Bharti AXA Life Insurance

FRAUD CONTROL POLICY

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A: Policy Statement

Bharti AXA Life Insurance is committed to fraud control with an emphasis on proactive prevention and detection measures in an effort to reduce opportunities which could lead to loss. The Company's approach to fraud control revolves around maintaining a legal, regulatory and ethical climate which encourages all stakeholders to protect the Organization's assets and escalate any suspicion of fraud.

Bharti AXA has a zero tolerance to fraud.

When a fraud is detected, suspected or alleged, Bharti AXA will fully investigate the matter, and implement measures to recover, minimize and prevent further loss to the Company. Loss may be judged in financial, reputational or regulatory terms. Bharti AXA considers as fraudulent wrongdoings intended to cause a loss but detected before the occurrence of such loss. Internal controls will be reviewed in the light of detected fraud events to further reinforce mitigation measures.

B: Related Standards and Policies

This policy should be read in conjunction with the following policies

1. The Anti-Money Laundering and Counter Terrorist Financing policy
2. The Compliance and Ethics guide, including the Whistle blower policy
3. Policyholders Protection and Grievance redressal policy
4. The Enterprise Risk Management Policy
5. Entity level policy (e.g. Conflict of interest)

C: Objectives and Scope

1. Objectives

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

- Defines what fraud means for Bharti AXA Life
- Fraud Detection & Mitigation measures
- Sets out the elements of the Fraud Control Framework
  - Roles and responsibilities of management and staff in proactively reducing fraud, through prevention and controls
  - Required elements of an investigation response function
  - Periodic reporting requirements to the regulator (IRDAI)

2. Scope

This policy applies to all types of fraud (including ISNP Fraud) that may be experienced by Bharti AXA Life, regardless of the origin of that risk.

Fraud in insurance is an act of omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties.

Some examples:

- Misappropriating assets
- Deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurer's state
- Abusing responsibility, a position of trust or a fiduciary relationship

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 staffs make themselves aware of this policy.

D: Definitions

Bharti AXA defines fraud as a deliberate action or omission carried out by an individual or organisation which intends to create a loss to Bharti AXA or its business partners, or a gain to the perpetrator.

Fraud is a conduct issue, having at least one 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.

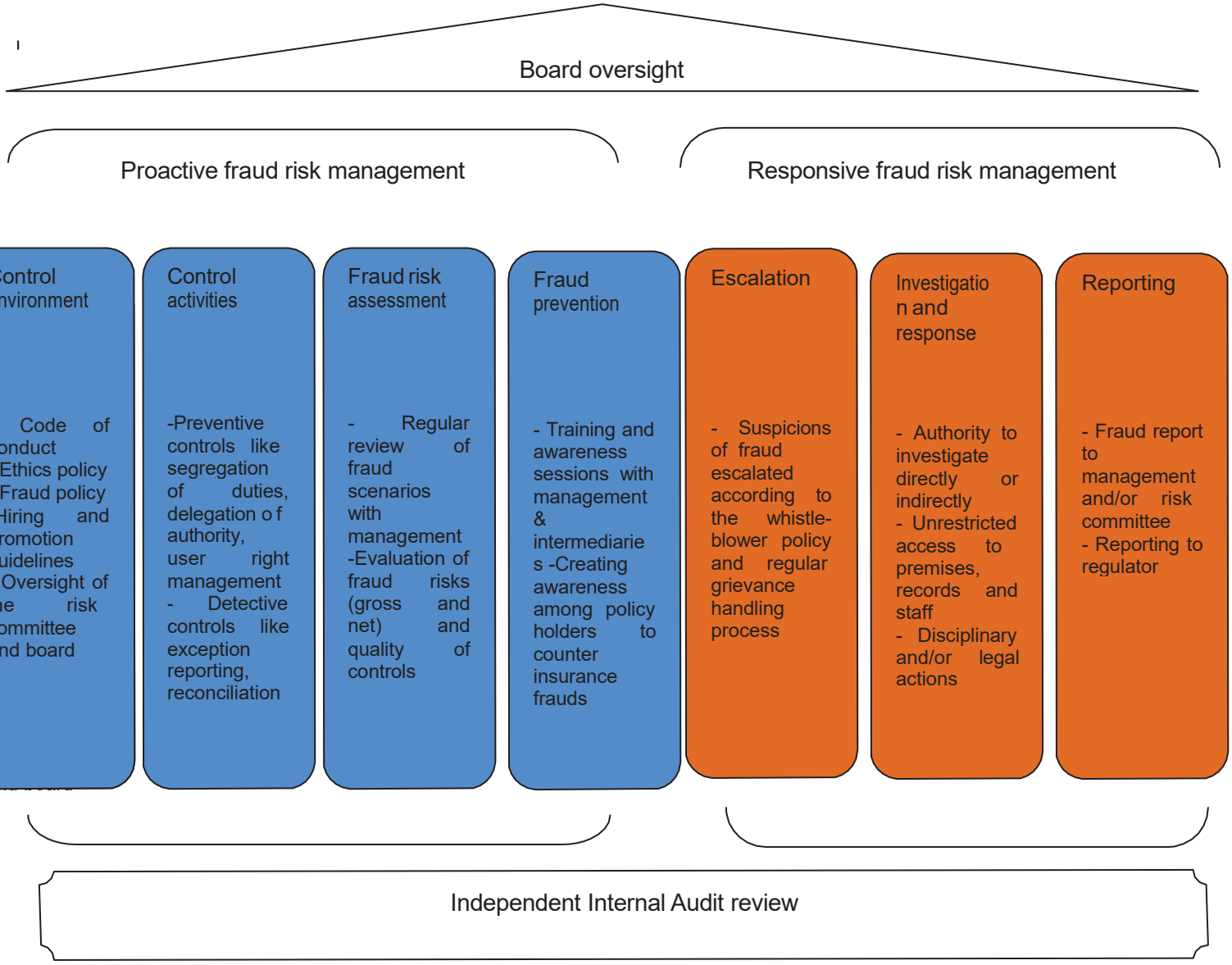
- Failure to disclose information – a person becomes a fraudster if he dishonestly fails to disclose to another person, information which he has duty to disclose and intends by doing so to make a gain for himself or another, or to cause loss to another, or to expose another to a risk of loss.

- 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 Bharti 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 Bharti AXA or its business partners and gain to the perpetrator may be of a financial, regulatory and reputational nature. Manner of detecting and identifying fraud and details of such malpractices & illustrative list of Insurance frauds are highlighted in the internal Fraud Control manual. We will also have a repository of those committing frauds and sharing with other market participants as and when they will seek it from us.

E: Fraud control framework

Bharti AXA Fraud Control Environment is composed of 7 pillars gathered in two groups; to detect, monitor & mitigate occurrence of such insurance frauds within the company.



The framework includes measures to protect the insurer from the threats posted by the following broad categories of frauds:

- Policyholder Fraud and / or Claims fraud
- Intermediary Fraud
- Internal Fraud

F:Roles and responsibilities

1. 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 Risk Management Committee.

The Board shall review the Fraud Control policy at least on an annual basis and at any such interval as it may be considered necessary. The management of the Fraud Control Framework is outlined below in the "three lines of defence" model.

	Bharti AXA 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*	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 Control Team must report to a sufficiently senior level in the organisation and have unrestricted access to the Risk Management Committee to safeguard independence and objectivity.

2. Management

Management is responsible for establishing and maintaining an effective control system at a reasonable cost which includes designing and operating fraud controls, fraud investigation responsibilities.
Fraud Control Officer and Fraud Control Officer's role must be formally appointed by the Senior Management of the Company.

3. Staff

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

4. Fraud Control Officer

The Fraud Control Officer has the overall responsibility for the oversight of fraud controls in the Company. The Fraud Control Officer should do an Annual review of Fraud Control policy & submit recommendations to Secretarial team, if any. In addition, following needs to be done:

- Implementation of a Fraud control policy approved by the Board.
- Fraud awareness campaigns to increase staff understanding of the impact of fraud risks on the firm
- Co-ordination of fraud control efforts across 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, Risk Management Committee and Executive Committee on the impact of frauds detected and the measures taken to mitigate identified fraud risks
- Reporting to the Regulator for detected, suspected or alleged internal and external frauds in accordance with the reporting standard prescribed in section "Reports to the Authority(IRDA)"

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

5. The Internal Audit

Professional Standard 12201 [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 recognize that this restricts the Internal Audit's ability to fulfil its assurance role.

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

G: Escalation

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

Bharti AXA encourages any complaint to be nominative to facilitate the investigation. Nevertheless the complainant's name can be kept confidential at all stages of the investigation if required so by the complainant.

H: Fraud Detection & Mitigation

1. Statement of intent

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

2. Procedure for Fraud Monitoring

Fraud monitoring in the entity is an independent function. The procedures to identify, detect, investigate and report insurance frauds are detailed in the Fraud Control manual.

3. Identify Potential Areas of Threat

Entity has a detailed Operational risk assessment process conducted once in a year to identify operational issues, frauds (internal & external) for all the departments. These items are then rated according to their impact and action points to address them are identified. Different functions also trained to identify potential areas of risk/fraud and report to Risk Monitoring Function.

4. Coordination with Law Enforcement Agencies

The Fraud Control Team to report complex cases of fraud (Cash defalcation, Employee fraud, etc.) to Law enforcement authorities. Reportable cases needs to have management approval and internal FIR policy to be referred for the same.

5. Framework for Exchange of Information

Sharing of critical fraud related information through Life Council (as and when called for), which would help the industry in fighting with organized frauds.

6. Due Diligence

Bharti AXA Life has a process in place to carry out due diligence of the employees (basis certain criteria set by HR department), Outsourcing Vendors and other intermediaries before appointment**.**

7. Regular Communication Channels

Whistle blower policy is available and communicated to all. Training & awareness in form of communication to all the functions are done on a periodic basis.

8. Investigation Standard

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

Entities will maintain escalation criteria, response procedures and protocols which describe how they will manage identified fraud events, which specifically describe the resources which will be made available to undertake investigations in compliance with laws and regulations. These protocols must be reviewed by the Fraud Control Officer.

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 Bharti AXA Board whilst complying with legal requirements to avoid putting prejudicing legal and criminal prosecution.

9. 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 organisation.

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

The Fraud Control Team will also assist the Complaints Unit in the investigation of mis-selling cases, however these cases would be reported in the Complaints Management Report presented to the Policyholders Protection Committee.

10. Response to Investigation Findings

Where suspicions are confirmed by the facts, Bharti AXA will take such actions as it deems appropriate:

- Disciplinary action if the matter involves employees, salaried or non-salaried agents, in compliance with relevant Human Resources policies and regulatory requirements.
- Civil action to recover funds from the alleged perpetrator(s), wherever required.
- In case of confirmed fraud Bharti AXA Fraud Control Team along with Legal to consider reporting the matter to the local Police Station or other regulatory authorities or any other law enforcement team. Internal FIR policy to be followed.

11. Governance

Bharti AXA Life has detailed Malpractice matrix (disciplinary action matrix) in place which is approved by the Chief Executive Officer and the process is governed by Market Conduct Committee.

I: Fraud Monitoring Function

The Fraud Monitoring function in Bharti AXA will be responsible for the following:

- Laying down procedure for Internal reporting from/and to various departments
- Creating awareness among their employees / intermediaries / policyholders to counter insurance fraud
- Furnishing various reports on frauds to the Authority as stipulated in this regard &
- Furnishing periodic reports to their respective Board for its review

J: Preventive Mechanism

Bharti AXA shall inform both potential clients and existing clients about their anti-fraud policies. We would include necessary caution in the relevant servicing documents, duly highlighting the consequences of submitting a false statement and / or incomplete statement, for the benefit of the policyholders, claimants and the beneficiaries. Caution statements already part of Proposal form (Declaration) & Policy bond in form of Section 45 of the Insurance Act 1938. Fraud Control Policy is also available on our company website.

Fraud Reporting

All proven frauds of threshold limit of Rs.1 lakh are to be reported to Local Risk Management Committee ('LRMC') and Risk Management Committee of board on quarterly basis.

Internal Fraud - Fraud/ mis-appropriation committed by the Director, Manager and/or any other officer or staff members (by whatever name called).

Intermediary Fraud – Fraud perpetuated by an insurance agent/ Corporate Agent/ intermediary/ Third Party Administrators (TPAs) against the company and/or policyholders.

Policyholder Fraud and/or Claims Fraud – Fraud against the company in the purchase and/or execution of an insurance product including fraud at the time of making a claim.

Other Fraud – Fraud perpetuated by vendors, contractors, consultants and any unrelated party against the company and/or the policyholders of the company.

Non-disclosure and mis-selling to customer will not be the part of the fraud control report presented to the Board and IRDAI, however action on account of non-disclosure or mis-selling will be governed as per the malpractice action matrix and will be handled by the Fraud Control Team.
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All fraud related issues can be reported at: *Compliance.life@bhartiaxa.com*

K: Regulator (IRDA) Reporting

The Statistics on various fraudulent cases which come to light and action taken thereon shall be filed with the Authority in forms FMR 1 and FMR 2 providing details of:

- Outstanding fraud cases &
- Closed fraud cases

Every year within 30 days of the close of the financial year

Fraud Monitoring Report (FMR 1)

Name of the Insurer: Report for the year ending:

Part 1:

Frauds Outstanding- Business segment wise*

1. Non Linked									
1.1 Non Linked- Participating									
S.No	Description of Fraud	Unresolved cases at the beginning of the year		New cases detected during the year		cases closed during the year		Unresolved cases at the end of the year	
		No.	Amount involved (in Rs. Lakhs)	No.	Amount involved (in Rs. Lakhs)	No.	Amount involved (in Rs. Lakhs)	No.	Amount involved (in Rs. Lakhs)
A	Policyholder Fraud								
	*								
B	Intermediary Fraud								
	*								
C	Internal Fraud								
	*								
D	Sub Total (A+B+C)								

1.2 Non Linked- Non Participating									
S.No	**Description of Fraud**	**Unresolved cases at the beginning of the year**		**New cases detected during the year**		**cases closed during the year**		**Unresolved cases at the end of the year**	
		No.	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**
E.	**Policyholders Fraud**								
	*								
F.	**Intermediary Fraud**								
	*								
G	**Internal Fraud**								
	*								
2. Linked									
H	**Sub total (E+F+G)**								

S.No	**Description of Fraud**	**Unresolved cases at the beginning of the year**		**New cases detected during the year**		**cases closed during the year**		**Unresolved cases at the end of the year**	
		No.	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**	**No.**	**Amount involved (in Rs. Lakhs)**
I.	**Policyholders Fraud**								
	*								
J.	**Intermediary Fraud**								
	*								
K.	**Internal Fraud**								
	*								
L.	**Sub Total(I+J+K)**								
M	**Total (D+H+L)**								

Part 2:

Statistical details: (unresolved cases at the end of the year)- Business segment wise*

Sl.No	Description of fraud	No. of cases	Amount involved(in lakhs)
	Total		

Part 3:

Sl.No	Description of fraud	Preventive/Corrective action taken

Part 4

Cases reported to law enforcement agencies:

Sl. No	Description of Fraud	Unresolved cases at the beginning of the year		New cases detected during the year		Cases closed during the year		Unresolved cases at the end of the year	
		No.	Amount involved(in lakhs)	No.	Amount involved(in lakhs)	No.	Amount involved(in lakhs)	No.	Amount involved(in lakhs)
	Cases reported to Police								
	Cases reported to CBI								
	Cases reported to Other agencies(specify)								
	Total								

*Business segments shall be as indicated under IRDA (Preparation of financial statements- and auditor's report of Insurance companies) Regulations, 2002

Certification:

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date:

Place:

Signed/-
Name of the Chief Executive Officer of the Insurer

Fraud cases closed during the year (FMR 2)

Name of the Insurer:
Report for the year
ending

Sl.No	Basis of closing a case	Number of cases closed
1.	The Fraud cases pending with CBI/Police/Court/ were finally	
2.	The examination of staff accountability has been completed	
3.	The amount involved in the fraud has been recovered or written	
4.	The insurer has reviewed the systems and procedures; identified the causative factors; has plugged the lacunae; and the portion take note of by appropriate authority of the insurer(Board,	
5.	Insurer is pursuing vigorously with CBI for final disposal of pending fraud cases, staff side action completed. Insurer is vigorously following up with the Police authorities	
6.	Fraud cases where: The investigation is on or challan/charge sheet not filed in the Court for more than three years from the date of filing of First Information Report (FIR) by the CBI/Police; or Trial in the courts, after filing of charge sheet/challan by CBI/Police has been started, or is in progress.	

Certification:

Certified that the details given above are correct and complete to the best of my knowledge and belief and nothing has been concealed or suppressed.

Date:

Place:

Signed/-
Name of the Chief executive officer of the Insurer

 # Closure of Fraud cases:

For reporting purposes, only in the following instances of fraud cases can be considered as closed:

1. The fraud cases pending with CBI/Police/Court are finally disposed of
2. The examination of staff accountability has been completed
3. The amount of fraud has been recovered or written off
4. The insurer has reviewed the systems and procedures, identified the causative factors and plugged the lacunae and the fact of which has been taken note of by the appropriate authority of the insurer (Board /Audit committee of the Board)
5. Insurers are allowed, for limited statistical /reporting purposes, to close those fraud cases, where:
    a. The investigation is on or Challan/ charge sheet not filed in the Court for more than three years from the date of filing of First Information report (FIR) by the CBI/Police, or
    b. The trial in the courts, after filing of charge sheet/challan by CBI/Police, has not started, or is in progress.
6. If the company is not able to find any evidence despite investigations and interviews then the case will be closed based on facts and circumstances of the case

Insurers should also pursue vigorously with CBI for final disposal of pending fraud cases especially where the insurers have completed the staff side action. Similarly, insurers may vigorously follow up with the Police authorities and/or court for final disposal of fraud cases and/or court for final disposal of fraud cases.