Quidan Pag-inupdanay Mutual Benefit Association, Inc.

Anti-Fraud Manual

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Introduction

Quidan Pag-inupdanay Mutual Benefit Association (QPI MBA) is an association owned and controlled by the members. The members mutually agreed to pool their resources to help them and their family members to combat any unforeseen event that may happen in their lives. The implementation of its program and services underwent social and scientific study to ensure its viability and sustainability. The Government thru the Insurance Commission (IC) regulates the Association to ensure that its policies and procedure conformed to the existing insurance laws and regulation.

The Association in its implementation practices adheres to the principles of transparency and accountability. It also ensures that the resources of the association are properly and prudently manage. All financial transactions must follow the policies and procedures that were designed based on the acceptable recording and accounting practices and in compliance with the existing laws and regulation.

What is Fraud?

In general, Meriam-Webster Dictionary defined Fraud as the intentional distortion of truth in order to induce another party to part with something of value or to surrender a legal right.

Moreover, fraud as defined by the International Association of Insurance Supervisors, is a deceptive act or omission intended to gain advantage for a party committing the fraud (the fraudster) or for other parties.

QPI MBA recognizes that as an institution implementing a micro insurance program and services must take a proactive, as well as a reactive, stance against fraud.

Statement of Anti-Fraud Policy

QPI MBA does not tolerate fraud, whether carried out by the Association's members or by outsiders/non-members, its trustees, management or staff, or by its partners (Microfinance, cooperatives and other people's organization), consultants or suppliers. As appropriate, QPI MBA will investigate any suspected or actual fraud including but not limited to insurance claims, benefits, premiums, contributions, or misappropriation of assets. If there is probable cause, the Association will take action based on the gravity of the offense or even take legal action including reporting the fraud to the proper authorities in order to get conviction, recover assets or obtain compensation for loss.

Purpose of this Anti-Fraud Plan

This Anti-Fraud Plan aims to do the following:

a. Define the procedures involved in preventing, detecting, reporting, and investigating suspected or actual cases of fraud involving members, intermediaries and internal staff, in the areas of membership enrollment, collection of contributions, claims, and handling of assets.

b. Confirm the Management's *overall responsibility* for the Association's anti-fraud efforts.

c. Identify the Anti-Fraud Coordinator *directly responsible* for, and the procedures involved in, the following anti-fraud efforts:
   i. Development, implementation, review, and maintenance of the Anti-Fraud Plan;
   ii. Functioning of the Special Investigation Committee(SIC).

d. Identify the member of the Board of Trustees tasked with *oversight responsibility* over the Anti-Fraud Plan.

e. Confirm the Association's commitment to develop a program to provide continuing anti-fraud education and training for members and staff.

Oversight and Operational Responsibilities over the Anti-Fraud Plan

a. As a matter of policy, all officers and staff of the Association are responsible for preventing and detecting insurance fraud in their respective areas of operation.

b. The Board of Trustees, acting through the Chairperson of the Association Audit Committee, has *oversight responsibility* over the Association's anti-fraud efforts.

c. The Management has the *overall responsibility* for the development, implementation and regular review of the Anti-Fraud Plan.

d. The Independent Board who Chairs the Board Audit and Oversight Committee acts as the Association's Anti-Fraud Officer responsible for the continued maintenance of the Anti-Fraud Plan. He/she lead as the Head of the Special Investigation Committee (SIC), in charge of investigating of actual or suspected fraud, with assistance provided by the Audit Team. In working closely with the Executive Director, he/she is also in charge of contacting the police and law enforcement authorities whenever appropriate. If the subject of the complaint directly involve the Management Head, the complaint will be directly referred to the SIC.

Categories of Fraud

a. Member/Policyholder Fraud and/or Claims Fraud
This involves fraud in the application by, and enrollment of members and dependents, and in the purchase and/or execution of an insurance product, including claims and benefits.

b. Intermediary Fraud
This includes fraud committed by the Association's microfinance partners, other partner organization (formal and informal groups), insurance/MBA coordinators and other intermediaries.

c. Internal Fraud
This group of fraud includes misappropriation of cash/assets by any of the Association's trustees, executive director/ managers or staff. This also includes fraud at governance level, e.g., creation of a loan facility for the Trustees/Management that have terms and conditions highly disadvantageous to the members or to the Association.

Prevention and Detection of Fraud

Membership Enrollment

a. The business model of micro-insurance MBAs involves partnership with microfinance institutions and other organizations (formal or informal) which are the source of members for QPI MBA and which provide various services such as education and information, collection of MBA contributions, facilitating the reporting and validation of claims and disbursement of insurance benefits. Thus, for administrative and cost reasons, QPI MBA principally relies on the its partners to do the verification of member's personal circumstances such as identity, age, source of income, home/business address and name(s) and age(s) of legal spouse/dependents.

b. As co-owners of the Association, all members recognize that they play an important role in fraud prevention. Before an applicant is allowed to join a local group/center/unit, existing members of the group/center/unit screen the applicant's background and determine if he/she will be an asset or a liability to the group.

c. Apart from the assessment made by existing members, the Association also requires prospective members to fill up a membership application form in fulfillment of the know-your-customer (KYC) requirement. This is done through the microfinance and other organization partner as part of the support services provided by them to the Association.

d. The Membership Enrollment staff, having been trained to watch out for fraudulent applications, will examine the application form by checking the completeness of answers and the consistency of application information (such as name, date of birth, etc.) with information stated in civil documents (e.g., birth certificate, marriage contract), or alternative / substitute documents (e.g., Indigenous Persons Certification) or, if available, government-issued identification documents (e.g., Driver's license).

e. The Membership Enrollment staff have been given examples of fraudulent acts that they should watch out for. The examples listed below are not intended to be exhaustive but are rather meant to be instructive and serve as a guide for the detection of member- and intermediary-related fraudulent activity.

Member	• Falsification of application documents of applicant, dependent or beneficiaries • Falsification of applicant's age in order to qualify for membership and insurance coverage • Inclusion of over-age or otherwise ineligible dependents • Misrepresentation of relationship (by blood or by law) to overcome the lack of insurable interest
Intermediary	• Intentional acceptance of false member information • Manipulation of enrollment date to avail of continuous benefit • Adjustment of dates to make a member qualified • Padding of number of membership enrollment to qualify for cash incentives • Distribution of member quota to share incentives • Consolidation of member quota to share incentives • Submission by MFI/ partner organizations of fictitious data on non-existent members and/or spouse and dependents which data will eventually be used to claim insurance benefits; • Submission by MFI and other partner request for credit life insurance covering a fictitious loan.
Internal	• Intentional acceptance of fabricated documents • Collusion with the intermediary for groups to qualify for incentives

f. As additional preventive measure, and in view of Insurance Commission Circular Letter No. 2016-50, the Association will request/has requested approval from the Insurance Commission to include in staff orientation and communicate with partner the Insurance Code provision as stated below:

> **"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or**

causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

Collections

a. QPI MBA Finance is in charge of receiving collections of MBA contributions remitted by the partner institutions and issuance of official receipt thereof. Collection reports sent by the partners are regularly reconciled against bank deposits made by the partners to determine if there was any misappropriation of collections.

b. QPI MBA members of non MFI partner should remit their contribution to the designated collector agent. The collector agent maintains individual ledgers as records of member's contribution for reconciliation with MBA MIS and Finance.

c. QPI MBA designated collector agent should update and countersign the members' individual ledger as proof of receipt of payment of contribution.

d. QPI MBA MIS is in charge of posting members' payments to the members' corresponding subsidiary ledgers. Control totals of subsidiary ledgers are generated, both before and after making the ledger postings. The change in control totals should correspond to the total collection made and reported by partner organization. Similarly, withdrawals from members' ledgers due to death, resignation or retirement are reconciled. This ensures that all movements in ledger balances are fully accounted for, with audit trails as reference.

e. QPI MBA Finance regularly reconciles the members' subsidiary ledgers against the general ledger. Member subsidiary ledgers include: basic life premiums, equity values, credit life premiums, retirement fund contributions, etc.

f. QPI MBA Finance and MIS jointly conduct regular reconciliation with partner institutions' (branches /offices) record of collection in order to double check that member's contribution reconciled with the report submitted to MBA office.

g. QPI MBA Finance coordinates the regular reporting to the Management/Board of Trustees by the operating departments in charge of Membership Enrollment, MIS and Claims on new members gained or lost, status of membership, claims submitted/in-process/denied/paid, etc.

f. The Association look into the following instances or actions that may result to the fraudulent transactions involving members, intermediaries and internal management.

Member	• Insists of payments not made • Intentionally unrecorded collection from other group members • Purposeful unremittance of collection to branch ("hold-up me")
Intermediary	• Deliberate *non-remittance or partial remittance* of collection to branch • Deliberate non-issuance of provisional receipt/passbook/collection sheet/center logbook • Misappropriation of funds (e.g. contribution intended for payment of MBA insurance applied to loan/savings of MFI, advanced MBA contribution of a member used to pay other member's unpaid contribution) • Tampering of original payment made in the original receipt • Imitating bank deposit formats and layout to prove that payments are made • Intentional double recording of collections

MIS

a. Management Information System (MIS) is a series of processes and actions which capture raw data and then process the data into a usable information, so that this information can be disseminated to users in the form needed. The MIS should be able to maintain databases of member and dependents, products, payment or transactions, and claims, at the minimum.

b. The purpose of the MIS is to support effective and efficient management as well as facilitate good governance on the part of the Board of Trustees.

c. MIS is in charge of safekeeping member records. MIS staff are not allowed to do postings, withdrawals or any changes to member records in order to ensure segregation of duties/responsibilities between Finance (account updates) and MIS (safekeeping).

d. There are audit trails on any changes in the members' database and a defined hierarchy of positions who are authorized to make changes or to view records.

Intermediary	• Deliberately encoded false entry of member details, payments, and claims • Forced balancing on records/remittances
Internal	• Manipulation of client's account/records which may include equity value, retirement savings fund and premiums (e.g. encoding of payments which is not made) • Creation of fictitious clients' records • Unauthorized deletion and addition of information • Connivance of management and claimants

Claims

a. Once an insurance claim is filed by a beneficiary, the MBA Coordinator / MBA field staff / partner institution field staff will conduct on-site validation. Claims staff relies on the submitted validation report and other necessary documents such as the following (as applicable):
   - Death certificate;
   - Birth or baptismal certificate;
   - Marriage contract;
   - Police report;
   - Hospital records;

b. Claims Unit under the Operation Division also validates insurable interest issues. If there is no insurable interest, Claims Unit denies the claim and notifies the claimant accordingly.

c. The Claims Unit will also coordinate with Membership Enrollment /MIS or Finance in order to confirm if the coverage is in force / within the grace period / lapsed.

d. The one-year contestability period provides some measure of protection from uninsurable applicants especially if death occurs within a relatively short period after acceptance of membership. If death is due to a pre-existing health condition, the Association pays a lower amount of benefit according to a pre-defined benefit schedule.

e. If the Claims Unit suspects fraud was committed (especially in case of death due to accident), a *cost-effective investigation* is initiated to gather evidence including police report, hospital/medical clinic record, and interview of witnesses.

f. If the initial investigation points to a need for a deeper investigation by the Special Investigation Committee, the Claims Unit will report it to the Anti-

Fraud Coordinator who will, together with Special Investigation Committee (SIC), conduct a full investigation. The investigation will include the cause of death, place of death, financial and medical circumstances of the insured, and his/her relationship to the beneficiary.

g. If the insurance coverage or policy is already incontestable, the Claims Unit verifies only the needed information (in-force or within the grace period) before approving payment of the claim.

h. In case of a claim filed by a partner institution for Credit Life benefits, the Claims Unit requires the submission of a statement of account showing the amount of original loan, repayments made and outstanding (unpaid) principal balance. The Association settles the outstanding principal balance and pays the remaining amount (if any) to the borrower's beneficiary.

i. To aid the Claims Unit in validating the claim, following are some examples of "red flags" that may trigger further investigation (these "red flags" are also included in the claims procedure manual).
   - Death happened outside of the country;
   - Cause of death is "undetermined";
   - Dates on submitted documents are conflicting;
   - Death certificate looks irregular;
   - MBA is notified of the death claim only after burial.

j. Examples of fraudulent acts:
   - Submission of fake death claim documents by beneficiary;
   - Submission of fake resignation / retirement documents;
   - Submission by a non-member / outsider of fake membership documents.

k. To raise anti-fraud awareness and to help deter claims fraud, the Association has released appropriate Advisories addressed to members, intermediaries and internal staff, respectively, regarding the anti-fraud warning stated under the aforementioned Circular Letter No. 2016-50.

l. The following acts but not limited to are the things to look into that will probably constitute fraudulent claim.

Member	• Submission of fake death/disability/hospitalization claims' documents (e.g. fake police report, death certificate, medical certificate, incident report, and blotter report from the barangay) • Tampering of death/disability/hospitalization documents • Manipulated cause of death (whether or not natural death or accidental death)

Intermediary	• Payment of unqualified claims due to sympathy • Intentional tampering of documents to qualify as beneficiary • Account officer aid in the processing of fictitious claims to benefit from the claims proceeds • Account officer forge the signature of inactive member to withdraw members' equity value and retirement savings fund, if applicable • Payment of understated benefit to the beneficiary
Internal	• Process a fictitious claim in order to benefit from the claims proceed • MBA coordinator asks for "processing fee" to hasten the claims benefit acquisition

Internal Audit

a. Internal Audit performs audit and operational reviews of the Association's functional areas based on the amount of risk exposure of the area and also based on available resources. These audits aim to identify weakness in internal controls, pinpoint responsibility for non-compliance to procedures and make recommendations for operations improvement. At the end of the review, Internal Audit holds an exit meeting with the Management to discuss findings and agree on corrective steps or improvements in processes and procedures. To ensure independence with respect to its own audit function, Internal Audit directly reports to the Oversight and Audit Committee of the Board.

b. QPI MBA tap the services of the internal audit unit of the partner MFI (Pag-inupdanay, Inc.) to do the examination of the internal affair of the Association.

c. As Internal Audit is not involved in the line operation of the Association's insurance business, Internal Audit is in a distinct position to do audit reviews covering all of the three (3) abovementioned categories of fraud. In particular, Internal Audit pays special attention to Membership Enrollment, MIS, Finance and Claims, as these areas normally have significant risk exposures to fraudulent activity. Among other audit steps, the auditor reviews transactions on audit sampling basis, reviews membership enrollments for completeness of required information, traces contributions, and reviews changes in members' records and claims payments if properly authorized.

d. It is important for Internal Audit to distinguish between errors or omissions in insurance operations due to incompetence, lack of training, lack of

supervision, etc., and those that are due to fraudulent activity. For instance, a claims payment may have been made erroneously due to wrong posting of contribution; on the other hand, the payment may have been made as a result of fraud/collusion among staff in charge of membership records and claims by creating fictitious records on non-existent members and proceeding to process fake insurance claims. In the former case, Internal Audit proceeds with its usual review, while in the latter, the auditor will discuss it with the Anti-Fraud Coordinator to determine if there is a need for a deeper investigation by the Special Investigation Committee.

Compliance Officer

a. The Compliance Officer works with the individual departments to ensure compliance with rules and regulations issued by the Insurance Commission and other regulatory bodies such as the Anti-Money Laundering Council, Securities & Exchange Commission, etc. Compliance Officer also provides advice to management on conduct of insurance business and other compliance issues.

b. While the Management has overall responsibility over the Association's anti-fraud efforts, the Compliance Officer, as the Anti-Fraud Coordinator, has the direct responsibility for the development, implementation, review, and maintenance of the Anti-Fraud Plan and the functioning of the Special Investigation Committee(SIC).

c. The Compliance Officer/Anti-Fraud Coordinator is also a member the SIC.

Internal Fraud and Financial Management

a. It is of utmost importance that QPI MBA maintains at all times the trust of its members. Thus, the goal of the Association is to detect at the earliest possible time any theft of cash, investment collections, padding of expenses and other forms of misappropriation of assets. Any actual or suspected internal fraud committed by staff, management or trustees, calls for immediate investigation by the Anti-Fraud Coordinator and/or Internal Audit.

b. In order to prevent or detect fraud, the Association has implemented measures and internal controls such as separation of duties, setting of levels of expense approvals and designation of authorized check signatories.

c. Following are the internal controls implemented by QPI MBA:

- Staff cannot approve his/her own expenses.
- Executive Directors/ Division Head, depending on job function, are authorized to approve only those expenses within their area of responsibility.
- Maximum amount of expense allowed to be paid from the petty cash fund is Php 1,000.00.

- All requests for payment either through the petty cash fund or in check must be properly supported by invoice, receipts, statement of account, etc.
- Advances to operation or emergency by staff are allowed upon approval of the Executive Director.
- Expenses for travel, accommodation, entertainment, representation must be reviewed for compliance with the Association's guidelines before payment.
- Checks up to Php 200,000.00 should be signed by Executive Director and One of the Department Head.
- Checks higher than the foregoing amount should be signed by Executive Director/Division Head and President.
- Bank reconciliations are regularly prepared to detect any forged/fraudulent checks paid, collections not deposited, unauthorized debits to bank account, etc.

d. If any Finance staff notices a fraudulent activity, he/she must first report it to the Finance/Accounting Head, who will then report it to the Anti-Fraud Coordinator who shall take the necessary action in accordance with his/her role.

Education and Training

a. Applicants for membership in QPI MBA are required to attend the Pre-Membership Education Seminar (PMES). Among the topics included in the seminar is anti-fraud awareness, claims fraud prevention and the negative effects of fraud on the institution's solvency. Through this seminar, the Association widens its anti-fraud prevention network by involving members in screening applicants and providing community-based (informal) claims validation.

b. In order to keep the Membership Enrollment, Claims and Internal Audit staff up-to-date on insurance claims handling and fraud investigation, the Association requires the aforesaid staff to attend regular training, conferences / seminars on the subject. Training also covers fraud "red flags" as well as high profile current events and topics related to insurance fraud.

c. The Association requires all new/existing staff including managers to read and follow this Anti-Fraud Plan. Management emphasizes the importance of strictly following the policies, procedures and internal controls laid out in the Plan in order to discourage fraud and to increase the staff's awareness of suspicious acts.

d. From time to time and as necessary, the Association shall revise procedure manuals and internal controls in order to incorporate improvements to policies and procedures.

e. This Anti-Fraud Plan, including the reporting policies contained herein, shall be maintained in the office of the Compliance Officer/Anti-Fraud Coordinator and shall be open for inspection by the Insurance Commission. The Association shall also maintain appropriate records to determine the effectiveness of this Anti-Fraud Plan.

Reporting Fraudulent Activity / Suspected Fraud

a. In case any member sees or suspects a fraudulent activity involving any co-member, management or staff, he/she should report it immediately to the proper authority Anti-Fraud Coordinator or any of the Board Member through personal appearance, email or telephone call.

b. In case any member sees or suspects a fraudulent activity is happening, he/she must report it to his/her Division Head, or directly to the Compliance Officer/Anti-Fraud Coordinator. In turn, any Division Head who receives such report must immediately notify and forward the Incident Report Form to Compliance Officer/Anti-Fraud Coordinator.

c. The Compliance Officer/Anti-Fraud Coordinator will make a preliminary evaluation as to whether the matter appears to be fraudulent. If fraud is detected, he/she will initiate a full internal investigation within the prescribe period through the Special Investigation Committee (SIC). The report should be treated with utmost confidentiality.

Special Investigation Committee

a. The SIC is composed by the Audit and Oversight Committee, Compliance Officer/Anti-Fraud Coordinator and Divisions Head. The Chairperson of the Board Audit and Oversight Committee acts as the Head of the SIC.

b. The Chairperson of the committee report directly to the Board of Trustees. He/She is assisted by the members of the committee in undertaking fraud investigations.

c. The SIC shall determine if an internal investigation is sufficient or if an external resource is needed to conduct the investigation. Each reported case of fraud or suspected fraud will be handled in a way suitable to its size and nature.

d. The SIC expects full cooperation from specific staff or Unit who have responsibility over the matter being investigated. The investigative team will interview, as necessary, those individuals with knowledge or information related to the suspected fraud and will review pertinent documents. Each staff or member of management is required to cooperate fully with the investigation process and shall not in any way hinder the investigation. Pertinent records will be made easily available to the SIC. The investigative team should observe procedural fairness and due process.

e. As earlier stated, all claims submitted within the Basic Life's contestable period are initially investigated by the Claims Unit. If fraud is suspected, the investigation is placed under the guidance of the Anti-Fraud Coordinator. The investigating team will call upon the departments and specific individuals whose responsibilities are important to the investigation and may also request help from an outside investigator, if necessary, for external investigations.

Reporting and Monitoring Results of Investigation

a. The SIC will issue an initial briefing report to be distributed to the following: Executive Director, Division Heads, Treasurer, and the Audit Committee of the Board of Trustees. This report will provide a summary of the issue, an outline of procedures for the investigation, liaison with or notification to the proper authorities, other areas of the business for which the fraud might be relevant, the reporting timetable of the investigation and any other relevant information.

b. Upon completion of the investigation, the SIC will issue a final report to the, Executive Director, Treasurer and Audit Committee which will further report to the Board covering all aspects of the case. This will serve as formal record of the case including action taken. Contents of this report will include the following:
   - Facts and circumstances of the fraud and its discovery;
   - Procedures and findings;
   - Damage inflicted whether financial or non-financial in nature;
   - Amount involved;
   - Recommended sanctions (based on Staff/Employment Manual) for erring staff or member of management;
   - Recommended corrective action to improve procedures;
   - Recommendation, if any, to pursue legal action.

c. The Anti-Fraud Coordinator given a specific timeframe shall ensure that the recommended sanctions, corrective actions, and the pursuit of legal action once deemed necessary, is enforced.

Referral for Legal Action

a. The Board of Trustees will make the final decision regarding the cost-effectiveness and practicality of pursuing legal action against the ones who committed the fraud.
   - The decision to institute legal action depends not only on the amount of loss/fraud involved but also in instances wherein the Association's interest will benefit from showing the case as an example of the Association's non-tolerance of fraud, especially if staff or management are involved.
   - If the case involves members, the decision shall take into account possible negative effects against the Association's reputation including loss of members' trust.

- If the case involves the microfinance partner, the decision shall take into consideration all factors involved including ramifications of any action.

b. If the decision is to pursue legal action, the Anti-Fraud Coordinator will coordinate to the proper authorities, and the Insurance Commission, if deemed necessary. The Association shall fully cooperate with law enforcement authorities in any criminal investigation.

Annex 1 – Examples of Fraudulent Activity

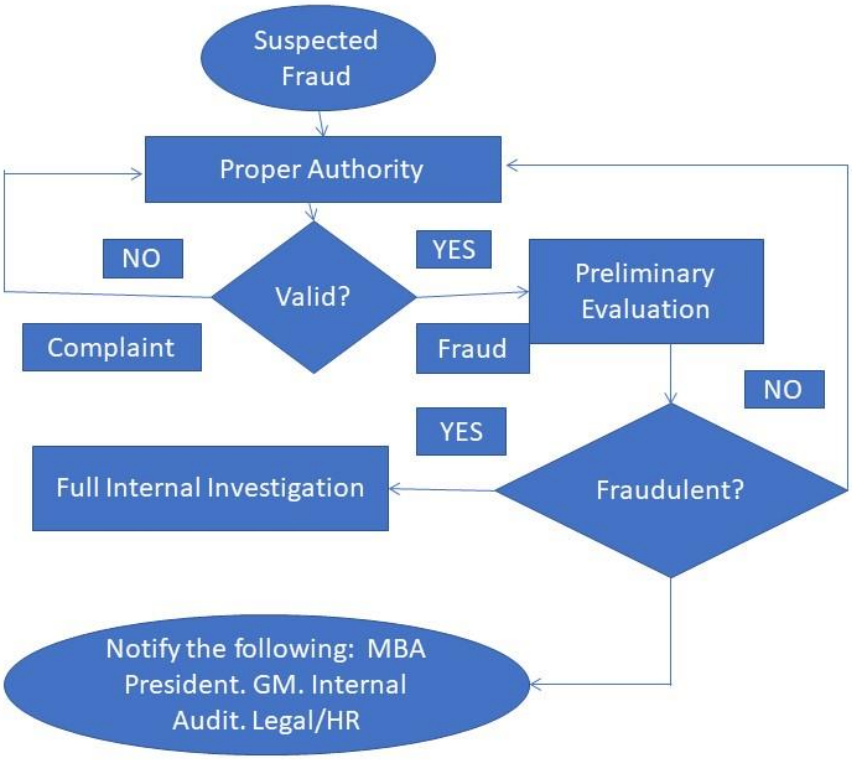
Intermediary Fraud

- Microfinance partner creates a fictitious loan to a member, insures with the Association the credit exposure, pays for the insurance premiums and collects insurance benefits.
- Microfinance field staff files fictitious claims.
- Microfinance partner inflates its membership roster and subsequently claims insurance benefits in behalf of non-existent members.
- Microfinance partner's account officer/loan officer creates a fictitious Center or Member Cluster/Group and subsequently claims insurance benefits.
- Kiting or lapping of collections by microfinance partner.
- Connivance by MBA Coordinator with other parties (e.g., the member, account officer/loan officer) in filing fraudulent claims.

Internal Fraud

- Internal staff creates fictitious membership records, pays for the regular contributions, and after some time claims the insurance benefits.
- Internal staff processes fictitious claims and finds a way to claim the benefits.
- Internal staff manipulates membership/premium records to pay a claim for the benefit of a family, relative or friend.
- Board of Trustees/Directors/ Management misappropriate assets by ratifying and implementing policies for their own undue benefit

Annex 2 – Process Flow for Reporting Fraudulent Activity



Annex 3 – Incident Report Form

Date: _____

Full Name of Person Reporting: _____

Department: _____

Person/s Involved: _____

Department: _____

Act/s Committed:

When: _____

What: _____

Others: _____

Details: _____

Received by:

Date:

For Anti-Fraud Coordinator's Use:

Type: ____ Complaint _____ Fraud

Tracking No.