NORTON ROSE FULBRIGHT

Big Read Book volume 21:

Insurance Fraud

December 2024

Introduction

Dearest Reader

Welcome to Norton Rose Fulbright South Africa's The Big Read Book Series. This is volume 21 of the series – Insurance Fraud. An online version of this publication is available through our Financial Institutions Legal Snapshot blog at https://www.financialinstitutionslegalsnapshot.com/.

You can also keep up with developments in insurance law including South African judgments and instructive judgments from other countries by subscribing to our blog through that link. You can access the other volumes here .

Norton Rose Fulbright South Africa Inc
December 2024

Contents

We address insurance fraud from two angles in this volume: first, we consider fraud by insureds and second, fraud within insurers.

Part 1: Fraud by insureds

What is insurance fraud?

By insured we mean the person applying for the policy, the policyholder, or the policy beneficiary.

Insurance fraud by an insured entails the insured making an intentionally false representation to its insurer with the aim of causing the insurer to rely upon the representation to its prejudice (by, for example, paying the claim or paying more than the insured's loss).

This type of fraud is at claims stage. It should be distinguished from fraudulent pre-contractual misrepresentation and non-disclosure by insureds, because the requirements and consequences differ. To learn more about pre-contractual misrepresentation and non-disclosure, refer to volume 2: Avoidance and cancellation of non-life insurance policies.

Insurance fraud is prevalent in South Africa. Some estimate that it costs the South African insurance industry between R6 and R8 billion annually. Others suggest that approximately half of all claims entail an element of fraud.

Fraudulent claims at common law

Three types of fraudulent claims

- An insured has a duty to act in good faith towards its insurer. Submitting a fraudulent claim breaches that duty.
- At common law, there are three types of fraudulent claims, namely the:
  - fabricated claim, such as when an insured intentionally causes the loss by, for example, setting fire to the insured property in order to receive an insurance payout, or claims for the loss of an item which never existed or was never lost, or when a beneficiary under a life policy murders the life insured in order to claim the life insurance proceeds;
  - exaggerated claim and deliberately claiming materially excessive amounts as the value of items lost or damaged; and
  - valid claim accompanied by fraudulent means and devices, such as fabricating evidence (eg accident circumstances or invoices) in support of a valid claim.
- These types of fraud can occur in combination. For example, one could take out cover on jewellery that does not exist, and then falsify valuation certificates and other documentation when submitting a claim alleging it to be stolen or otherwise lost.

Consequences at common law

- If there is no fraud clause in the insurance contract which alters the common law position (which there usually is, as we delve into under the next section), the fraud impacts the insured's claim to the extent that it was causally relevant to the loss. Consequently, in the case of the:
  - Fabricated claim, the claim can be rejected;
  - Exaggerated claim, the valid portion of the claim must be paid and the exaggerated portion can be rejected; and
  - Valid claim accompanied by fabricated evidence, the claim is payable because the fraud is not causally relevant to the loss.
- In addition:
  - The insurance contract can be cancelled prospectively from the date of the notice of cancellation (not retrospectively) by the insurer. The payments due or made on any prior valid claims, are payable or not recoverable from the insured;
  - The insurer can claim, in delict, whatever damages it suffered on account of the fraud from the insured. Insurers rarely exercise this right in our experience; and
  - Even if the insured's claim is payable as with the valid claim accompanied by fabricated evidence, the insured may attract an adverse costs order as a mark of the court's displeasure at its conduct.

Clauses regarding fraudulent claims

Insurance contracts usually include a general condition which addresses fraud. Such conditions are enforceable, even though courts have sometimes criticised that the forfeiture they provide for can be out of proportion to the effect of the fraud on the insured's loss.

A fraud clause might simply affirm the common law position regarding the consequences of fraud, but it typically provides the insurer with more protection than it has at common law. The purpose is to discourage and resist fraudulent conduct by insureds.

Fraud clauses vary across the market and need to be considered carefully before being invoked, to ensure that the circumstances fall within the scope of the clause, and that the consequences imposed by the clause are implemented by the insurer who relies upon a breach of the clause.

One might find a clause along the following lines:

- *"If any claim under this policy is in any respect fraudulent, or if any fraudulent means or devices are used by the Insured or anyone acting on their behalf or with their knowledge or consent to obtain any benefit under this policy, or if any event is occasioned by the wilful act or with the connivance of the Insured, the benefit afforded under this policy in respect of any such claim shall be forfeited."*

This type of clause will allow even valid portions of a claim to be forfeited in the event of fraud, and for an insurer to recover any portion of the fraudulent claim which was paid before the fraud was discovered. Given that a breach of this general condition constitutes a breach of contract, the insurer can cancel the insurance contract prospectively (thought if it wants to do so retrospectively from, for example, the date of the fraudulent claim or some earlier date, it will need to say so in the fraud clause).

As already indicated, fraud clauses vary in scope and effect. What a particular fraud clause means is – naturally – a matter of interpretation. The basic approach to the interpretation of insurance contracts is dealt with here .

Insurers should draft their fraud clauses so that they make it clear:

- Which types of fraudulent claims they relate to;
- That any cancellation operates retrospectively (and from when) if that is the intention.

Proving fraud

The onus is on an insurer to prove fraud – be it common law fraud or fraud in terms of a fraud clause – on a balance of probabilities.

Although proof on a balance of probabilities is required, courts will not easily impute fraud to an insured.

Fraud requires proof of a deliberate misrepresentation with the intention that the insurer will pay what is not due. Proof of a careless untrue representation in a claim is not sufficient. Negligent conduct does not meet the required burden.

The court must be persuaded that the insured intended for the insurer to rely upon the misrepresentation to its prejudice. Only potential (as opposed to actual) prejudice needs to be established. The insured must have tried to obtain a benefit under the insurance contract by perpetrating the fraud. A false description of the circumstances of the loss (eg of a motor vehicle for damage) cannot be relied on if it has no effect on whether the loss is covered.

The fraud must be attributable to the insured. Either the insured or someone acting on its behalf in perpetrating the fraud must have committed the fraud or it must have been involved in the way described by the fraud clause featuring in the insurance contract. So, for example, it would be sufficient for purposes of the fraud clause quoted above for the fraud to have been perpetrated by someone acting on the insured's behalf, or with the insured's knowledge or consent. The false version of an event given to a loss adjuster by a non-executive employee may not suffice. Fraud needs to be established on a balance of probabilities (the civil burden of proof) and not beyond reasonable doubt (which is the burden applying to criminal proceedings).

The types of evidence which an insurer will seek to secure and produce in support of a fraud rejection will always be fact dependent, but may include:

- Factual witness evidence. Cross examination of the insured or its witness (if they testify for the insured) will often be important to the outcome of the litigation, as the credibility findings will impact upon whether the insurer has discharged the onus of proof. An adverse inference may be drawn in some instances if the insured does not testify in circumstances when the insured would be expected to;
- Expert evidence (for example, when dealing with a fire claim, does the expert evidence prove that the cause of the fire was arson?);
- Video footage, photographs;
- Vehicle tracking records, beacons and billings information;
- Fingerprint evidence, ballistics;
- DNA evidence;
- Documentary evidence;
- Polygraph evidence. This will, however, not usually be available, as both life and non-life policyholder protection rules deem provisions in policies which oblige claimants to undergo polygraphs in connection with claims as void, and state that an insurer cannot decline liability solely because a claimant fails a polygraph test. Even where a claimant agrees to take a polygraph, the results will be approached with caution by a court, and the value is mainly of a corroborative nature. See, for example, *Mustek Ltd v Tsabadi NO & Others* [2013] 8 BLLR 798 (LC).

It is useful for the insurer to establish the insured's probable motive for the fraud in proving that the insured's misrepresentation was made with the intent to deceive. As the motive will often be related to the insured's financial position, evidence of that position (viewed holistically) at the time of and leading up to the incident to which the claim relates, is important. Consider however *Renasa Insurance Company Limited v Watson* 2016 JDR 0453 (SCA) where the insurer argued, amongst other things, that the fire which damaged the print finishing business operated by the insured, including the insured's sports car, was set by the insured. The court observed that:

- It was illogical and untenable that the insured would set his beloved sports car alight, when he could have sold it for virtually the same price as he bought it for if he was in need of funds;
- Although the insurer sought to argue via an expert accountant that the insured business was in decline, unlikely to survive, and barely profitable, the accountant conceded that the insured was factually solvent at the time of the fire, had access to significant funds and virtually no liabilities or creditors of note. Consequently, the insurer could not establish a motive to perpetrate the arson.

More often than not, direct evidence (eg CCTV footage of an insured present at the insured property) is absent and an insurer will seek to rely on circumstantial evidence. In *Cooper and Another NNO v Merchant Trade Finance Ltd* 2000 (3) SA 1009 (SCA) the court stated the following in relation to circumstantial evidence:

"If the facts permit of more than one inference, the court must select the most "plausible" or probable inference. If this favours the litigant on whom the onus rests it is entitled to judgment. If, on the other hand, an inference in favour of both parties is equally possible, the litigant will not have discharged the onus of proof."

In *Govan v Skidmore* 1952 (1) SA 732 (N), the court's approach is usefully summarised as follows:

"... in finding facts or making inferences in a civil case, it seems to me that one may... by balancing probabilities select a conclusion which seems to be the more natural, or plausible, conclusion from amongst several conceivable ones, even though that conclusion be not the only reasonable one."

In *Stellenbosch Farmers' Winery Group Limited and Another v Martell & Cie SA and Others* 2003 (1) SA 11 (SCA), the court provided a method for resolving factual disputes, useful for claims professionals:

- Credibility of witnesses: Assess honesty, behaviour, biases, internal and external contradictions, likelihood of the account, and overall persuasiveness;
- Reliability of witnesses: Evaluate the witness' ability to observe the event and the quality of their memory;

- Probabilities of each party's version: Analyse the plausibility of each account, integrating credibility and reliability findings.

Other considerations

An allegation of fraud may be defamatory in nature, and if the insurer's fraud defence fails, it could be sued by its insured for defamation, though this does not occur frequently in our experience. Nevertheless, allegations of fraud should not be made without real evidence or based on speculation.

Apart from fraud being a breach of the insurance contract, it may also be a crime. An insurer can therefore report suspected fraudulent conduct to the South African Police Service. In fact, it will have an obligation to do so in some instances. Section 34 of the Prevention and Combating of Corrupt Activities Act, 2004 places a duty on certain persons in a position of authority to report defined offences over R100 000. This duty applies when a person in authority knows or ought reasonably to have known or suspected that any other person has committed an offence of theft, fraud, extortion, forgery, or uttering a forged document involving an amount of R100 000 or more.

Part 2: Fraud, corruption and related misconduct within insurers

Introduction

Apart from insurance fraud by an insured, insurance companies ought not to overlook misconduct that could occur within the company itself. That misconduct can take various forms, including through bribery, corruption and self-benefitting fraud, and may be perpetrated by employees, management or appointed third parties.

The impact of the misconduct could be severe, resulting in in financial losses, legal penalties, criminal and civil action, reputational harm and importantly, erosion of customer trust.

In this section, we deal with:

- Examples of fraud, corruption or related misconduct could occur within insurers.
- Prevention, detection and mitigation of risks.
- Investigation guidelines.
- Reporting obligations.

Definitions

Broadly, corruption is the abuse of entrusted power for personal gain. South Africa's primary anti-corruption legislation, the *Prevention and Combating of Corrupt Activities Act*, 2004 (PRECCA) creates 14 different corruption offences. The patterns for the specific offences are similar in nature. Any person who directly or indirectly accepts or gives any "gratification", to act, or to influence another person to act in an illegal or dishonest manner, that amounts to the abuse of a position of authority or the violation of a legal duty, and that is designed to achieve an unjustified result, is guilty of the offence of corruption.

Bribery, which could be part of reportable corrupt conduct, includes the offering, promising, giving, accepting or soliciting of an advantage as an inducement for an action which is illegal, unethical or a breach of trust. An "advantage" under PRECCA, is defined as gratification, which could include money, gifts, entertainment, the award of a contract, donations, or a right or privilege.

Fraud is the unlawful and intentional making of a misrepresentation which causes actual prejudice, or which is potentially prejudicial to another and is reportable under PRECCA.

How could these offences occur within insurers?

The risks that companies face are similar in nature. Some examples include:

- Kickbacks: the receipt of kickbacks for favouring certain vendors or contractors. This often occurs within the procurement process.
- Influence peddling: offering of something of value to an official or a decision-maker in exchange for influencing the outcome of a business decision, such as the award of a contract or paying a claim.
- Financial misstatement fraud: manipulation of a company's financial reports to present a more favourable picture than reality.
- Procurement fraud: collusion with suppliers to overcharge the company for goods and services.
- Conflicts of interest: employees and executives may make decisions that are influenced by their personal interests rather than that of the company.
- Nepotism: hiring or promoting friends or relatives over other qualified candidates.

Insurers operate similarly to most corporate entities and are exposed to similar risks. Important in a company's risk assessment, however, are the risks associated with that industry specifically. We mention some risks that may pertain to the insurance industry, below.

- An insurance agent or employee accepting bribes to provide coverage at lower premiums.
- An employee receiving kickbacks for referring customers to a particular service provider, such as a vehicle repair shop or medical professional.
- An adjuster or investigator taking bribes to inflate damage estimates and thus increase claim payouts, with the intention to benefit from the misconduct.
- An underwriter approving policies for uninsurable friends or family members.
- Senior executives manipulating financial statements to meet targets or hide poor performance.
- Employees may purport to issue fake or fraudulent policies to former, existing or non-existent policyholders and provide personal account details for payment of premiums.
- Employees may alter claims, misappropriate funds or manipulate systems to create ghost beneficiaries or policyholders.
- Service providers may bill for services not rendered, or inflate the cost-of-service, often in collusion with claimants or insurance company employees.

Prevention, detection and risk mitigation

To prevent, detect and mitigate risk, companies ought to establish a strong ethical foundation and a culture of integrity. This begins by developing and implementing an effective anti-bribery, corruption and fraud program.

The measures that a company should put in place will depend on various factors, and should ideally be based on, amongst others, the nature and operations of that company, its client and third-party base and the jurisdiction in which it operates. While there is no one-sized-fits-all approach, the measures described below are effective foundational guidelines.

Prevention:

- Conducting periodic company specific risk assessments to identify and evaluate exposure to bribery and corruption risks.
- Implementing a code of conduct that outlines the company's stance on bribery, corruption and fraud.
- Develop and implement detailed policies and procedures, checks and balances to address specific areas of risk.
- Roll out effective, targeted and periodic employee training to employees at all levels.
- Establish a zero tolerance culture and employment terms towards unethical behaviour in the workplace.

- Demonstrate a leadership-level commitment to anti-bribery and anti-corruption practices.
- Conduct careful due diligence on all potential employees.
- Conduct risk-appropriate due diligence on third parties, including on reputation, ownership and their own commitment to anti-bribery and anti-corruption practices.
- Requiring external parties, such as service providers, brokers and adjusters to abide by the company's anti-bribery and corruption policies.

Detection
Detecting bribery and corruption can be challenging, but there are several measures that companies can implement, including:

- Establishing a secure and confidential whistleblower hotline managed by an independent third party.
- Conducting periodic internal audits to review compliance with anti-bribery and corruption policies and procedures, and the effectiveness of internal controls.
- Implementing ongoing monitoring and review programs to detect red flags or irregularities in amongst others, financial records and transactions.
- Implementing clear processes to investigate allegations of bribery, fraud and corruption.

Risk mitigation
Once a company has established its risk areas, steps should be taken to mitigate those risks. Those could include:

- Establishing and strengthening internal controls to prevent and detect fraud, bribery and corruptions.
- Incorporating appropriate anti-bribery and corruption contractual provisions in contracts with employees, clients and third parties.
- Ensuring that policies and procedures are periodically reviewed to ensure compliance with developments in laws, and any new risks that the company may identify.
- Ensuring that appropriate remediation steps are taken to address any weaknesses in the company's anti-bribery and corruption program.
- Ensure that appropriate disciplinary measures are taken and consequences are spelt out.
- Establishing a culture of continuous improvement within the employment force.

Failure to prevent corruption
In April 2024, PRECCA was amended to create a new offence of "failure to prevent corruption". In terms of s34A, companies within the private sector may be found to be guilty of an offence if a person associated with that company commits a corruption offence, with the intention to obtain or retain business, or some other advantage for that company.

Notably, the description of an associated person under PRECCA is broad, inclusive of any person that "performs services for, or on behalf" of the entity in question, and "irrespective of the capacity in which such person performs such services". It would therefore include employees of a company, or other third parties that provide services for a company.

Section 34A does however afford companies with a defence, in that no offence is committed where a company had in place "adequate procedures" designed to prevent associated persons from committing corrupt activities. As the amendment is still in its early stages of being in effect, there is no case law or judicial pronouncement on the interpretation of "adequate procedures" for the defence to stand. However, the guidelines referred to above for prevention, detection and mitigation would be a useful base off which to develop appropriate safeguards.

Investigation guidelines

An internal investigation may be triggered by various internal or external triggers. Internal triggers may include identification of an issue through a risk assessment or a whistleblower report. External triggers may include an industry-wide, or peer-related investigation, or media reports.

If it is identified that an investigation into bribery, corruption or fraud is required, an appropriate investigation process should be implemented, consisting of taking immediate action, implementing investigation steps, and closing off the investigation.

- Immediate actions: Determine the facts to be investigate, the relevant persons required to conduct, or to assist with the investigation (including where necessary, external legal counsel and forensic experts), and determine whether any immediate remedial steps must be taken. Important during the initial stages is the preparation of an investigation plan, and to establish investigation objectives.
- Investigation steps: Scope the investigation, gather and review evidence, conduct necessary research, interviews and external enquiries, determine impact of any wrongdoing, determine culpability and control failures, and determine response and remediation steps.
- Closing off: Conclude the investigation, prepare recommendations, communicate the report to key decision makers, implement recommendations, including response and remediation steps as soon as possible.
- Importantly, the nature of the investigation should be proportionate to the allegations and consequences.

Reporting obligations

Knowledge or a reasonable suspicion of bribery, corruption, fraud and money laundering may result in a statutory reporting obligation in terms of PRECCA or the Financial Intelligence Centre Act, 2001 (**FICA**). Companies ought to remain aware of these reporting obligations, as a failure to report, where there is an obligation to do so, is an offence. It should also be noted that the duty to report is triggered by specific times and events.

- **PRECCA**: Section 34 of PRECCA imposes a reporting obligation in terms of which "persons in a position of authority" (which includes the CEO, management and directors of a company), as set out in s34(4) of the Act, are required to report to a designated police official (the Directorate of Priority Crime Investigation, also known as the Hawks) knowledge or a reasonable suspicion of the corruption offences contained in PRECCA, any of five common law offences, including fraud, theft, , extortion, forgery or uttering a forged document.
- **FICA**: Section 29 of FICA places an obligation on "any person who carries on a business, or is in charge of, or who manages a business, or who is employed by a business" who knows or ought reasonably to have known that (amongst others) (i) the business has received or is about to receive the proceeds of unlawful activities; or (2) the business is a party to a transaction in which there has been, or is likely to be the facilitation of transfer of proceeds of unlawful activities, or has no apparent purpose; or (3) the business has been used, or is about to be used in any way for money laundering purposes, to report such suspicion or knowledge to the Financial Intelligence Centre.

Contributors to the publication

Fraud by insureds:

Donald Dinnie
Director
Tel +27 11 685 8847
donald.dinnie@nortonrosefulbright.com

Ina Iyer
Director
Tel +27 11 685 8752
ina.iyer@nortonrosefulbright.com

Fraud within insurers:

Jason Whyte
Director
Tel +27 21 405 1208
jason.whyte@nortonrosefulbright.com

Sabeeha Kathrada
Senior associate
Tel +27 11 301 3243
sabeeha.kathrada@nortonrosefulbright.com

NORTON ROSE FULBRIGHT

Norton Rose Fulbright is a global law firm. We provide the world's preeminent corporations and financial institutions with a full business law service. We have more than 3700 lawyers and other legal staff based in Europe, the United States, Canada, Latin America, Asia, Australia, Africa and the Middle East.

Law around the world

nortonrosefulbright.com