RGA Middle East Life Insurance Claims Survey: Fraud, Abuse and Leakage

September 2020

RGA

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Foreword

RGA conducted its first Middle East Market survey in 2020, focusing on Claims Fraud, Abuse and Leakage. We surveyed 37 prominent life and health insurance companies, both conventional and Takaful, in the United Arab Emirates (UAE), Kingdom of Saudi Arabia (KSA), Oman, Bahrain, Egypt, and Qatar and are impressed and inspired by the amount of response and the expert insights shared by the participants.

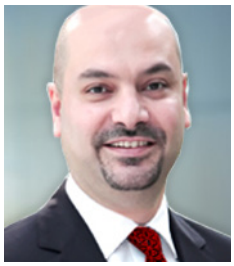
Fraud and/or abuse causes significant problems in the insurance industry as it is difficult to detect or prevent these incidents. Negative outcomes from these claims include increases in claims cost and premiums, and the need for prolonged and complex claims adjudication.

The scope of the survey pertains to fraud and abuse of claims of all benefit types under life insurance across the Middle East market, as well as its overall impact on the insurers' business, which includes group life, credit life, and individual business.

Fraud is a risk that every life insurance company must manage effectively throughout the policy life cycle. The survey findings capture information on fraud or abuse trends, common mitigation practices followed by insurers, as well as the challenges of combatting fraud. The most important elements and insights are summarized here in the report.

RGA is grateful to all participating companies for their valuable insights into this important topic of claims fraud and/or abuse, and for trusting RGA as your preferred Risk Management partner.

RGA conducts numerous experience studies and surveys on industry topics on behalf of our clients. These analyses provide clients with tools to increase efficiencies and enhance profitability. We hope the survey results motivate and enable the life insurance industry to undertake important changes in preventing and identifying claims fraud particularly with respect to changing the paradigm in risk management, in light of growing incidence of fraud and abuse globally.



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About This Survey

The detection and management of fraud is a critical element of an insurance company's risk management activities. Fraud in life and health insurance is not unique to the Middle East; rather, it is a global phenomenon, though the scale and impact differs by region and country.

Fraud and abuse experienced by the Middle East region's life and health insurers appears to have increased over the past several years.

RGA's survey scope included all the benefits under life business, i.e. group life, credit life, and individual business. In the context of this survey, fraud, abuse, and leakage are defined as the following:

Fraud is defined as an intentional non-disclosure or misrepresentation of material facts in order to claim the benefit from the insurance company. Some of the examples include:

1. Non-disclosures or misrepresentations of past medical history that are material to the issuance of insurance cover
2. Submission of falsified documents, or fabrication of documents, e.g. financial and medical information including forged medical certificates.
3. Insurance cover on ill or mentally unfit lives.
4. Buying multiple policies on the life to be Insured

Abuse is defined as misuse of insurance in order to claim or inflate the benefit from the Insurance company. Some examples include:

1. Misuse of total and temporary disability (TTD) benefit by claiming for long sick leaves that are not justified by the medical condition, or TTD sickness reported as an accidental claim
2. Medical expenses claimed for treatment unrelated to the diagnosed medical conditions
3. Exaggerated repatriation benefits
4. Hospital cash benefits claimed for a medical condition that doesn't warrant hospitalization
5. Misuse of free cover limit (FCL) by the policyholders

Leakage is simply defined as money lost through underwriting or claims management inefficiencies that ultimately result from failures in existing processes (both manual and automated).

RGA conducted the survey online for three weeks from May to June 2020. Responses were requested from the Claims functions within the insurance companies. A total of 37 companies (40 participants) around the Middle East region – United Arab Emirates (UAE), Kingdom of Saudi Arabia (KSA), Oman, Bahrain, Egypt and Qatar – responded representing most of the market. Survey findings reflect insights and data collected from 2019 experience.

RGA would like to once again thank all of the respondents for participating in this survey. Based on this initial study, RGA may conduct this survey again in the future, pursuant to online industry trends. A full list of participating companies can be found in Appendix A.

Executive Summary

The results from this survey, the first of its kind conducted in the Middle East market, confirmed concerns and areas for improvement as observed by RGA through our interaction with clients over the last few years.

Although fraud and abuse occur in all insurance products, some types of business are more susceptible to this.

Almost half of all respondents (49%) indicated that group credit life business is more prone to fraud compared to group life (employee benefits) and individual business. The protective value of underwriting and protection against anti-selection is clearly demonstrated through individual business where appropriate application and disclosures are embedded in new business processes. Better alignment between financial institutions granting loans, and insurers that provide protection to the life assured, is recommended to reduce the potential for fraud and abuse.

Survey results do, however, indicate potential mis-use of group life benefits, including Temporary Total Disability (TTD), Medical Expense and Repatriation by some group policyholders, which is further exacerbated by market competition driving unsustainable pricing and frequent replacement (i.e., “insurance shopping”) as the top two reasons for fraud and abuse under group life business.

An overwhelming majority (96%) of participants responded that up to 10% of the total claims reported are declined due to pre-existing exclusions under the policy. The protective value of this exclusion is clearly demonstrated, however there seems to be an increasing demand from financial institutions to remove the pre-existing exclusions, together with an increase in Free Cover Limit. The concerns in complying with these demands are that the opportunity for anti-selection and the inclusion of many individuals with poor health will increase, perhaps to an extent where the viability of a product can be eroded over time.

In recent years RGA has noted an increase in disability claims and respondents indicated that two of the main reasons for this increase may be a lack of due diligence by the bank at the time of loan disbursal (76% participants), followed by the relative ease of obtaining a disability certificate from the medical board declaring individuals disabled and eligible for benefits (72% of the participants).

Paying legitimate claims provides the necessary security to various beneficiaries in their time of need. More than 90% of all claims are settled, however two thirds of respondents indicated that at least 2% of all their claims were declined due to fraud and abuse, and an additional 16% reported that as many as 10% of claims are declined. Whilst this is significant, it is concerning that many insurers are not monitoring and tracking high risk claims; a quarter of respondents could not confirm the number of claims that they declined due to fraud. One of the consequences of this lack of reporting is the impact it has on the profitability of a portfolio where products may not be priced appropriately.

Half of all participants do not record and maintain any record of litigated claims, nor are they aware of the outcomes of the litigated claims. This reflects minimal involvement by the claims team in litigation, and this can be one of the attributing factors for an increasing loss ratio on litigated claims.

Claims adjudication can only be performed in the context of the insurance contracts, and specifically the terms and conditions of the policy. Survey results confirmed that a significant proportion of respondents do not have the required definitions contained in their contracts to allow them to act on fraud and abuse. Specifically, detailed definitions of fraud and abuse and the consequences thereof, as well as a sunset clause, should be included as a standard policy language. In group life and credit life business the absence of appropriate declarations by the life assured at the application and claim stages obstructs a carrier’s ability to investigate claims appropriately, making it highly vulnerable to fraud and abuse.

In response to the survey findings, RGA recommends the following changes that will be most effective if addressed by the industry as a collective.

- *Policy Language, Declarations and Exclusions* - the insurance contract, application, and claim forms should be enhanced to provide adequate protection to insurance companies against fraudulent acts while at the same time providing certainty and transparency to policyholders.
- *Data Management* - identifying, recording, and analyzing high risk claims helps identify emerging trends and changes in customer behavior, allowing insurers to respond proactively and appropriately by adjusting new business, pricing and claims practices.
- *Risk Control Unit* - the survey findings identified a need to have an internal risk management unit to manage internal and external fraud. The team should be able to investigate fraud for the company and implement corrective measures to ensure strong risk management practices.
- *Involvement in Product Development/ Legal/ Risk Management Practices* - the claims team should be involved at every stage of product development in order to highlight the potential challenges and gaps where fraudulent practices arise. In addition to detecting, preventing and managing fraud, Claims should also take part in the design of terms and conditions, particularly definitions and exclusions, to ensure there is increasing alignment between the intention of the product, its terms and conditions, and the execution thereof at claim stage.

Finally, closer collaboration between the insurance regulator and insurers, through an industry association, is encouraged. Creating a platform where pertinent issues affecting insurers and their customers can be addressed in a transparent and responsible way helps provide protection for, and bolsters confidence in, the insurance industry.

Middle East Life Insurance Claims Survey: Fraud, Abuse and Leakage

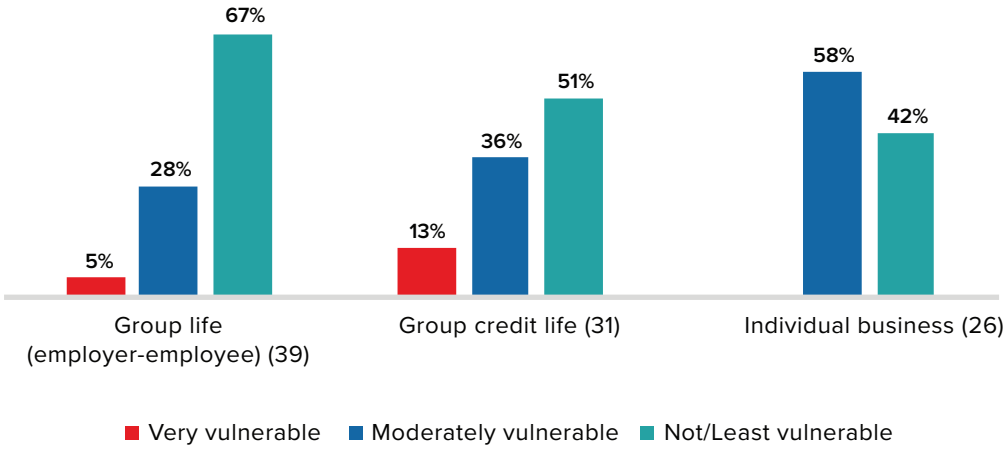
1. What lines of business does your company participate in?

Group life (employer- employee)	100%
Group credit life	82%
Individual business	67%

N=40

As anticipated, all participants are currently active in the group life (employer-employee) business, followed by 82% that are providing credit life business, while individual business is supported by 67% in the Middle East region.

2. In your experience, how vulnerable are your active business lines to fraud and abuse?



RGA Observations

Interestingly, 49% of participants believe that the group credit life business is more susceptible to fraud and abuse, predominantly falling under the “moderate” to “very vulnerable” brackets compared to group life business and individual business.

Individual business is less common in the market, and it tends to be fully underwritten, therefore 58% of the participants believe it to be moderately vulnerable to fraud and abuse compared to the group credit life business. Group credit life is offered on various loans and the due diligence in this line is carried out by the banks and not the insurance companies, who have minimal control over selection of lives. There is also somewhat of a misalignment of interests: i.e., the bank wants to issue the loan, and is not concerned with the risk management, passing this on to the insurer, who in turn has little control over risk management.

In addition, RGA’s internal observation is that the credit life policies tend to have higher Free Cover Limit (FCL), and many banks have negotiated to further limit exclusions, making policies more vulnerable to fraud and abuse.

There is also a lack of validation of claims evidence, both financial and medical, at the time of claim. This is especially true on high risk claims if assuming that loans are being issued to financially eligible and healthy lives. RGA has reviewed early claims on loans where the life assured was already in poor health at the time the loan was granted, raising an additional question on the financial viability of the loan. This highlights the misalignment between the interests of the bank (to issue a loan), and the limited sources available to insurers to manage their risk.

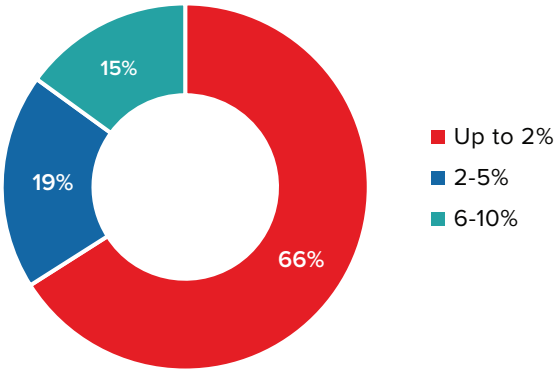
Recommendations

It is prudent to share claims experience with the policyholders – the banks - on an ongoing basis, highlighting the challenges faced at the claims stage.

Striving to reach alignment between the bank and the insurer on the ease of doing business, granting a loan, and managing the associated insurance risk should be the objective of these discussions. Additional risk management measures to be considered are ensuring that the FCL's are appropriate, that the relevant policy terms and conditions inclusive of exclusions are included in the insurance contract, and that these are explained to the life assured at the time of applying for the loan and insurance cover.

3. In 2019, what percentage of your company's total reported claims by count was due to fraud or abuse for all lines of business?

PERCENTAGE OF TOTAL REPORTED CLAIMS IN 2019 BY COUNT DUE TO FRAUD OR ABUSE



N=32 (8 Participants reported Don't Know)

RGA Observations

In 2019, up to 2% of total claims reported – by count – was selected by 66% of participants due to fraud and abuse in the Middle East region. Another 19% said between 2% to 5% of claims reported last year, and 16% indicated between 6% to 10% of total claims reported. 20% of participants indicated that they 'don't know' the number of claims due to fraud and abuse reported in the Y2019, which could be an indication of a lack of awareness or inadequate processes that don't allow identification of suspected fraud or abuse.

With an increase in fraud across various markets, it is important to flag high risk and fraudulent claims. During RGA internal claims assessments, a rise in fraud claims were noted under various life benefits such as medical expenses, disability claims, and death abroad. It is also noteworthy that a few of the high risk claims (up to 5% by count) are settled due to lack of evidence; however, these claims have not been recorded for future referencing/analysis and pricing purposes but are rather considered under valid claims potentially affecting profitability of the business.

Recommendations

Fraud and/or abuse may not be eliminated but leakage can be managed by identifying, recording and actively tracking such claims. Subsequent trend analysis of these claims can help to inform a strategy to deploy appropriate measures to manage the leakage and price the business appropriately. The following strategies are to help mitigate fraud and control leakage:

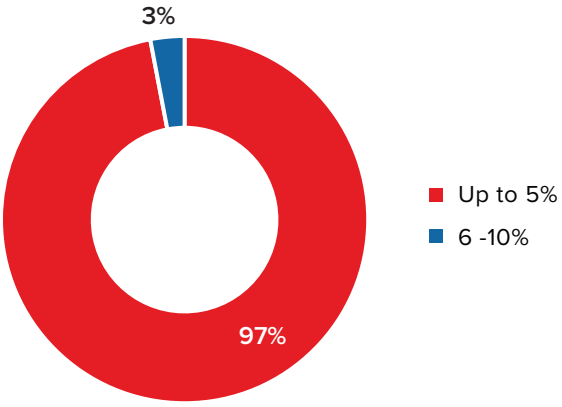
- Fraud/abuse can be further controlled by standardizing the proposal forms, policy wordings, and claims documentation procedures

- Insurers form an association and maintain and share a database on fraud/abuse.
- Investing in a robust claims system allowing insurers to accurately capture data in order to identify trends in abuse and control anti-selection

Managing fraud and abuse by controlling the leakage in our process will have a positive impact on claim experience and reduce claims cost, with a positive impact on appropriate pricing in the market.

4. What percentage of fraud and abuse claims (by count) in 2019 were paid due to lack of sufficient evidence?

PERCENTAGE OF CLAIMS (BY COUNT) PAID IN 2019 DUE TO INSUFFICIENT EVIDENCE



N=29 (11 Participants reported Don't Know)

RGA Observations

Twenty-nine survey participants reported that 97% paid up to 5% of claims (by count) that were flagged as high risk for fraud and/or abuse, due to lack of sufficient evidence. 3% paid 6% to 10% of claims; however, 11 participants indicated 'don't know'.

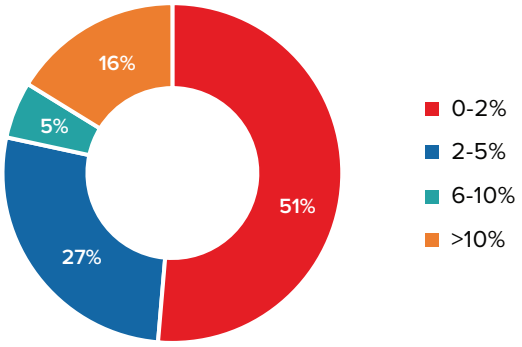
In addition to this, RGA has experienced that only declined claims are considered/assumed to be fraudulent excluding high-risk claims which are settled due to lack of evidence. These claims are recorded as valid instead of maintaining a separate log of high-risk claims. The ability for an insurer to identify high risk claims, will enable them to assign claims investigation resources appropriately focusing on complex claims that require specialist expertise to investigate and manage such claims. Regular and in-depth analysis of these claims will provide insights into high risk behavior and allow for strategies to be implemented to identify and manage fraud.

Recommendations

Identifying and monitoring high risk claims helps to develop trend analysis and deployment of appropriate measures to control the leakage. The impact of these claims can be considered by the pricing function to the assist with appropriate and accurate pricing.

5. What percentage of the total claims reported (by count) in 2019 were declined?

PERCENTAGE OF TOTAL CLAIMS REPORTED (BY COUNT) DECLINED IN 2019



N=37 (3 Participants Don't Know)

RGA Observations

A little more than half (51%) of participants reported declining 2% of claims in 2019. The second largest group, 27%, reported declining between 2%-5% of claims, while 5% reported declining between 6% to 10%; an additional 16% of participants stated they declined more than10% of total claims. Three participants stated that they didn't know the amount of the claims declined.

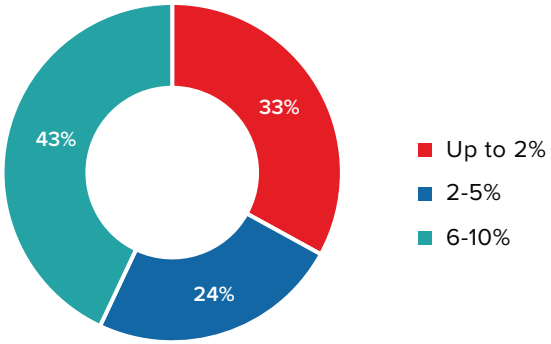
RGA notes that the group life business has the lowest declined ratio compared to group credit life, and this appears to be a result of the Free Cover Limits (FCL), with most claims occurring below the FCL.

The credit life business has a higher ratio of declined claims compared to group life. The majority of claims are declined due to non-disclosure of past medical history. There appears to be limited validation of the financial eligibility of the life assured, or the evidence provided at the time of loan, to support eligibility for the cover. The evidence is taken at face value and believed to be authentic and accurate, making it vulnerable to fraud. Other reasons for declining claims are due to claims falling under policy exclusions such as mental illness, disability prior to a policy period, drug and alcohol abuse, and so forth.

It will be interesting to monitor this data in the future to see if insurers become more sophisticated in detecting fraud and abuse, and in combating it through the application and claims processes, as well as the wording of terms and conditions underpinning the insurance contract.

6. What percentage of those declined claims by count were referred to litigation?

DECLINED CLAIMS REFERRED TO LITIGATION



N=21

RGA Observations

Litigated claims are managed by the legal team of the companies with minimal involvement of the claims team, hence the litigated claims details were not readily available with the participants. Only 21 of 40 participants were able to provide information regarding how many declined claims their companies litigated, with 33% of these reporting 2%, while 24% stated between 2%-5%, and 43% reported litigating between 6%-10%.

Interestingly, of the 21 survey respondents, only 17 provided the details of win-to-loss ratio of these litigated claims. The win-to-loss ratio reported is 60:40.

In group credit life, there are two main reasons for a claim going to court:

1. A Claims decision to decline was not acceptable to the beneficiary or insured.
2. Policyholders (banks) involve the insurance company in the litigation against the claimant for non-payment of installments.

A few companies highlighted some of the practical challenges in managing litigated claims:

- The external lawyer appointed may not be well versed with the case or the reason for rejection, and they treat the claim as any other litigated matter.
- The external lawyer, in some cases, may not be present for hearings, or may fail to provide facts related to the case to the court, weakening the insurers' position.
- Further non-involvement of the claims team makes it vulnerable losing in the court.
- There have been a few instances where an insurer isn't notified that a claim is being litigated, and the company doesn't have the opportunity to validate the claim. It is assumed that either the policyholder under the credit life business is either not forwarding the claims, or communicating the nature of the declined claims, without consulting with the insurer.
- There have been incidences wherein the advisors are leading the claimants to court for faster claims settlement, making it more vulnerable to fraud and abuse.

Recommendations

The appointment of the legal counsel is important and only those that are well experienced in life insurance matters should be instructed to represent the life insurer.

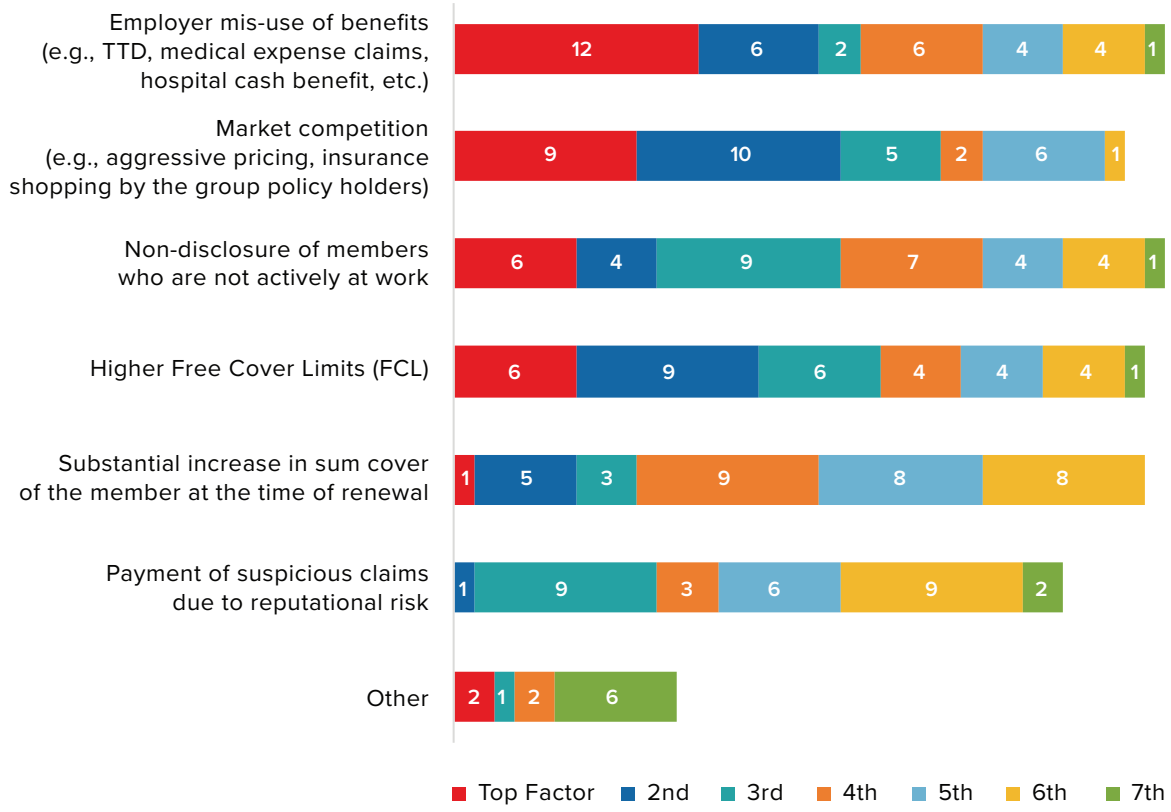
The detailed and accurate instruction of the legal counsel is critical, and this means that the claims manager must be involved together with the insurers' internal legal team.

Update policy terms and conditions reflecting that the bank/claimant/life assured must advise the insurer within a specific number of days of intended litigation – this is to avoid the insurer being taken by surprise and not having enough time to prepare their defense.

Group Life Claims

7. Which of the following factors, in your experience in 2019, contributes to fraud or abuse under group life business? Please rank the factors in order from most contributing factors to least for fraud and abuse.

TOP RANKED FACTORS CONTRIBUTING TO GROUP LIFE CLAIMS FRAUD/ABUSE



N=36

RGA Observations

The top-ranked factors contributing to group life claims fraud and abuse are "employer misuse of benefits (e.g., TTD, medical expense claims, hospital cash benefits, etc.)" with 12 rankings as the top contributor and 35 total rankings. The second top contributing factor is "market competition", such as aggressive pricing and insurance shopping by group policyholders, with 9 top-ranked responses and 10 second rankings (and a total of 33 rankings for this category). For group life members currently not actively at work, six participants list "non-disclosure" as a top factor contributing to fraud and abuse and a total of 35 responses. "Higher Free Cover Limits (FCL)" also garnered 6 top-ranked responses and a total of 34 rankings. Substantially increasing the sum cover of a member at the time of renewal earned 34 total rankings (with less emphasis on top three rankings), while payment of suspicious claims due to reputational risk had 30 rankings total.

The other factors provided by the respondents regarding group life claims fraud and abuse included:

- Non-disclosure of pre-existing diseases or conditions
- Including employees close to retirement in the group during the policy period, leading to early claims
- Fraudulent documents being used for involuntary loss of employment (ILOE) benefit
- Fraudulent information about monthly salary details being supplied
- After the contestability period, for a non-disclosure case, the claim becomes admissible

Based on RGA's internal claims assessment files, there are more factors contributing to fraud and abuse under group life business as opposed to credit life business. Predominantly, this is due to abuse of covered benefits and aggressive pricing leading to settlement of non-admissible claims. Despite the quality of services provided by the group insurers – such as claims settlement ratios, good turnaround time and policy servicing – groups continue to shop for insurance cover annually, causing aggressive pricing practices and making it very vulnerable to abuse.

Other factors:

- Renewals sometimes bring up requests for certain conditions, such as claim settlements and limited exclusions (even within the FCL), that increase the possibility for anti-selection.
- Medical histories, actively at work details, and leave records are not readily shared by the policyholder at claim time. Requests to provide additional cover for employees nearing retirement or a sick leave is another way in which the cover can be exploited.
- With the continued competition on the pricing, what appears to be a minor change in practice and behavior can have a negative impact on profitability over time. In the longer term these practices become standard and tolerated, potentially impacting the life insurance industry as a whole.

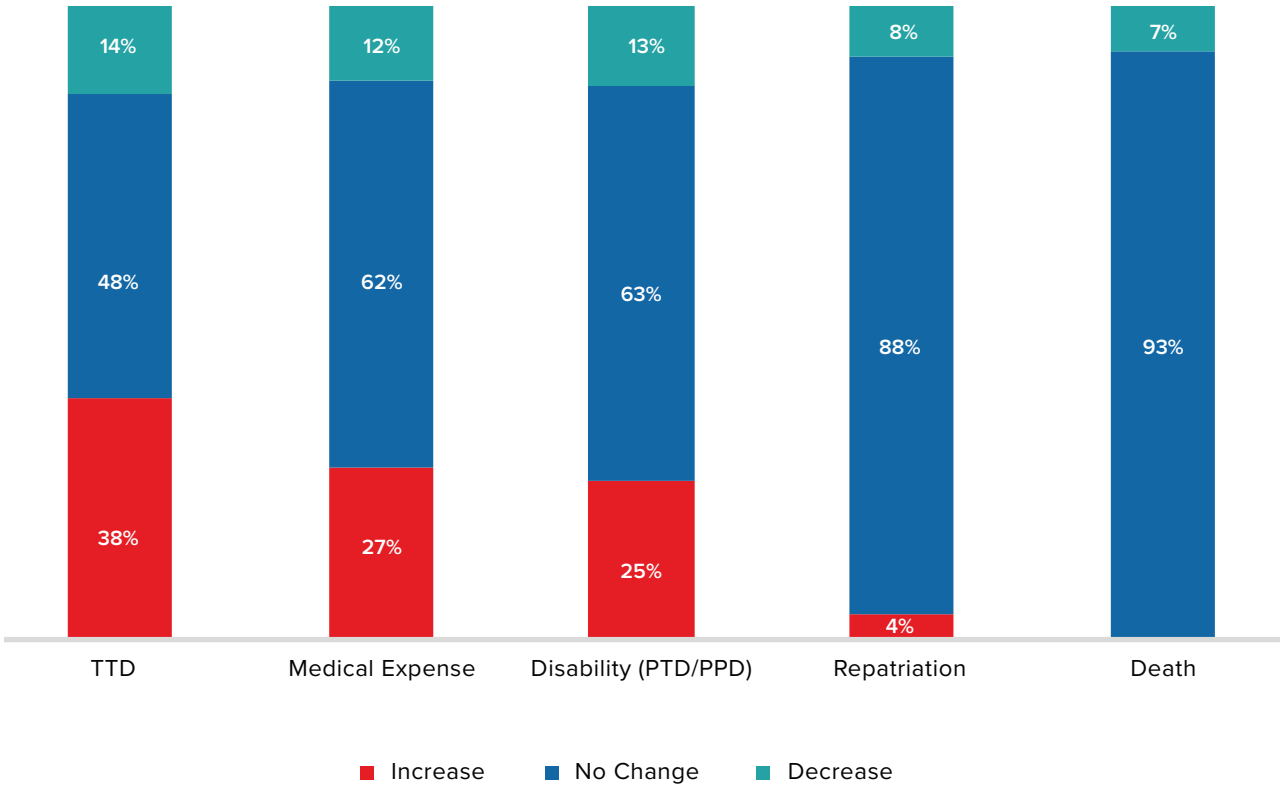
Recommendations

Good client service is important to retain clients but should not be at the expense of settling claims that are high risk, or where appropriate evidence has not yet been provided to prove the insured event. A clear and transparent claims philosophy and process document should be shared with policyholders and claimants to provide guidance on the claim assessment process and increasing trust that the insurer will settle genuine and valid claims. Communication on the consequences of fraudulent and invalid claims should also be included in policy terms and conditions; this includes premiums that may have to be adjusted for all policyholders, and that invalid and fraudulent claims will not be settled.

In an increasingly commoditized market, with high FCL's and pressure being applied to rates being charged, additional focus on identifying and managing claim fraud and abuse can help maintain profitability. Ceding companies should proactively involve their claims teams on a regular and frequent basis in designing and reviewing the policy terms and conditions, the application, and the claim forms to incorporate learnings from recent cases. Working with reinsurance partners to obtain their global insights and expertise can form part of this regular review.

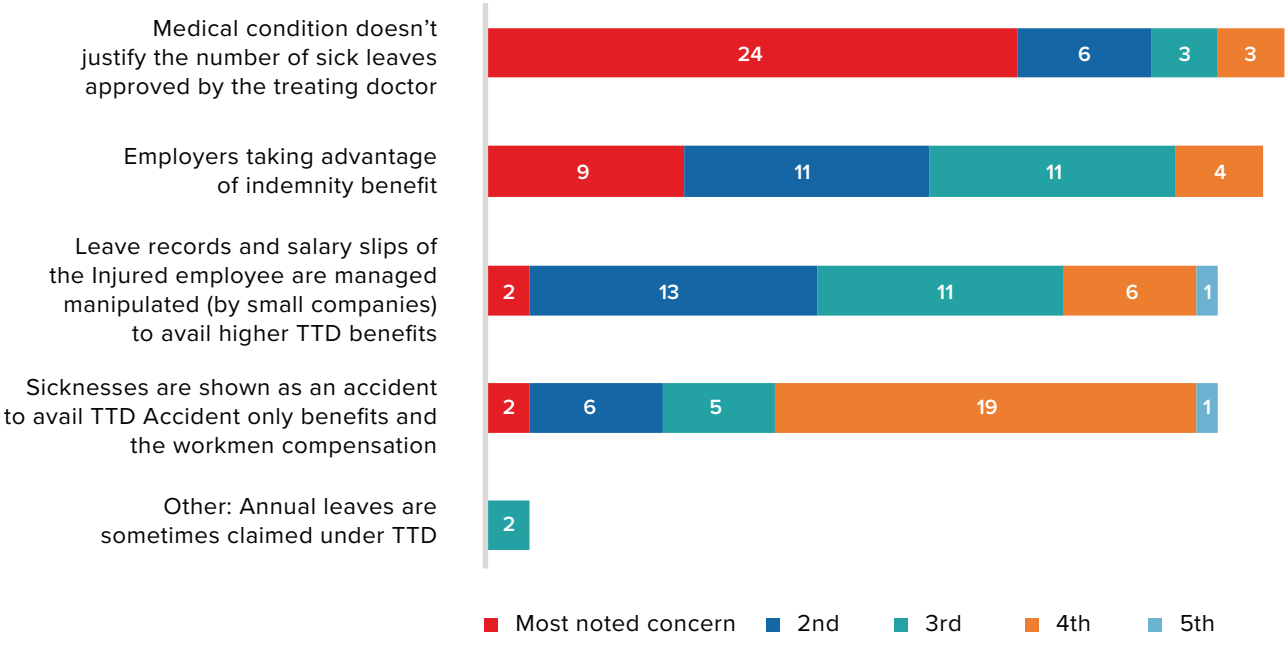
8. Based on your company's experience in 2019, is there a change in fraud/abuse claims under your group life business for the following benefits and the concerns with respect to these benefits.

CHANGES IN FRAUD AND ABUSE BY GROUP LIFE BENEFITS



Specific to TTD and Medical Expense Benefits, the following observations were noted.

TOP RANKED CONCERNS ABOUT TTD BENEFITS



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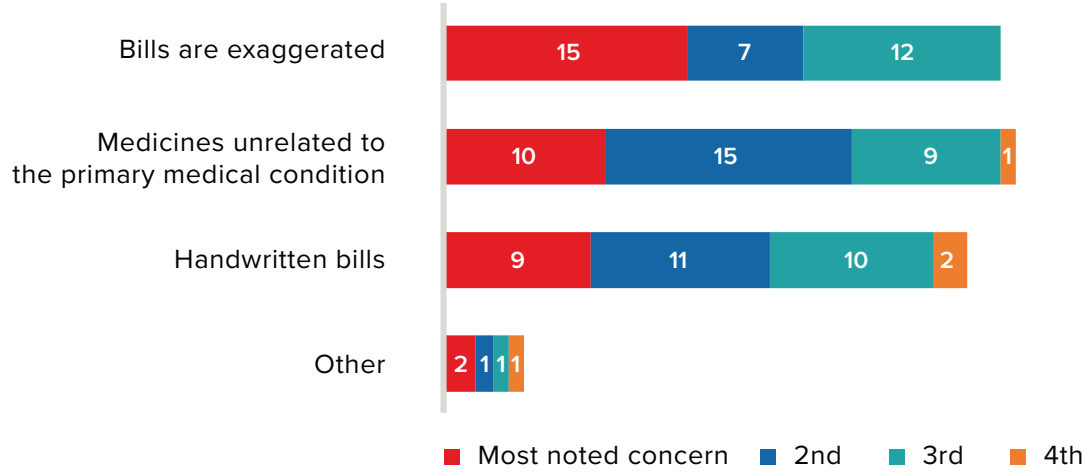
TOP RANKED CONCERNS AROUND MEDICAL EXPENSE BENEFITS



N=34

RGA Observations

Participants predominantly indicated that there was 'no change' in fraud and abuse from 2019 experience with regards to death benefits and other supplementary life benefits. During RGA's claims assessment, however, we observed some increases in fraud and abuse from the 2019 experience data for the following products: Total and Temporary Disability (TTD), medical expense, disability, and repatriation benefits.

TTD benefits experienced the largest increase of fraud or abuse according to 38% of 29 participants. Medical expense benefits had a 27% increase (of 26 participants); while disability benefits that include Permanent and Total Disability (PTD) and Permanent and Partial Disability (PPD) garnered a 25% response rate (of 32 participants) for increased fraud and abuse based on 2019 claims experience.

With additional investigation into the reasons for fraud and abuse under TTD, the participants ranked the most notable concerns to be: the medical condition does not justify the number of days sick leave being approved by the treating doctor; employers taking advantage of the indemnity benefit as detailed below; and leave records and salary slips of the injured employee(s) being manipulated, usually by smaller employer groups, to increase TTD benefits.

Fraud was flagged when absences from work due to sickness are shown as an accident so as to fall under TTD accident, and/or additionally claimed for workmen compensation benefits. Additionally, documents are sometimes fabricated so that the annual leaves are claimed under TTD.

For medical expense benefits, participants rated exaggerated bills as the top-ranked reason for fraud and abuse, followed by treatment prescribed unrelated to the primary medical condition. Some of the other responses included the following:

- Handwritten bills
- Duplication of paid bills settled by another insurer
- Lack of itemized bills from government hospitals
- Extended hospital stays that are not consistent with clinical guidelines
- Duplication of medical expense claims being submitted to a group life insurer that has already been settled under a health benefit

Industries such as construction, manufacturing, and small-to-medium enterprises appear to be more vulnerable to fraud and abuse.

Recommendations

TTD sickness claims experience in practice tends to be more abused than TTD accidental claims and hence the waiting period should be mandatory for the TTD sickness. Fraud and abuse can be controlled under group life business by standardizing the proposal forms, policy wordings, and claims documentation procedures.

RGA suggests using standardized data sets such as the medical disability guidelines to help benchmark appropriate time off work periods or durations.

RGA also recommends enhanced collaboration between insurers, especially where duplicate billing is taking place, where only one insurer should pay or consider an agreement to share liability.

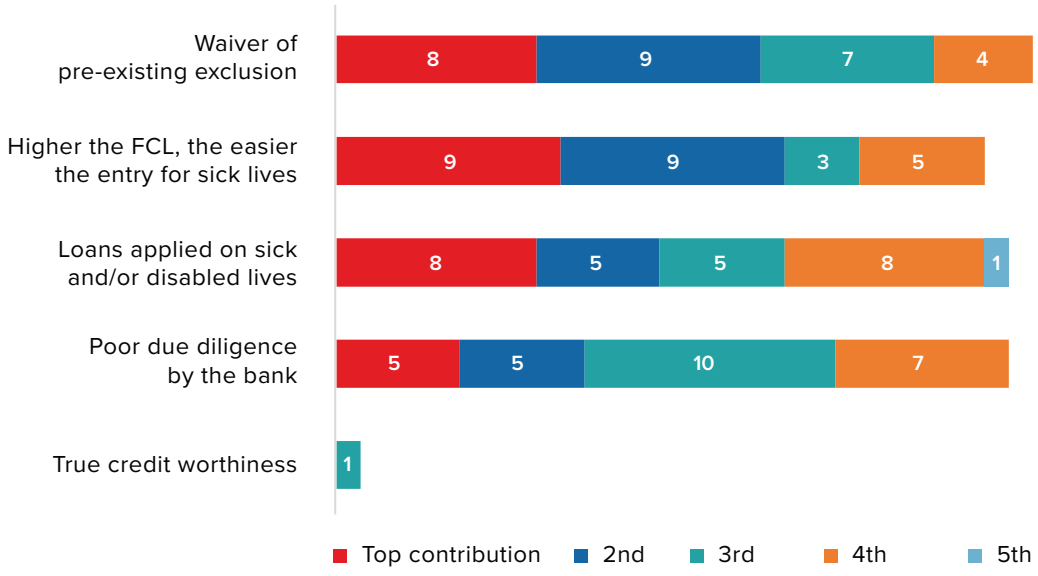
Increase standard verification processes for high risk industries, e.g., telephone verification of details when an accident is reported to confirm details of the accident, etc.

Similarly, call and verify medical appointment and treatment details for handwritten medical notes.

Group Credit Life Claims

9. Please select and rank in order of relevance the factors that have made the greatest contribution to increased fraudulent or abused claims under group credit life business.

FACTORS CONTRIBUTING TO FRAUD AND ABUSE IN GROUP CREDIT LIFE



N=30

RGA Observations

Fraud and abuse in group credit life was largely attributed to waiver of pre-existing exclusion (with 8 top rankings, 9 second rankings and a total of 28 rankings); this was closely followed by the greater the increase in free cover limit (FCL) on renewal, the easier the entry for sick lives (9 top rankings, 9 second rankings and a total of 26 rankings). Loans applied on sick or disabled lives ranked third for factors contributing to fraud/abuse in group credit life (27 rankings total). Poor due diligence by the bank was ranked fourth, with 27 total rankings. One respondent rated the "true credit worthiness or credit history of the member" as a factor as well for increased fraudulent or abused group credit life claims.

Waiver of pre-existing illness exclusion and providing higher FCL are the two major factors leading to abuse of the credit life business.

RGA has reviewed a number of claims where loans appeared to have been issued to individuals that were sick, some terminally ill at the time of loan application. This has been supported by the response of 10 participants who indicated poor due diligence by the bank at the loan application stage as a significant driver of fraud and abuse.

For the policyholder (the banks), attaching insurance to the loan sets the policyholder free of any financial liability, including managing fraudulent claims. The management of this risk, i.e., fraud and abuse, is the sole responsibility of the insurance company even though the acceptance of the risk has largely been made outside of its control.

Allowing the insurer to apply an appropriate risk matrix to ensure the customer's medical and financial status is suitably considered at the time of approving the loan will allow for more appropriate and realistic risk management at claim stage.

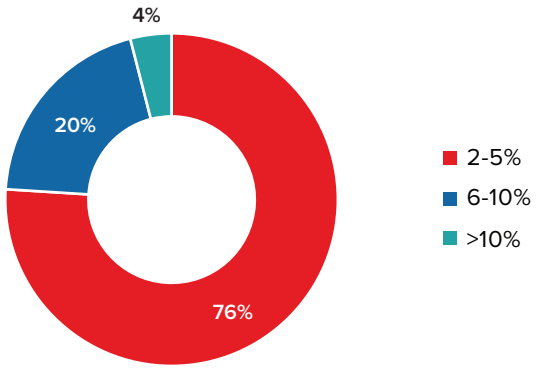
Recommendations

There should be alignment between the bank approving the loan, which is accepting the insurance risk on behalf of the insurer, and the insurer, which needs to manage the risk at claim stage.

A matrix that is well thought through and agreed to by all stakeholders should be implemented, and this matrix should include certain triggers to allow the verification of financial, employment, and medical information at the loan application stage.

RGA believes that the consequences of false information should be called out in policy terms and conditions. For example, if there is a fraudulent claim and the insurer is not liable, the bank should therefore have to recoup the money for the life assured or the deceased's estate as applicable.

10. Based on your company's experience in 2019, what percentage of the claims by count under group credit life is declined due to pre-existing illness exclusions?



N=31

RGA Observations

The majority of survey participants, 76%, reported between 2% and 5% of group credit life claims (by count) were declined due to a pre-existing illness exclusion. Another 20% reported declining between 6% to 10% of claims, and 4% of participants said they rejected more than 10% of claims.

It is important to note that all of the companies that have a pre-existing illness exclusion in their contracts are able to decline claims appropriately due to the existence of an excluded pre-existing illness. Conversely, it is the primary cause for fraud and abuse if it is not included in the policy terms and conditions as an exclusion.

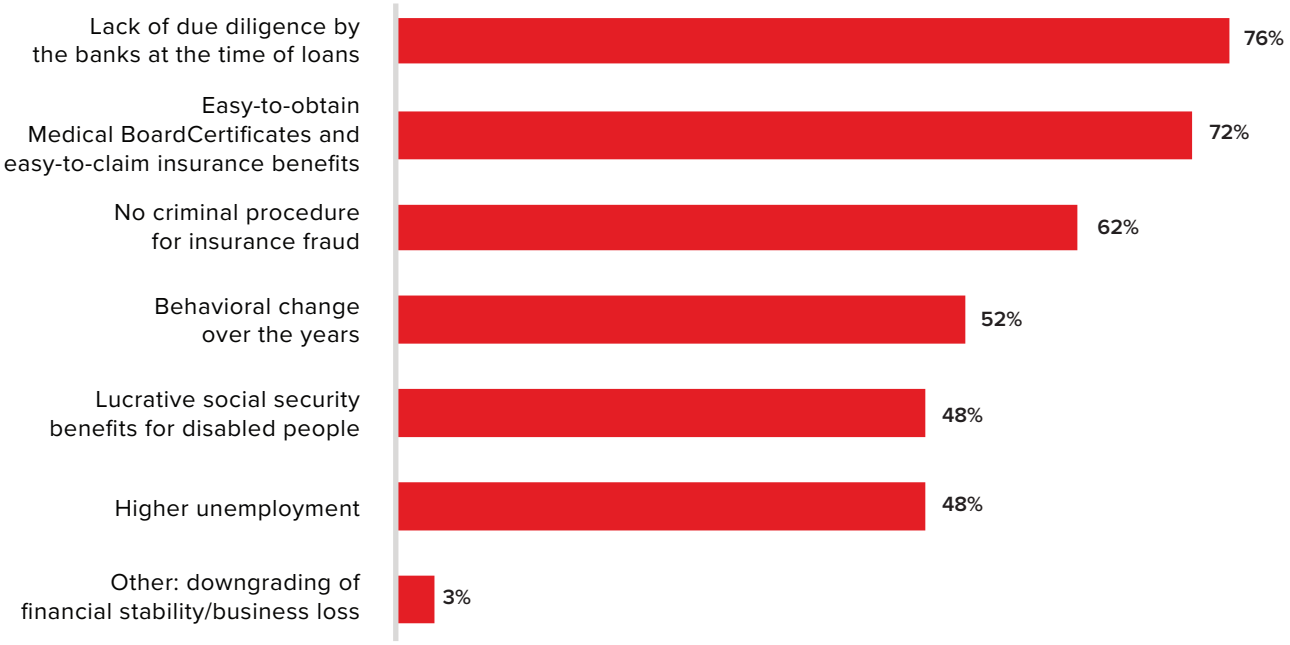
Recommendations

Pre-exiting illness provides protection against fraud claims and mitigates the risk to a greater extent. It is assumed that a sick life would not wait for 12 months or more to claim under the policy.

As credit life is noted to be moderate to very vulnerable to fraud and abuse, a pre-existing illness exclusion should be included in policy terms and conditions for a minimum period of 12 to 24 months prior to policy issuance.

11. RGA notes a behavioral change in disability claims over the years. In your opinion, what could be the reason(s) for this change? Select all that apply.

REASONS FOR BEHAVIORAL CHANGES IN DISABILITY CLAIMS



N=29

RGA Observations

During RGA's internal claims assessment, we have observed a rise in disability claims over the past few years. We asked our survey participants about their perspectives on this observation, and 76% of participants indicated that these changes are a result of the lack of due diligence by the banks at the time of loan processing. The second highest rated factor with 72% was the ease of obtaining Medical Board Certificates and claiming insurance benefits. Sixty-two percent of respondents indicated that there is no criminal procedure for insurance fraud, making life insurance an easy target to be exploited through fraud and abuse. Approximately half of the participants selected behavioral change over the years (52%), lucrative social security benefits for disabled people and higher unemployment (48%, respectively) as factors attributing to increasing fraudulent or abuse of disability claims.

According to the survey participants, multiple factors are contributing to behavioral changes in the Middle East market and the resultant increase in disability claims. One major factor may be that insured lives tend to be more aware of the opportunities for fraud and abuse under the disability benefits. For example, Oman provides lucrative social security benefits on permanent disability, and it is relatively easy to obtain a Medical Board Certificate supporting permanent disability, which in turn makes it more vulnerable to abuse.

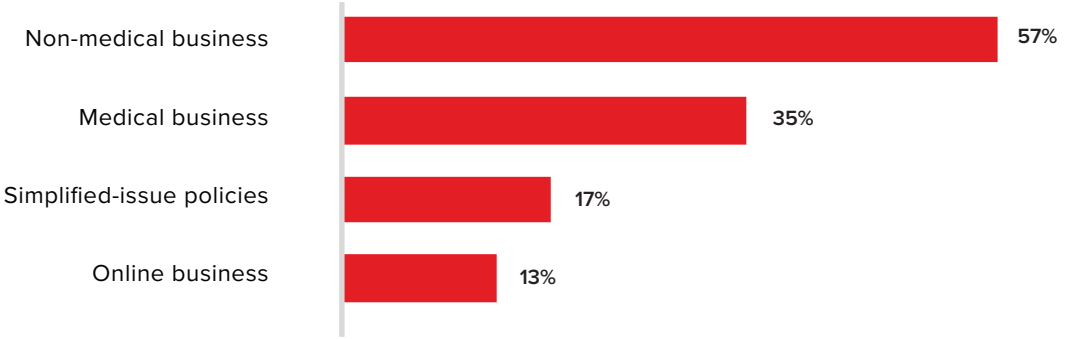
Recommendations

Policy terms and conditions should clearly define what constitutes disability as well as the date of the event. The Insurance Association should work with the regulator and disability board to agree on a distinction between the two entities and benefits. A set of guidelines that are agreed to by all parties would be a good standard practice in the market.

Individual Business

12. Within your company's individual business, in what area(s) do you see a rise in fraud and abuse? Select all that apply:

REASONS FOR BEHAVIORAL CHANGES IN DISABILITY CLAIMS



N=23

RGA Observations

Insurers that participate in individual business previously reported a moderate level of vulnerability to fraud and abuse in claims. As indicated above, 57% of 23 participants stated that their non-medical business (individual policies accepted basis the application for insurance) is seeing a rise in fraud and abuse. For 35%, the medical business (individual policies requiring medical exams) is at risk, followed by 17% who selected simplified-issue policies, and 13% who reported online business as the area with increasing instances of fraud and abuse.

The survey responses indicate that non-medical business is being abused and is the most vulnerable to fraud claims. We believe that the agent or the insured knowingly applies for a policy up to the non-medical limit to avoid any medical examination. Non-disclosure of medical history is a major cause of fraud compared to falsifying or omitting financial information.

Recommendations

Based on RGA's internal underwriting experience, roughly 12% to 15% of insurance applicants with no medical history are found to be substandard once subjected to medical exams.

It is accepted that not all lives applying for insurance must undergo medical examinations; however, verifying some policies post-issue can help to detect the true extent of non-disclosure or misrepresentation.

We advise insurers to carry out tele-verification with the applicants to ensure that they personally submitted their applications, confirm that they understand the benefits covered under the policy, and to cross-reference the answers provided on the medical questionnaire. We understand that this is not currently a standard practice within the market, but telephone interviews would help highlight the consequences of misrepresentation of material facts and act as a deterrent to anti-selection.

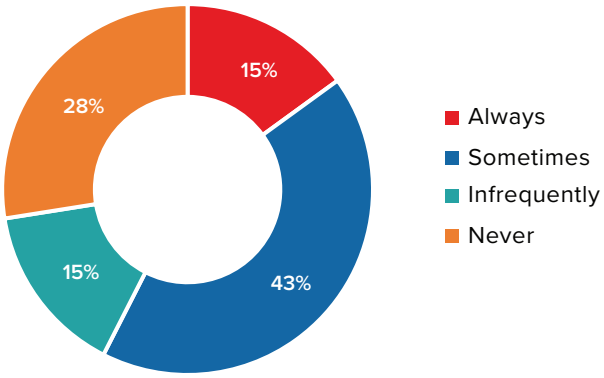
The industry should also focus on training the empaneled doctors, those performing insurance assessments and pre-policy medical tests, for a comprehensive and a better-quality outcome.

Conversely, simplified-issue policies are mostly for investment purposes, and come with their own set of challenges. One of the issues indicated in the survey is an investment made in the name of a spouse who is unaware of the policy being taken on his/her life, thereby making it a high-risk case. Tele-verification can reduce the element of potential moral hazard. Due to abuse of simplified-issue policies, many insurers will need to limit the maximum cover amount on these products to offset the cost and incidence of fraud.

Claims Assessment

13. How often does your company use social media as a tool to assess or verify claims? What are the platforms used to access claims?

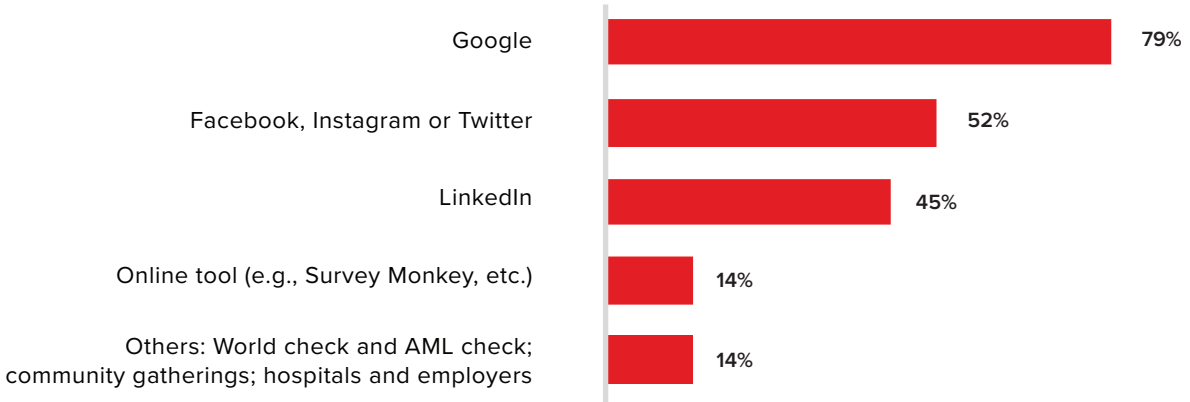
FREQUENCY OF USE OF SOCIAL MEDIA AS A TOOL TO ASSESS OR VERIFY CLAIMS



N=40

As reported in the survey findings for the claims assessment and verification process, 15% of survey participants always use social media and 43% use it sometimes. Conversely, 15% use it infrequently, and 28% reported not using it.

MOST COMMON SOCIAL MEDIA PLATFORMS USED TO GATHER INFORMATION AT THE TIME OF CLAIMS



N=29

RGA Observations

For the 73% of survey participants that reported they use social media to verify and assess claims, the majority use Google searches (79%), followed by more than half (52%) that use Facebook, Instagram, and Twitter. LinkedIn is used by 45% of participants. Online tools, such as surveys and interviews, were selected by 14% of respondents. Another 14% specified that they are using other methods and sources of verification for their claims process, including the World-Check database, anti-money laundering (AML) checks, community gatherings, and hospitals and employers.

Today social media platforms are used by most of the population and are one of the most effective tools to verify disclosures made by claimants. Insurers can learn quite a lot about an insured on various social media platforms, such as their place of work, family, background, as well as death notifications via condolence messages to family members. This kind of data provides additional confirmation to accept low-risk claims and at the same time provides triggers to verify or further investigate high-risk claims.

Employer information along with company registration and other relevant details can also be sourced for higher-value claims.

Traditionally, insurers were more dependent on the documents submitted at the claims stage; however, with an increase in fraud and abuse, they should rely less on evidence submitted by the claimant and more on independent sources to verify information.

Recommendations

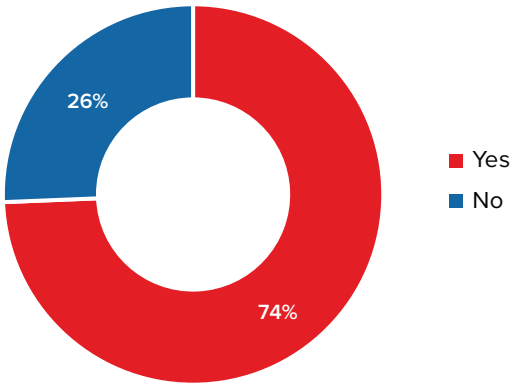
RGA recommends utilizing social media as another claims assessment tool to verify the facts of claims. Insurers should have a practice document about the use of social media and to what extent the information should be taken into account when assessing claims. The document should include the process(s) to be followed with information found on social media, such as determining what information could trigger an investigation, confirming the identity of the claimant, etc.

Disclaimer

It is advisable to corroborate the results of a social media investigation before declining a claim. In addition, the assessor needs to understand that, for disability claims, a few posts on social media about getting out to places or to visit people are not sufficient evidence to decline a claim. Social media evidence adds to the assessment process, but one cannot make a decision solely based on this information alone.

14. Do all your company's policy documents include a definition of fraud and consequences related to fraudulent claims?

PROPORTION OF COMPANIES THAT USE A SUNSET CLAUSE IN GROUP LIFE, GROUP CREDIT LIFE OR INDIVIDUAL POLICIES



N=39

RGA Observations

Approximately three-quarters of participants have policy documents that include fraud definitions and the consequences related to fraudulent claims.

RGA has observed that a number of group and credit life policies in the market do not include the definition of fraud or its related consequences. Just having a pre-existing condition exclusion under the policy or fully underwritten policies doesn't mean the insurer would have 100% protection in a court of law. Fraud has a wider definition than just having a pre-existing condition exclusion, which will screen out anti-selection to a greater extent.

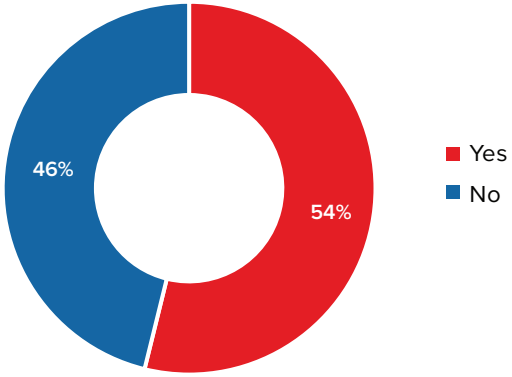
The policy document is considered the legal document, and acceptance of the document binds the policyholder to the terms of the contract. Stating the consequences of committing fraud in the policy document will make the policyholder aware of the consequences of committing fraud and provide warning in doing so. Further, the policy document will stand in a court of law and provide the necessary protection to the insurer when fraud is discovered.

Recommendations

RGA advises insurers to include the definitions of fraud, non-disclosure, and misrepresentation in underwritten policies along with pre-existing exclusions in the applicable group business. This will make the insurer's position stronger in a court of law.

15. Does your company have a sunset clause in group life, group credit life, or individual policies?

PROPORTION OF COMPANIES THAT USE A SUNSET CLAUSE IN GROUP LIFE, GROUP CREDIT LIFE OR INDIVIDUAL POLICIES



N=39

RGA Observations

This type of clause is a provision in a policy which states that the insurer will respond only to losses reported before some predetermined future date (sunset), usually a set period after the expiration of the policy. A sunset clause acts as a deterrent to late notification unless and until there is a valid reason provided by the claimant or the policyholder to waive this clause.

Regulators have not defined a sunset clause period for claims reporting. The sunset clause varies with each company and by the business underwritten. Almost 54% of the survey participants have a sunset clause period of six months to three years in order to ensure timely reporting of any claims.

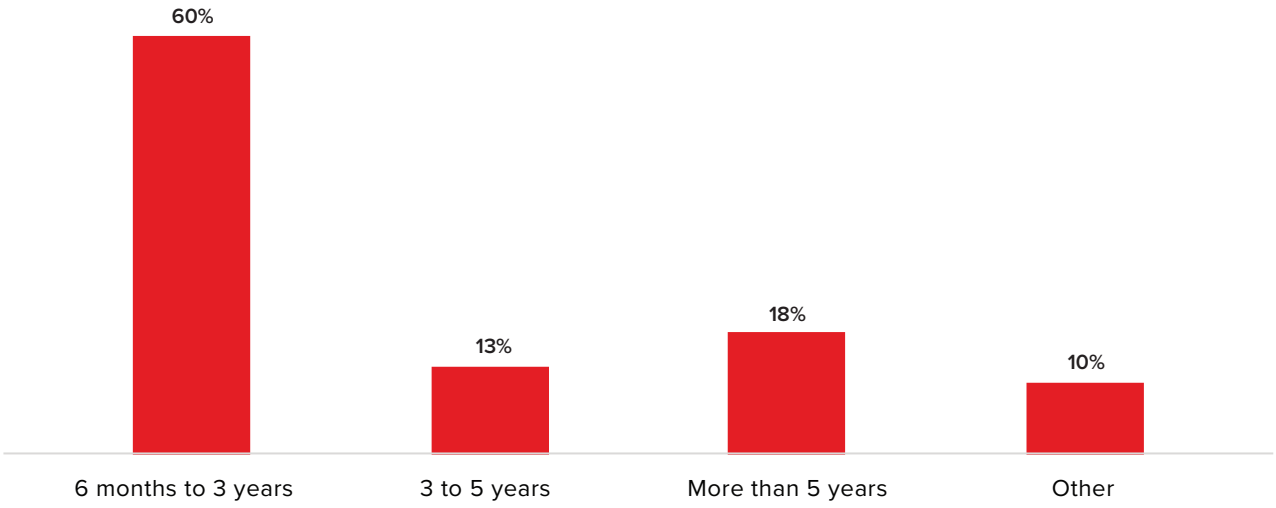
The premise of the sunset clause is not to avoid genuine claims but to ensure reporting of claims within an appropriate time frame. It reduces the risk of anti-selection and ensures appropriate reserving. A lengthy delay in claims notification can compromise the insurer's ability to verify the insured event with regards to disability claims.

Recommendations

RGA recommends including a sunset clause of not more than six months for group life (yearly renewal) and up to three years for the group credit life business from the date of event in order to protect insurers from potentially fraudulent claims.

16. How long does your company keep long-outstanding claims open in the financials (write-off policy)?

TIME PERIOD TO KEEP LONG OUTSTANDING CLAIMS OPEN IN THE FINANCIALS (WRITE OFF POLICY)



N=40

RGA Observations

Sixty percent of the participants stated that claims pending because of outstanding documents are kept open up to three years, while 18% of the participants keep the claims open for more than five years. There are a number of reasons for this, including the lack of related regulatory guidelines for long-outstanding claims. The process followed varies with each client and by country. There is no standard approach across the industry.

Notably, regulations across the Middle East market don't specify any time frame for long-outstanding claims, hence some of the companies keep the claims open until they receive the necessary documents.

At the same time, the majority of clients will, after the third and last communication to the claimant, keep the claim open up to three years and then the claims are closed in the company's financials. During our discussions with clients, they explained that in no more than 5% of these closed claims do claimants respond with further documents, and less than 1% of the claims are open after five years.

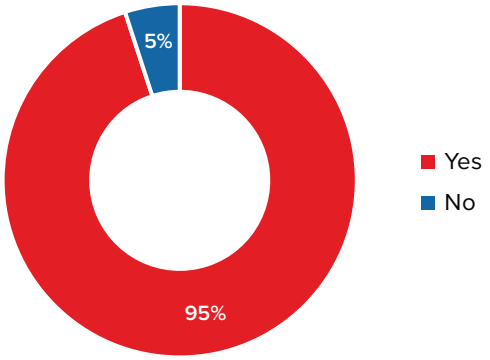
Furthermore, a few clients stated that group life claims are closely monitored with the policyholder and closed at the time of renewal with them or any other insurance company.

Recommendations

RGA recommends including the write-off policy period in the document, stating that claims that are without supporting documents for more than three or five years from the date of claim intimation will be written off the book.

17. Do the declarations signed by the life insured at the insurance application stage and/or signed by the claimant at the claims stage authorize the company to investigate and gather all pertinent financial and medical information of the life insured at the time of claim?

DECLARATIONS SIGNED AT THE APPLICATION STAGE TO AUTHORIZE INVESTIGATION



N=40

RGA Observations

Ninety-five percent of respondents stated that the declarations that the life insured signed at the insurance application stage and/or that the claimant signed at the claims stage authorize the company to investigate and gather all the pertinent financial and medical information for the life insured at the time of claim.

Declarations collected both at the application stage and at the claims stage provide the insurance company with additional protection in order to procure medical or financial documents or investigate the claim.

Recommendations

During RGA's internal assessment, we have found that when the policies issued within the FCL wherein there are no application forms, the claims forms used are also short forms without any declarations from the claimant that grant the insurance company the authority to validate or investigate the claims.

The authorization/consent is of limited use or efficacy if the insurance application and claim forms are not adequate in eliciting detailed and necessary information, or if the authorization is not included in the application and claims forms at all.

Furthermore, for the credit life policies, the claims forms are filed and signed by the banks, making it much more difficult to validate a claim suspected to be fraudulent. Life assureds should be completing their own documentation, even if it is for insurance attached to a bank loan.

Application forms require consent, and they should be duly signed, detailed, and specific. Application and claim forms that are well designed and thorough can be regularly reviewed to ensure that disclosures are verified and that potentially false information can be captured so that insurers can act on it.

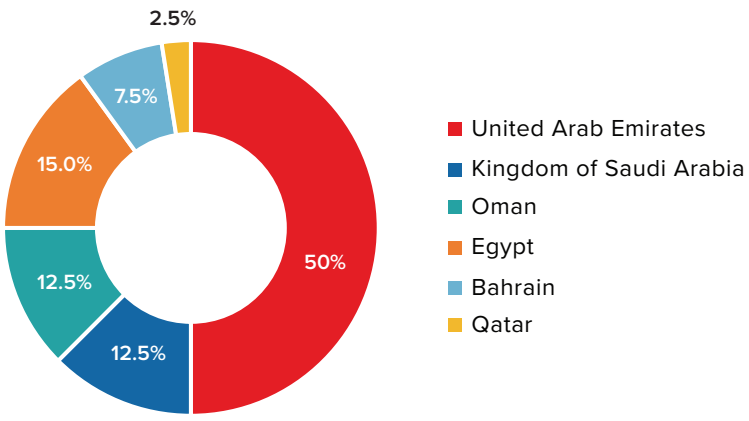
RGA would recommend that insurers include strong declarations in the claims form under the policies within/outside the FCL to minimize the leakage in their processes. ■

Appendix A: Participating Companies

This detailed summary of the all the survey results is being provided to each company that participated below. RGA would like to thank each participant for their valuable insights to support our survey findings.

Abu Dhabi National Takaful Co,
Abu Dhabi National Insurance Co.
Al Ain Ahlia Insurance Co.
Al Buhaira Insurance Company
Al Jazira Takaful
Al Madina Insurance Co SAOG
Al Ahli Takaful Company
AL Hilal Life
Alinma Tokio Marine
Allianz Egypt
Aman
AXA Egypt
Bahrain National Life Assurance
CHUBB Arabia Cooperative Insurance Co.
Dubai National Insurance & Reinsurance Co.
Emirates Insurance Co.
GIG Takaful
MEDGULF Co.
MIC Life - Mohandes Life Insurance
Misr Life Insurance company
Muscat Insurance Company SAOG
National General Insurance Co.
Noor Takaful
Oman Insurance Company PSC
Oman United Insurance Co SAOG
Orient Insurance PJSC
Qatar Insurance Company
QLM Life & Medical Insurance Company WLL
Suez Canal Life Insurance Co.
RAK Insurance
SALAMA
Sharjah Insurance Company
Takaful Emarat-Insurance Co. PSC
Takaful Oman Insurance SAOG
Tokio Marine Family Takaful
Union Insurance Company
Vision Insurance

MIDDLE EAST PARTICIPANTS



Contact us to discuss your company's claims practices and ask further questions regarding the survey results to provide insights and analysis. RGA strives to enable the life insurance industry to undertake important changes in preventing and identifying claims fraud particularly with respect to changing the paradigm in risk management and the growing incidence of fraud and abuse globally.

For more information regarding this survey, please contact Rahul Gupta, Claims Manager | Tel :-+9714 3896 023 | rgupta@rgare.com

About RGA

RGA Reinsurance Company Middle East Limited (regulated by the Dubai Financial Services Authority) is an operating subsidiary of RGA Reinsurance Company, which is the principal operating subsidiary of Reinsurance Group of America, Incorporated (NYSE: RGA). RGA is one of the largest global providers of life reinsurance and the only global reinsurance company focused solely on life and health reinsurance. With headquarters in St. Louis, Missouri, and operations around the world, RGA delivers expert solutions in individual life reinsurance, living benefits reinsurance, group reinsurance, health reinsurance, financial reinsurance, facultative underwriting and product development.

Disclaimer

This detailed, confidential summary of the survey results is being provided to each company that participated in the survey.

This report is for information purposes only. The information contained herein is not exhaustive and does not cover all the issues, topics, or facts that may be relevant to this subject.

All participating companies have agreed that the results gained from this survey will be used for internal purposes only, and will not be used in marketing, sales materials, or part of any sales activities.

RGA Reinsurance Company Middle East Limited assumes no responsibility for the accuracy of data submitted by participating companies, nor for any action or results arising from use of the survey, and reserves the right to publish high-level overviews and analyses of any key survey result findings.