FRAUD CONTROL POLICY AND PROCEDURES

AXA Cooperative Insurance Company

Policy owner: Babar Ali Senior Risk Manager, on behalf of the Audit Committee
Date: December 2011

Authorised For Issue February 2011

Prepared …….. **Date……**
Babar Ali,
Senior Risk Manager

Reviewed……. **Date……..**
Ali Khamis Shawish
Senior Internal Audit Manager

Approved by ……. **Date……...**

Mr. Kamel S. Al Munajjad
Member of Board of Directors / Chairman of Audit Committee
(Authorized to sign on behalf of the Audit Committee which approved the policy in their meeting held on ……..…)

The following is a brief summary of the most recent revisions to this document.

Version No.	Date	Author	Scope / Remarks
Version 1.0	December 2011	Babar Ali	Initial issue

AXA GULF FRAUD CONTROL POLICY

Contents

1. POLICY STATEMENT

AXA Cooperative Insurance Company ("ACIC" or "AXA") is providing general and Group life insurance services in Saudi Arabia and is committed to conducting its business according to the highest standards of honesty and fairness. This commitment to observing the highest ethical standards is designed not only to ensure compliance with applicable laws and regulations but also to earning and keeping the continued trust of our clients, shareholders, personnel and business partners.

AXA is committed to fraud control with an emphasis on proactive prevention and detection measures in an effort to reduce opportunities which could lead to fraud. The Company's approach to fraud control centers on maintaining a legal and ethical climate which encourages all stakeholders to protect the Company's assets and escalate any suspicion of fraud. This policy is intended to establish certain minimum Company-wide requirements and guiding principles.

AXA has a zero tolerance to fraud. When a fraud is detected, suspected or alleged, AXA will fully investigate the matter, and implement measures (e.g. containment of the area under investigation, sanction, police/judicial claim) to recover and minimize any loss to the Company. Loss may be financial, reputational or regulatory. AXA also considers fraudulent all intentional wrongdoings intended at causing a loss to AXA but detected before the occurrence of such loss. Internal controls will be reviewed in the light of frauds to reinforce mitigation measures.

This policy is based on Anti Fraud Regulations issued by Saudi Arabian Monetary Agency (SAMA) and AXA Group's Fraud Control Policy of July 2011 which intends to establish certain minimum requirements and guiding principles.

2. RELATED STANDARDS

This policy should be read in conjunction with the following:

- Anti Fraud Regulations
- Anti Money Laundering and Counter Terrorist Financing rules
- AXA-Group Standard on Fraud Control
- Compliance and Ethics guide including the whistle-blowing and employee complaints policies

3. OBJECTIVE AND SCOPE

A. Objective

This Policy outlines an organisational approach to managing fraud. It:

- Defines what fraud means for AXA
- Sets out the elements of the Fraud Control Framework:

- Roles and responsibilities of management and staff in proactively reducing fraud, through prevention and detection controls
- Required elements of an investigation response function
- Reporting requirements to AXA Group

B. Scope

This policy applies to all types of fraud that may be experienced by AXA, regardless of the origin of that risk.

The policy applies to all staff, be they employed on a permanent or temporary basis, regardless of seniority and position in the organisation. Management should ensure that all staff are required to make themselves aware of this policy.

4. DEFINITIONS

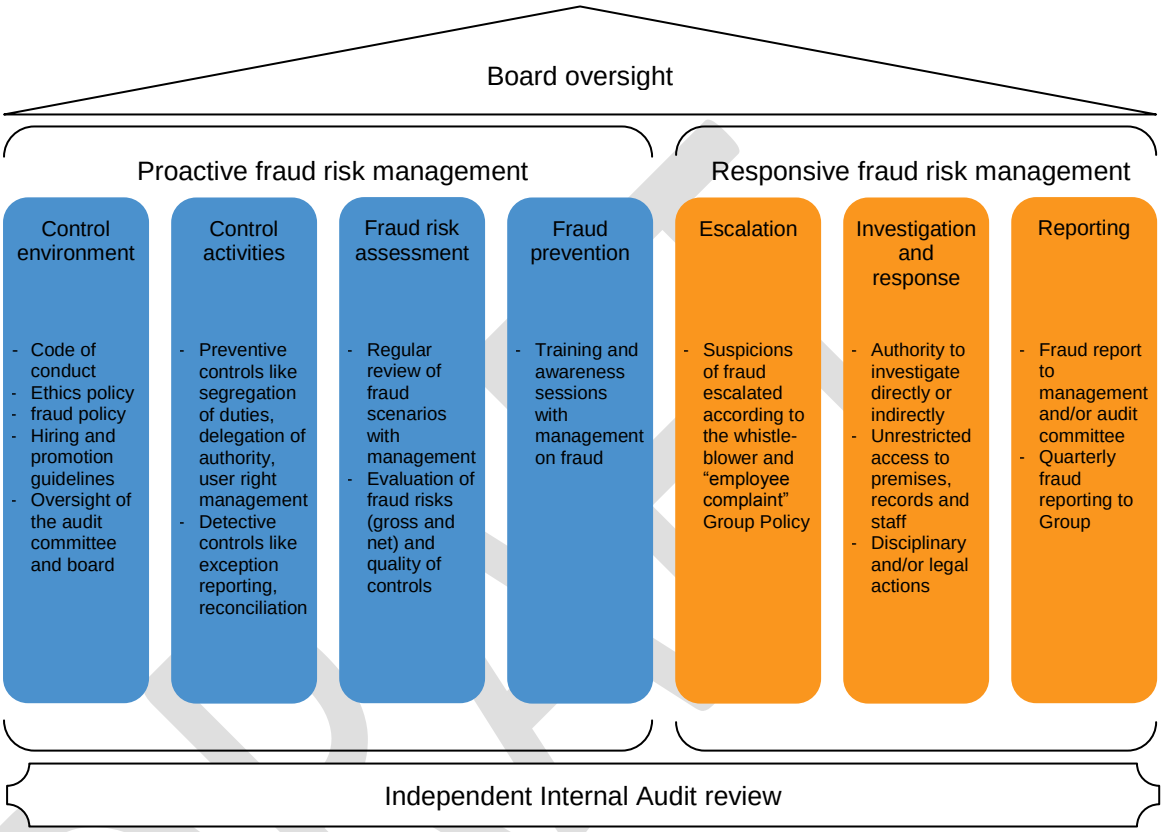
AXA defines fraud as a deliberate action or omission carried out by an individual or organisation which intends to create a loss to AXA or its business partners, or a gain to the perpetrator.
Fraud is a conduct issue, having at least of the following features:

- False representation or misstatement – a representation is false if it is untrue or misleading and if the person making it knows that it is or might be untrue or misleading
- Failure to disclose information – a person becomes a fraudster if he dishonestly fails to disclose to another person information which he has duty to disclose and intends by doing so to make a gain for himself or another, or to cause loss to another, or to expose another to a risk of loss.
- Abuse of position – a person becomes a fraudster if they dishonestly fail to safeguard the financial interests of another person, in a way that exposes that person to the risk of or actual financial loss. A genuine error becomes a fraud if the responsible person fails to disclose it to management, and AXA suffers a loss.

Any intentional wrongdoing intended to cause a loss but which is prevented by controls is still considered to be a fraud. The actual or suspected loss to AXA or its business partners and gain to the perpetrator may be of a financial, regulatory and reputational nature.

5. FRAUD CONTROL FRAMEWORK

The AXA's Fraud Control Environment is composed of 7 pillars gathered in two groups:



6. ROLES AND RESPONSIBILITIES

A. The Board

The Board of Directors has the overall responsibility for overseeing the Fraud Control Framework and is responsible for approving, reviewing and monitoring compliance with the Policy. The Board may delegate this responsibility to the Audit & Compliance Committee and Executive Committee. The management of the Fraud Control Framework is outlined below in the "three lines of defence" model.

	AXA Cooperative Board Board committees	
1st line	**Management and staff** *Executive management, management and staff*	Management and staff are responsible for implementing and operating the necessary controls to mitigate fraud risks. Fraud prevention and detection is primary responsibility of management.
2nd line	**Risk / control functions** *Risk management, Compliance, Fraud detection and investigation, Legal and Finance*	These functions are responsible for facilitating the implementation of the fraud control framework and monitoring its effectiveness. Fraud investigation should be handled by specialist staff; remote from day-to-day operations, who may also guide the 1st line of defence in such activities where trained resource is available.
3rd line	**Internal Audit**	Internal Audit provides independent assurance on the effectiveness of the Fraud Control Framework. It may also be in charge of anti-fraud activities whose effectiveness shall then be assessed by non Internal Audit personnel.
	External review *External audit, Regulators, Rating Agencies*	

The preferred organisational structure of the Fraud Control Framework locates anti-fraud functions in the 2nd line of defence either as a distinct team or integrated in larger teams. This Fraud Team must report to a sufficiently senior level in the organisation and have unrestricted access to the Audit Committee to safeguard independence and objectivity.

For further information please refer to the section "Investigation and Response".

B. The management

Management is responsible for establishing and maintaining an effective control system at a reasonable cost. This includes designing and operating fraud controls. Strict adherence to KPI may show fraud have occurred.

Fraud investigation responsibilities and the Fraud Control Officer role must be formally appointed by the management in co-operation with the Group Fraud Control Officer.

C. Staff

All permanent, temporary and contract staff are required to make themselves aware of this policy, report all suspicions of fraud to the Fraud Team or management, and to co-operate fully with investigations.

D. Fraud Control Officers

(i) Group Fraud Control Officer

The Group Fraud Control Officer is in charge of steering the anti-fraud framework of the Group. Specific responsibilities are to:

- Updating the Fraud Control Standard and Policy at least every two years.
- Assessing the effectiveness of the anti-fraud efforts carried out in AXA Group companies.
- Co-ordinating the anti-fraud efforts by initiating a fraud community whereby best practices may be transferred.
- Follow-up on most significant frauds and remediation plans.
- Reporting to the Group Audit Committee.

(ii) AXA Cooperative Fraud Control Officer

The Fraud Control Officer must be formally appointed by Senior Management, and has overall responsibility for the oversight of fraud controls in AXA Cooperative. The Local Fraud Control Officer is responsible for:

- Implementation of a fraud policy approved by the Audit Committee on behalf of Board.
- Organisation of fraud awareness campaigns to increase staff understanding of the impact of fraud risks on the firm,
- Co-ordination of fraud control efforts across local businesses to include,
    - Oversight of the assessment of fraud risk,
    - Foster fraud detection and prevention controls,
    - Oversight of adequate resources and implementation of procedures to respond to fraud events as they are detected,
    - Dissemination of fraud control best practice,

- Provision of regular reports to the Board, the Audit Committee and Executive Committee on the impact of frauds detected and the measures taken to mitigate identified fraud risks,
- Reporting to the Group Fraud Control Officer all detected, suspected or alleged internal and external frauds in accordance with the reporting standard described in section "Group Fraud Reporting".

Fraud Control Officer must have direct access to the CEO and to the Chairman of the Audit Committee to escalate concerns. Fraud Control Officer must maintain oversight of all fraud investigations carried out, will be authorised to access any data and personnel in the context of fraud investigations.

The CEO shall nominate a staff member from the Compliance Department as the Fraud Control Officer of the Company. This role will currently undertaken by:

Babar Ali Senior Risk Manager who can be contacted as follows: Phone: +966 3 895 1250; Fax: + 966 3 894 5053; E-mail: babar.khan@axa-gulf.com / compliance.ksa@axa-gulf.com

E. The Internal Audit

Professional Standard 1220[1] of the Institute of Internal Auditors requires internal auditors to apply due professional care with respect to fraud detection in conducting audit engagements. This means[2]:

- Consider fraud risks in assessments of control designs
- Have sufficient knowledge of fraud to identify red flags
- Be alert to opportunities that could allow fraud such as control weaknesses
- Evaluate the indicators of fraud and decide whether any further action is necessary
- Notify the appropriate authorities within the company when fraud has occurred and recommend investigation

Internal Audit should provide assurance on the efficiency of the Fraud Control Framework. In the event anti-fraud responsibilities are allocated to the Internal Audit (IAD), the IAD charter should specifically recognise that this restricts the Internal Audit's ability to fulfil its assurance role.

7. ESCALATION

AXA encourages all employees to escalate suspicions of fraud within the framework set out in the Compliance and Ethics Guide.

AXA encourages any complaint to be nominative to facilitate the investigation.

[1] *New release of Standards issued in May 2010*
[2] *2010 Fraud Examiners Manual issued by the ACFE (Association of Certified Fraud Examiners)*

Nevertheless the complainant's name can be kept confidential at all stages of the investigation if required so by the complainant.

8. INVESTIGATION AND RESPONSE

A. Statement of intent

AXA will maintain cost effective mechanisms that ensure suspected fraud is thoroughly and appropriately investigated, so that the firm understands the impacts and root causes of all such events, and responds consistently to each issue as it arises.

B. Investigation Standard

All fraud investigations will be overseen by a Fraud Control Team.

The escalation criteria, response procedures and protocols will be defined depending on the fraud and should address the how they will manage identified fraud events, which specifically describe the resources which will be made available to undertake investigations in compliance will applicable laws and regulations. These protocols must be reviewed by the Audit & Compliance Committee and Group Fraud Control Officer. The escalation process for AXA is covered in Section 9 - REPORTING OF SUSPECTED FRAUD.

Investigations will be concluded with a final report detailing the allegation, inquiries undertaken, findings, conclusions, resolution and corrective steps to be undertaken, and control improvements recommended. The report will be prepared in a manner which meets the needs of the Audit Committee/Board whilst complying with local legal requirements to avoid putting prejudicing legal and criminal prosecution.

C. Investigation Objectives

A fraud investigation consists of gathering sufficient information to determine whether fraud has occurred, who was involved, the methods used to circumvent controls, and the loss or exposures arising. Investigations will be sensitive to the rights of individuals but will be conducted on an independent basis regardless of the suspected wrongdoer's length of service or position in the organization.

Key elements which must be taken into account in undertaking an investigation include

- Confidentiality
- Maintaining the integrity of the investigator, ensuring no possible conflict of interest with the area being investigated
- Evidence collection, preservation and presentation standards
- Documentation of the investigation steps and decisions taken

D. Response to Investigation Findings

AXA considers a fraud event as "significant" when it meets any of the following criteria:

• Foreseeable net financial loss exceeds €1m
• Extended reputational risk occurs (for example, one-off adverse national media coverage, an inability to service customers for extended period of time, frequent major impacts on customers)
• Severe legal and regulatory risk arises (from for example a breach in regulations, or where a product is required to be withdrawn by the regulator)

The local Fraud Control Officer must report all fraud events according to the following table:

	Internal fraud	**External fraud**
Threshold	All fraudulent events from 0€	All fraudulent events from €10k
Frequency of reporting	Every quarter on the 10th working day of the following month: - 10th working day of April for Q1 - 10th working day of July for Q2 - 10th working day of October for Q3 - 10th working day of January for Q4	

Internal fraud relates to all fraudulent behaviors and acts perpetrated by salaried staff of the Group or by tied agents (commercial external parties under a contract of exclusivity to represent AXA).

External fraud relates to all fraudulent behaviors and acts perpetrated by non-tied distributors, vendors, contractors, consultants, outside agencies, governmental or non-governmental organizations and any unrelated party.

Insurance claim frauds are perpetrated by customers or third party claimants declaring false of exaggerated claims. Organized crime occurs when a number of otherwise disparate events are believed to be influenced by an overarching co-coordinating force. This does not include suspicious events that are deemed to be similar, but where there is no evidence of collusion or co-ordination between the parties. Organized claims fraud is within the scope of this Policy and must be reported. Other claims fraud only involving customers or third parties acting alone should not be included in the Group Fraud Reporting.

Reporting must be made in English using the Operational Risk System (ORS) deployed by Group Risk Management. Fraud Control Officer is responsible for making the information available on time and with the adequate level of detail necessary to understand the fraud scheme, and for updating ORS fraud reports when appropriate.

The 2011 IFC manual includes reporting needs on frauds impacting IFC controls. In agreement with Group IFC, fraud control officer is expected to stress out frauds that occurred due to a deficiency in an IFC control. This detail is required twice a year (Q2 and Q4 returns).

The following process is suggested:
- Local IFC and Fraud control officer get together to flag the IFC related events. Failure description should be written jointly to ensure adequate explanation on the IFC failure (type of control involved)
- Fraud Control officer reports frauds in ORS

- Fraud Control officer indicates to Group Fraud Control Officer in his/her accompanying e-mail which of the reported events where jointly flagged "IFC related" (ORS event number or Excel flag)

Group Fraud Control Officer will report relevant items to Group IFC on the same frequency.

The Group Fraud Control Officer is in charge of collecting the information and reporting to the Group Audit Committee in an agreed format. Any fraudulent events below €100k (or equivalent Saudi Riyals) individual loss impact will be considered as an "incident". Any fraudulent event above €1m (or equivalent Saudi Riyals) individual loss will be reported with additional detail to be provided.

9. REPORTING OF SUSPECTED FRAUD

a) The prevention of fraud and the protection of the Company is the responsibility of every member of our staff. Where Management or staff become aware of an actual fraud, or have satisfied themselves that there is a strong possibility that a fraud is being committed, they are encouraged to report promptly within 24 hours of having obtained the information.

b) A It is not possible to provide an exhaustive list of incidents and conditions that should be reported. However, below are incidents that **MUST** be reported even in cases where there is some element of doubt.

- Fraud, alleged or suspected fraud, business or financial irregularities, and any other doubtful transactions concerning AXA or a third party involving employees;
- Requests by police or similar official bodies for information, documentation or a witness statement, except for questions on the existence of compulsory insurance cover;
- Known, alleged, or suspected forgery of documents or signatures, irrespective of the source;
- Theft or unaccountable loss of any assets owned by, or in the care of AXA
- Malicious damage to offices and equipment, including computer systems and data by viruses or similar related security threats;
- Anonymous letters or phone calls containing either threats or allegations of wrongdoing against the company by any employee;

c) Where the following apply to an employee, a report should also be made:

- The questioning, arrest, impending prosecution or conviction by the local authority for serious offences either committed or alleged;
- The unexplained disappearance from their usual place of business, employment, or residence

- The institution of bankrupt proceedings or the insolvency of any company that they may have been involved with, where malpractice is suspected and which results or may result in a loss to AXA.

- Activities designed to defraud the company are regarded as theft. Where fraud is established, a report to the authorities is a likely outcome.

d) As per the AXA Whistleblower policy, any person with a complaint or concern has the option of –

- Informing
  a) their immediate supervisor, who will report it to:
  - **Internal Audit Office (email: ali.shawish@axa-gulf.com)**
  - **Fraud Control Officer (email: compliance.ksa@axa-gulf.com)**
  - **a representative of your company's Human Resources**
  - **Legal Department (email: adeeb.ibrahim@axa-gulf.com)**

  b) Directly to any of the above offices

  OR

- Where it pertains to **Accounting, Internal Accounting Controls, or Audit Related Issues**, submitting such complaint directly to:

  Mr. Kamel S. Al-Munajjed, Chairman of the AXA Cooperative Audit Committee, Fax: +973 17229122 email: johnskinner@ybakanoo.net)

e) The information can be in writing or orally - with as much specific factual information possible. Identity of person reporting should always be disclosed while submitting the report, except where:

(1) relates to accounting, internal accounting control or auditing matters (including fraud in connection with any of these matters, and
(2) relates to an employee whose responsibilities provide them with a role or knowledge in these areas.

For these two situations, the report can be made anonymously if so desired by the person reporting.

f) Anyone reporting in good faith any practices or actions that he/she believes to be inappropriate will be protected against retaliation. Any AXA Associates (ie directors, officers or employees) involved in retaliation will be subject to serious disciplinary action by the Company. Furthermore, the AXA could be subject to criminal or civil actions for acts of retaliation against AXA Associates who "blow the whistle" on certain violations.

g) Anyone who makes a report in bad faith or otherwise abuses the reporting system may be subject to disciplinary action and may also be subject to legal action.

10. CONTINGENCY PLAN

Contingency plan should address small and large scale frauds and in particular it should:

i. Detail the escalation steps of the fraud.
ii. Stress the need to preserve evidence.
iii. Require to bring in an external expert if necessary (e.g., auditor, IT specialist, etc.).

11. INFORMATION EXCHANGE WITH REGULATORY AUTHORITY

Where necessary AXA should share information on incodences of fraud as well as fraudsters with relevant authorities and with SAMA.

12. FRAUD INDICATORS

Examples of typical fraud indicators are provided in Appendix I.

13. REVIEW AND CHANGES

A review on this document shall be carried out once in two years or when there is a material change in the procedure during anytime during the intervening period.

A review of the document is also to be carried out and appropriate modifications be carried out in line with any change in Anti Fraud Regulations or AXA Group Anti-Fraud Policy and Guidelines.

Appendix I
Typical Fraud Indicators

Table I: Internal Fraud Indicators	
Business practices and conditions	
Governance and Organizational structure	Single individual or group of individuals acting together drive operations and/ or financial decisions
	Company's strategy changes suddenly
	Organizational structure is Complex
	Executive directors are numerous
	Directors, managers, members of staff, external businesses and contractors have conflict of interest
	Commission structures are unusual
Operational Management	Training programs are weak
	Transaction time, place, and parties are unusual
	Activities are inconsistent with the insurer's stated policy
	Management turnover is high
	Staff turnover is high in financial and/ or accounting departments
	Obsoleteness or lack of procedural manuals
	Documentation for transactions, processes or expenses is limited
	Tasks and transactions are complex and require special skills
Accounting and Finance	Assets are restructured without justification
	Accounting procedures are weak
	Financial results and ratios are uncorrelated
	Share value changes without explanation
	Costs rise unjustifiably or are high compared to Competitors
	Financial issues emerge
Internal Control	Internal control structure is weak
Internal Audit	Information from prior audits is insufficient
	Internal audits are weak or non-existing
Information Technology	Data and asset security system is weak
Complaints	Number of complaints received from external parties is high
Conduct	
Governance and management matters	Board of directors emphasizes unduly on meeting earning projections
	Board of directors and management take undue risks
	Board, managers, or members of staff have insufficient levels of income to meet personal debts or financial losses
	Board, managers, or members of staff appear to be living beyond their means
	Board, managers, or members of staff change lifestyles suddenly
	Board, managers, or members of staff display marked personality changes or intense family pressure
	Board, managers, or members of staff have a feeling of unfair treatment
	Board, managers, or members of staff display extreme greed for personal gain
	Board members and managers incur significant increase of expenses
	Board of directors and/ or management provide unsatisfactory answers to the supervisor's or auditor's questions

	Directors and/ or management have a poor reputation in the business community
	Board of directors and/ or management display overly aggressive attitude toward financial reporting
	Board of directors and/ or management place undue pressure on the auditors
	Board of directors and/ or management do not comply with laws and regulations
	Board of directors and/ or management display dominant management style, discouraging critical or challenging views from others such as members of staff
Working environment	Morale is low within the insurer or within certain departments of the insurer
	Relationships at work are inappropriate or acting of individuals is unusual
	Earning ability is lower than that of other comparable Insurers
	Company faces adverse legal conditions
	Managers or members of staff work late, are reluctant to take vacations and display signs of stress
Operational management	Staff recruiting processes contain problems
	Management fails to follow proper policies and procedures in making accounting estimates
	Processing of payments is done at odd times (e.g., late in the day, after business hours, etc.)
	Insiders reduce holdings of insurer's stock

Table II: Typical Insurance Service Provider Fraud Indicators	
Finance	Intermediary is in financial Distress
Portfolio	Portfolio is small but has high insured amounts
	Number of insurance policies where the commission is higher than the first premium is high
	Portfolio contains an arrear of premium payments
	Portfolio displays high amount of claims fraud or a disproportionate number of high risk insured individuals, (e.g., elderly people)
Operations	Intermediary operates outside the region of the policyholder
	Intermediary asks for an immediate or in advance payment of commission
	Intermediary asks the policyholder to make payments via the intermediary himself which is an unusual business practice
	Intermediary receives premiums and pays commissions that are above or below the industry norm for the type of policy
	Intermediary has a relatively high claims ratio
	Intermediary has an exceptional increase in production without apparent reason
	Intermediary has a high level of early cancellations
	Intermediary has a high number of unsettled claims
	Intermediary insists on using certain loss adjusters and/ or contractors for repairs
	Intermediary changes control or ownership frequently
Conduct	Intermediary has a personal or a close relationship with the client
	Intermediary changes name and address frequently
	Intermediary has a number of complaints or regulatory inquiries

Table III: Typical Policyholder Fraud Indicators	
Claimant's Behavior	
General conduct	Claimant doesn't do anything to prevent or limit the damage
	Claimant provides evasive answers and does not cooperate during a reconstruction
	Claimant gives inconsistent statements to the police, experts, and third parties
	Claimant hides details of claim to other people (e.g., family, friends, neighbors, etc.)
	Claimant handles business in person or by phone, while avoiding written communication
	Claimant displays detailed knowledge about insurance terms and claims processes
	Claimant checks the insurance coverage shortly before the claimed event
	Claimant modifies address, bank or telephone details shortly before a claim is made
	Claimant insists on using certain contractors, engineers, or medical practitioners without a

	convincing reason
	Claimant avoids giving information concerning denial of previous insurance when applying for a new insurance
Coverage	Policyholder possesses several policies with the same insured object and coverage
	Policyholder changes insurers frequently
	Policyholder insists on changing terms and conditions
	Claimant does remarkable filing of the claim (e.g., claimant seeks help of a lawyer or other professional advice in reporting the claim)
Payment	Claimant requests that payment is made in cash
	Claimant requests that payment is made into different accounts
	Claimant requests that payment is made to a third Party
	Claimant insists that the payment exceeds the value of the damaged goods
Speed of settlement	Claimant insists on quick settlement of a claim
	Claimant threatens to bring in a lawyer if the claim is not settled swiftly
	Claimant enquires frequently about the progress of the claim
	Claimant accepts a low payment to settle the claim quickly
Claimant's Characteristics	
Background Information	Claimant provides vague information regarding identity of policyholder and/ or beneficiary
	Claimant uses a post office box or hotel as an address, moves repeatedly, gives false addresses, or has a non-matching telephone number and address
	Claimant refuses the disclosure of claims history with other insurers
Personal and Financial Situation	Claimant has an usual and/ or difficult occupational situation (e.g., unemployed, self-employed, frustrated with job, facing disciplinary action, seasonal worker, or in an industry experiencing downsizing and lay-offs)
	Claimant is experiencing a bad financial situation
	Claimant faces a difficult family situation (e.g., divorce)
	Claimant has a relationship with known fraudsters or criminals
	Claimant has a history in bad claims
	Insurer is experiencing difficulties reaching the Claimant
	Claimant lives in a known fraud area
Documents	
Forms	Application forms are incomplete and/ or Unsigned
	Claim forms are incomplete and/ or unsigned
	Claim forms are modified Frequently
	Application form and the inception date of the cover are different
	Application form and claim form are inconsistent
Receipts and	Minor losses are sufficiently documented while major ones are not

Reports	Documents/ receipts are unspecific, modified, or unreadable
	Original documents/ receipts are missing; only copies are provided
	Receipts are new (e.g., not wrinkled, clean) for old events or products
	Receipts contain different Handwritings
	Documents display odd dates (e.g., during holidays, after business hours etc.)
	Doubtful receipts are provided, from companies that do not exist, have ceased operations, or are insolvent
	Doubtful receipts are provided, with differing dates but with successive numbering
	Foreign receipts contain unspecified currency
	Reports from medical practitioners or other authorities (e.g., police) are inconsistent
	Documentation from foreign countries is different from the expected format or content (e.g., use of incorrect language)
Claims' Characteristics	
Submission of Claim	Claims are submitted by a third party without proper power of attorney
	High claims are submitted Frequently
	Claims submitted display prevailing connections
Timing of Claim	Claim is filed in one of the following cases: – Shortly after coverage becomes effective. – Just before cover ceases. – Shortly after the cover has been increased or the contract provisions are changed.
	Loss occurs just after payment of premiums that were long overdue
	Damage occurs in the period of provisional cover
Size of Claim	Loss is actually far higher than first reported
	Loss claimed is just below the threshold that causes additional checks by the insurer
	Amounts insured and the characteristics (e.g., age, profession) or life style of the policyholder are inconsistent
Indicators Specific to Business Classes	
Property claims (including disaster fraud)	
General Property Losses and Claims	Losses and the characteristics (e.g., residence, occupation, income, lifestyle, etc.) of the policyholder are inconsistent
	Claimed losses and the findings in the police report are inconsistent
	Damaged items cannot be/ are not examined by loss adjusters
	Destroyed items are in bad Shape
	Large amount of cash is Stolen
Fire	Fire affects a single property or building without affecting others
	Policyholder, family and pet are absent during a fire
	Items of sentimental value (e.g., photograph albums) or family heirlooms are not lost or damaged during fire
	Absence of physical evidence of the place where heavy items were located (e.g., indentations in the carpet from furniture)
	There are multiple sources of fire
	Origin of fire is unknown
	There is no evidence of burglary in case of arson
	Building is unoccupied and without surveillance at the time of fire
	Building is disconnected from public utilities at the time of fire
	Fire is not detected by fire alarm

	Fire alarm is switched off Coincidently
	Fire alarm is switched on, but blocked by objects
	Fire is detected shortly after people leave the building
Car Accidents	Car damage and/ or injuries are exaggerated, claims are fabricated or accident is staged
	Circumstances of accident are identical as a previous claim or with the same lawyer
	Blame on the accident is accepted too easily
	Police and/or emergency services are not contacted immediately after an accident with substantial damage
	Claim for recovery damage is not made immediately after an accident with substantial damage
	Relationship exists between the people involved (e.g., between passengers of the different vehicles, between patient and doctor, etc.)
	One of the individuals involved has a rental car
	Driver of the rental car accepts blame easily
	Eye witness is very cooperative
	One of the vehicles involved in the accident is old and the other is new
	Severe damage occurs without a collision (e.g., swerving)
	Both people involved are foreigners from the same country
	Claim involves victims with no own damage insurance and/or one who would be at risk if found at fault
	Testimonies are very similar or strikingly different after an accident
	Reported injuries are remarkably similar
	Damage does not match the injuries (e.g., little physical damage but severe personal injuries)
	Inconsistencies in the damage of the cars involved (e.g., one with minor damages, the other with severe damages)
	Injuries are difficult to observe objectively (e.g., headaches or whiplash)
	Marks at the location of the accident are absent or difficult to find
	Accident occurs in a deserted location
Car Theft	Vehicle has an unusual registration number
	Vehicle has been registered very recently
	Vehicle is stolen just after the end of the "new-value period"
	Registration certificate is inside the vehicle or is lost before the theft
	Vehicle keys are not the original ones
	Vehicle alarm is switched on but does not work
	Stolen vehicle is recovered completely undamaged
	Stolen vehicle is recovered with valuables/ documents
	Age or social position of the insured and the make and model of the vehicle are inconsistent
Claimants Conduct and Employment Information	Losses are described Vaguely
	Claim is filed with delay
	Items are over-insured Substantially
	Claimant gives very detailed description of the property or a detailed photo report at the preliminary stages of the claim
	Lists of property in the claimant's and the loss adjuster's reports are in the same order

	Items insured are new according to the claimant
	Inconsistencies exist in the claimant's account
	Claimant does not want the claim handler to contact his employer directly
	Claimant's employment information is suspicious
	Claimant started his employment shortly before the accident occurred
Police Reports	Police report is not provided when expected
	Discrepancies exist between the claimed losses and the findings in the police report
Travel	
	Loss is reported a long time after the trip
	Mismatch exists between insurance term and holiday period
Life	
Policyholder Information and Conduct	Relationship between the policyholder, the insured and the payer of the premiums is unclear
	Policyholder or beneficiary owns several policies with different addresses
	Policyholder accepts unfavorable conditions
	Insured amount and standard of living of the policyholder are inconsistent
Payments and Beneficiaries	Payments are requested to be made to others rather than the policyholder or the Beneficiary
	Premium is paid in cash
	Premium is made in foreign currencies or from a foreign bank account
	Payment is made to unrelated third parties
	Policyholder and beneficiary have a significant age difference
	Beneficiaries of policy are frequently changed
	Beneficiary's name and account number are Inconsistent
Cancellation of Policy	Request for cancellation of policy or refund of premiums are made shortly after the cooling off period
	Request for cancellation is not signed or signed by an unauthorized third party
Time and Place of Death or Claim	Claim of suicide or a criminal offence is made shortly after inception of the policy
	Change of policy provisions or beneficiary is made just before death or disability
	Insured is claimed dead while abroad
	Disability claim is made just after a premium default
Missing Death Information	Body of deceased is missing or unidentified
	Original death certificate is Unavailable
	Cause of death or disability is suspicious
Transport	
Operations	Weighbridge is non-calibrated
	Goods are delivered after Theft
	Drivers are paid per trip
	Documents are handled without sufficient supervision (e.g., in hotels, restaurants)

	Goods are transported to a destination that does not have a market or proper processing facilities
	Goods are repacked to larger volume entities
	Goods destined to developing countries are over evaluated
Inconsistencies	Inconsistencies exist between insured volume/weight and the real weight
	Inconsistencies exist between the insured volume/ weight and the type of goods
	Inconsistencies exist between the insured amount and market prices
Related Parties	Parties involved have a bad reputation in the business
	Endorser is different from Claimant
	Intermediaries are non-cooperative
Healthcare	
Conduct of Claimant	Physicians are changed Frequently
	Claimant has multiple disability policies
	Claimant claims a disability and is involved in active employment or in a physical sport or hobby
	Claimant develops additional injuries allegedly related to the initial injury or illness when it appears that the claim will be Terminated
	Claimant's illness or injury occurs shortly before an employment problem (e.g., disciplinary action, demotion, layoff, strike, termination, or down-sizing)
	Claimant visiting more than two medical providers for the same case
Conduct of Physicians	Emergency services are not Contacted
	Prescriptions are cut or Altered
	Documents contain misspelling or misusing of medical terminology
	Improper identification numbers are used
	Attending physician is not in the same geographic region as the claimant
	Incorrect or conflicting diagnosis from different medical providers are given
	Treatment provided to the claimant is inconsistent with the report diagnosis
	Treatment is scheduled on holidays or other days when medical facilities are normally closed
	Attending physician's specialty is not consistent with the diagnosis