PNB MetLife India Insurance Company Limited

Anti-Fraud Policy

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1. Background and Objective

Financial Fraud poses a serious risk to all segments of the financial sector. Fraud in insurance reduces consumer and shareholder confidence; and can affect the reputation of individual insurers and the insurance sector as a whole. It also has the potential to impact economic stability.

PNB MetLife is committed to conduct the business with high standards of integrity and has a policy of zero tolerance to fraudulent activities.

This document aims at laying down the broad framework for fraud risk management for timely detection and prevention of fraud and fraud losses.

2. Relevant Regulation

Insurance Regulatory and Development Authority of India (IRDAI), as per its circular IRDA/SDD/MISC /CIR/ 009/ 01/2013 dated January 21, 2013 had instructed all the Insurance companies to have in place the Fraud Monitoring Framework.

The Corporate Governance Guidelines issued by IRDA mandate insurance companies to set up a Risk Management Committee (RMC) of the Board. The RMC is required to review the formulation of a Fraud monitoring policy and framework for approval by the Board. It is also required to monitor implementation of Anti-fraud policy for effective deterrence, prevention, detection and mitigation of frauds.

As part of the Responsibility Statement which forms part of the Management Report filed with IRDA under the IRDA (Preparation of Financial Statements and Auditors' Report of Insurance Companies) Regulations, 2002, the management of the Company is required to disclose the adequacy of systems in place to safeguard the assets for preventing and detecting fraud and other irregularities, on an annual basis.

3. Scope and Responsibility

This Policy draws its scope and relevance from the IRDA Guidelines on Insurance Fraud Monitoring Framework released on January 21, 2013. This Policy covers all employees, processes, functions and entities associated with PNB MetLife.

Management has the primary responsibility for the prevention, detection and investigation of fraud. Management must take care to instil a culture in which unethical and fraudulent behaviour is

unacceptable and must also take appropriate measures to recover any losses incurred and in principle bring perpetrator to justice.

4. Definition of Fraud

Fraud in insurance is an act of omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties. This may, for example, be achieved by means of:

a. Misappropriating assets;

b. Deliberately misrepresenting, concealing, suppressing or not disclosing one or more material facts relevant to the financial decision, transaction or perception of the insurers' status;

c. Abusing responsibility, a position or trust or a fiduciary relationship.

For the sake of clarity, and not limited to, Fraud will include any forms in which applicants intentionally submit false information on an insurance application or in connection with the renewal or reimbursement of insurance, or to support a claim or causing deliberately any event, making it appear accidental, to collect an insured sum. Fraud will also include representations or fraudulent simulations of sales and marketing, and any removal, concealment, alteration or destruction of assets or reports of an insurance company, as well as embezzlement or theft of funds or premiums.

5. Classification of Frauds

Frauds may be classified on below basis:

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

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

c. Internal Fraud – Fraud/ mis-appropriation against the insurer by its Director, Manager and/or any other officer or staff member (by whatever name called).

The frauds could also be further classified as internal or external depending on the relationship that the subject of investigation maintain with PNB MetLife.

6. Fraud Monitoring Framework

All employees of the organization owe a responsibility towards the organization to safeguard organisation and its assets from frauds, report and prevent misuse of assets or breach of procedures.

The Company has adopted a well-defined Anti-Fraud Framework to identify, detect, investigate and report insurance frauds. The controls deployed by the Company shall include measures to protect the Company from the threats posted by the above broad categories of frauds.

6.1. Three Lines of Defence

PNB MetLife will ensure the "Three Lines of Defence Model" is well defined and instituted, that defines the roles and responsibilities for each line in detecting and deterring fraud.

6.1.1. **1st Line of Defence**, comprising of business management, operations and supported by process / system redesign team, shall have accountability over control health and risk protection, and will be responsible to identify, measure and mitigate fraud risks.

In this regard, each department will evaluate the processes under its responsibility and identify opportunities of fraud risk, and implement the required procedures and controls to reduce risk exposure. Policies and procedures in writing are mandatory and should be updated based on changes in operations.

Monitoring controls must be comprehensive enough to ensure that each transaction is adequately supported, approved, aligned to local regulations, in accordance with company policies and adequately recorded in the administrative systems and accounting. This line of defence is also responsible for implementing adequate segregation of duties during transaction processing and to establish controls to avoid possible conflict of interest.

The Fraud Control Unit (FCU) would proactively identify suspected cases basis red flags and referrals from other unit such as Underwriting, Business Intelligence , Acturials and others. Post investigations, actions based on Malpractice Matrix should be undertaken.

Departments maintain alertness to frauds and notify the Fraud Control Unit within the Corporate Ethics & Compliance Department of the suspected frauds. Members of management may also use the confidential channels implemented by the Company to bring suspicions of fraud or other matters of concern to the attention of SIU or Chief Compliance Officer. Business units can also investigate fraud aspects related to their business keeping second line of defence informed and share findings with concerned stakeholders including Fraud Control Unit.

6.1.2. **2nd Line of Defence**, comprising of Ethics and Compliance Risk Management, and other supporting functions such as IT Risk & Security) shall be responsible for facilitating and monitoring the implementation of effective fraud risk management practices by operational management. It shall also provide advisory and support services to management.

The Fraud Control Unit (which includes its sub unit Special Investigations Unit) will be an independent investigative unit within Corporate Ethics and Compliance. FCU within Ethics and Compliance shall provide assistance with investigations relating to employee related frauds and sales practices fraud in particular. In relation to other fraud types (such as customer fraud),

FCU shall provide an oversight / advisory role to the business. Among other responsibilities, FCU will monitor compliance with the anti-fraud policy, evaluate the adequacy and effectiveness of PNB MetLife's anti-fraud controls and will be responsible for reporting on fraud to the Board and the Regulator.

Risk Management shall assist the risk owners in the reporting of fraud risk in the company, as part of the Operational Risk reporting framework.

Legal team shall assist in legal recourse towards relevant cases, and shall co- ordinate with law enforcement agencies for reporting frauds on timely and expeditious basis and follow-up processes thereon.

6.1.3. **3rd Line of Defence**, comprising of Internal Audit shall perform independent reviews and validate control health and provide objective opinion.

The investigation functions shall investigate cases basis process and procedures outlined in the Company's Fraud Investigation Methodology.

6.2. Board and Management Oversight

Board Risk Management Committee shall oversee and monitor implementation of this policy.

In order to ensure management focus, the Risk Management Committee of the Company responsible for implementing the Anti-Fraud frame work in the organization with well-defined processes and procedures. The Committee shall have the role to,

- Review areas of business and the specific departments of the organization that are potentially prone to insurance fraud and lay down a detailed department-wise, anti-fraud procedures;
- Review procedures to carry out the due diligence on the personnel (management and staff)/ insurance agent / Corporate Agent/ intermediary / TPAs before appointment/ agreements with them;
- Oversee fraud mitigation communication within the organization at periodic intervals and/ or adhoc basis, as may be required;
- Review and approve reporting to the Board and the Regulator.

The FCU team shall facilitate periodic update to the Board and the Risk Management Committee in this regard.

6.3. Preventive mechanism

The Company shall inform both potential clients and existing clients about the anti-fraud policy, on a periodic basis, and appropriately included necessary caution in the insurance contracts / relevant documents, duly highlighting the consequences of submitting a false statement and / or incomplete statement, for the benefit of the policyholders, claimants and the beneficiaries.

The Company shall have a strong system of internal controls for fraud prevention, detection and deterrence. Also, the first line and the second line of defence will actively engage with the Analytics Unit for generating fraud related red-flags as early warning indicators for fraud management and for further investigation and action.

6.4. Fraud Response

The investigation functions shall investigate fraud cases basis Company's Fraud Investigation Methodology. Fraud investigations should lead to identification of root cause and appropriate staff accountability should be conducted and action recommended as per the relevant Malpractice Matrix.

In principle, the Company will report fraud to the relevant local enforcement agency in order to initiate proceedings as and when the need arises or as prescribed by the Authority. Company shall also lay down procedures to co-ordinate with Law enforcement agencies for reporting frauds on timely and expeditious basis and follow-up processes thereon.

7. Whistle blowing process for fraud prevention

Fraud escalations can also be made under the Whistle Blowing Policy, through the Hot Line number by dialling 000-117 then 888-320-1671 to report issues. Alternatively, person may also choose to log their concern on https://Metlifehelpline.ethicspoint.com for suspected fraud, management irregularities, governance weakness, financial reporting issues or other such matters. Employees, if they choose to, can also write in confidence to the Chairman of PNB MetLife's Audit Committee at chairman_auditcommittee@pnbmetlife.co.in.

Complaints, if received under the Whistle Blower Policy, shall be forwarded to the designated official of SIU(which is a sub unit of FCU) for investigations. This designated official would be responsible for ensuring closure is available for reported Complaints which may require involving Investigators from other departments depending on the nature of complaint.

8. Fraud Reporting to Authorities

The statistics on various fraudulent cases which come to light and action taken thereon shall be filed with the Authority (IRDA) or such other Authority as may be required in the prescribed formats.

9. Exchange of Information

The Company shall actively participate in the various life and general insurance sub councils and committee with an objective to share the fraud trends, lessons learnt, exchange appropriate information in order to create awareness, reduce and prevent frauds in the insurance industry.

10. Record Keeping

The documentations for all the fraud investigation cases and reporting to the Board and Risk Management Committees and to the Regulator will be maintained for audit trail and reference purpose.

11. Review of Policy

This policy document will be reviewed annually and if necessary, updated when there are significant changes in the applicable regulations. Changes to this policy shall be approved by the Board.