-out with the help of medical records and will eventually pass these claims to the police if these results are found to be fraudulent. During the interviews some questions were amended according to the type of the company.

A common question that was put in all the interviews asked about the trends of fraud in life assurance in the last ten years. The majority of the responses declare that the trend is on the increase. One of the interviewees specified that this is attributed to an increase in the number of people applying for life insurance (thus the possibility of fraudulent claims increased proportionally). This positive correlation had also been reported in the FIAU annual reports (FIAU, 2012). The interviewee representing the FIAU quantified that the year 2012 has been characterised by the highest number of STRs ever received by the unit since its establishment in 2002. On the other hand the Police Inspector warned that there was consistency in the reports during the last ten years.

The second question asked interviewees to give an estimate of how many claims actually end up being fraudulent. Four options were given to answer this question including; 0% to 25%, 25% to 50%, 50% to 75% and 75% to 100%. Most of the participants agreed on the lower quartile percentage. Respondents clarified that products offered under life insurance policies; thus including both investments and protection policies are kinds of complex products and thus it reduces the anticipation for one to commits fraud. Other respondents said that unlike other countries, in Malta it is very rare for one to commit fraud and this also applies for money laundering since insurance companies are investing heavily in mechanisms to detect these types of cases.

The police inspector contended that this low figure can be attributed to several factors. Insurance companies are at times quite hesitant to report cases. Sometimes they are not equipped well enough with the necessary apparatus to detect fraud. In other cases they might detect or suspect fraud they often do not consider reporting the case to the police. Finally, they may try to reach an amicable settlement with the claimant in that particular case. By contrast, a representative of the FIAU stated that year 2011 had recorded the highest number of STRs amounting to 102 while 2012 have registered over 130 STRs and cases since 12th December 2012 (the day on which the interview was conducted). This figure

however represents the amount of fraudulent claims for insurance licenses and thus these figures might not necessarily relate to life assurance cases.

Another question asked the age group of people that according to the interviewees are more prone to commit fraud. There were four possible age groups to answer this question; 18 to 25 years old, 25 to 40 years old, 40 to 65 years old and 65 years and older. The majority of the interviewees were in agreement that the age range 25-40 years old and 40-60 years old are the most prone to commit fraud. One of the interviewees also stated that:

> *"A life insurance policy would usually be taken up by somebody who either needs it because it is mandatory as in the case of loans, or because they would like to save something for their heirs and these would generally be policyholders over forty years of age. "*

From the analytical point of view, a representative for FIAU stated that the unit does not hold these types of statistics because they are not considered as relevant data to their studies.

The question that followed concerned gender. Interviewees were in consensus that males are more prone to commit fraud than females. One of the interviewees argued that this is not because "males are bad but because usually we have more requests from males for loans".

The Police Inspector reported that insurance companies cannot limit themselves into suspecting only males because over the past years there had been two women in particular who were relatively very good in committing fraudulent activities.

An interesting fact in this primary data was the fact that insurance companies are confident that life assurance fraud is not a problem in Malta. It was also stated that insurance fraud in

Malta it is not leading to economic problems as yearly reports indicate that volumes are still very low. They were all in agreement that it is far less than half a million euro a year and this figure is being considered as part of their standard costs. One of the interviewees said that at times they just settle claims as it is far less expensive than the costs that are involved in investigating a claim. Another concerning statement during the interviews was that in general, doctors are not helpful in reporting the actual health assessment when policyholders are sent for medical tests as medical records at later stages prove otherwise. This however does not apply to doctors at Mater Dei Hospital for whom all of the interviewees had positive remarks.

An issue that was also discussed with the interviewees was that concerning the current legislative system in place. Various answers were recorded. A money laundering reporting officer (MLRO) and an underwriter stated that the Prevention of Money Laundering Act[6] is considered to be quite harsh and thus there is no need for it to be revised. Others, especially those involved in claims with respect to the protection side, believe that there is room for improvement and suggested harsher penalties. One of the interviewees mentioned the fact that cases most often take a lot of time to be settled and this results in an accumulation of interests. The interviewee also pointed out that in these circumstances insurance companies would suffer reputation repercussions and emphasized the fact that sanctions in terms of convictions should be increased so that "people would realise that insurance fraud is a serious crime." He also suggested that all the laws concerning insurance fraud:

> *"...should be amended to make it clear that insurance companies can investigate people for insurance fraud and that there will be no limitations as to what investigations they can carry out provided that the investigations that they are doing are intended to prevent and suppress insurance fraud."*

[6] Prevention of Money Laundering Act. Source: (Malta, 1994)

The police inspector explained that insurance fraud is covered by two criminal offences within the criminal code. He explained that according to the Criminal Code[7] article 310 where fraud amounts to €2329.37 or more, a citizen is punished by up to seven years imprisonment. Article 295 is where the code itself names this crime and fraud relating to insurance. The police inspector explained that while article 295 implies a maximum of three years imprisonment penalty with regards to article 308 aggravated by article 310 the imprisonment penalty amounts to seven years. He also considers that the penalties imposed are reflecting the seriousness of these offences.

Another relevant question that was put to interviewees was about the anti-fraud mechanisms that are being adopted by insurance companies. All of the respondents agreed that the most useful method to detect fraud remained that of providing intensive training to underwriters and other personnel. This applies both for detecting fraudulent claims and money laundering. One of the interviewees stated that: “Sixty or seventy per cent of fraudulent claims are identified at underwriting stage and not later ‘” and thus the need for proper and continuous training remains an important asset for insurance companies to detect fraud as early as possible.

From the aspect of money laundering, insurance companies treat highly financial underwriting. One of the interviewees explained that the most viable tool to check for money laundering consists of firstly understanding the policyholder’s needs and subsequently checking if the policyholder’s demands make sense relative to the occupation and income. Another respondent insisted that his company puts great emphasis on call-smurfing, whereby the policyholders pay in irregular and large instalments. He also explained that when a policyholder requests for policies that are greater than fifteen thousand euro, these are automatically flagged for monitoring. This also applies to those events in which a policyholder increases the regular premium drastically. It was also explained that nowadays

[7] Criminal Code Chapter 9. Source: (Malta, 1854)

money laundering obligations are very tough and insurance companies are obliged to provide staff with training on money laundering detection techniques. Some of the interviewees explained that in addition to this their companies designate a money laundering reporting officer and a deputy money laundering reporting officer to be able to detect money laundering effectively.

A representative for a life assurance company in particular affirmed that underwriters are sent overseas on a regular basis to be able to anticipate the recent trend for fraud as part of the mechanisms adopted. Training for this particular company is held by reinsurance companies as the latter tend to have a more mature experience in the field. Life assurance companies revealed that they also have access to hospital records from anywhere in the world. One of the interviewees mentioned the importance of the Insurance Business Act and the Professional Secrecy Act in the duty of information exchange between insurance companies to effectively eliminate fraud.

The interviewee representing the FIAU stated that the unit provides various training sessions to entities that are subject to money laundering activities including training for life assurance companies. These include comprehensive training sessions on customer due diligence, record-keeping and that of reporting on latest development. On the other hand the police inspector indicated that:

> *"Insurance companies rarely or never approach the police for any training programmes for joint programmes and as police we are rarely or never invited by insurance companies to attend seminars they might organize in their field. So I might add that there is the need for better co-operation between police and insurance companies."*

Other stakeholders include the Malta Financial Services Authority (MFSA) and the Malta Insurance Association (MIA). Insurance companies are all aware of these associations to

these stakeholders and they hold different relationships with them. However a Claims Department officer stated that there is no kind of assistance from these bodies and that whenever they were faced with a fraudulent case they had always dealt with them independently.

On the other hand, in the case of money laundering there is an excellent level of communication between the MFSA, compliance officers and the MLRO. Moreover the MFSA assists in new products and also protects the interest of the policyholder so whenever there is a complaint from a client, the authority will call for communication to take place.

The MIA has also a very close relationship with insurance companies as the latter are active members within the association. One of the interviewees stated that the insurance companies are trying to reach an agreement between the local life insurance companies to act through the MIA to reduce bureaucracy. He also explained that MIA organizes life sector meetings and are now also trying to co-operate both on the underwriting side as well as on the claims side in anti-fraud. The Police Force on the other hand had never been invited by the MIA and as a result knows nothing about this association but they are on very good terms with the MFSA and have also access to their online system where they have the permission to check who is being investigated and the MFSA itself is a witness in cases where the Police Force prosecute in court.

4.3 Quantitative analysis

This section summarises the overall findings which were obtained through the use of questionnaires to give a deeper understanding of the perceptions, beliefs and attitudes of participants towards life assurance fraud. Questionnaires were provided in both printed and online forms. The sample size used was 150 and the researcher managed to distribute the

questionnaires proportionately so as to get responses from various people of different ages and with dissimilar occupations. The questionnaire had two sections. In the first section the participants were provided with a general background on life assurance and they were presented with ten questions to answer. Questions were of two types. Some of them were open-ended questions where the author was after the subjective opinion of the respondents while others requested the respondent to choose a preferred answer in multiple-choice style questions. Section B consisted of two case studies where the participants had to express their reactions towards the scenarios described. A copy of the questionnaire is provided in Appendix B. The following is a summary of the responses which were gathered from the questionnaires.

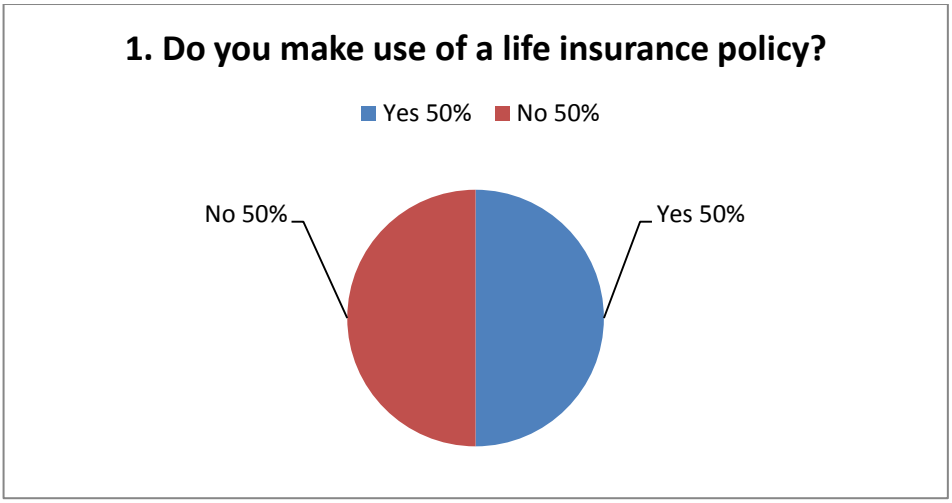

Figure 4.3 A graph depicting the ratio of male to female respondents.

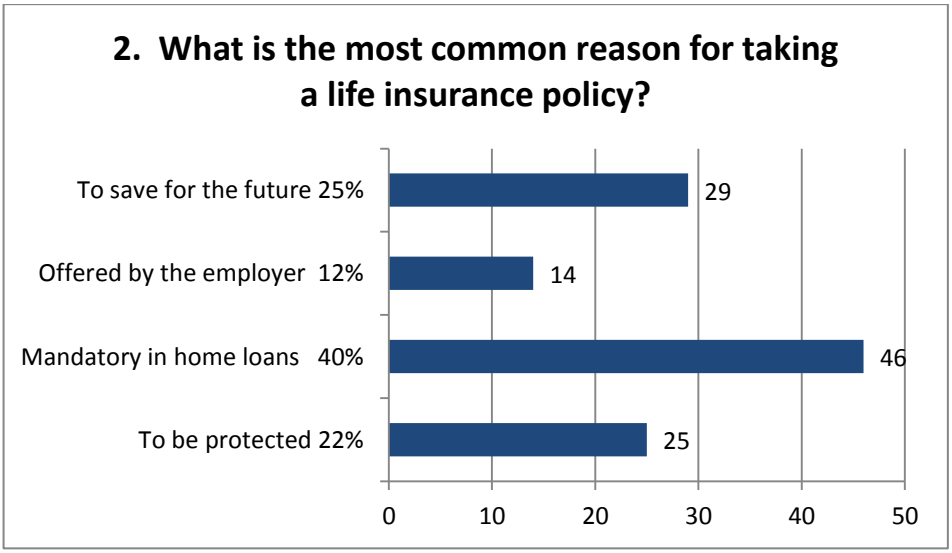

Figure 4.4 A bar chart showing the motives for taking a life insurance policy

The first graph (Figure 4.3) shows that half of the respondents had a life assurance policy. The second graph (see Figure 4.4) shows that the onus for having this type of policy is because it's mandatory in home loans and not because they actually need it which could create a deficient in insurable interest.

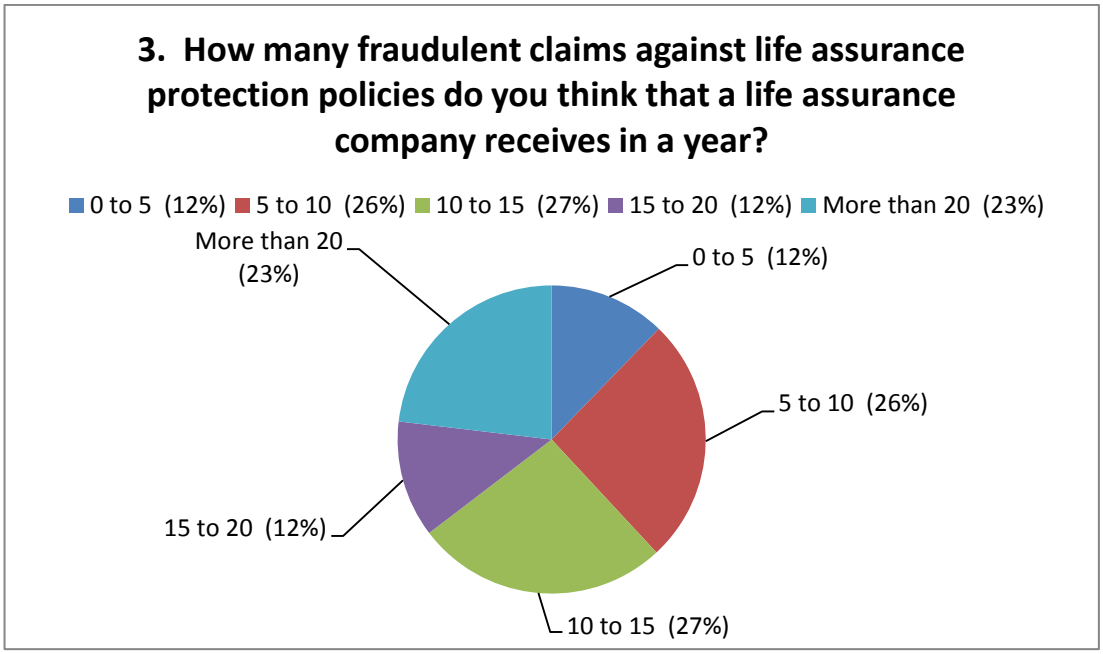

Figure 4.5 A chart showing the number of fraudulent claims that life assurance companies register according to the respondents' rational.

The majority of the respondents (figure 4.5) think that a life assurance company receives more than ten fraudulent claims in a year.

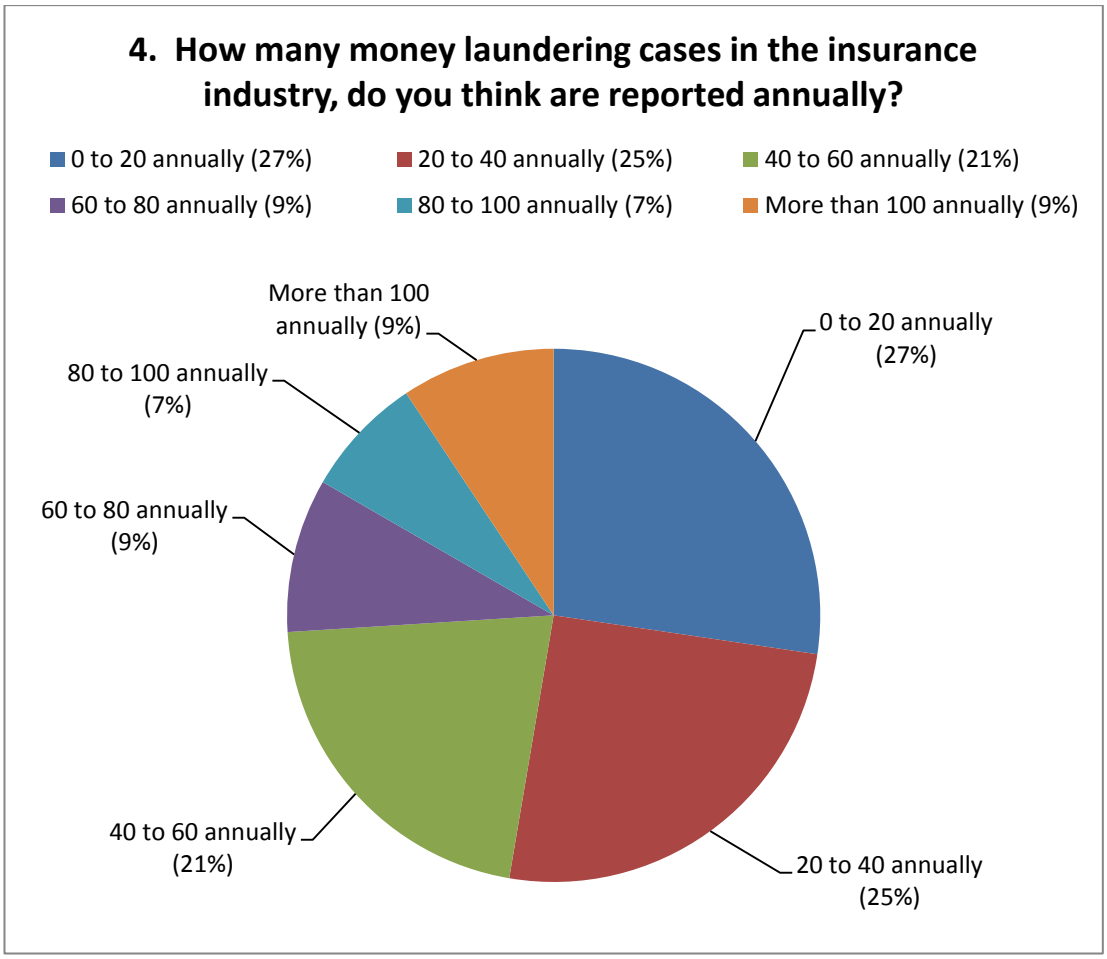

Figure 4.6 A chart showing the respondents' answers to how many money laundering cases are reported annually in the insurance industry.

The graph in figure 4.6 describes the perception of the respondents towards how many money laundering cases are reported annually in the life insurance industry. As indicated clearly in the graph the majority believes that there are 20 to 40 fraudulent cases of money laundering that are reported annually.

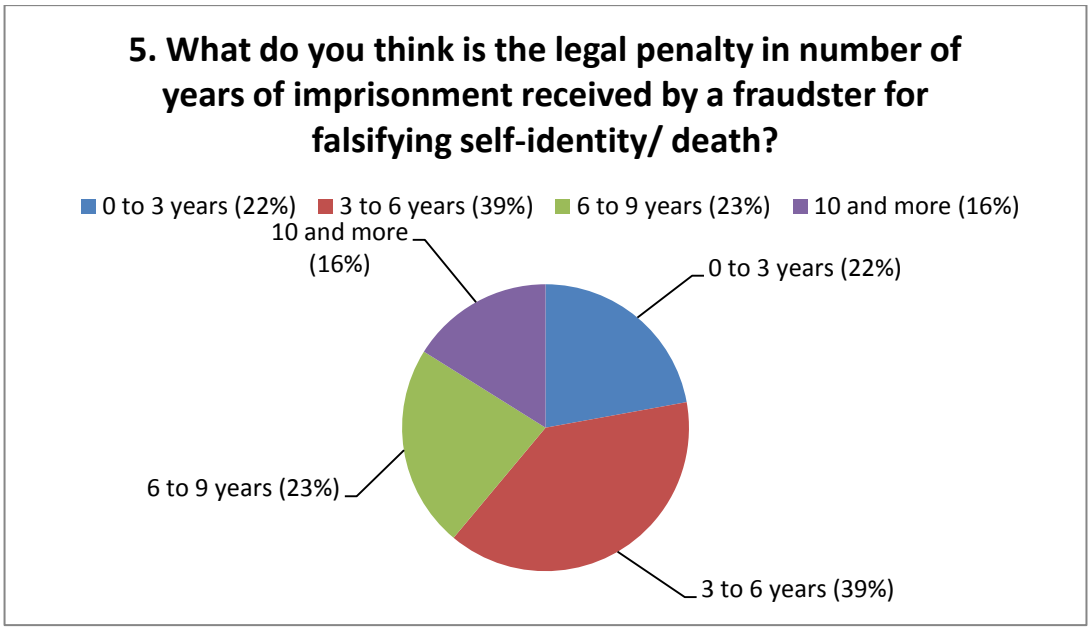

Figure 4.7 A chart showing the number of years for imprisonment that a fraudster would receive according to the respondents' knowledge.

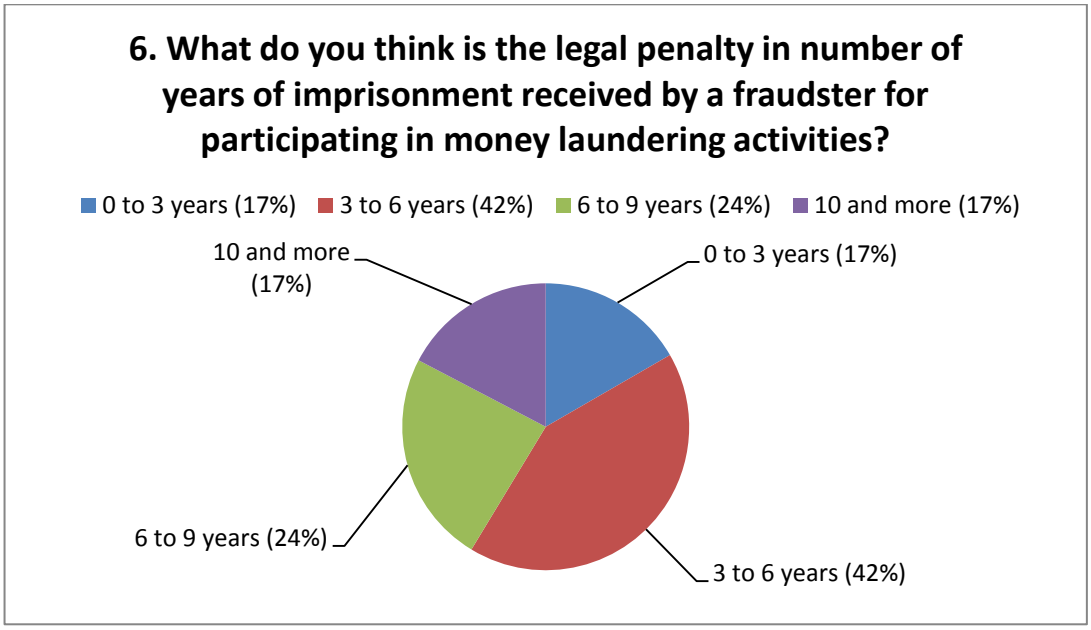

Figure 4.8 A chart showing the legal penalty that a fraudster would receive for money laundering activities according to respondents' beliefs.

The majority of the respondents think that fraudsters who falsify self-identity or death are punished by imprisonment of 3 to 6 years (figure 4.7). The same imprisonment term was chosen by the majority for fraudsters in money laundering (figure 4.8).

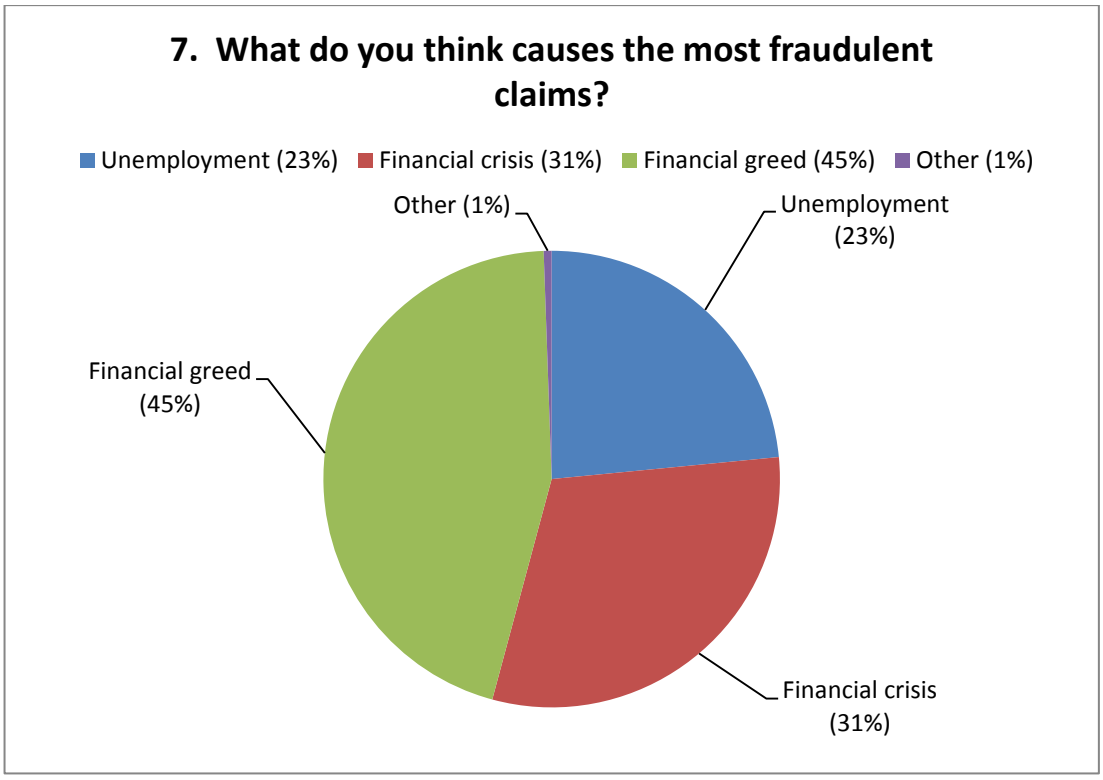

Figure 4.9 A chart showing the perception of respondents to why a fraudster would commit an illegal activity.

The seventh question (figure 4.9) asked for the main reasons that instigate fraud. The majority of the respondents, 45%, think that fraudsters commit fraud due to financial greed while 31% of the respondents think that fraudsters would turn to commit fraud when they are in financial difficulty. 23% of the respondents think that policyholders would defraud due to unemployment whereas 1% of the respondents think that it's due to other reasons.

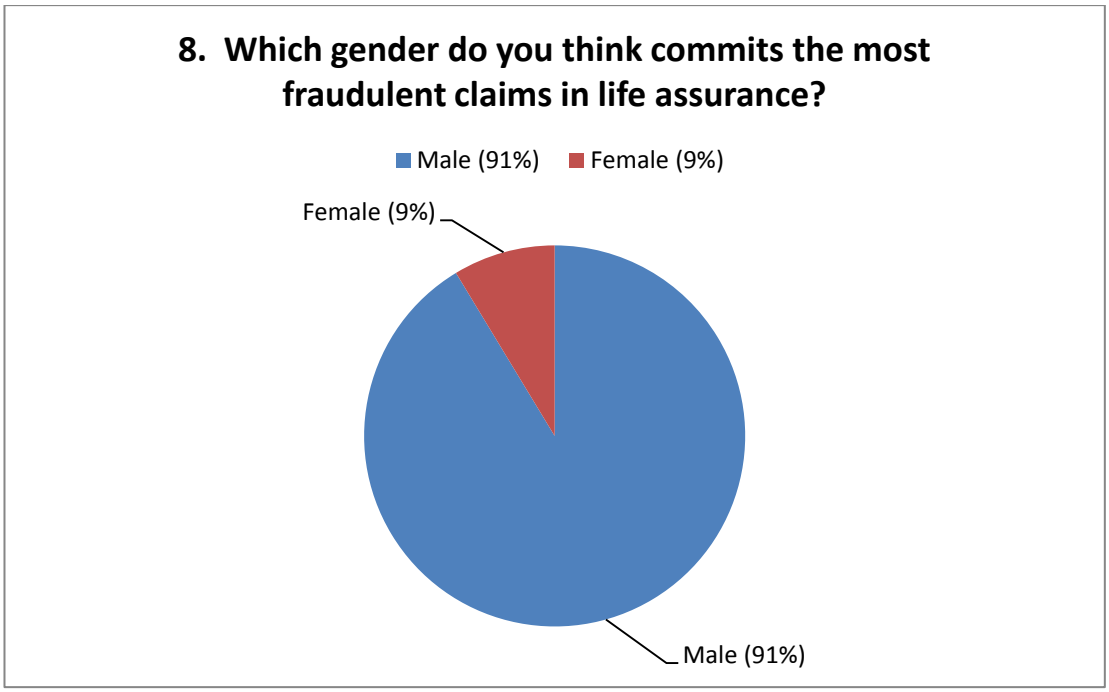

Figure 4.10 A chart showing the perception of respondents with respect to fraudsters' gender.

In figure 4.10 participants seem to agree that males are much more prone to defraud life insurance companies. This ratio is approximately 9:1.

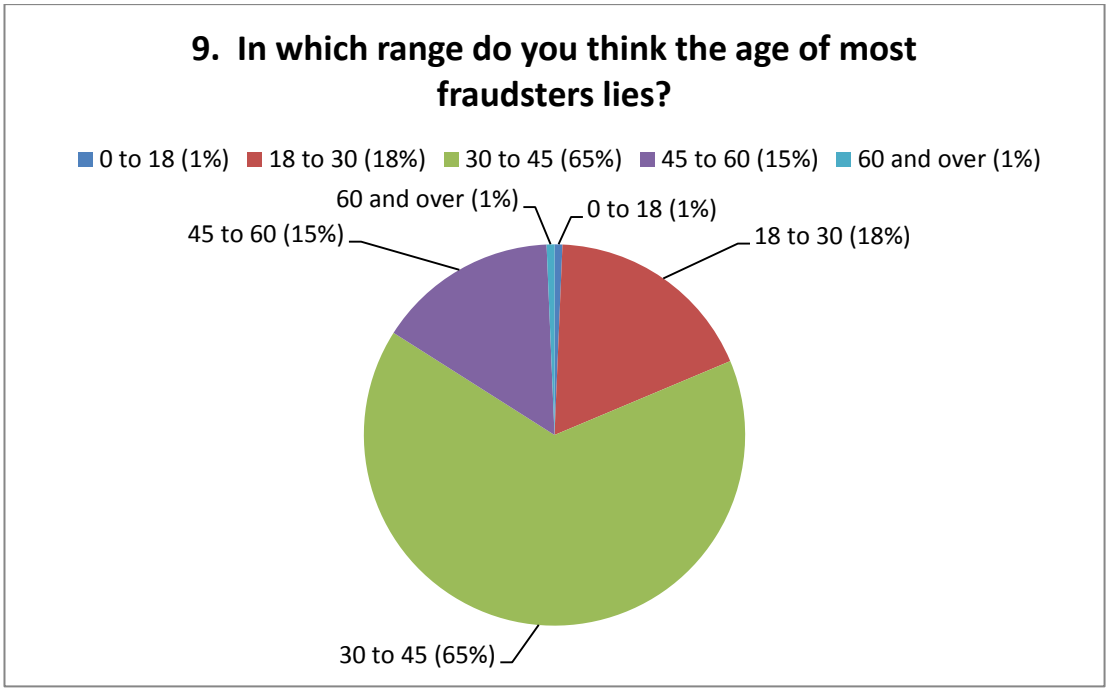

Figure 4.11 A chart indicating in which age group do most fraudsters lie.

Participants were asked (figure 4.11) in which age group they think the most fraudsters lie. According to the sample chosen, 65% consider that the group between 30 years and 45 years is the most risky. Following, 18% of the sample thinks that the age group 18 years to 30 years is the more popular age group. This was accompanied with a 15% of the sample thinking that age 45 years to 60 years is the most risky while just 1% of the respondents said that age 60 years or older are the most popular.

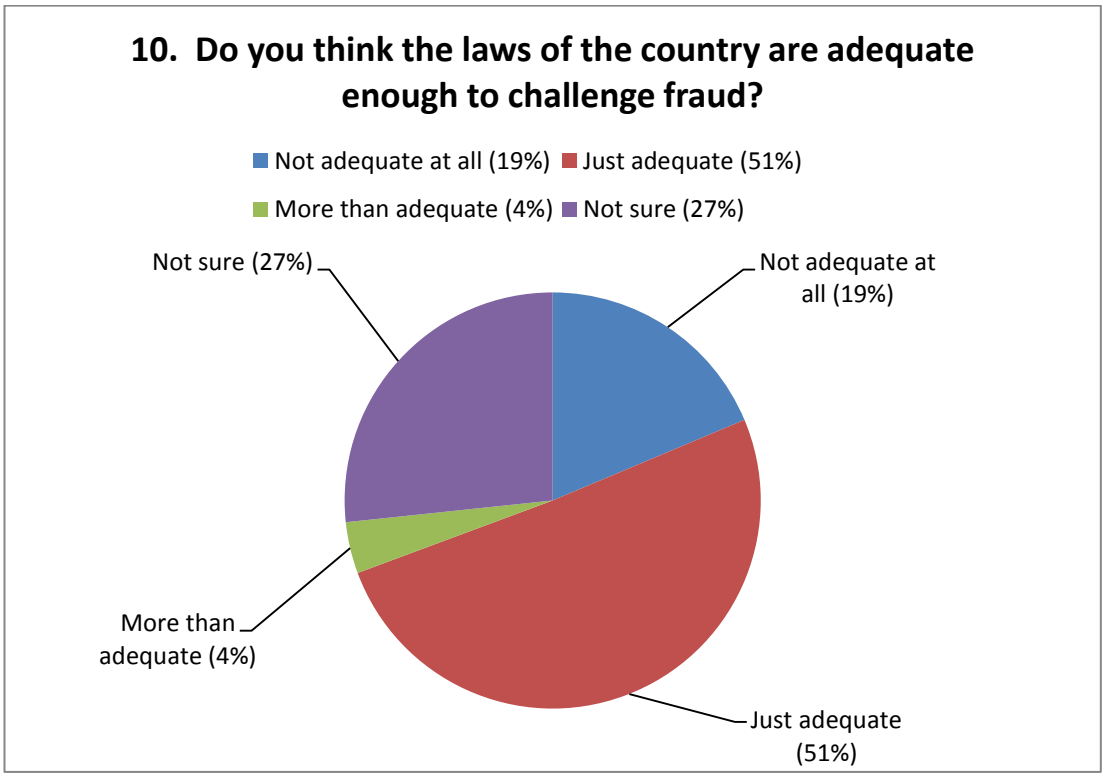

Figure 4.12 A graph describing the attitude of respondents towards the adequacy of the current legislation.

Various opinions were recorded in respect of the current legislation in place (figure 4.12). Most of the respondents (51%) think that the current laws are just adequate to challenge fraudulent life insurance cases while 27% of the respondents said that they are unsure of this situation. On the other hand 19% of the respondents revealed that the current legislation is not adequate at all while 4% of the respondents said that laws are more than adequate to challenge fraud.

In section B, participants were presented with a case study in which they had to give their views based on their beliefs and attitudes. The case study was as follows:

> *"Vanessa and Peter, both unemployed, are facing difficult times and cannot afford to keep up with the expenses. Moreover, their three year old son is suffering from a severe illness and requires urgent expensive operations abroad. The couple is in distress. Peter comes out with an idea to fake his death and receive a sum of money from his life insurance policy. He thinks that this will solve the issue. After all Peter says that he has been paying premium for more than fifteen years now."*

Participants were then asked to give their opinions to how much they agree to Peter's actions in a Likert scale (where zero represents a negative reaction and ten is perfectly agree to Peter's actions). Responses are shown in figure 4.13. The responses show that 49% (73 participants) of the whole sample chosen definitely disagree with Peter's actions while the others agree to Peter's actions on different levels.

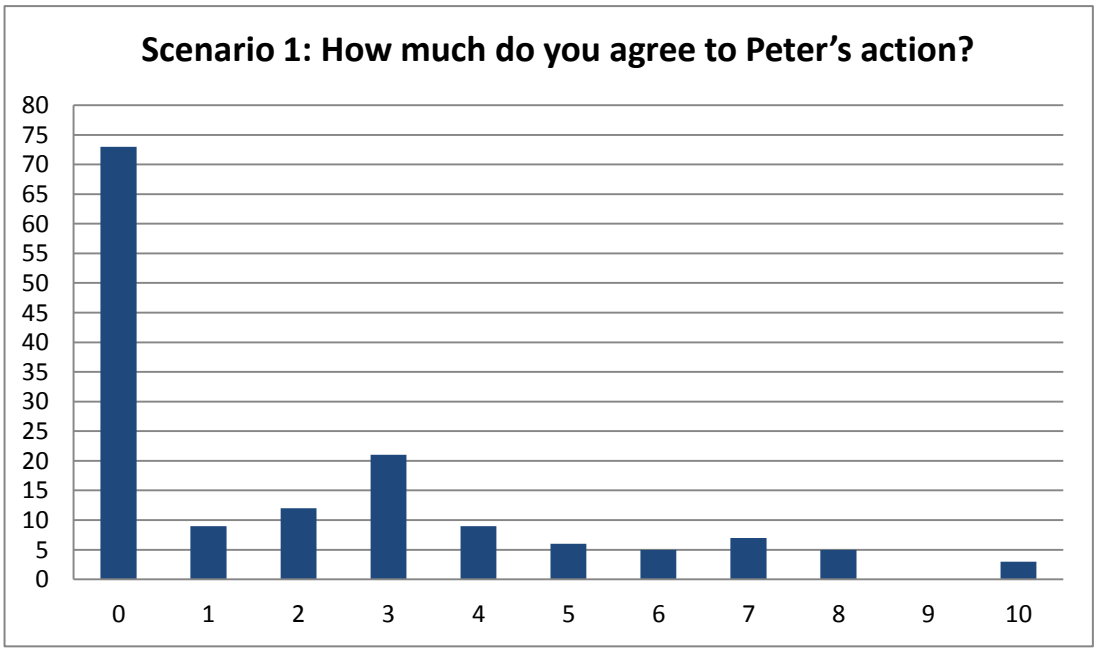

Figure 4.13 Participants' responses to the first scenario in Section B

In the second scenario Peter came up with the idea to commit a robbery instead, out of which he would invest the money into various types of policies with the plan of early surrendering in order to be able to legitimise that money. Participants were asked anew to share their opinions. Figure 4.14 shows that 43% (65 participants) were in disagreement with Peter's actions while the other 57% were in agreement with different intensities.

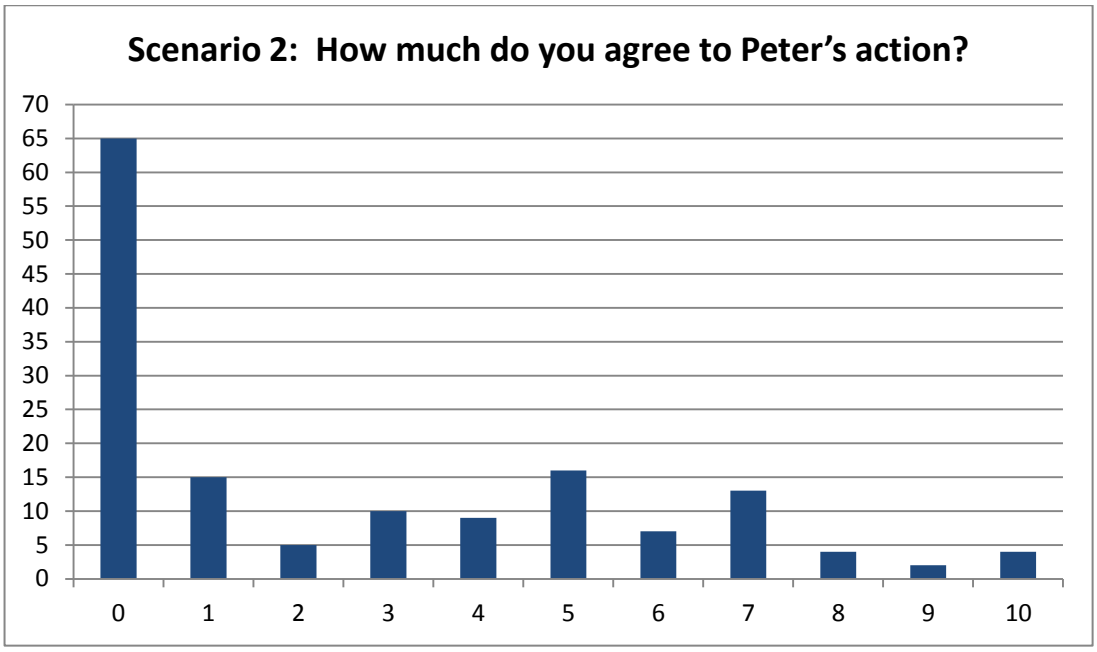

Figure 4.14 Participants' responses to the second scenario in Section B

4.4 Conclusion

In this chapter an overview was given of the results obtained from interviews and questionnaires. In the next chapter a discussion is provided on these results together with the degree of inconsistency between the answers given by the experts and the general public and a comparison to the statistical data obtained through literature.

5. Discussion, Conclusions and Recommendations

"Studies have supported the conclusion."

Dave Mitchell (1947-)

5.1 Introduction

In this chapter, a discussion follows on the findings in this study with recommendations on what should be the constituents for an effective fight against fraud and conclusion.

5.2 General reflections

Primarily it was noted that the main motive of the majority of people for taking life assurance policy is because it is mandatory in home loans and not because they actually needed it therefore the existence of a deficient in insurable interest.

The majority of the respondents thought that three to six years imprisonment is the legal punishment for faking death or self-identity. The same period was given by the majority for the case of money laundering. The Prevention of Money Laundering Act (Malta, 1994) states that a person found guilty of a money laundering offence is liable to a fine not exceeding 2.3 million euros, or to an imprisonment of up to fourteen years or to both. Article 310 in the Criminal Code (Malta, 1854) imposes an imprisonment of up to seven years for those who defraud life insurance in general. Resultantly, it seems that people do not yet understand the seriousness caused by money laundering activities.

The majority of the public answered that the law is just adequate (51%) to challenge fraud. This was mutually agreed by the majority of the interviewees who were in consensus that the penalties are harsh enough. However, one of the interviewees has highlighted the fact that increasing the harshness of the penalties is one of the most effective ways to explain the gravity of the crime to the general public. Another interviewee stated that in Malta the cases take longer to be settled. The example that was given by the interviewee was that in the case that someone misrepresents facts in the proposal form for a life insurance policy (protection), the insurance company may reject the claim from the conjugal partner to settle the home loan. This would often lead the latter to take legal proceedings against the insurance company. Since, as indicated in figure 5.1, cases in Malta take much more time than other European countries to be resolved, this would accumulate the interests on the home loan to very high amounts. Cases such as this one decrease the reputation of insurance companies with the general public. Re-engineering the court processes for higher efficiency would also benefit the insurance companies' reputational risk in the longer term. This would allow the perception of the general public to switch from thinking that the life assurance companies are there only to take money from premiums to being there to protect the honest policyholder. The inefficiency in judicial processes in Malta may also be attributed to the low budget that is available for the Maltese courts and its employees (see figure 5.2).

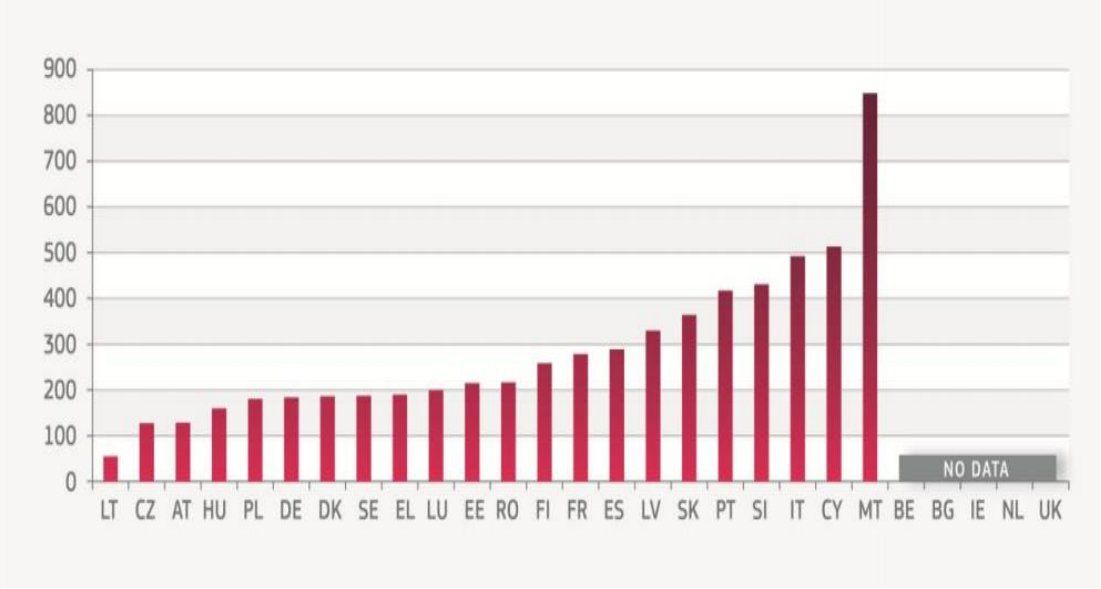

Figure 5.1 Time needed to resolve litigious civil and commercial cases. Source: (European, 2013, p. 6)

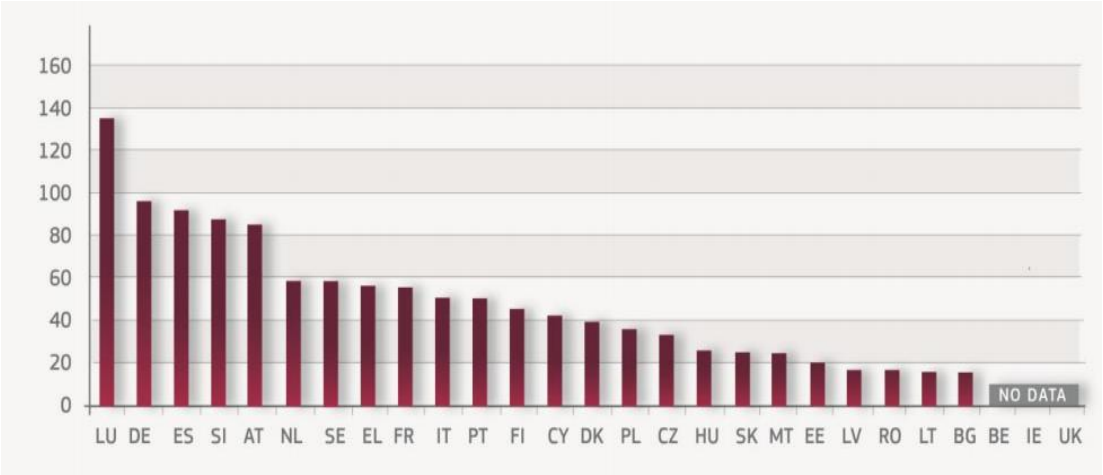

Figure 5.2 Budget for European courts. Source: (European, 2013, p. 19)

The interviews were in consensus that fraud in life assurance is not a problem in Malta. The main reason is that when people are faced with a financial crisis they do not turn to defrauding with a life insurance policy as the process may seem complex. The replies given to the questionnaire's scenarios by the members of the general public however prove otherwise (figure 5.3) where more than half of the sample size agreed on different levels with the actor's attempts in both scenarios. The graph (figure 5.3) also shows that people are more prone to commit fraud involving money laundering rather than fake death as life fraud as the former may seem more trivial.

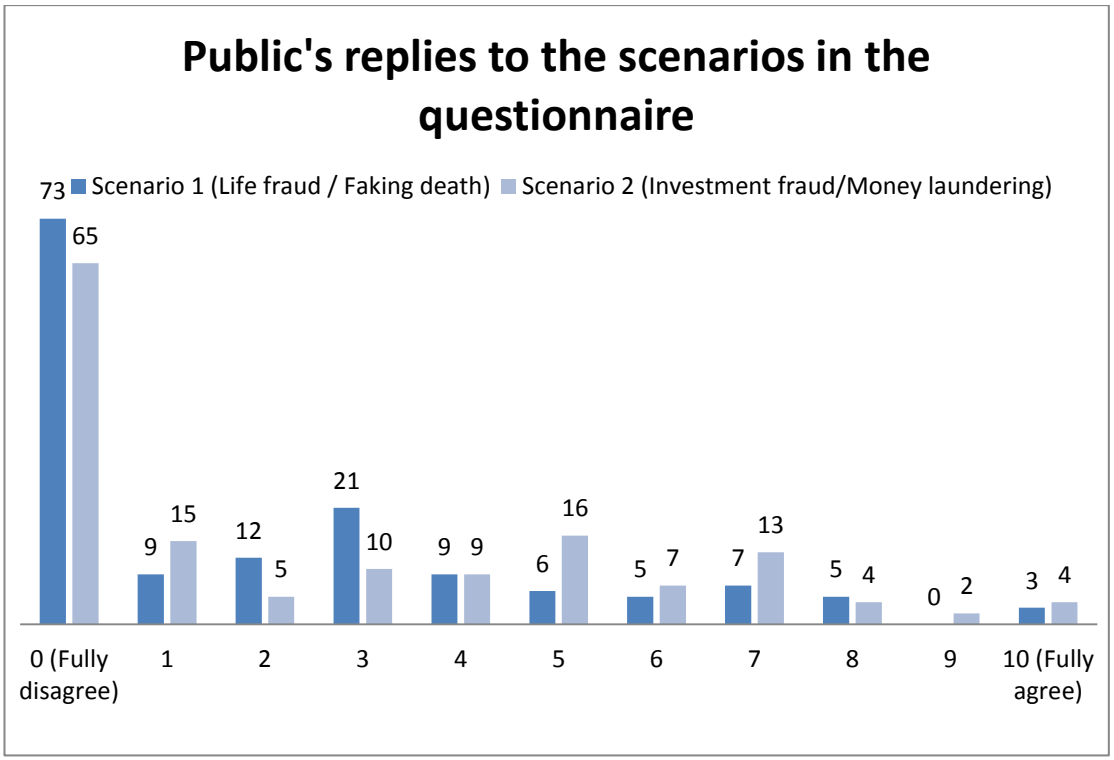

Figure 5.3 A chart showing the public's replies to the scenarios in the questionnaire.

Figure 5.4 shows the number of fraudulent cases in life assurance in the United Kingdom for the period 2006 to 2011[8]. (Logan, 2012) The grey trend line on the figure represents the future growth for the years 2012, 2013 and 2014. This extrapolation was based on a polynomial trend line showing a trend that is oscillating smoothly. The oscillatory curvature is analogous to a boom and recession sequence which may be a direct contributor to an increase or a decrease in the number of fraud cases over time.

It was noted that respondents to the questionnaires that were students were more in agreement to Peter's actions to commit fraud. This may hint that the newer generations take relatively more risks that cause an increase in the number of fraudulent cases. Conversely, older and more mature subjects may be less willing to commit fraudulent activities as peace of mind may be a higher priority.

[8] The data for 2012 has not yet been published by ABI at the time of writing.

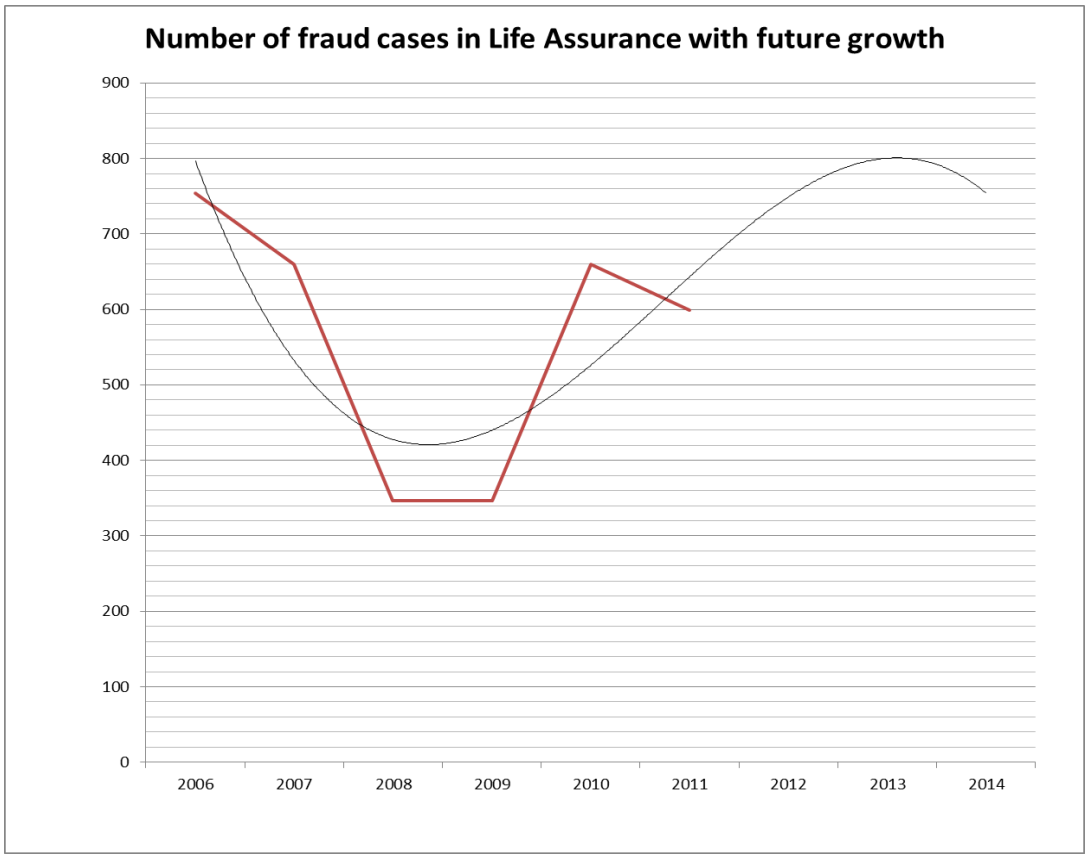

Figure 5.4 A graph showing the number of fraud cases in Life Assurance with future growth. Adapted from: (Logan, 2012)[9]

The representative for a life assurance company stated that "sixty or seventy per cent of fraudulent claims are identified at underwriting stage and not later" thus the need to provide intensive training to underwriters on fraud is essential. Moreover, the representative for the Economic Crime Unit added that the insurance companies rarely or never approach the Police Force for training or joint programmers. He also emphasized that the police were never invited by insurance companies to attend seminars that they organize on fraud. Thus the need for co-operation with the Malta Police Force is present.

In the following section, recommendations are provided for effective techniques that can be used to fight against fraud in life assurance based on the study that was conducted.

[9] The extrapolation was based on data from (Logan, 2012)

5.3 Recommendations

One of the interviewees, a representative for a life assurance company, mentioned the lack of co-operation or sharing of information between insurance companies to create a joint effort into supressing fraud. It was suggested to build an information system for which the underlying database allows the sharing of information between insurance companies. This can be achieved through concepts of federated database in which a common view allows an insurance company to view rejected or pending claims made by a prospective or existing client of theirs to other insurance companies, suspected fraudsters and other inevitable information. This would allow retrieval of information instantly at proposal time without the need for requesting it to other companies through electronic mail or fax. The major stakeholders in the deployment and execution of the system would be the Malta Financial Service Authority, the Data Protection Commissioner, the Economic Crimes Unit in the Malta Police Force and the life assurance companies.

Richard Davies (Axa fraud chief and lead for the Insurance Fraud Register) reiterates this idea for the Insurance Fraud Register that was deployed in the United Kingdom in 2012 that consolidates all reported fraudsters from different insurance companies thus enabling insurers to eliminate fraudsters who have committed fraud (of any type) with other insurers in the past. As in our recommended approach, this information will enable insurers to make a quick and feasible evaluation in the underwriting of insurance and when processing claims. (Davies, 2012)

The deployment of whistle blower hotlines, which is reportedly missing in Malta, is also another recommendation (KPMG, 2012). These lines would provide the means for people to report suspected fraudulent behaviour thereby detecting fraud proactively at an initial stage.

In the paper “Survey of insurance fraud detection using data mining techniques” (Lookman Sithic & Balasubramanian, 2013), the importance of data mining techniques in fighting against fraud was highlighted. In this study, the data collected from the questionnaires that were distributed to the general public was transformed into a dataset with the correct format and was inputted into data mining software to extract a decision tree. The decision tree is based on the ID3 algorithm (Wilson, 2008) and it is depicted in figure 5.5. In each questionnaire the respondents were provided with two scenarios in which they were requested to provide their subjective agreement towards the actor’s actions to fake death in the first scenario, and in the second scenario to be involved in money laundering to gain money from the insurance company. The respondents’ agreements to these actions in each scenario were recorded in a ten point Likert Scale. Members of the general public whose replies in the 10-point Likert Scales in both scenarios were 0 (fully disagree with the author’s actions to commit fraud) were considered as subjects that do not commit fraud whatever the circumstances are. Members of the public that replied with a non-zero number to the 10 point Likert Scale were considered as possible fraudsters. The age, area of residence, gender and the number of dependants of each respondent were inputted into the ID3 together with an indicator of whether the respondent may be a possible fraudster.

The samples that were collected from students were not included in the dataset for the decision-tree as it was assumed that students do not generally apply for a life assurance policy. Similarly, occupations were not included in the tree as it was observed that is not a dependent variable and it would create a larger tree unnecessarily. In actual fact two lawyers, one being 55 years old and the other being 27 years old responded completely differently towards Peter’s actions in the scenarios.

The age variable at the root of the decision tree indicates that it had the largest information gain on the samples provided. This was followed by the number of dependents the respondent had, the gender and the hometown’s location in either of the two main divisions

of Malta (South West and North East). The decision tree is implemented in software and it would allow underwriters to check whether a prospective customer of an insurance policy could be a fraudster. The age, gender, area of residence and the number of dependants that the prospective customer has are inputted into the tree and the underwriter is alerted whether the prospective customer needs to be double checked. The decision tree presented can be further improved by including various other data fields and a much larger data set can be used to train the decision tree.

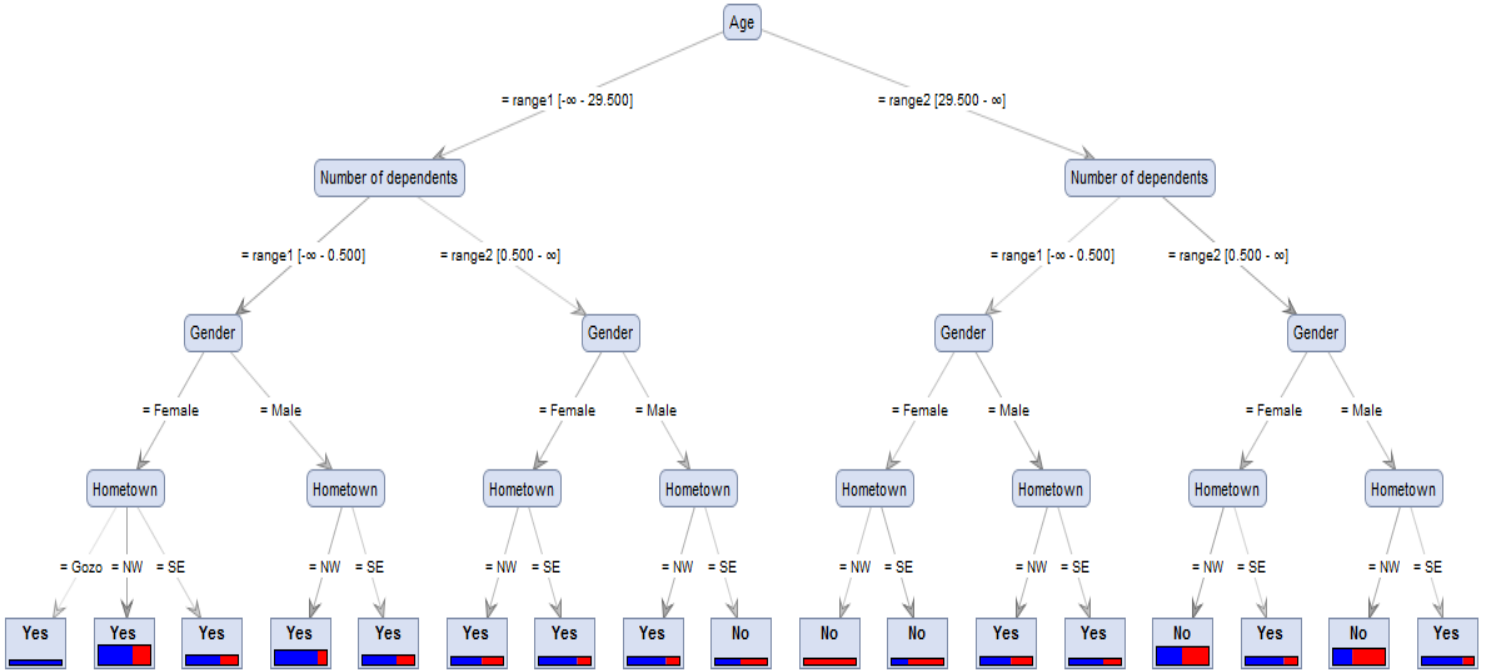

Figure 5.5 A proposed decision-tree.

5.4 Conclusion

This thesis was started by a problem definition, an overview on life assurance and the different existing types of fraud in this domain. This was supported by summaries of real-world cases and the different ways to combat fraud including the different tools and mechanisms that are generally used. In the methodology chapter, the research method used in this study was described including the mixed research method composed of qualitative and quantitative techniques based on the triangulation approach. The main techniques that were used in the study included interviews and questionnaires. The results obtained from the techniques adopted were discussed. Notably, there were the analytical systems including the proposed decision tree, the trends of fraud cases in life assurance, the federated databases, the Insurance Fraud Register and the training and joint programmes including the Economic Crimes Unit.

The aim of this thesis, that is to analyse the public's perceptions and the expert's views on the problem of life assurance fraud was successful. Moreover, effective and practical recommendations to fight against fraud in life assurance were also provided that can be easily implemented in the future, such as in Malta, if there is joint effort including all the major stakeholders.

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Appendices

Appendix A: Consent letter

Address of Interviewee

Date

Dear [Interviewee],

I am a fourth year student, reading a Bachelor of Commerce Honours Degree in Insurance at the University Of Malta. Part of my course programme entails the submission of a dissertation and the topic I have chosen to research is: “The fight against fraud in Life Assurance – (The lacuna in the life assurance industry)”.

I would be more than grateful should you spare some of your time to answer my questions preferably through a short interview wherein you can voice your beliefs on such a matter. I am bound to follow all ethical considerations and will keep your replies anonymous should you prefer to do so. The given answers will be strictly confidential and will be used solely for my dissertation. Your experience in this field is considered an important milestone for my studies. Your invaluable help in granting me an interview would aid me to further my dissertation to completion.

Your participation is voluntary; however it would be much appreciated should you accept to grant me an interview at your disposal. Terminating the interview is permissible at any time without the need for an explanation or a justification. Please let me know if you would like a

summary of my findings. I am more than happy to provide some relevant material beforehand. Should you wish to contact me, I can be reached at muscat.marika@gmail.com or on my personal mobile phone on (+356)99045687.

This project has been approved by the University Research Ethics Committee and after being reviewed by my Supervisor Mr Andre Farrugia.

Yours sincerely/Yours faithfully,

Marika Muscat

Appendix B: Questionnaire

This is a prototype of the questionnaire which was addressed to the general public before the pilot study.

The fight against fraud in life assurance Questionnaire

Dear Respondent,

I would like to invite you to fill in this questionnaire about life assurance fraud. The results will be used solely for the purposes of my thesis and your responses will remain anonymous.

Sincerely,
Marika Muscat

1. A life insurance policy can either take the form of a protection policy, a saving type of policy or a combination of both. This type of policy can either respond upon the death of the assured (policyholder), and grant a sum of money to the beneficiary or beneficiaries or else will pay a sum of money to the assured if the latter survives till the end of the policy period.

   Do you make use of a life insurance policy?

   ☐ Yes
   ☐ No

   If you replied No, kindly skip to question 3.

2. What is the most common reason for taking a life insurance policy?

   ☐ To be protected
   ☐ Mandatory in home loans
   ☐ Offered by the employer

3. How many fraudulent claims do you think that a life assurance company receives in a year?

   ☐ 0 to 5
   ☐ 5 to 10
   ☐ 10 to 15
   ☐ 15 to 20
   ☐ More than 20

4. What do you think is the penalty (in number of prison years) received by a fraudster?

   ☐ 0 to 3 years
   ☐ 3 to 6 years
   ☐ 6 to 9 years
   ☐ 10 and more

5. What do you think causes the most fraudulent claims?

   ☐ Unemployment
   ☐ Financial crisis
   ☐ Financial greed

6. Which gender do you think commits the most fraudulent claim in life assurance?

   ☐ Male
   ☐ Female

7. In which range do you think the age of most fraudsters lies?

   ☐ 0 to 18
   ☐ 18 to 30
   ☐ 30 to 45
   ☐ 45 to 60
   ☐ 60 and over

Case Study:

Vanessa and Peter are facing difficult times and cannot afford to keep up with expenses. There sixteen year old son wishes to pursue studies at a university in London but Vanessa and Peter cannot afford the fees. The couple is distressed that their son's prospective career could be ruined. Peter comes out with an idea to fake his death and receive a sum of money from his life insurance policy. This will solve the issue. After all Peter says that he has been paying premium for more than fifteen years now. What's your opinion from a scale of 1 to 10 (where 0 is I do not agree and 10 is I fully agree)?

0	1	2	3	4	5	6	7	8	9	10

Comments:

Respondent Information:

Age: _____

Gender: _____

No. of dependents: _____

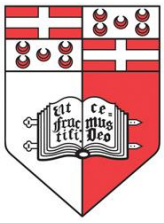
Occupation: _____

Hometown: _____

Thank you for your participation!

The questionnaire (which was addressed to the general public) after the pilot study has been conducted.

University of Malta



The fight against fraud in life assurance
Questionnaire

Dear Respondent,

I would like to invite you to fill in this questionnaire about life assurance fraud. The results will be used solely for the purposes of my thesis and your responses will remain anonymous.

Sincerely,
Marika Muscat

Background

A life assurance policy can either take the form of a protection policy, a saving type of policy or a combination of both. Under the protection policy we find mainly life and loan protection. On the other hand the savings and investments aspects of life assurance allow the policyholder to save for the future.

Life assurance policy can either respond upon the death of the assured i.e. the policyholder by granting a sum of money to the beneficiary or beneficiaries or else by paying a sum of money to the assured if the latter survives till the end of the policy period.

In the protection sub-type of life assurance policy, most often, fraud takes place in the form of falsification of the policyholder's identity or death. On the other hand, fraud in the investment sub-type of life assurance policy takes place in the form of money laundering. According to the Malta Financial Services Authority, money laundering may be described "as the process by which criminals attempt to conceal the true origin and ownership of the proceeds of criminal activities with the alternative aim of providing a legitimate and legal cover for their assets."

1. Do you make use of a life insurance policy?

   ☐ Yes
   ☐ No

   If you replied No, kindly skip to question 3.

2. What is the most common reason for taking a life insurance policy?

   ☐ To be protected
   ☐ Mandatory in home loans
   ☐ Offered by the employer
   ☐ To save for the future

3. How many fraudulent claims against life assurance protection policies do you think that a life assurance company receives in a year?

   ☐ 0 to 5
   ☐ 5 to 10
   ☐ 10 to 15
   ☐ 15 to 20
   ☐ More than 20

4. How many money laundering cases in the insurance industry, do you think are reported annually?

   ☐ 0 to 20 annually
   ☐ 20 to 40 annually
   ☐ 40 to 60 annually
   ☐ 60 to 80 annually
   ☐ 80 to 100 annually
   ☐ More than 100 annually

5. What do you think is the legal penalty in number of years of imprisonment received by a fraudster for falsifying self-identity/ death?

   ☐ 0 to 3 years
   ☐ 3 to 6 years
   ☐ 6 to 9 years
   ☐ 10 and more

6. What do you think is the legal penalty in number of years of imprisonment received by a fraudster for participating in money laundering activities?
   ☐ 0 to 3 years
   ☐ 3 to 6 years
   ☐ 6 to 9 years
   ☐ 10 and more

7. What do you think causes the most fraudulent claims?

   ☐ Unemployment
   ☐ Financial crisis
   ☐ Financial greed
   ☐ Other
   _____

8. Which gender do you think commits the most fraudulent claims in life assurance?

   ☐ Male
   ☐ Female

9. In which range do you think the age of most fraudsters lies?

   ☐ 0 to 18
   ☐ 18 to 30
   ☐ 30 to 45
   ☐ 45 to 60
   ☐ 60 and over

10. Do you think the laws of the country are adequate enough to challenge fraud?

    ☐ Not adequate at all
    ☐ Just adequate
    ☐ More than adequate
    ☐ Not sure

Case Study:

Vanessa and Peter, both unemployed, are facing difficult times and cannot afford to keep up with the expenses. Moreover, their three year old son is suffering from a severe illness and requires urgent expensive operations abroad. The couple is in distress.

Scenario 1:
Peter comes out with an idea to fake his death and receive a sum of money from his life insurance policy. He thinks that this will solve the issue. After all Peter says that he has been paying premium for more than fifteen years now.

How much do you agree to Peter's action? (Where 0 is I do not agree and 10 is I fully agree.)

0	1	2	3	4	5	6	7	8	9	10

Scenario 2:

Peter has another idea. He became aware that his gangster school friends are about to commit a robbery and decides to join them since this money will pay off the treatment required for his son. However he is also aware that since he is unemployed he cannot deposit this stolen large sum of money in a bank account as this makes him a suspect. Therefore he came out with the idea of investing the illegally obtained money in various shares and policies with the plan of surrendering (cancelling out) the policies to be able to claim legitimate money.

How much do you agree to Peter's action? (Where 0 is I do not agree and 10 is I fully agree)

0	1	2	3	4	5	6	7	8	9	10

Comments:

_____

_____

_____

_____

_____

Respondent Information:

Age: _____

Gender: _____

No. of dependents: _____

Occupation: _____

Hometown: _____

Thank you for your participation!

Appendix C: Interviews

All interviews who took part in the research study where asked similar questions, with a slight difference in questions depending on their role and responsibilities.

Prototype of interview questions before pilot study.

Dear Respondent,

I would like to invite you to fill up this questionnaire about life assurance fraud. The results will be used solely for my thesis and your responses will remain anonymous. I therefore kindly ask you to consider completing this questionnaire.

Sincerely,
Marika Muscat

Name of Company:

Position:

1. What are your trends towards fraud in the life insurance industry in the last 10 years?

   Increasing
   Decreasing
   Constant

2. In proportion to the number of claims received, how many do actually result in fraud?

   0%-25%
   25%-50%
   50%-75%
   75%-100%

3. How often do fraudulent claims occur?

   01-10 annually
   10-20 annually
   20-40 annually
   More than 40 annually

4. What kinds of anti-fraud mechanism/s are adopted by your company and what kind of training programs are available for your employees (i.e underwriters) in order to be able to flag any suspicious claim immediately?

5. Whenever your company is faced with a suspicious claim how does it react?

6. How much are fraudulent insurance claims costing the local insurance industry?

7. Do you find enough help from the MFSA and the MIA whenever the need arise?

8. Do you think that there is the need for a harsher legislation in our legislative system?

9. Other comments

Thank you for your cooperation!

Interview questions after pilot study.

The fight against fraud in life assurance
Interview

1. How are your company's trends of fraud in life assurance in the last ten years?
   - ☐ Increasing
   - ☐ Constant
   - ☐ Decreasing

2. With respect to money laundering cases, how do trends actually materialize? Do you think they increased, decreased or they remained constant in the last ten years?

3. In proportion to the number of claims received, how many do actually result in fraud?
   - ☐ 0% to 25%
   - ☐ 25% to 50%
   - ☐ 50% to 75%
   - ☐ 75% to 100%

4. How often do fraudulent claims occur?
   - ☐ 1 to 10 annually
   - ☐ 10 to 20 annually
   - ☐ 20 to 30 annually
   - ☐ 30 to 40 annually
   - ☐ More than 40 annually

5. What is the most common age-range of the fraudsters?
   - ☐ 18 to 25
   - ☐ 25 to 40
   - ☐ 40 to 65
   - ☐ 65 and over

6. Which is the most common gender of the fraudsters?
   - ☐ Male
   - ☐ Female

7. What kinds of antifraud-mechanism/s are adopted by your company? (Please include also the mechanisms that are used in the event where money laundering is possible.)

8. What kinds of training programs are available for your employees (i.e. underwriters) in order to be able to flag any suspicious claim immediately?

9. Whenever your company is faced with a suspicious claim how does it react?

10. How much are fraudulent insurance claims costing the local insurance industry?

11. Do you find enough help from the MFSA and MIA whenever the need arises?

12. Do you think it is the case where fraudsters are becoming more knowledgeable about fraud detection systems thus leading to an increase in the number of successful fraudsters?

13. Do you think that there is a need for a harsher legislation in our legislative system?

14. Are there any other comments you would like to add?

Appendix D: Interviews' transcripts

Following is a trasncribed interviewee that was held on the 27th November 2012 with a representative of MSV Life PLC.

Good Morning. First of all thank you for accepting my invitation to this interview. I put down some questions to discuss with you and here you can have a copy for yourself to follow. So when you feel comfortable we can start off. Would you kindly give me some information about your position and responsibilities within the MSV Life PLC and for how long have you held this position?

[This information was left out so as not to reveal the identity of the interviewee.]

... So, how are your company's trends of life assurance in the last ten years? Do you think it is increasing, decreasing or it remained constant?

We don't come across many fraudulent cases so it is very much constant.

In proportion to the number of claims received, how many do actually result in fraud? Do you think it is in the lower quartile of zero to twenty five, in the twenty five to fifty quarter, in the fifty to seventy five quarter or seventy five to hundred quarter?

It is zero to twenty five for sure.

How often do fraudulent claims occur? One to ten annually? Ten to twenty annually? Twenty to thirty? Thirty to forty or more than forty claims annually?

One to ten

What is the most common age range of the fraudsters? Do you think it falls under the eighteen to twenty five category?

Forty to sixty five

Which is the most common gender of the fraudsters? Are they male or female?

Male

What kind of anti-fraud mechanism are adopted by your company?

Many. First of all we have access to hospital records meaning that anyone who dies through a natural cause we have the right to investigate any hospital records both public and private that exist anywhere in the world. Number two, anyone who dies not by natural cause but by an alleged accident we have the right to obtain magisterial enquiries, reports etc. Three, we

follow and we investigate the financial situation of the person prior to his death to try and see whether there was any motive behind his death but then we get also fraudulent cases before someone dies, someone tells us that he has never suffered from anything, that he is in perfect health etc. and in those cases we can also investigate hospital records prior to accepting the application for life insurance. So if we then find that the person concerned has miss led us because he would have entered the hospital, had operations, had medical conditions that is also classified as fraud. Furthermore, both the Insurance Business Act and the Professional Secrecy Act allow us to exchange information between insurance companies to prevent and suppress insurance fraud meaning that we can exchange information with other insurance companies in Malta on any person provided that the motive behind that exchange is to try and prevent and suppress insurance fraud and all this is explained at the application stage to the applicant and he signs agreeing that we can do whatever I just told you.

What kinds of training programmes are available for your employees in order to be able to flag any suspicious claim immediately?

Ok. We obviously provide our employees with claims handling training both in terms of death claims, in terms of disability claims, in terms of accidental death claims but then we also get a different type of fraud which is money laundering. I don't know whether your thesis will go into money laundering but money laundering is a different type of fraud that is normally associated more with investments policies and savings policies rather than with risk policies, death policies and money laundering, our money laundering obligations are very tough meaning that we have to provide all our staff on an annual basis with training on money laundering techniques and we have very detailed money laundering procedures, internal procedures that we must follow, we have a money laundering reporting officer, we have a deputy money laundering reporting officer and we have very strict rules on how these money laundering procedures work. These are very detailed procedures I think it would be best to check whether we can give you a copy of them although they are very confidential.

So whenever your company is faced with a suspicious claim how does it react?

We would normally, depending on the situation. We would normally inform the hears if it's a death claim.If it's not a death claim and the life assured is still alive we would normally inform the life assured as well that the claim is being investigated. We do this because at law if you don't do that you may give the impression to either the hears or the life assured that you are dealing with the claim and that the claim will eventually be settled so the first thing that we do is that we are investigating this claim so that we put the other party on the alert. This does not apply to money laundering claims, not claims because they wouldn't be claims, to money laundering cases because by virtue of the money laundering regulations and law we cannot inform, inform someone that he is being investigated for money laundering so all the investigations will be carried out discretely, confidentially without the person knowing and obviously for money laundering on money laundering cases we are obliged to deal with the FIAU and we deal with them on a strictly confidential basis. So the person being investigated will not have any knowledge of the fact that he is being investigated.

What is the procedure that is executed by your company after a fraudulent activity is detected?

Again if it is not a money laundering case, when we have sufficient evidence that it is a fraudulent claim like someone has given us incorrect or misleading information as regards to his health, or if we have a suspicious death claim we would normally repudiate the claim or repudiate the application or decline the application in writing. We are not obliged to give our reasons why we have or why we are declining a claim or why we are declining an application but normally we give a very good indication. Ok but if the case then goes to court then in court we would be expecting to present all our findings. These are not very often, these cases are not very often, the most common cases of fraud that we come across are people telling us they are in good health that they have never had any problems, we accept them, we issue the policy and then they die shortly after and that would have meant that they would have been suffering from something else but we need to prove, we have to prove as an insurance company that the client had knowledge of the fact that he was not in good health. We cannot decline a claim merely on suspicion but we need to have full facts. Money laundering cases are completely different. A report have to be submitted to the FIAU who will continue to handle the case not necessarily with us but they do it independently but in our systems obviously that individual will not be able to come back to our company to take up a new policy or new investment because our system would be, would decline him automatically because of certain procedures that we take.

How much are fraudulent insurance claims costing the local insurance industry?

I think it's less than 500, 000. I don't think in life insurance. In general business it's millions but in life insurance I think because the island is small, because the market is small, because there are few life insurance companies operating on the island, I think the fraudulent cases are small.

Do you think the legal framework is adequate enough to challenge fraud?

Probably not. What can be done? I think that the sanctions in terms of convictions should be, could be increased. So sometimes people are found guilty of fraud but only fined a few thousand euros or not fined at all sometimes so I think the sanctions could be increased so the people realized that insurance fraud is a serious crime – that's number one. I think number two also, I think the laws, all the laws, mainly the insurance business act, the Professional Secrecy Act and the data protection act in particular should be amended to make it clear that insurance companies can investigate people for insurance fraud and that there will be no limitations as to what investigations that they can carry out provided that the investigations that they are carrying out are intended to prevent and suppress insurance fraud.

Are there any other comments you would like to add?

The comment I would like to add that overseas there is a higher degree of fraud in life why? Because in certain countries like for example developing countries like Africa, it is also possible for people to fake death certificates for example. In a country like Malta, in a market like Malta, in a small country the incidents of insurance fraud in life insurances is very low unlike the situation in non-life insurance where fraud is very very significant; in motor insurance, in property insurance, in accident insurance so we don't, I don't think has a problem with insurance fraud but another measure (I am going back to the question on the legal framework), another measure that could be taken by insurance companies this time, not by the legislators or by the regulators, by insurance companies is to establish between

them formal insurance, life insurance fraud database where they will exchange information on insurance fraud not on an ad-hoc basis like we currently have at the moment where an insurance company can contact another insurance company to see whether it has had an experience, the same experience with a particular individual or with a particular claim but creating a database of fraudulent insurance claims which could be based on id card numbers or company's registration numbers so that this information could be stored in a central place where insurance, life insurance companies could access. That is another measure that exists in most countries and which in Malta it does not currently exist.

Thank you very much for your time!

The interview that follows was conducted on the 30th November 2012 with a representative of the Financial Intelligence Analysis Unit

Good morning... First of all thank you for accepting my invitation to this interview. I put down some questions to discuss with you. Here you can have a copy for yourself to follow. So when you feel comfortable we can start off.

Can you kindly start by giving me your roles and responsibilities within FIAU?

[This answer has been removed so as not to reveal the identity of the interviewee.]

How are the trends for money laundering reports in the last 10 years?

The year under review was in fact characterised by the highest number of STRs ever received by the FIAU since its establishment in 2002. The number of cases subject to analysis was eleven for 2002, fifty-nine for 2003, forty-five for 2004, sixty-seven for 2005, eighty-two for 2006, sixty-eight for 2007, seventy for 2008, sixty-six for 2009, sixty-three for 2010, hundred and two for 2011 and to date (the interview was conducted on 12th December), we have over hundred and thirty STRs and cases.

How often do money laundering reports occur?

It varies. Usually it's something less than hundred. However last year we had one hundered seven reports in relation to money laundering and as already said, to date we have more than hundred and thirty reports.

How many of these are actually related to insurance?

We have one for 2003, ten for 2005, three for 2006, two for 2007, two for 2008, four for 2010 and 5 for 2011 and percentage-wise this amounts to four per cent of all the reports we receive.

What is the most common age-range of the fraudsters?

We don't maintain that type of statistics because it is not considered as an important tool for our study. I have to go in each and every case to give you an answer which doesn't make sense.

Which is the most common gender of the fraudsters?

By rule of thumb I can say that there are more males than females but there aren't official statistics which was conducted by the FIAU that say so.

What kinds of training programmes are given to insurance companies to help them flag suspicious transactions of money laundering?

So we do conduct training and we pretend that training is conducted. This year the FIAU organised a training session and three hundred participants attended throughout the year and out of these there were those coming from the insurance industry and it is a requirement in our legislative system that we conduct training for every institution and it's a requirement under the Maltese Law that all entities subject to money laundering regulations conduct training within the organisation for employees. We conduct comprehensive training sessions on all requirements; customer due diligence, record keeping, reporting on latest development. These three hundred participants had six afternoon sessions which were quite comprehensive.

What do you suggest in terms of anti-money laundering mechanisms that should be adopted by insurance companies?

It's not what I suggest. The law establishes anti-money laundering mechanisms that need to be in place. We have the regulations, implementing procedures and guidance which tell us what insurance companies need to hold and its mandatory by law. So if they don't have it in place, they can be penalised. So it's not what I suggest. There are legal obligations

What is the procedure that is executed by the Financial Intelligence Analysis Unit after a fraudulent activity is reported by an insurance company?

We forward any STRs that we receive in our unit to the Financial Analysis Section where the STRs and reports are processed through systematic and structured analysis. This information is supplemented by other relevant information that the FIAU may have already possessed or the information it obtains by requesting other persons who in the opinion of the FIAU could be in possession of further relevant information such as financial institutions, public authorities, law enforcement bodies and other FIUs. Upon completing the analysis conducted by the Financial Analysis Section, a preliminary report is presented to the Financial Analysis Committee, an internal body chaired by the director, composed of the FIAU's financial analysts and the Senior Legal and International Relations Officer. The committee, after having reviewed the findings and conclusions of the preliminary report, determines whether the requirements at law for dissemination to the Police have been fulfilled. If the committee determines that a reasonable suspicion of money laundering does in fact exist in the case, an analytical report together with all information considered to be relevant is submitted to the Police for investigation.

Is the legal framework adequate to challenge money laundering?

I think it is adequate but there is always a room for improvement.

Thank you very much for your time!

Following is a transcribed interview held on the 17th March 2013 with a representative of the Economics Crimes Unit.

Good morning. First of all thank you for accepting my invitation for this interview. I put down some questions to discuss with you and here you can have a copy for yourself to follow. So when you feel comfortable we can start off. Would you kindly give me some information about your position and responsibilities within the Police Force and for how long have you held this position.

[Some information has been left out not to reveal the identity of the interviewee]

This unit is part of the criminal investigations department. It is a specialised section the role of which is to investigate economic crimes in general. In the past, in the recent past years, my main focus has been mainly on corruption, but this as not excludes other crimes which I investigate on a daily basis. As police force in Malta we are both investigators and prosecutors. So a police inspector in Malta does not only investigate cases but also if a case is solved then and a case merits to follow in court then the same investigator would double as prosecutor in court and that's a different system in other countries. In other countries investigators are not also prosecutors. It has advantages and disadvantages. Our main advantage is that when you are doubling as prosecutor and you would have investigated the case yourself, than it's easier to prosecute because you would know the case by heart whereas in other countries the investigator would be one of the witnesses that has to be brought up the Attorney General office. In Malta the system is that the Attorney General would only feature in the appeals court so our system is that the accused, once sentenced whether it's a guilty or equitable sentenced then either the prosecutors or defence have a second chance to appeal the case. In the appeal stage it is the Attorney General that takes over the prosecution. Also in trial by jury it is also the Attorney General who is the prosecutor so we as prosecutors do feature in the first court, the court of majesties and as regards to our work here we are mainly six inspectors each with his or her own team and generally it is composed of a police sergeant and two constables and we are led by a police superintendent and an assistant commissioner.

How are insurance companies' trends of fraud in life assurance in the last ten years?

Prior to answering this question, I have to make it straight that we do not receive many reports from insurance companies or from third parties regarding claims of insurance fraud. So if you would ask me insurance fraud does feature rarely in our investigations but I have been here for the past nine years, I've also time after time been scrutinizing our own statistics and it shows that insurance fraud reports have been quite stable over the past years so I would answer this question by saying that reports from insurance companies have been quite constant and on average this might be around a maximum of five to ten reports a year and ten is quite a maximum. So it is very rare that we receive reports from insurance or other parties claiming insurance fraud.

In proportion to the number of claims received from insurance companies, how many do actually result in fraud?

It depends but I might say that it's a fifty per cent answer in this case. The problem is that having like five cases a year we can't really say how much of these because the group to be tested is quite a small group so it is not quite representative of the insurance fraud in general. My suspicion is that insurance companies are quite hesitant to report cases to the

police or they themselves are not equipped with the necessary apparatus to detect fraud in the first place or if they might detect or suspect fraud they often do not consider reporting the case to the police or try themselves to reach an amicable settlement with the claimant in that particular case. So I think I have answered question three with an average of one to ten annually so that's the case.

So what is the most common age-range of fraudsters?

If you ask me in general I would say that it is between the two middle groups; between twenty five to forty but the most professional once are generally in the range of forty to fifty years of age because in Malta like in other countries fraudsters can be of two types, there is the fraudster who is in need of money and would opt to commit fraud as the most, as perhaps an easier type of crime rather than for example armed robbery which entails more preparation and association needed and perhaps some tools needed but in the case of fraud all you need is to have some good word of mouth. But then there are the ones who are most experienced in this type of fraud so generally these tend to be in the range of forty to fifty years of age. These are the repeat offenders who then themselves tend to make our jurisprudence quite rich because in Malta like the U.K. system we adopt the common law system whereas in proving a case in court we also make reference to cases decided by the same court. So in that case the prosecutor would research previous cases and would find out that the same person who is today accused of fraud has already committed this case over a number of years. So then you realize that this same person has been doing this type of criminal offence over a number of years and would become very professional in such types of cases. So if you would ask me, I would say that perhaps the average age is forty so half way through.

So which is the most common gender of fraudsters?

Generally it's male but we had some two particular females over the past years who are very good in their job. I mean in this illicit job of defrauding others but generally its males who can really. Cause what's the crime of fraud? The crime of fraud is that you create this chimerical event this mise-en-scène whereby you can convince others in giving you something under false pretences. So generally male subject are much better than females in this case but yes we had some two particular females who are very good at that task.

So what kind of training programmes is available for underwriters of insurance companies in order to be able to flag any suspicious claims immediately?

As far as I know we have never been approached by any of these companies for any training programmes. As police force however I can say that on a regular basis we receive training both locally and abroad although I might say that insurance fraud does not often result to be a major issue in the cases received because being a member of the European Union we are constantly being updated of the modus operandi but generally it is about cases concerning the E.U in general. So it's fraud against the E.U., corruption etc. It's also cases of intellectual property rights which are also investigated by our unit. So I might say that; one insurance companies do rarely or never approach the police for any training programmes for joint programmes and two we as Police Force whilst receiving broad range of training and attend seminars often these do not result to be related to insurance fraud and we as Police are rarely or never invited by insurance companies to attend seminars they might organize in

their field. So I might add that there is the need for better co-operation between police and insurance companies.

How much are fraudulent insurance claims costing the local insurance industry?

I can't say. If I based my answer on the reports we receive and the cases solved, then I definitely go for less than half million dollars, sorry euros, but it all depends on the system adopted by these insurance firms on how efficient and effective they are in detecting fraud. But still I won't, I can't really say. It all depends on the systems in place actually and how firms are able to once receiving a claim they are equipped with both with technology and human resources that can identify suspicious claims which I think that they lack a bit in this case.

So do you think that insurance companies are effective in detecting fraudulent claims and reporting them immediately to the police?

I've been answering this question over a number of questions earlier. If I based my answer on the number of reports we received then it's an actual no. No they are not equipped because I do not actually believe that only five to ten false claims are made to insurance companies a year. In a decreasing economy, in a recession, our job is inversely related where in a difficult situation as it is outside, then we have seen a rise in fraudulent cases reported to the police. So I don't think that insurance fraud is an exception. But still we haven't seen an increase in reports by insurance companies. So I'd say that they are quite lacking in this case and they should invest more in detecting fraudulent claims. Definitely this is costing them money which they can actually save especially in such difficult economic situations.

How are the trends for money laundering cases in the last ten years?

So I see that money laundering in your questions is directly related to fraudulent claims. In order to solve a case of money laundering we must first establish a predicate offence. So for money laundering to take place someone must have generated money or other proceeds from a crime. So our first aim is to identify that crime because if there's no crime there's no money laundering and I can see that all money laundering cases investigated by the police over the past ten years, none of them have in any way been related to fraudulent claims, to insurance fraudulent claims but I can verify that after this interview would give you a definite answer but as to my knowledge no money laundering cases have been investigated where the predict offence has been insurance fraud.

What types of anti-fraud mechanisms are to be adopted by insurance companies against money laundering?

I'd rather ask you to elaborate on this question because it's not quite understandable as such for me because the insurance companies are not much interested in money laundering. It's the police who are interested in money laundering. Where we have a report whatever the case like drug trafficking, fraud, corruption then once identified the crime, we proceed to the next stage to what about the process generated from this crime and it's there where money laundering takes place. It's the illegal use of money or rather trying to legitimate the use of that money which has been generated from a crime that results in money laundering. So

insurance companies themselves are not much interested in money laundering. They are mostly interested in identifying insurance fraud. The instance where insurance firms might be or might suspect money laundering is where individuals are investing money in an insurance firm like investing money for a life insurance. So each and every institution has an obligation to report any such suspicious transactions where an individual who hasn't been employed for a number of years and on a regular basis invest money in an insurance scheme, then yes insurance companies are obliged by law to report these cases to the (FIAU). This unit will then analyse the report received, and if they themselves do have reasonable suspicions that the report received could be a prima facie case of money laundering then they would report it to the police for investigations. Otherwise I think that insurance companies often do ignore the issue of money laundering.

What is the procedure that is executed by the Economic Crimes Unit after a fraudulent activity is reported by an insurance company?

The procedure adopted is always the same for each and every criminal offence. A report is received. So first we do receive the report. We do carry out all necessary investigations. We also generally if the case requests information from banks that like other institutions are generally forbidden by law to report financial activities by their clients are in the case of police investigations expected from the Professional Secrecy Act. Therefore they are obliged to provide all requested information. Once we have reason to suspect that a criminal offence has been committed or an insurance fraud has been committed in this case would then request to have a search and arrest warrant issued by a magistrate on the basis of which we would then execute this warrant and arrest the suspect concerned. Where needed, on the basis of that same warrant, we would carry out searches in places where the suspect have access to so that it includes his or her residence or any other place which he has access to including offices for example and following the completion of the investigation, we would then conclude whether there is a case, a criminal case or not. Sometimes we would request the assistance of the office of the Attorney General where we are not hundred per cent sure of our conviction and on the basis of that advice we would either proceed in court or declare a case as unsolved or that no criminal offence has been committed. In the formal case charges are issued against the person and a person can be arraigned in court either under arrest but in such cases it is generally such persons are arraigned in court by way of citation that is you issue a court summons and the person receives it at home and then a magistrate is appointed for the test hearing and a compilation of evidence we call it that is the court proceedings are undertaking following which once the prosecution closes its case now it's the time for defence to defend their case. Like any other cases insurance fraud claims, insurance fraud criminal proceedings, the prosecution must prove a case beyond reasonable doubt so it's a difference between the criminal court and the civil court. The civil court cases are won or lost of the basis of probability but for criminal cases the police would need to prove a case beyond reasonable doubt. That is that there is no shred of doubt left for the magistrate to determine whether the person has actually committed the criminal offence or not. So it's quite an uphill struggle for the prosecution because in each and every case we must proof beyond reasonable doubt but depending on the level of evidence in our possession then we would have examined the case before going to court and I speak for myself whenever I prosecute cases in court it is because I am only convinced that the person has committed that criminal offence but then we are in a democracy it's a fair judicial system and if the magistrate deems that we haven't provided sufficient evidence to proof our case beyond any doubt then the person is acquitted. As explained earlier, both parties, the prosecutions and defence have the opportunity to appeal from judgement and any decision taken by the superior court, by the court of criminal appeal then it's definite. It's where at this

stage no one can further appeal the case. So in that case the judgement is definite it's where the case is actually closed.

What are your unit's relations, if any, with the MFSA (Malta Financial Services Authority) and the MIA (Malta Insurance Association)?

All right! With the MIA I don't really think that we have a relationship in the first place so I can't speak of a very good or bad relationship because we don't have any relationship in the first place. As to the MFSA we do have a relationship. It's quite a good relationship and we work with the authority on a regular basis. Thanks to the advancements in technology most of the time, we do not really need to have face-to-face communication with the authority as most of the information we do require in our investigations are generally provided online through their search engine which is available for those who are affiliated with the authority. As the Malta Police Force we have access to their online system and through this system we do for example have acccess to who are the ones behind companies that are investigated so yes we do have a good relationship with the MFSA and they themselves are generally witnesses in cases we prosecute in court. Up to this week, I was in quite a regular contact with the registrar of companies. So yes we do have quite a good relationship with the MFSA. I don't have complaints to make in that regard but with the MIA I myself don't know about this association. Don't know who the persons are in their board, not even where their offices are. So we do not have a relationship with the MIA.

Do you think that there is need for harsher punishments to be given to insurance fraudsters?

As to fraudsters, insurance fraudsters we must distinguish between two types of fraud. I don't know whether if you are much aware of the criminal codes? Insurance fraud is covered by two criminal offences within the criminal code. There are the fraudulent gains which is article 308 of the criminal code and according to article 308 of the criminal code where fraud is aggravated that is it exceeds the 2,329.37 euros, the traditional one thousand Maltese lira, if convicted a person is punished up to seven years imprisonment. So that for me is quite proportionate penalty. As to the other case of insurance fraud, it is actually named as insurance fraud in the criminal code. If I am not mistaken it's article 295, it's tend to be corrected yes. So according to article 295, this is where the code itself names this crime and fraud relating to insurance. But in this case this offence relates to an individual who has the intent to obtain money from insurance companies but has to do a number of things. In this case generally it's by destroying or deteriorating something that pertains to him or to her. Like having a car and wants to obtain money from insurance firms by destroying the car. In the case of fraud under section 308 as aggravated by article 310 of the criminal code, that is the general fraud we investigate on a regular basis and it also covers insurance fraud. If someone files a false complaint then it's not article 295 that applies but it's article 308 whereby you are creating a chimerical event, a mise-en-scène through which you are requesting the company for a claim. In that case it is the contents of article 308 that applies. So whilst article 295 implies a maximum of three years imprisonment penalty, with regards to article 308 aggravated by article 310 the imprisonment penalty amounts to seven years. So in my opinion whereas other crimes do merit harsher penalties in the case of fraud even because it doesn't appear that as a result of the current penalties we have witnessed an increase in the reports received so in my opinion the penalty is to reflect the seriousness of these offences.

Thank you!

[It was explained to the interviewee how money laundering is associated to the savings policies in life assurance. The interviewee subsequently gave further information on money laundering.]

The interview that follows was held on 21st March 2013 with an ex-underwriter in life assurance and a representative for HSBC.

How are your company's trends of fraud in life assurance in the last ten years?

According to my knowledge up to a year ago, it was increasing. Although policies concerning life assurance are complex products, they are becoming much more demanded nowadays than ever before. Thus an increase in demand will surely increase fraudulent cases because the sample of people will increase.

With respect to money laundering cases, how do trends actually materialize? Do you think they increased, decreased or they remained constant in the last ten years?

With regards to my knowledge I've never been notified with a money laundering case within HSBC Life. However we used to take really care when a policyholder opt for a single premium plan since it could result in a classical method of money laundering. Money laundering is very much prone in life assurance policies. The dishonest policyholder asks to surrender a policy since and the life insurance company in this case HSBC gives a cheque to policyholder and this would become world-known recognized and 'legally' considered.

In proportion to the number of claims received, how many do actually result in fraud?

It will surely stand in the lower quartile, that of zero to twenty-five per cent. In Malta fraudulent life assurance claims are very rare. Although you will find that somebody who will try to opt in doing fraud. But yet again this is very rare. And in Malta the most common way of defrauding a life insurance company is either by misrepresentation or by not submitting the required information, by saying that that one wasn't aware of such information when in fact one would have.

How often do fraudulent claims occur?

I would classify it under the one to ten cases a year. It is very rare!

What is the most common age-range of the fraudsters?

From experience, I believe that this will fall under the forty to sixty five range categories. A life insurance policy would usually be taken up by somebody who either needs it because it is mandatory as in the case of loans, or because they would like to save something for their heirs and these would generally be policyholders over forty years of age.

Which is the most common gender of the fraudsters?

Male. Male are more prone to fraud than women.

What kinds of antifraud-mechanism/s are adopted by your company? (Please include also the mechanisms that are used in the event where money laundering is possible.)

Firstly application forms are very inquisitive, in the way that a lot of questions are asked to try and evaluate case by case independently. Questions are set very straight-forward so that policyholders will become liable to give a definite answer and not a retrospective one. We also share information with other companies on clients to check for any information which might have been left out from the policyholder's end. Moreover, clients sign a data protection agreement where HSBC can go to hospital and check for medical history. Since life assurance is mandatory in home loans we might ask for a higher loading and this is surely one of the risks which we face. This is so as many policyholders would prefer to keep back from giving the whole picture to obtain lower premiums. Moreover once to twice a year we are given overseas training in Germany through General Reinsurance in order to be able to check for trends. HSBC Life works hand in hand with General Reinsurance since as a company HSBC Life transfers a portion of its premiums via layering to GeneralRe to share its risks.

What kinds of training programs are available for your employees (i.e. underwriters) in order to be able to flag any suspicious claim immediately?

HSBC Life has three underwriters who had to acquire a diploma besides the basic requirements for them to be able to underwrite polices. This diploma known as CUS (Certified Underwriting Specialist) and it is spread over a two year course. In the case of money laundering we ask for source of funds. This is generally done when the policyholder wants to issue a policy which is greater than fifteen thousand euros or if the policyholder wants to surrender a single premium plan.

Whenever your company is faced with a suspicious claim how does it react?

Here I need to make it clear that whenever a claim arises, we leave from the point that we are going to pay. Heirs will already be in a desperate situation when somebody close to him or her dies. The least answer they would be expecting is that you will not be going to pay. However, having said that we, HSBC Life and all other insurance companies are not a charity and at the end of the day we need to generate profit. Thus whenever we are faced with a suspicious claim, the first thing we do is that we investigate the application form. We also talk to the reinsurers and from their experience in the field they can be of great help in assisting whether we should proceed any further or not.

How much are fraudulent insurance claims costing the local insurance industry?

Close to nothing! The product is very complex for one to be able to defraud a company.

Do you find enough help from the MFSA and MIA whenever the need arises?

With no doubt! The MFSA and insurance companies are completely separate units from each other. The MFSA assists generally in new products and thus yes we do have a relationship with the MFSA and we also find help from the authority. On the other hand HSBC Life is a member in the MIA since the MIA is represented by every insurance company.

Do you think it is the case where fraudsters are becoming more knowledgeable about fraud detection systems thus leading to an increase in the number of successful fraudsters?

The answer in general is a yes. However insurance is not the preferred vehicle for fraud.

Do you think that there is a need for a harsher legislation in our legislative system?

Not really! We as insurance companies have the same obligations as banks do. Therefore what applies to the bank applies also to insurance companies. The Prevention of Money Laundering Act applies to both banks and insurance companies and this Act is considered to be quite harsh. So no I do not think that there is a need for a harsher legislation to take place.

Thank you very much for your time!

The interview that follows was held on 22nd March 2013 with two other representatives of HSBC Life PLC.

So good morning to all. First of all thank you for accepting my invitation to this interview. I put down some questions to discuss with you are here you can have a copy for yourself to follow. So when you feel comfortable we can start off. Can you kindly start by giving me your roles and responsibilities within HSBC?

R1: [Information has been removed so as not to reveal the identity of the respondent.]

Ok. So how are your company's trends of fraud in life assurance in the last ten years?

R1: All right, so with regards to fraud, we as a company started operating fifteen years ago so you need to imagine that during the first few years you won't be dealing with so many claims. You would start seeing an increase in claims approximately from your seventh year of operation onwards. Therefore in reality the experience we have when we come to claims is for these last seven years since at the beginning your clients would probably be young. Now obviously from these claims, we would have fraud but at least from my experience these are increasing not because fraud is on the increase but because claims are increasing. So if in the past we used to deal with four claims, nowadays we are dealing with forty claims. Thus you would expect that in these forty claims there might be some which will result in fraud but once again not because fraud is increasing but because claims are increasing in my opinion. I believe that a lot of customers make a life insurance not to defraud it but because they actually really need it. But then there will be those one-offs who will try to defraud yes. So strictly speaking it is on the increase but not because fraud is increasing but because claims are on the increase. Certainly it is not decreasing.

So with respect to money laundering cases, how do trends actually materialize? Do you think they increased, decreased or they remained constant in the last ten years?

R2: The issue of money laundering as far as insurance is concerned, is a bit different from the claims stage in the sense that since our company does offer a range of products which would seem attractive upfront, you have on one side the aspect of protection policy which is not traditionally associated with money laundering, although there is a connection in reality, but then you have the with profits and the unit linked types of policies which basically they are investment vehicles in which you yes over there you have a close association with money laundering. We can't say that in our company we had various cases where we report policies as suspicious transactions under the money laundering legislation but we are, as time goes by, we are placing much more onus on this regard. I'm sure that the FIAU explained about source of wealth and source of fund. Specifically because we are seeing an increase in lump sums as against regular premium and lump sums are within our standards, huge amounts of lump sums, when we are talking about huge amounts of sums we are saying about five thousand per month or else you would have forty thousand as a lump sum in one year. So over there yes there is an indication. Till now, at least for the last three and a half years we haven't presented an STR but we do continually ask questions on sources of wealth.

R1: So we never had a case?

R2: No till now we never presented a case.

R1: And the bank did ever come across such instances?

R2: The bank yes but you need to understand that the banking relationship for a client is different from the one we practice where you will find the principal of turnover with regards to banking. We usually question for example those people who with all respect would be for example clerks who would ask for a two thousand euro policy a month. On the other hand the bank might be in a position where it notifies that a person with a common job would have going in and coming out with an amount of thirty/forty thousand euro in a month. So that would be a suspicious transaction report query.

R1: Which would be investigated in that case.

In proportion to the number of claims received, how many do actually result in fraud?

R1: Under twenty five percent. As already said the intention of the client who would opt for a life insurance policy wouldn't be to make fraud. Generally they would be genuine. Fraud would generally be divided into two types; there would be those people who would not do it because they are fraudsters, but they would actually do it because they would either find themselves in a really bad position and make a life insurance policy and they will see how it goes and then there would be other who would be aware of something specifically and they would not declare it at proposal stage because they would know that if they would actually declare it they wouldn't be tolerated for loans. Obviously in both situations there is fraud and we should continually take precaution not to pay in such instances.

How often do fraudulent claims occur?

R2: I believe it's one to ten then, correct me if I'm wrong?

R1: Yes it's one to ten.

R2: I think that the issue of fraud in our case, and even for MSV because we are pretty much the major players. I think that it should be taken in the context that it is very much in the local playing field. Imagine if our company makes active trading of insurance policies abroad. Over there it would be a completely different scenario. However in our case, I am pretty much sure that it is not the case. So as my colleague has been stating previously, everything need to be taken in the context of the local scenario. For example a lot of protection policies are still associated with loans. Although you might be surprised that the culture of having a policy because I might need it in the future irrespective from loan purposes is increasing. And it's here where one needs to start paying more attention to fraud.

R1: Fraud is more associated with foreign places. For instance you are insuring a foreigner. Fraud exists for example when you receive a claim from Nigeria which would not be a truthful one and after two years you would see the same person on television. It can go to that type of fraud. Or else you would receive a report from a police from Mozambique, to who in fact the policyholder would have paid money to make a false report that somebody had hit him and resulted in death. We are constantly visiting other places and doing courses overseas and for example it is a known fact that in South Africa you can buy a cadaver for ten euros. Imagine you have a person, let me take my instance for example which is of standard height, weight etc, you can easily find a cadaver of the same height and weight, you burn it off and you send it over as me for example. Over there you are really faced with fraud. For instance two years ago I was on a course abroad and there were a few

investigators who told us that Malta is really famous for these types of people who come over to hide their identification. One of them told me that recently in summer they came across a claim where someone from Australia was claiming against one million Pervasive Developmental Disorders (PDD) cover and they found him in Paceville drinking in bars. Actually they didn't mention Malta in good terms!

What is the most common age-range of the fraudsters?

R1: As already stated, and as my colleague was correctly saying earlier on, many local clients request a policy with us because they have a loan meaning that if there is somebody who wishes to defraud such a policy he has to be capable of being able to take a loan. Therefore I am anticipating the age twenty five to forty but not because this age is the average age range but because this kind of business requests these specific types.

Which is the most common gender of the fraudsters?

R1: Generally males. But with the same reasoning not because males are bad but because usually we have more requests from males in order to be able to get a loan which eventually will result in taking life insurance and because we have more business men who are males rather than females.

So what kinds of antifraud-mechanism/s are adopted by your company? (Please include also the mechanisms that are used in the event where money laundering is possible.)

R2: From the aspect of money laundering, as we were saying before, firstly there is the very basic principle as expressed from the FIAU, that of knowing your customer. So here it has to be taken from the context that all policies by HSBC Life are not actually sold by HSBC Life but we have a tied insurance intermediary which in our case, it is our bank. Thus the policies which are passed to HSBC Life as sold by a financial planning officer firstly be it San Gwann branch, Gżira branch etc and it would be that particular situation where the FPO needs to check that the proposal form is filled and certain documentations are also attached. Then eventually it comes to us. If the policy is a protection type of policy and has a considerable amount of money involved then it would go to for underwriting but one needs to appreciate the fact that the FPO that is situated in a branch has collected a series of information on the client which can help out in deciding whether or not the policy has to be issued. Cases where in with profits or unit linked; the investment vehicles, there are extreme sums involved both for regular premiums or lump sums, which for us will befuori dall'ordinario, the processing team of HSBC Life will go to the MLRO and will ask whether a two/three thousand euros a month is adequate for a teacher who is considered to have a normal wage from out of which he/shesurely doesn't afford. At that point the client's cheque will go back to the FPO and will ask him where is the gap in such situation since from the basis of the information given it doesn't make sense. However it may be the case where the FPO will have information which will fill in the gap but which wasn't necessary to be given a priori. For example if the client has sold a property or he came into inheritance, then yes it would make sense. Thus in relation to money laundering yes there are checks in place because the obligation under the current legislation is that before we actually issue the policy we need to be sure that the policy makes sense versus what we know about the customer.

R1: Apart from that, one of the fundamental aspects of underwriting, in my opinion is that sixty/seventy per cent of fraudulent claims are identified at underwriting stage and not later.

After the policy has been issued it is much more difficult to detect. Another important thing is that underwriting has to be taken in the aspect of financial underwriting. For instance when we receive a policy of half a million/ one million, we can't say that this is an extreme policy. We need to establish whether the client needs such policy and whether he is able to pay it because in many instances fraud takes place when large amounts of money are involved. Thus, the aspect of financial underwriting is extremely important. We are continually faced with situations where a person could pass in the medical test but will fail when it comes to financial issues and obviously we have to reject such a form. So it's not easy as that! For example if you come to take a policy of one million euro we need to firstly establish why you need it, if you are capable of paying it and if you have any liabilities in place. So I have to agree with my colleague here that the first step of fraud is not when the actual fraud takes place but beforehand. What can you do to prevent fraud and be able to anticipate it beforehand? We pay a lot of attention to high sums assured. Since Malta is small we are aware that certain companies might be extreme but we cannot judge from the outside. We cannot base our judgement on how much cars does a company hold. Their financial situation might prove otherwise. Thus our job is to ask our clients for their financials including those regarding their company, balance sheets, profit and loss accounts to be able to judge if the financials are good or not. There might be also instances where a client would ask for a three million euro policy with the intention of committing a suicide after two or three year from the date of inception. This is concerned as almost fraud because if he was intentionally deliberating suicide it would be considered as fraud. That's why financial underwriting is of utmost importance. In many cases what will happen is that both banks and even people who work in insurance, don't take care of financial underwriting but for us it is extremely important. In fact this week I was presented two cases like this and obviously we didn't accept them due to financial underwriting.

R2: Maybe with [the representative for the FIAU] you talked about the process of money laundering versus insurance policies and the most evident way in which insurance policies can be used is in the savings. So if I have a policy which started at a low level but I'm noticing that instantly regular premiums increased drastically, I can say that it's a good sign that of having assets under management increasing but in reality it might be the start of a fraudulent episode. For instance if I have a pensioner and he used to deposit one hundred a month over a period of twelve months and all of a sudden he started depositing three thousand euro I need to start asking questions. On one hand it is a good sign but is this policy really making sense to this individual? We need to keep in mind here that a good ninety-five per cent of the clients who opt to take a policy under HSBC Life including those policies which include even the investment vehicles, are the same client for HSBC bank. So I can't reassure that the money involved are 'clean' on the basis that the money are coming out from the client's account. I need to dig deeper. I can't just say that such matter had to be taken care of by the bank that for me is not an issue. I need to assure myself that when I see the type of policy chosen and the individual, it makes sense.

R1: However you need to keep in mind that if a bank has a client who is passing through difficult moments, the easiest way is that of suggesting a life insurance. But you need to analyse everything. Is this person capable of paying premiums? For instance a person who earns seventeen thousand euros, do they actually need a two million euros policy?

What kinds of training programs are available for your employees in order to be able to flag any suspicious claim immediately?

R1: So we in the underwriting department attend regularly for foreign training. A friend of mine at the moment is in Germany. He has a full week over there and he assists in claims.

The course would be divided into four sessions and participants need to attend every six months. In these types of training there will be people from all around the world, all sharing their experience in the field. In these courses we will also discuss how fraudulent claims can be eliminated and how we can conduct their assessments.

Yes yesterday I was doing a similar interview and the same course was mentioned.

R1: Yes because he was part of our team and had done this course, not this actually the one of underwriting. But due to the limitation of our country, yes we need to conduct such trainings overseas. Over there you will come across various types of cases and you will also meet various people from various locations including America, Hong Kong, China, Europe etc. Usually we will be around twenty to twenty-two participants and we will be able to see the real types of fraud cases that take place overseas and which in Malta we are not used to.

Whenever your company is faced with a suspicious claim how does it react?

R1: Obviously whenever we are faced with suspicious or early claims we conduct the normal procedures as follows. The first step is that you write to the doctor who had previously examined the client before he actually died. From our own experience, I need to say that doctors are not that helpful in this regard. This is due to the fact that if the doctor would have known the client and he would be aware that the same client had hidden information which is considered to be valuable to our company, usually they still won't disclose it to us. On the other hand one of the sources which we found really efficient is the Mater Dei Hospital. They have their customer service really excellent. It is really easy for us to write to them and in just one to two weeks we will have access to the files of the dead client. We usually go onsite to investigate files and even computer records, out of which we really find useful information. We find that type of information where the client broke his leg when he was just a child. There are really detailed documents. They still have records from St. Luke's and the Blue Sisters. Obviously what we are after is the more recent information as most of the fraudulent claims are detected from there. Doctors, usually do not disclose information which will affect his clients in not receiving money from insurance.

R2: And we had cases over the last two years where we managed to detect them. We have a process in place and it is not an issue that the client is in a hurry or that the heirs need the money. Surely there is a process to follow and essentially because you managed to follow it you would manage to discover such instances. However, we cannot be intimidated by having too much of these fraudulent claims because the process is embedded and if you follow it through if everything goes well you just pay and it's ready. However when you are faced with a case where you need to dig deeper, then you need to follow other procedures.

R1: Our clients would usually take a life insurance policy for a loan that is taken with HSBC as well. When we don't pay the loan the other departments obviously won't be happy but when you explain the facts and what have happened they would be really surprised about what their client had done.

In cases when there is a suicide and it is an obvious planned suicide, how do you as a company react?

R1: As a life insurance company we do not pay for suicide which took place during the first year. After the first year yes we need to pay. Obviously when we are faced with a suicidal

case we ask for police reports or that of a magisterial one. Some of the cases are really funny whereas others might be really painful. That type of case where the wife tells you that at the time of the incident her man phoned her up and told her to take care of their children and not to forget to give them their lunch for school because he was not going to see them anymore. Actually these types of situations are seen on films but we have to deal with these occasionally. And the worst scenario for us is to deal with their wives afterwards because in most of the cases it is man who commits suicide and we have to deal with the emotions that these wives would be passing from.

R2: But the principle is always the same. You have the terms and conditions and if you have a client who commits suicide after the first year of the issue of the policy, then yes you need to pay.

R1: The most strange case we have experienced was when somebody committed a suicide exactly I year and a day from when he had the policy issued. Obviously this was a case where he really planned things out. But it is irrelevant. If in the terms and conditions there was written that you need to pay after a year from the issue of inception you need to pay. Generally most of the suicides would have been planned out. If one day you find some time I will show you the reports which actually indicates that these persons have planned it wellbefore actually deciding to commit suicide. There were cases where the policyholder had organized all the required staff of the funeral beforehand.

How much are fraudulent insurance claims costing the local insurance industry?

What we haven't talked about yet is that sometimes you are faced with situations where you would be hundred per cent sure that they are fraudulent but yet if you won't have the necessary proofs you need to pay. Investigations costs money. Ok not in the case of Mater Dei but in most instances we need to call out for doctors to check private hospitals. Apart from the expenses incurred from the investigations you would have to pay for fraudulent claims since as my colleague was saying before, if you wouldn't have enough knowledge on the case you need to pay. If we are talking on foreign insurance agencies, then you might need to send investigators forexample from Australia to Malta and this costs a lot. There are many foreign private investigators who take care on just fraudulent claims. However their fees are really high. Then you need to establish how much the claim is going to cost you and what type of information do you have in hand and whether it is better off if you just pay out the claim or keep investigating the case. But in many cases as already stated, you would know that they might be cheating but if he was clever enough that you can't find anything against him than it is another story. As already stated doctors aren't much helpful as there is a number of whom they leave out patient's information with regards to health issues. For instance if you send a report on someone who is clean you will receive it back in two weeks whereas others which might have medical issues will argue that they never received reports irrespective of how many times we have sent it to them. Sometimes we also receive them empty...

Do you find enough help from the MFSA and MIA whenever the need arises?

R1: Till now we never had a case where we informed the MFSA or the MIA. We have always dealt with cases in-house. I think there isn't a connection between the MFSA and ourselves.

R2: If we're talking about connection with the MFSA and the MIA on claims, it is very minimum, at best maybe you will have a penalty fee on a return which you had to send back

to MFSA on number of claims paid but that is it as far as it goes. In terms of assistance on how we have to do things then it's zero.

R1: Irresistible.

R2: And on the very much same lines with the MIA especially in my colleagues's area. In my area it's a bit different because I report to the regulator in the company. So for instance if there are changes in the legislation in connection with insurance they will issue a communication procedure to the insurance industry and I would have the chance to read it through, give feedback, ask questions and more often than not they will answer you. Ok they might take a bit long to answer but my unit has quite a good relationship especially with the insurance business unit. We feel free to phone up and question things that matter to us. We have English colleagues that most of the time they never dream of asking the regulator by phone. It's at that level abroad. But we are lucky we don't face this kind of problem. There will be circumstances where they will ask you to write them up and will answer you shortly but generally speaking it's across the phone.

R1: At least there is communication! But when it comes to claims it's a different scenario.

R2: Another issue which can arise is where the MFSA comes into play where you will have a claim which you haven't settled it yet and will result in a complaint. Over there generally the person whom you didn't pay will go to the regulator instead of writing to you and as to my records we haven't experienced such situations either.

Do you think it is the case where fraudsters are becoming more knowledgeable about fraud detection systems thus leading to an increase in the number of successful fraudsters?

R1: As I already told you most of the clients make a life insurance policy not to defraud insurance companies but because they would need it. However saying so one needs also to understand that in Malta we don't have the culture of having a life insurance policy like abroad. So you will have cases where a person makes a life insurance after they felt ill and then they would go to do medical tests afterwards. They will do it more to protect their family instead of to defraud us. Ok it's still bad but the intention behind it is for good purpose.

R2: I think it is the other way round with regards to question twelve. At least most of the clients which I meet regularly don't have an idea how to defraud. In the sense that sometimes due to height and weight I would send them for medical tests to be able to agree on the sum assured and sometimes from the medicals, it results that the client was suffering from something which he/she wasn't aware of. And then when you come to load the premium they would start asking but what does it affect the much? In most cases the client would realize that if he declares that he suffers from a particular illness it will affect the the premium. For instance in Malta most of the clients suffer from high blood pressure and diabetes and they would know that these conditions will have an effect on the premium that they will be paying. Again we're saying this in our company's context and because it is local because if you go overseas it's complete different.

R1: You will need a private investigator. Two things which I can mention is that if someone wants to defraud you he will do so. If there is a client who is suffering from something, in Malta we don't have a lot of private hospitals; two/three and if he is going to receive treatments yet again there aren't much where to go. But if he is wise enough to go and take the treatment overseas, then it would be difficult to find out. We had a case where someone went specifically abroad for an operation and we wrote to that hospital and we received a

favourable reply. But as already stated if he wants to defraud you he will do so. If you have a client where he went to Greece on purpose you would never think of what he is doing there. On the other hand those cases which we don't pay because they resulted to be fraudulent will pass a positive message to our employees; that of we don't pay every single claim. If someone is fraudulent or hasn't declared everything at proposal stage there is the possibility of not paying out. So our employees, more than ever before are explaining to customers that listen if you leave something out or you don't let us know with your illness, the insurance company won't pay you. Because clients think that it's like doing a motor insurance policy where you go and fill in the proposal form and everything is set out. So even downstairs at commercial centres they are taking much more care on high amount of money.

R2: This goes in full circle with what my colleague was saying earlier on, on financials. If the client is asking for two million cover and then he is giving you accounts which shows that he earns twenty thousand in a year. Ok he might be a millionaire but you need to do your homework very well. That is the issue. If the company is in connection with an intermediary like in our case, you need to pass on a message that we don't accept every proposal form. Thus it has gone that time when everybody used to tick no in order to be eligible to sell a policy. And it has also gone that time when people used to skip questions because they might felt that it was an embarrassing one. It doesn't go like that! Because they know that if a claim arises and we found out that due to an embarrassing question we have an untruthful answer, then we are not going to pay. Thus the message needs to be crystal clear as my colleague was saying that not because they are HSBC bank and we are HSBC life we need to pay. It's irrelevant who the bank is, if we have a fraudulent claim we just won't pay. Nowadays we're seeing that even at branch level they are being much more careful than ever before.

Do you think that there is a need for a harsher legislation in our legislative system?

R1: From the aspect of claims as regards to underwriting there is no law. I think that each company makes its own assessment. There is no kind of help from the MFSA, the MIA, the government and legislations. The only thing that as regards to legislation is very helpful is that the client will give us the permission while he is still alive and obviously even after his death, we have the right to investigate with his authority (the sharing of information). We have no problems with any of the government departments.

R2: From the aspect of claims simply because as far as we are concerned it is under control but if you would have the number of claims on the increase it goes to show that who is being insured is either finding a loop hole in the legislation or is being wise enough to go around it. In that case it would have been yes there is the need to question thirteen because there a lot of these cases or because these are coming from a particular sector for instance people suffering from smoking. Over there yes but presently it is not the case.

Are there any comments you would like to add?

R1: No

R2: No

The interview that follows was held on 25th March 2013 with another representative of MSV Life PLC who specializies in money laundering. Some information has been omitted so as not reveal the identity of the interviewee.

With respect to money laundering cases, how do trends actually materialize? Do you think they increased, decreased or they remained constant in the last ten years?

Now with respect to money laundering cases it depends what you mean because we will only have a suspicion that there might be some illegal activity. If there is fraud in an underwriting activity we wouldn't know. We basically, to simplify matters, if we suspect that client's process came from an illegal activity we would submit a suspicious report to the FIAU and then they will analyse the matter themselves and maybe they will it pass to the police but we wouldn't know to a certain extent whether our suspicions were correct or not. So from our end, being MSV, we saw a decrease in cases being suspected.

How often do money laundering cases occur?

Vis-à-vis a subject person in our case it's maybe how many cases we have suspicions about because we wouldn't know. The FIAU do give us feedback of how many STR's were actually passed on to the police. According to our last record there were approximately 25% which were passed on to police. Now whether the police had conducted an investigation and had stopped there we wouldn't know as also the FIAU wouldn't know. So basically I'm not saying that we wouldn't have a suspect but we wouldn't know if that suspect had turned into money laundering case or not but as regards to the number of claims, they decreased. This is not because we are not doing our job. We offer a lot of products. Let's take money laundering as an example. This relates to when there is savings where the client deposits money with the intention to withdraw them soon. On the other hand with regards to fraud it's the other way round. Probably fraud would be more present in a protection policy rather than with a savings policy. Because as I was explaining before. Ok abroad it happened but in Malta we never heard of a case that somebody killed someone to take his money or that somebody disappears. The most common cases that we have in relation to fraud are attempts of non-disclosure meaning when somebody fills in an application today who has been in hospital and he wouldn't declare it and a year later he dies in connection with a medical impairment that he had before, that is non-disclosure and that amounts to fraud because it was a deliberate non-disclosure and not something I forgot to mention. If I hide something in order to accept me at a normal rate of premium I will have the cover when I shouldn't have to. Unfortunately those circumstances would be detected at time of claim and then we repudiate the claim and who will suffer? The heirs because they might have a bank loan and the bank would obviously need the money while at the same time we wouldn't pay. Then the bank will turn to the heirs and the heirs would need to sell the property etc. So I think a lot of people do not understand the consequences that are related to fraud. Some people have the perception that insurance companies have a lot of money, the same old story but at the end of the day we are here both to protect our own interest, even those of shareholders and the interest of honest clients because if we don't take the appropriate measures and we start facing a lot of fraudulent claims, what will happen? We would raise the premiums and then who will suffer? The good get blamed with the bad. Then when we raise the premiums whoever will be sick will remain with us because he knows that no one will accept him and those in a good condition will go to someone who is offering better prices. Thus we will be facing with bad risks while we will lose the good ones which in the long term it is very risky.

What is the most common age-range of the fraudsters?

It varies. Probably more the second and the third. And let's don't forget that statistically we're dealing with small numbers thus the law of large numbers is not in our favour but I would say the second and the third.

Which is the most common gender of the fraudsters?

I would say male. It is split, there is no significant either way. It's a fair distribution.

What kinds of training programmes are given to insurance companies to help them flag any suspicious claim immediately?

So we provide training internally in fact I just had one before this meeting. Work will be structured like this. Firstly the application comes in from an intermediary, then it goes to our own underwriters and then they will assist the risk which in turn would decide whether the policy has to be issued or not and on what conditions. Now the underwriters have a lot of medical knowledge and information on certain occupations that are of a certain risk and based on this information they will assist the risk and afterwards will issue the policy. In the case of a claim, the latter will go to the Claims Department and over there are trained people and there will be more training in the following days. These will check that for example if someone issued a policy today and in a year's time this person dies from cancer and that type of cancer is not aggressive they will suspect that there might be a non-disclosure in the policy and will send a report to the doctor. Thus training is conducted to anticipate these red flags as early as possible before claims. If we suspect that the client might have left something out we investigate. We also have a suicide exclusion under the policy for the first two years meaning that if we find out that someone has died because he fell off the cliffs, especially if the policy was taken a few days before, that this persons had done it intentionally maybe he is bankrupt etc so we investigate not just the medical side even accidents..

What kinds of anti-fraud mechanisms are adopted by your company against money laundering?

The question presented is a bit ambiguous, I'm going to re-word it to my own linking - the similarities between anti-fraud and anti-money laundering. As already stated certain red flags for fraud for example if a client comes to us we will be very careful because we have also apart from medical underwriting, we will look at the risk assessment for medical, financial and occupational. With regards to medical obviously it falls on the medical side, occupational on occupational while the financial we will also look at the financial circumstances of the client. Meaning what occupation he holds, what income does he receive, also his financial strengths and how many policies does he have with our company. Thus if I am a government secretary, single not married and I am going to take a protection policy for one million euros, why am I going to take such policy? I don't have a family or children to bear. I am still young let's say I have twenty five years so then we start investigating and this is not done just for anti-fraud. We do it for anti-fraud because we don't want (all right it doesn't happen frequently) where one takes a policy of one million euro and then he disappears. We also want to make sure that the client is being sold the right type of policy because it's useless having a client being attracted by a large policy and then he fails to pay the third year and he stops the policy (surrender). Generally when you surrender a policy you will lose quite a lot

of money and then the client will be dissatisfied with our product and will start saying that the intermediary sold him a policy which was not adequate to him so we want to make sure from day one that the sum assured (the sum that will pay upon death) and the premium that is being paid make sense so that when we consider how much money does the client receive which is known as *Know Your Customer* (KYC) which is basically common sense, you don't go to an unemployed client and make him buy a policy of five thousand euros in a year because it doesn't make any sense. Thus number two, financial underwriting both indirectly and directly there are certain anti-fraud mechanisms which aren't common to what we do for *Know Your Customer* in the case of money laundering. For money laundering you need to think in a similar way. If you are faced with a client, and this occurs mainly on the savings policy, you would need to know what occupation does he occupy and his expected income so that if someone comes to invest a fifty thousand euros in a policy while his only income is ten thousand for instance, from where does he bring this large amounts of money? And then we repudiate the policy. And what do you know on your customer? And we also look not just on the policy being processed but also on his insurance history because you can apply today for five thousand euros and then six months later you acquire another policy for ten thousand euros. Because someone who wants to fraud you instead of giving you a bulk at one go, he will pay you in instalments. It's what we call smurfing. He gives you five thousand today, ten thousand the following year etc. For instance we have a feature in the savings products which includes top-ups. For example you can issue a policy for one thousand euros per year and then any time throughout the year you can make further payments whatever the amount and can accumulate so when we are faced with a new application and this is part of the anti-fraud mechanisms, we print out the client's insurance history he has with us and will indicate what policies does he have with us and how much he paid on each so then when we underwrite his application we underwrite the whole client sort of meaning if the clients issued various types of policies in a period of two years and that total does not make sense then we start acquiring whether it’s for anti-fraud and whether it’s for money laundering purposes so in fact certain financial instructions apart from that they amalgamate fraud, the same unit will handle both fraud and money laundering because if you will use the I.T software there are certain red flags which are very similar and can be easily picked up.

What do you suggest in terms of anti-fraud mechanisms that should be adopted by insurance companies against money laundering?

Common sense which is the least common sometimes. Joking apart, we know that when something is too good to be true generally it isn’t true. To make use of available tools is not rocket science. As stated the process of checking the insurance history of clients with every application form, can be easily done and I'm sure they do it because of medical underwriting. With every application form you have the sum assured according to the total sum assured of the client he has with us and according to age we might send him for medical tests. Now to arrive at this stage we need to print out what he has with us meaning the underwriting sum assured is needed for the medical underwriting, for anti-fraud and for anti-money laundering. So there are certain tools that are available and nowadays they can be easily bought but they are not cheap. However one needs to check the business volume and where he is going to conduct his business and what type of products he is going to offer. There is I.T. software which helps in implementing automated anti-fraud measures and money laundering measures so there is a lot that can be done.

How much are fraudulent insurance claims costing the local insurance industry?

This I have no idea to be honest. To cost insurance industry something if you become aware of fraud later on and you can do nothing about it. The MIA might have some sort of statistics, whether they have such statistics vis-à-vis life insurance I don't know to be honest. And this is one area where we are trying to improve even vis-à-vis our competitors in the market. In fact one of the things we want to do is the sharing of information. There is already sharing of information on the non-life side of potential fraudulent claims and we want to adopt a similar system on the life side because it will help. Because it might be that someone applies with more than one company because he knows that if he goes to one company due to those limits which we mentioned before, they will ask him to go for various medicals but if he divides the sum assured with various insurance companies they are not material to those individual companies but in their totality they will be. It might be the case that I have one company which had repudiated the claim on the one policy so it's good to share all the information. It might be that he applied with us and he didn't tell us that he had applied with someone else and was refused. We would want to have that type of information if we want to check the claims. In these cases we don't pay our claims. So co-operation in the market already exists within the life insurance industry but it has to be more structured.

What are your unit's relation, if any with the MFSA (Malta Financial Services Authority) and the MIA (Malta Insurance Association)?

Primarily the MFSA is our regulator and we are active members within the MIA. This is the agreement we are trying to reach between the local life insurances to act through the MIA to reduce bureaucracy and the number of escalations. We meet at the MIA and conduct what we call life sector meetings and there is good co-operation between all. We want to take this to the next level to co-operate both on the underwriting side and on the claim side in anti-fraud. Anti-fraud in the life assurance industry is not as seen on TV like someone kills another or someone disappears, there were cases which in Malta we may never had. In England there was a case where an elderly couple fabricated a story in which they got out on canoes and the husband did not return. With time the guilt feeling took over the woman and she told the truth to the authorities and she was thrown in jail but these are remote cases. The most cases we have are on non-disclosure. We consider mostly protection business as anti-fraud is mainly on protection-business not in savings. In savings there can be money laundering and vice-versa. For example, with HSBC bank, in the case that you have a client who's applying for a mortgage and needs a life policy, the client goes to HSBC Life and likewise with BOV probably he's coming to us even though the clients like to shop around and that's the way it should be. This means that if we got application form and the application form is lengthy we ask why the client did not go to HSBC and HSBC Life say the same thing so there are certain indicators that trigger something like listen, this customer came to us directly he did not go to a broker, as if he went to a broker and intermediary where he/she could search through the whole market not like tied intermediary where he's only attached to us, but if he went to a broker and the broker sent him/her to HSBC Life, if he/she got through a broker, you will say ok as the customer made his research and our rate was better but if the customer got with us directly he/she could have easily been serviced at HSBC directly. It's a one-stop shop like in BOV and he/she would have been serviced from 'A' to 'Z'. Why did he/she come to us? So let's enquire HSBC Life as we have the right to do so and if we suspect that there's fraud we can consult or talk to other banks, insurance companies, or hospitals. It's important what to ask in the application form and the type of questions that you ask in the proposal form and even the wording. The questions have to be specific not ambiguous that can create ambiguity or give different possible interpretations for the client's side. If I want to ask you whether you have ever been to a hospital I ask you "Have you ever been to a hospital". It's a silly example but straight to the point otherwise the clients or his/her heirs would in court complain that the questions were not clear or were ambiguous in

the case you try to repudiate their claim. The court can rightly tell you that you were not clear in your questions, that there are grey areas and there is some ambiguity that the client couldn't have understood. Obviously when there's doubt the heirs are going to win. So, one of the most important factors is that the insurance company must be clear in what types of questions it wants to ask and what type of questions they want to consolidate. Also, we have questions on the application form that ask specifically whether the client have gone to other companies and whether they did not accept him/her, also if he/she's applying concurrently (he has applied at more than one company). It could be that the client is going to multiple insurers so it's important to have this in the underwriting process, internally, printed on the underwriting summary sheet. The insurance company must ask itself whether the questions are clear, what information is needed from the client, whether he/she is able to get away with them, whether there's doubt etc. If you don't have these questions, it would be your fault, or if the questions are not clear, you then don't have the tools to fight future claims. Fighting is unfortunate as we're here to pay claims. We accept the premium from our clients at the understanding that what they've told us is correct. It can also be the case, however, that certain circumstances might arise, that the duty of disclosure is not at application only. If the policy starts today and the renewal premium was not paid, this becomes lapsed. To re-instate the life cover the client re-fills a health application form, what we call a revival application form. Although even on that we make it clear to the client on that form that if he/she doesn't tell us all the facts it can be that at the time of the claim you're going to prejudice the dependents' right to claim under the policy so we make it clear, repeat the process but we also remind the client that he/she has to tell us the truth. We had cases that even at revival we had non-disclosure and we have repudiated the claim. We don't like to do so because at the end of the day if for example someone dies at a young age and he has his wife and children who want to survive and we're here to pay the claims and it's not a good publicity if we don't even as we're a large insurance company and people start saying things that are not fair. We have to safeguard our interests, shareholders and honest policyholders, percentage-wise fraudsters are at a low percentage. Those clients that have to get through the window (instead of the door) hopefully we get them but unfortunately you only get to know at the time of the claim and when this happens you have to undergo through some pain as it's not easy to face the widow of someone and tell her "listen, we're not going to pay you". This is not a nice feeling, we're all human, the money is not getting out of our own pockets individually, true, but it's not a nice feeling.

Do you think it is the case where fraudsters are becoming more knowledgeable about fraud detection systems thus leading to an increase in the number of successful fraudsters?

So let me tell you this, today even with technology they might be trying to become more wise and crafty. However from the other, side insurance companies are also becoming wise. Why? These are happening overseas. But locally we started as well - the use of social media. There were cases, but these are more on the non-life for example on motor and health claims when for example someone makes a claim on a car or that somebody is injured, the insurance pays out and then they go on Facebook and will tell the other way round. Some people think that they can cheat insurance companies. For example somebody declares that he became ill and then he writes on Facebook that he's off for skiing while the insurance company would have paid him for disability claim. And these are happening. In fact insurance companies abroad are turning to social media in their claim investigation process. However certain fraudsters are not as wise as they think they are as some of them would post certain comments on Facebook and other social media which would prove otherwise and these cases did occur luckily to us. Hopefully we will continue on the same track to continue tracing these fraudsters. The Americans use private investigators to detect fraudsters especially if there is a large sum of money involved. Abroad, there were cases

where somebody declared that he was injured, and then he was caught on cameras working. For example it doesn't have to do with this but the Italian police caught a lot of fraudsters on taxation and social benefits fraud. For instance there was someone who claimed for a twenty year benefit because he said he was blind and then they saw him driving a car and push his niece's pushchair. So there are ways and means but then you need to keep in mind that you cannot investigate each and every claim but certain investigation processes, yes, they need to take place.

Do you think that there is a need for a harsher legislation in our legislative system?

Good question! There could be room for improvement for example they could include harsher penalties because when it comes to insurance fraud I don't know whether they are taking it lightly or not. Most importantly is that the system in place should be revised. For instance if you would have a case in court, it shouldn't take ten years because we as MSV have a case in court on death claim which is already ten years old and the sentence has not yet been given out. It shouldn't be the case. Why? The heirs think they have a legitimate claim. They might have been in collusion with the deceased that he has submitted an application form while being in hospital. We had a case that a client was dying in hospital and the intermediary together with the client's family were aware of that and it turned out that we didn't pay as you can have cases where the heirs wouldn't have known what the deceased wrote in the application form and for them it was a legitimate claim but if the client hadn't declared everything we have to repudiate the claim. In such circumstances the heirs would be surprised with our decision and most often we end up in court and then the longer it drags on someone, the worsen it becomes. Firstly the heirs would have already been suffering emotionally and secondly if there is a bank loan in connection with the policies, the loan is not being paid and interest would start to accumulate. The system should be faster, not faster at the expense of justice being done but at least if there are people suffering these should be catered for. We don't have a problem in going several times to court because if we actually manage to win the case we would pass our own expenses to the heirs. That's how it works unfortunately. But whoever is claiming be it the heirs, the bank or whoever although it's better if we leave the bank out because it's a big boy, they are all suffering and as time passes by it becomes even worse. If for example we have a case in court which is associated with bank loans and after certain years it resulted that we have to pay, the amount which we would be eligible to pay will not be suitable but we only have to pay up to the sum assured plus some interest which the court would allocate so yes the legislative system can be improved.

Are there any other comments you would like to add?

Not really.

Appendix E: University Research Ethics Committee form

UNIVERSITY OF MALTA

UNIVERSITY RESEARCH ETHICS COMMITTEE

Check list to be included with UREC proposal form

Please make sure to tick **ALL** the items. Incomplete forms will not be accepted.

		YES	NOT APP.
1a.	Recruitment letter / Information sheet for subjects, in English		✓
1b.	Recruitment letter / Information sheet for subjects, in Maltese		✓
2a	Consent form, in English, signed by supervisor, and including your contact details	✓	
2b	Consent form, in Maltese, signed by supervisor, and including your contact details		✓
3a	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in English		✓
3b	In the case of children or other vulnerable groups, consent forms for parents/ guardians, in Maltese		✓
4a	Tests, questionnaires, interview or focus group questions, etc, in English	✓	
4b	Tests, questionnaires, interview or focus group questions, etc, in Maltese	✓	
5a	Other institutional approval *for access to subjects*: Health Division, Directorate for Quality and Standards in Education, Department of Public Health, Curia...		✓
5b	Other institutional approval *for access to data*: Registrar, Data Protection Officer Health Division/Hospital, Directorate for Quality and Standards in Education, Department of Public Health...		✓
5c	Approval from person *directly responsible for subjects*: Medical Consultants, Nursing Officers, Head of School...		✓

Received by Faculty office on	
Discussed by Faculty Research Ethics Committee on	
Discussed by university Research Ethics Committee on	

1

UNIVERSITY OF MALTA

Request for Approval of Human Subjects Research

Please type. Handwritten forms will not be accepted

You may follow this format on separate sheets or use additional pages if necessary.

FROM: *(name, address for correspondence)*	PROJECT TITLE:
Marika Muscat 34 "Goreve" Minfah Street Naxxar NXR2655	The fight against fraud in life assurance (A lacuna in the insurance industry).
TELEPHONE: (+356)21431462	
E-MAIL muscat.marika@gmail.com	
COURSE AND YEAR: Bachelor of Commerce (Honours) 2009-2013	
DURATION OF ENTIRE PROJECT: from Oct 2012 to June 2013	FACULTY SUPERVISOR'S NAME: Mr. Andre Farrugia

ANTICIPATED FUNDING SOURCE:
(include grant or contract number if known)

1. Please give a brief summary of the purpose of the research, in non-technical language.

The main aim in this thesis is to analyse in perspective the problem of insurance fraud particularly in life assurance. The idea is to identify what tools are being used to lessen the problem of insurance fraud. This will be done through the use of questionnaires and interviews within the insurance industry.

An additional element of this study is to identify the most vulnerable people who may commit fraud. As a result I would be conducting a questionnaire with a sample of 100 people to understand better their beliefs and attitudes towards life assurnace.

2. Give details of procedures that relate to subjects' participation

(a) How are subjects recruited? What inducement is offered? *(Append copy of letter or advertisement or poster, if any.)*

Subjects are recruited on a voluntary basis. Recruits are members of the general public. The questions that are asked are easily understandable without the need for inducement or background knowledge.

(b) Salient characteristics of subjects—number who will participate, age range, sex, institutional affiliation, other special criteria:

I will distribute questionnaires to a sample of approximately hundred people including different sexes, ages, religious beliefs, occupations and hometowns.
In addition, I will also be conducting face-to-face interviews with life assurance companies. Moreover I am targeting to interview a police investigator and the Financial Intelligence Analysis Unit in particular.

(c) Describe how permission has been obtained from cooperating institution(s)—school, hospital, organization, prison, or other relevant organization. *(Append letters.)* Is the approval of another Research Ethics Committee required?

This is not applicable to my research study however I'm planning that interviews will be recorded and approval to publish the digital files is sought by the protagonists.

(d) What do subjects do, or what is done to them, or what information is gathered? (Append copies of instructions or tests or questionnaires.) How many times will observations, tests, etc., be conducted? How long will their participation take?

As previously stated I would be conducting questionnaires to the public together with face-to-face interviews to life assurance companies and other concerned bodies such as the Financial Intelligence Analysis Unit. Questionnaires and interviews would take roughly about twenty to thirty minutes. There is also a case study attached to the public's questionnaire in which they can express their response to the situation detailed in this case study.

(e) Which of the following data categories are collected? Please indicate 'Yes' or 'No'.

Data that reveals – race or ethnic origin	No
political opinions	No
religious or philosophical beliefs	No
trade union memberships	No
health	No
sex life	No
genetic information	No

3. How do you explain the research to subjects and obtain their informed consent to participate? (If in writing, append a copy of consent form.) If subjects are minors, mentally infirm, or otherwise not legally competent to consent to participation, how is their assent obtained and from whom is proxy consent obtained? How is it made clear to subjects that they can quit the study at any time?

As regards the questionnaires that are given to the general public, a verbal consent is sought prior to the interview. As regards the interviews conducted to life assurance companies and concerning bodies a written consent is sought.
In each form of consent the subject is advised that termination can be triggered by the interviewee at any time during the interview without the need for an explanation or a justification.

4 .Do subjects risk *any* harm—physical, psychological, legal, social—by participating in the research? Are the risks necessary? What safeguards do you take to minimize the risks?

Subjects are not victimised to the aforementioned risks. Moreover the questionnaires that are adressed to the general public do not hint or indicate the identification of the interviewee.

5. Are subjects deliberately deceived in *any* way? If so, what is the nature of the deception? Is it likely to be significant to subjects? Is there any other way to conduct the research that would not involve deception, and, if so, why have you not chosen that alternative? What explanation for the deception do you give to subjects following their participation?
There is no intention to deceive any subject in this research study.
6. How will participation in this research benefit subjects? If subjects will be "debriefed" or receive information about the research project following its conclusion, how do you ensure the educational value of the process? *(Include copies of any debriefing or educational materials)*
Members of the general public are made aware of the existence of fraud in the insurance industry. Moreover they are made aware of the gravity of the situation and of the related laws that are in execution by the Courts of Malta.

TERMS AND CONDITIONS FOR APPROVAL IN TERMS OF THE DATA PROTECTION ACT

- Personal data shall only be collected and processed for the specific research purpose.
- The data shall be adequate, relevant and not excessive in relation to the processing purpose.
- All reasonable measures shall be taken to ensure the correctness of personal data.
- Personal data shall not be disclosed to third parties and may only be required by the University or the supervisor for verification purposes. All necessary measures shall be implemented to ensure confidentiality and, where possible, data shall be anonymised.
- Unless otherwise authorised by the University Research Ethics Committee, the researcher shall obtain the consent from the data subject (respondent) and provide him with the following information: The researcher's identity and habitual residence, the purpose of processing and the recipients to whom personal data may be disclosed. The data subject shall also be informed about his rights to access, rectify, and where applicable erase the data concerning him.

I, the undersigned hereby undertake to abide by the terms and conditions for approval as attached to this application.

I, the undersigned, also give my consent to the University of Malta's Research Ethics Committee to process my personal data for the purpose of evaluating my request and other matters related to this application. I also understand that, I can request in writing a copy of my personal information. I shall also request rectification, blocking or erasure of such personal data that has not been processed in accordance with the Act.

Signature:

APPLICANT'S SIGNATURE:
I hereby declare that I will not start my research on human subjects before UREC approval

DATE 18th February 2013

FACULTY SUPERVISOR'S SIGNATURE
I have reviewed this completed application and I am satisfied with the adequacy of the proposed research design and the measures proposed for the protection of human subjects.

Andre Farrugia MSc FCII FIRM
Chartered
Director of Studies
Malta International Training Centre

DATE

Return the completed application to your faculty Research Ethics Committee

To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance **Refusal** **Conditional acceptance**

For the following reason/s:

Signature Date

To be completed by University Research Ethics Committee

We have examined the above proposal and grant

Acceptance **Refusal** **Conditional acceptance**

For the following reason/s:

Signature Date

UREC Proposal Form - Marika Muscat

Brenda Bonnici <brenda.bonnici@um.edu.mt>

Wed, Mar 6, 2013 at 1:51 PM

To: andrefarrugia@mitcentre.com
Cc: SIMON GRIMA <simon.grima@um.edu.mt>, Carl Camilleri <carl.camilleri@um.edu.mt>, Nathaniel P Massa <nathaniel.massa@um.edu.mt>, Francis Debono <francis.debono@um.edu.mt>, muscat.marika@gmail.com

Dear Mr. Farrugia

During a meeting held on Tuesday 5th March 2013, the FEMA Research Ethics Committee has come to the conclusion that no ethical clearance is required in relation to the proposal submitted by Ms. Marika Muscat with regards to her proposed research.

Nevertheless it is important that you ensure that Ms. Marika Muscat obtains all necessary consent forms in this regard.

Your are kindly requested to inform Ms. Marika Muscat accordingly.

Needless to say, please feel free to contact me should you require further information and/or any clarifications.

Kind Regards

Brenda Bonnici
Administrative Assistant
Marketing Department, Room 431
Faculty of Economics, Management and Accountancy
University of Malta
Msida MSD2080
MALTA

Direct line: 2340 3478
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