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Navigating the insurance sector through a fraud risk lens

February 2023

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Foreword

The COVID-19 pandemic significantly impacted individuals, society, businesses, and the wider economy. The insurance industry was no exception, especially during the early days of the pandemic. This saw the industry change and adapt at a pace like never before. Insurers responded quickly to the crisis with increased digitalisation of sales, customer service and claims management and by enabling their staff to operate in a hybrid working model. This has led to significant innovation and accelerated adoption of technology across the value chain, enabling the industry to be even more agile and responsive to customers' needs.

This of course has not been without its challenges. With improved benefits from productivity and customer and intermediary service, insurers have increased their exposure to fraud and the consequent adverse financial and reputational impact.

Our survey showed that 60 percent of respondents believe that an increase in digitisation and remote working has contributed to an increase in fraud whilst further, 50 percent of the respondents said that they believe that weakened controls and the absence of strict regulations have led to an increase in fraud.

We strongly believe that industry participants must continue to leverage technology as a 'force-multiplier' across the Insurance enterprise - and indeed across their broader value chain. However, this must be done holistically with an eye on strengthening capabilities concerning fraud prevention and protection.

Deloitte's Insurance Fraud Survey 2023 focuses on the key challenges faced by Indian insurers in managing and mitigating fraud risk. The primary objective of our survey was to understand and analyse emerging trends and approaches taken by insurers to contain fraud risk including establishing a robust Fraud Risk Management (FRM) framework.

Baumann, Neal
Global Leader, Financial Services Industry, Deloitte Global

Executive summary

The insurance sector, under the impact of the pandemic, has undergone a sea of changes in the way it operates and delivers services. Insurers swiftly responded to the crisis, bringing in significant shifts through innovation and digitisation, setting a new norm, and enabling the sector to become more responsive to customers' needs.

As a result, the Indian insurance sector grew significantly faster than the global average, with life insurance premiums increasing by 14.16 percent and the non-life insurance sector recording an 11.30 percent growth. As insurers focus on building customer satisfaction as their core, apart from lowering costs and higher growth, fraud risk can act as a plague effecting overall progress. Fraud in the insurance sector could pose serious risks to both insurers and the insured, as it will not only affect the growth and reputation of insurers but also indirectly impact policyholders through increasing premiums.

Given the significance of the life and health insurance segments within insurance, post-COVID-19, Deloitte initiated an interview-based survey of senior leaders in this sector. Deloitte's Insurance Fraud Survey 2023 focusses on the key challenges faced by 'these insurance segments' in fighting fraud. The objective of the survey is to gain insight into the current scenario of fraud in the sector and the emerging trends and approaches taken by organisations to fight this menace.

We are also particularly keen to understand the obstacles in creating a more robust Fraud Risk Management (FRM) framework that CXOs must tackle.

The survey included insurers across varied market shares in the country as well operations for an in-depth understanding of the issue.

The survey focuses on the following key areas

What is the significance/relevance of fraud?

- Current perception of fraud in the sector
- Types of fraud encountered by insurers

Why are insurance frauds happening?

- Increased avenues for fraud after COVID-19
- Controls not at pace with increased digitisation

How are insurers fighting this menace?

- Existing anti-fraud measures
- Role of technology and data
- Challenges in creating an effective anti-fraud framework

Key themes emerging from the survey results

Frauds are on the rise

While the insurance sector has grown significantly over the last two years with the adoption of new technology, products, and service delivery, this growth can be impacted by increased fraud instances. An overwhelming majority of respondents across life and health insurance have indicated that they witnessed a significant increase in fraud over the last two years. Sixty percent indicated a significant increase while ten percent showed a marginal increase in fraud incidents. With the broader economy recovering, and growth in the insurance sector expected to gather momentum, insurance companies will need to manage fraud risk proactively, as it may affect not just insurers but also the insured.

New fraud trends emerge while traditional fraud continue to persist

Our survey indicates that while new fraud trends are emerging, traditional frauds continue to prevail and are still a significant worry for the sector.

Interestingly there are some commonalities between fraud types for both health and life insurance, such as data theft, collusion between third parties, and misselling of insurance products. While respondents from the life insurance segment indicated fraudulent claims, forgery, and application fraud, respondents from health insurance indicated unrendered billing for services, data theft, and hospital fraud as the top three concerns. This raises the following questions about the current monitoring and anti-fraud programmes of insurer:

If traditional fraud typologies continue to persist, are the Fraud Risk Management (FRM) frameworks and investments made to date effective?

Have the controls implemented to manage fraud weakened over time, or have outsourcing (with a cost-reduction objective) and the introduction of new technology further diluted institutional control, leading to new fraud scenarios?

With increased digitisation, many changes have been deployed at the front end; however, back-end processes and systems remain untouched, which raises the question: have all changes been assessed for their vulnerability to fraud?

Fraud mitigation is a board-level issue

The insidious nature of fraud can have serious financial and reputational consequences. It was encouraging to note that fraud mitigation was identified as a focused board level agenda. More than 40 percent respondents across life and health insurance segments indicated fraud mitigation to be one of the most important priorities for the board and management, while the remaining highlighted it as one of several key priorities. Interestingly, only 50 percent respondents indicated fraud mitigation to have risen in priority over the last two years since the pandemic.

The board and senior management of the insurer are ultimately responsible for the sound fraud risk management and setting the tone from the top. This includes ensuring that adequate resources, and investments are made for the effective implementation of their fraud management strategy, policies and procedures.

60 percent respondents indicated that investment in enhancing FRM framework will increase slightly this year, it was surprising to note that **40 percent** respondents felt that the investment will remain the same this year.

Existing FRM frameworks need to be enhanced

The challenge for insurers is to develop a comprehensive FRM framework, which includes identifying, assessing, and categorising risks faced by the organisation proactively, and developing appropriate mechanisms for preventing, detecting, and responding to fraud.

The first step is to undertake a periodic fraud risk assessment to understand the risks faced by the organisations. More than 80 percent respondents indicated that they conduct a rigorous fraud risk assessment periodically.

In addition, insurers have indicated the following as additional challenges:

- The survey revealed that data-quality issues (reported by 70 percent respondents) are a common challenge amongst life and health insurance respondents.
- Further, 80 percent indicated that the lack of information sharing in the community is a key challenge
- About 60 percent respondents also faced issues with data protection and privacy, and keeping up with new fraud risks/modus operandi as challenges.

The lack of data availability and quality is a big challenge for insurers as it directly affects the efficacy of the technology tools being implemented. The lack of t consolidation either as a data store or warehouse, and across business units, operations, and other functions, tends to create challenges in aggregating and analysing data. Limited sector-level organised

fraud data is also a contributing factor, as it can help identify fraudsters and prevent them from taking advantage of the system.
As organisations navigate these extraordinary times, they must take certain actions to protect their businesses. The way insurers harness new opportunities, while mitigating fraud risk, will determine whether they thrive or simply survive in the future.

An effective fraud-risk management strategy, enabled with the right structure, governance model, a rigorous fraud-risk assessment, and robust fraud prevention and detection strategies can significantly mitigate fraud risks.

With the intent to provide insights and initiate dialogue across the insurance ecosystem, we aim to focus the spotlight on “insurance fraud”.

We hope you find this report to be insightful, and thank every participant for their invaluable support towards this initiative.

The prevailing insurance landscape

The Indian insurance sector is growing at a strong momentum, enabled by regulations, innovative insurance products, and better awareness about the relevance of insurance.

The sum insured for the life insurance segment grew at 16.81 percent in 2021-22, while in the past five years, the total number of lives covered nearly doubled, from 120 million to 230 million. At the same time, the gross premium collected by life insurers in India increased from US$39.7 billion in FY12 to US$89.3 billion in FY22. It is estimated that premiums from India's life insurance segment will reach US$317.98 billion by FY31.[1]

The insurance sector is now operating in a transformed world with new technology, digitisation, and talent transformation. Today, insurers are increasingly using digital tools across the spectrum of their operations and service offerings to provide clients with seamless and customised solutions. Technology, as an enabler for customer service, customer acquisition, risk profiling, and claims processing, has also contributed to the ease and speed of transactions, improving the overall access to insurance products and enhancing customer experience.

However, it can be argued that these innovations may have also introduced new vulnerabilities and risks into the overall ecosystem.

Per sectoral estimates, insurance fraud costs insurers approximately US$6 billion annually, while insurers lose close to 10 percent of their overall premium collection to fraud.[2] As new risks begin to emerge, companies will need to be vigilant and ensure that they establish effective mitigation measures. The way insurers harness new opportunities, while mitigating fraud risk, will determine the course of the future.

Overall, India's insurance penetration has witnessed steady growth increasing from 3.3 percent in FY15 to 4.2 percent in FY21, with life insurance penetration at 3.2 percent and non-life insurance penetration at 1.0 percent.

Correspondingly, the non-life insurance segment has also witnessed significant growth. In the period April 2021-March 2022, gross premiums written by non-life insurers reached US$ 28.14 billion, an increase of 11.1 percent over the same period in FY21. In May 2022, total premium earned by the non-life insurance segment stood at US$ 4.61 billion, registering a 24.15 percent increase compared the same period in the previous year. The number of non-life insurance policies issued have doubled from 116.7 million in FY15 to 236.2 million in FY21. Within this larger segment, health insurance has garnered a significant portion of the gross direct premium in FY22, comprising 33 percent of the overall premium pool.

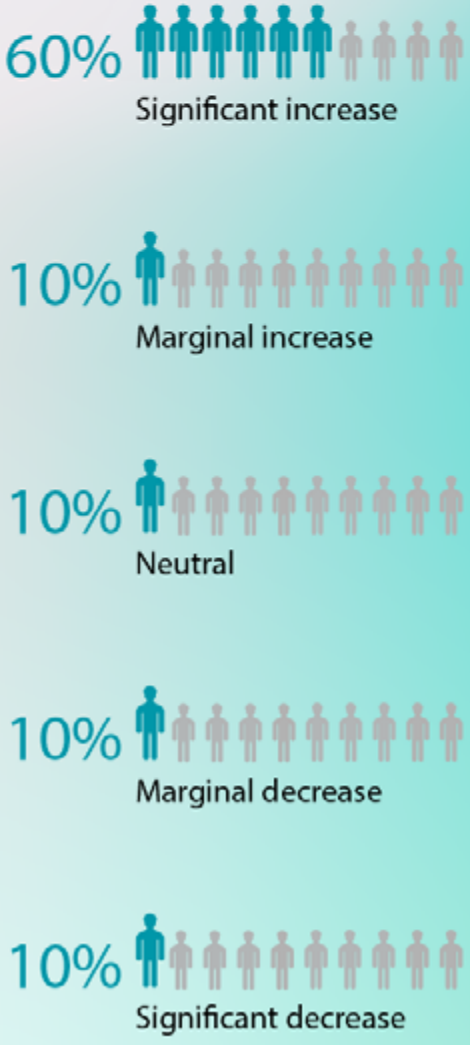
The contours of fraud and risk mitigation

2.1 Insurance fraud: An all-pervasive malaise

What is happening: The big picture

COVID-19 has had a significant impact on the insurance sector. On one hand, there has been a marked increase in the number of insurance policies being issued, whether life or health, underscoring the relevance of insurance as an important risk mitigation tool. Whilst on the other, there has also been a sharp increase in fraud instances with over 60 percent survey respondents affirming a significant increase over the last two years.

Evolution of fraud in the last two years



While some common fraud types plague both life and health, insurers, each insurance segment is also witnessing some specific fraud typologies. These include:

One in every two respondents in the life insurance segment indicated fraudulent claims, forgery, and application fraud as a major concern

Two in every five respondents in the health insurance segment indicated billing for services not rendered, data theft, and hospital fraud as a major concern

Data theft, collusion between third parties, and mis-selling of insurance products appear to be a common concern for both segments

It is interesting to note that while new frauds are emerging, traditional types of fraud continue to prevail and are contributing to concerns amidst the sector.

This raises the following questions:

Are the established systems, processes, and frameworks effective?

Are companies aware of emerging fraud trends and techniques, and are any steps being taken to detect or prevent them?

If substantial investments towards compliance have been made, are they bearing fruit?

2.2 Why are frauds happening?

In today's day and age, technology has become a mainstay for almost all industries. This has only accelerated with the pandemic. While the pandemic necessitated the need to practice physical distancing and work from home, it has been observed that many of these practices continue to prevail even in the aftermath of the pandemic. A key driver of this change has been digitisation, which has enabled employees to work from home and helped companies seamlessly connect with their customers. For example, during the pandemic, many insurers accelerated their cloud migration journey—a shift that enabled teams to access the right data and information remotely, and function seamlessly. Further, most insurers utilised their digital assets, such as websites and apps, to better engage with their customers and offer a wider range of services. Inarguably, digitisation has acted as a key catalyst for growth in the insurance sector.

Kapil Punwani
Star Health
Chief Risk Officer
"Rapid digital progress in India and the health insurance business, establishing new norms that allow the industry to remain open and responsive to consumer needs and services." With the increasing expansion of the healthcare business, the incidence of medical insurance fraud is on rise as well. It is the shared obligation of customers and hospitals to be equally honest in disclosures, as well as the industry to collaborate in leveraging the digital development for growth and efficient fraud control management."

But the impact of digitisation is not just limited to its benefits. Our analysis indicates that fraudsters are increasingly becoming technology-savvy, finding newer ways to perpetrate fraud. Our survey highlighted a similar sentiment amongst respondents, who indicated increased digitisation and remote working, followed by weakened controls as the top reasons for increased fraud incidents.

This brings up the following questions:

? Is the introduction of new tools and technology leading to increased fraud?

Is the risk-assessment process robust enough to identify the vulnerabilities of these new technology solutions and products?

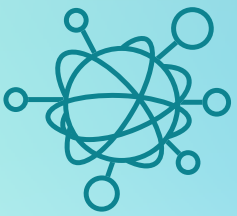
Are companies ensuring that mid-office and back-end processes have the controls in place to manage risks from digital adoption?

Reasons attributed for fraud

34%
Increase in digitization

22%
Remote working

22%
Weakened controls



22%
Others

It is imperative that new tools and technology are introduced while ensuring that risk controls continue to be thorough. For example, insurers now have multiple assets, such as online portals, claims automation, and alternative underwriting, tied to their digital transformation efforts. At the same time, fraudsters can access customer due to breaches. Thus, it becomes imperative for insurers to recognise cybersecurity and technology-induced risks as a strategic business problem, and not just an a 'Technology issue', and further, prioritise FRM strategies as a part of their digital strategy.

2.3 The path to mitigation (What are insurers doing?)

Insurance products are designed to protect the insured against significant, but uncertain losses. Insurance fraud undermines this system, as fraudulent claims and the cost of investigating suspected frauds not only lead to higher premiums for customers, but also affect the financial health of the insurer, besides causing reputational damage. Higher incidents of fraud, accelerated by the pandemic, digitisation, and a host of other factors, are a cause for concern for the insurance sector. Hence, it was not surprising that 50 percent respondents shared that addressing fraud risks has risen in priority over the last two years, and will continue to be a priority in the future. However, only 50 percent respondents indicated that this has risen in priority over the last two years.

Organisational priority assigned to fraud management

Most important priority for the future

One of several key priorities

Important, but there are more pressing issues

Low priority

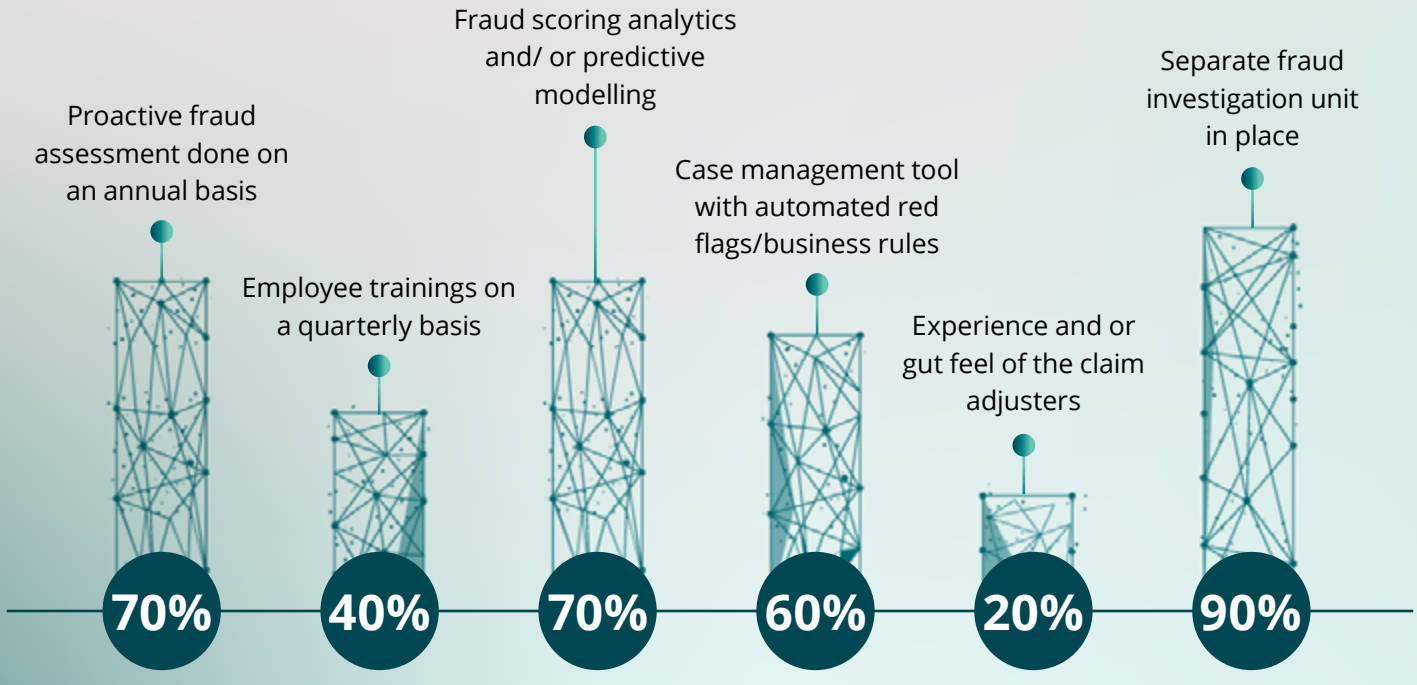
2.4 What are organisations doing?

The challenge for insurer lies in developing a comprehensive FRM framework, which includes proactively identifying, assessing, and categorising risks faced by the organisation, and developing appropriate mechanisms for preventing, detecting, and responding to fraud.

The first step in any effective FRM framework is knowing the risk faced by the organisation. A majority of respondents indicated that their organisation is extremely rigorous in its fraud assessment process. Fraud risk assessment helps insurer analyse different types of risks that they could face based on their organisational structure, complexity of operations, products and services offered and distribution modes. Identifying prevailing and potential risks can help insurer prepare for new types of fraud by envisaging the right set of mitigation measures and practices. Underscoring its relevance, 80 percent respondents said that they were extremely rigorous towards fraud risk assessment.

Some additional measures instituted include setting up separate investigative units and using a fraud-scoring analytics and/or predictive modelling and case management tool with automated red flags/business rules to manage fraud.

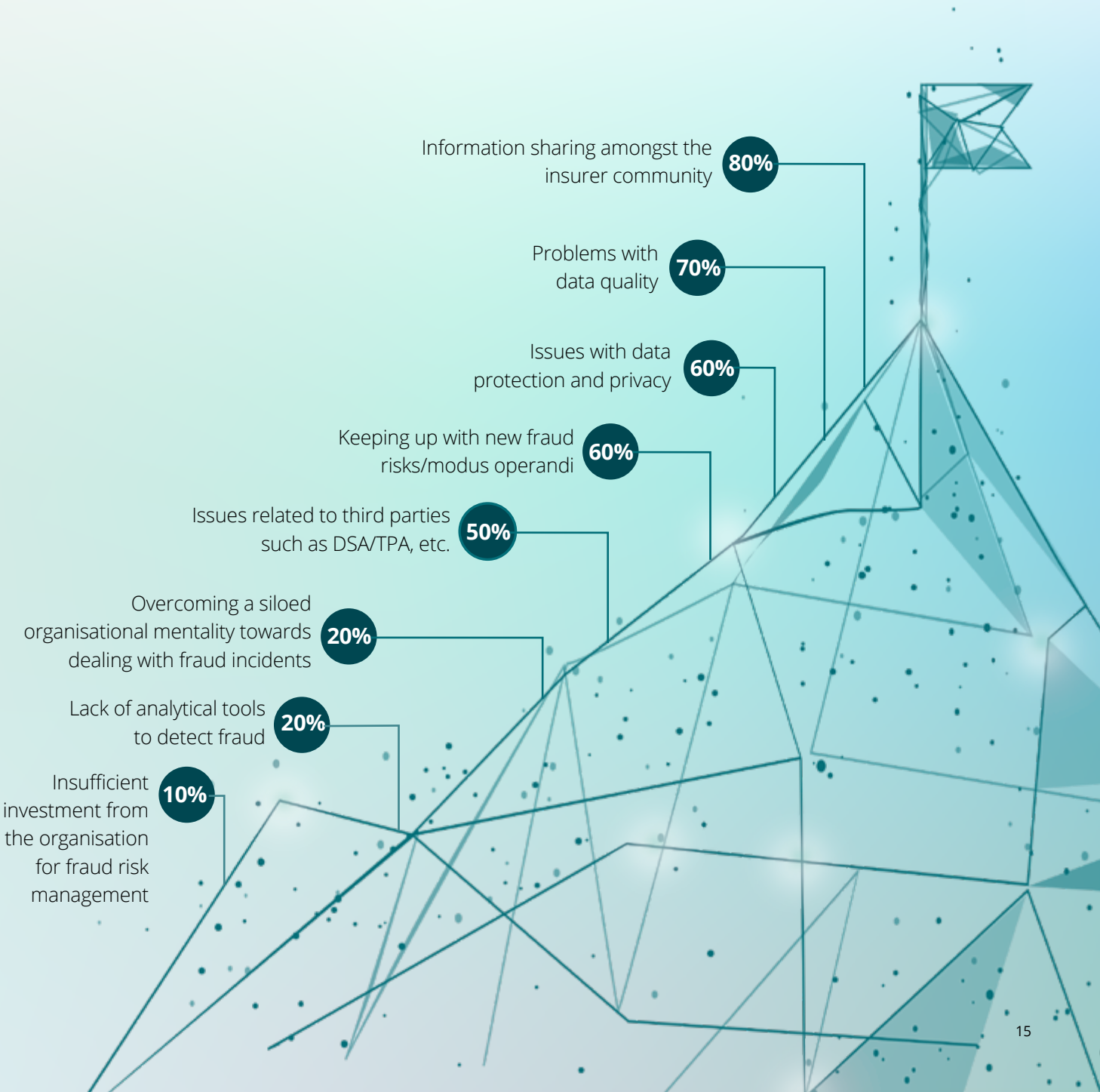
Fraud management techniques adopted by insurer



"However, it was interesting to note that one in every five respondents still relies on experience of the claim adjusters as a way to manage fraud."

Challenges faced in fraud risk mitigation

1. Inadequate mechanisms to promote data sharing amongst insurers
2. Poor data quality/inadequate data to predict fraud



Top five challenges faced by life and health insurers:

1. **Issues with data protection and privacy:** Data protection offers the tools and regulations to limit access to data, while data privacy specifically keeps a check on who has access to such data, Considering that insurance is a data-intensive sector that houses a large quantum of client-sensitive data, data protection and privacy become critical. Data protection and privacy policy can therefore lead to potential lack of access/availability of data which all respondent acknowledged to be one of the biggest challenges in optimally mitigating fraud risk.

2. **Information sharing amongst insurer**: Due to the absence of a formal industry-level fraud database, and the propensity of fraudsters to exploit this loophole, all respondents respondents indicated that limited information sharing amongst insurers deters and relevant third party support them from enhancing their fraud prevention and detection capabilities.

3. **Problems with data quality:** Data quality and data architecture are key for insurer in their fight against fraud. A primary structural problem is the vast amount of structured and unstructured data stored in a plethora of systems—both legacy systems and new applications. This is further compounded by data errors or omissions, including missing, inaccurate, or inconsistent data across such systems. Additionally, there is a dearth of common data models, structures, and definitions. The problem with data quality will also hurt the effectiveness of analytical tools and models.

4. **Limited use of analytical tools:** In the case of fraud detection, it is important to be proactive, accurate, and timely. Each of these imperatives can be met by using the right technology tools. Conversely, the lack of tools such as predictive analytics/modelling and fraud detection, can become an impediment to optimal fraud detection and risk mitigation. Fifty percent of life insurance respondents believed this to be a significant challenge.

5. **Keeping up with the modern fraudster modus operandi:** We live in a dynamic world where technology is empowering fraudsters to think of new and innovative ways to commit fraud. With 50 percent of both, life and health insurance respondents considering this to be a challenge, it becomes imperative for the sector to stay ahead and pre-empt fraudulent incidents.

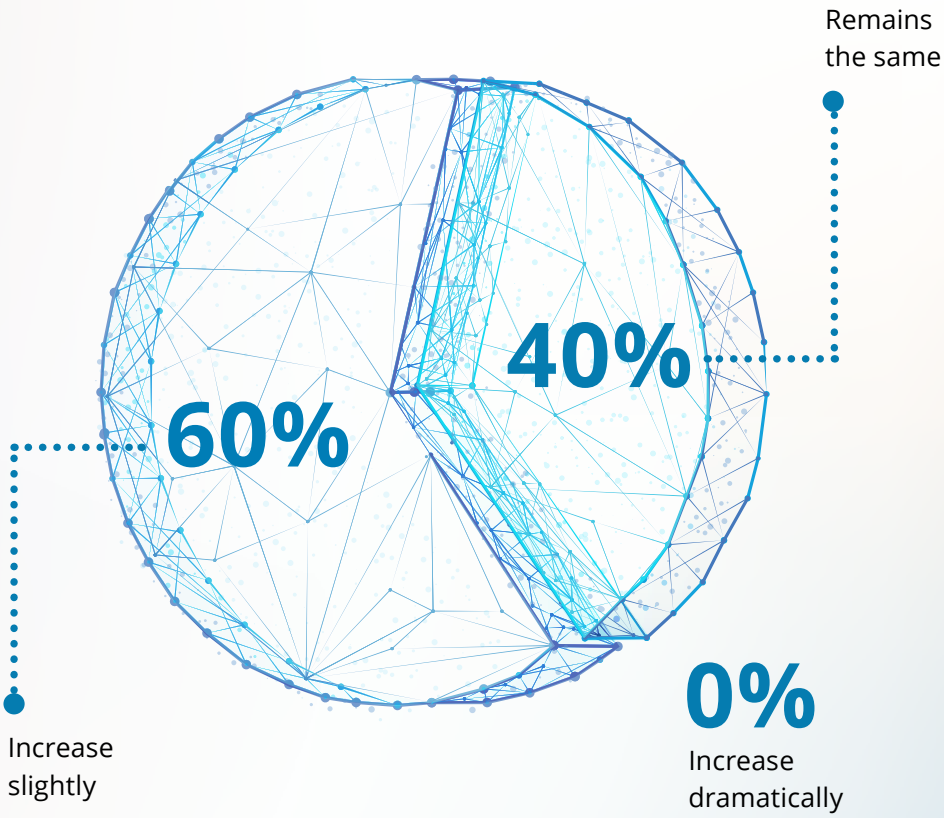
Overall, both external as well as internal factors contribute to the challenges that insurer face in optimal fraud risk mitigation. Further, it was observed that internal challenges, such as the risk of new fraud types, data quality, third-party issues, and siloed organisational responses, are more pressing. Given their internal nature, the onus lies primarily with insurer to proactively alleviate these pain points.

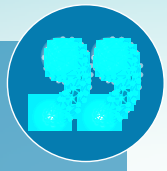
Way forward: The imperatives for tomorrow

Fraudulent activities committed within or against the insurance companies can adversely affect its financial soundness and reputation, besides impacting policyholders due to higher claims costs. One important aspect of why fraud occurs is the loophole within the organisational system/controls, which provide the opportunity to commit fraud. This condition can be principally managed by designing and implementing a controlled environment that prevents, detects, and deters fraudulent behaviour, whether from employees, vendors, or intermediaries.

More than half of the respondents (60 percent) surveyed said that they aim to slightly increase investments in fraud prevention and response over the next 12 months. However, 40 percent also said that their investments in fraud prevention are likely to remain the same. This is surprising, as respondents indicated that fraud is on the rise, and they are witnessing the emergence of new fraud trends while traditional frauds continue to prevail. Considering the strategic priority already assigned to fighting fraud, insurers appear to have pressed the pause button on future investments and are possibly watching the fraud landscape evolve (in the post-new normal) before embarking on additional investments.

Investment in fraud prevention over next two years





Muralikrishna Cheruvu
Kotak Life
Chief Compliance Officer and Company Secretary
"Fraud and counter fraud practices evolve very swiftly and organisations must be agile and change their approach to deal with these evolutions. A change in perspective is the need of the hour so that identification of a fraud is viewed as a positive and proactive achievement fighting fraud.

Our perspective

Insurers need to create an integrated fraud management framework, built on a robust foundation of a well-articulated strategy and aligned with the operating model. An effective operating model ensures that the fraud management strategy is optimally implemented, while access to consistent, high-quality data, and the latest tools and analytics provides an opportunity to optimise the operating model as well as the FRM framework. Thus, an end-to-end and robust fraud management framework should focus on strategy, operating model, information quality, and tools and analytics.

As part of such a control environment, there are seven key anti-fraud measures that insurers can implement, and it begins with the tone at the top.

1. Tone at the top

An insurer should have a sound strategy to manage fraud risk arising from its operations, ensuring that it assumes significant relevance in the business strategy. It should, at minimum, provide direction to the overall fraud management plan and facilitate the development of quantitative risk tolerance limits on fraud, considering the size of the business, products offered, and market conditions. This should also be periodically reviewed to ensure that it is in line with changing market dynamics and the organisation's risk profile.

There is a growing need for the board or other governing committees to ensure that its governance practices set the tone for FRM. The top management should implement policies that encourage ethical behaviour and demonstrate an enhanced ethical culture (tone at the top).

The roles and responsibilities of personnel from across organisational levels and involved in FRM should be defined clearly. The board of directors could appoint a senior professional to be responsible for anti-fraud efforts and report to the board of directors. As one of the strongest anti-fraud deterrents is awareness around fraud prevention and controls, it is crucial for the top management to communicate its relevance to employees across levels/functions. Additionally, communicating the action taken to employees through reports will go a long way in reinforcing this message.

2. Develop a fraud management strategy

A well-articulated fraud management strategy acts as a guiding post for the fraud management framework and creates a roadmap for actionable items, as well as checks and balances.

The fraud management strategy should ideally identify the overarching end goal that it aims to achieve, list the resources and investment required, and draw out an action plan. The strategy should first address the high-priority areas that generate the majority of the company's fraudulent claims and have the maximum impact. At this juncture, an important question to ask is how aggressive and visible the company wants to be in pursuing potentially fraudulent claims. The balance between attempting to limit losses through aggressive mitigation measures and ensuring that the client experience is optimal can be a tenuous one. Establishing clear processes to separate the true and false cases of fraud can be helpful in this regard.

3. Align the operating model

A purely reactive approach or response to fraud is now a thing of the past. As highlighted earlier in this

Sunder Natarajan
IndiaFirst Life Insurance
Chief Risk Officer
"Access to relevant data through smart software + humanware through skills which can be taught + a hyper-connected environment = Fraud intelligence"

report, both risk and incidents of fraud, across life and health insurance, have been increasing. Insurers can no longer choose to react to rising incidents of fraud. Rather, they need to be proactive about fraud risk mitigation and adopt the right set of frameworks and practices to ensure that potential fraudulent events are identified even before they occur. Immediate and timely measures can reduce the ripple of impact. In this regard, insurers can consider creating a robust and holistic fraud risk assessment framework that covers fraud prevention, detection, and response. While a reactive FRM system will focus on detection and response, a proactive system is designed to be agile and continually implement plans to prevent fraud. Thus, it becomes imperative to create a fraud operating model that supports and enables a company's fraud management strategy. This means aligning the necessary resources, organisational structure, business processes, competencies, and training. Responsibilities for fraud management should be clearly defined and assigned across business units and geographies.

4. Execute detailed fraud risk assessments

One objectives of fraud risk assessment is to help focus the management's attention on significant fraud risks to be addressed. Fraud risk assessment can be recurring and systematic, and it can involve various levels of management across business functions.

An effective fraud risk assessment may include specific fraud schemes that could be perpetrated against the organisation, including the people or departments within the organisation that could commit them. In determining the potential sources of fraud risk, the insurer should analyse the adequacy of measures to verify customer information before accepting a customer's proposal and take into consideration the risk factors posed by various distribution channels, such as virtual customers and intermediaries. Certain products or lines of business may be more susceptible to particular types of fraud, and insurers should also identify fraud risk factors in product design during the early stages of product development. Specific fraud schemes identified can be linked to existing internal controls within the organisation, which can mitigate fraud risk.

5. Improve information quality and access

In the insurance sector, the insured may typically go through several touchpoints before purchasing an insurance policy. At each touchpoint, relevant information from the insured is captured by the systems in place. With increased digitisation, the availability of alternative data has resulted in a vast quantity of data being generated and captured by various stakeholders in the ecosystem. This data can be invaluable to insurers and play a catalytic role in mitigating the risk of fraud and enhancing the efficacy of the analytical tools.

Traditionally, it has been widely believed that data sharing can be bad for competition. However, today, insurers are increasingly realising that access to a common shared pool of data is beneficial for the entire sector. Fraud data pools can potentially enable insurers to detect and prevent fraud more accurately and proactively, thereby helping the insurance sector as a whole.

To enable this, there is a need to create a holistic ecosystem for data and information sharing amongst insurers. Further, such an ecosystem can be powered by third-party companies or insurance associations or the regulator, which can pool together publicly available data, and shared data from insurers. This could include information about false claims, individual claim history, a list of unscrupulous entities, and professionals. At the same time, the right privacy and data-sharing protocols should be established to

ensure that the data is not being misused and is true and accurate.

6. Promote tools for the effective detection of suspected fraud

The insurer should develop specific scenarios that when triggered, suggest a higher risk of fraud. This should include scenarios related to the policyholder and claims fraud and intermediary fraud. If one or more indicators are triggered, the insurer should ascertain the facts to determine whether further investigation and follow-up actions are warranted. There should be adequate documentation of the verification actions taken. The indicators should be reviewed regularly for their continued relevance and effectiveness in detecting fraud.

Insurers should proactively monitor the performance and trend of business brought in by intermediaries concerning the insurer's products, to detect any indication of intermediary fraud, besides undertaking periodic fraud focussed audits. Additionally, a feedback mechanism should be implemented for the investigating team to provide feedback on the root causes of reported fraud incidents and create additional scenarios for fraud detection.

7. Respond to fraud allegations

Regardless of the size of the fraud allegation or the individual involved, the organisation should consider drafting a documented policy on how fraud allegations will be investigated and resolved. The policy should typically include procedures for preserving documentation and gathering evidence and can address which individuals or departments should be responsible, accountable, consulted, and informed based on the nature of the allegation. Depending on the nature of the fraud, insurers can consider availing help from external independent agencies, including certified fraud examiners and attorneys, who may be able to conduct an effective investigation.

Over and above the seven pillars required to create an integrated risk management framework, success hinges upon the voice at the top. There needs to be an overall organisational "buy-in" driven by the senior management and holistically executed across the organisational structure. Given the importance of fraud risk mitigation, it cannot be executed in silos, and there is a clear need for insurers to integrate a larger agenda that will work across the business, compliance, legal, underwriting, and operations departments.

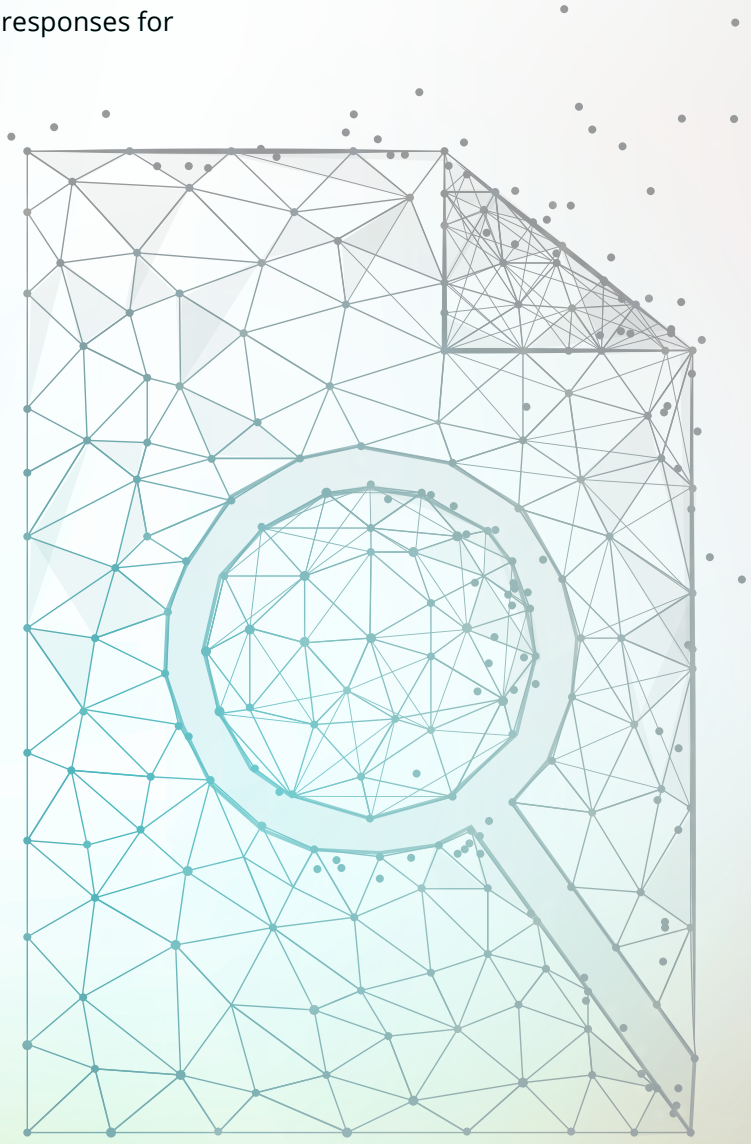
About the survey

The survey, conducted in the second quarter of FY2023, was based on qualitative interviews with 10+ key C-suite stakeholders/senior management responsible for compliance and FRM across leading private insurers.

The views were obtained through detailed discussions on the current and future fraud landscape.

Each statistic used in this report indicates a consolidated number of responses for the respective question.

For multiple-choice questions, the weighted average of responses for that question has been used to derive the statistics.



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