NATIONAL CONFEDERATION OF COOPERATIVES MUTUAL BENEFITS ASSOCIATION, INC.
(NATCCO MBAI) ANTI FRAUD PLAN

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SECTION 1. INTRODUCTION

National Confederation of Cooperatives Mutual Benefits Association, Inc. (NATCCO MBAI) is a duly licensed provider of microinsurance coverage for various risks involving life, accident, sickness and other contingencies. NATCCO MBAI was established in 2009 to further support the NATCCO Network in its needs to provide microinsurance products to its members. Since then, it has been extending financial assistance to members and their dependents, in the form of death benefits, sickness benefits, provident savings, and loan redemption assistance.

SECTION 2. WHAT IS FRAUD?

In general, fraud is defined as the intentional distortion of truth in order to induce another party to part with something of value or to surrender a legal right.

Fraud, as defines by the International Association of Insurance Supervisors, is a deceptive act or omission intended to gain advantage for a party committing the fraud (the Fraudster) or for other parties.

SECTION 3. STATEMENT OF ANTI-FRAUD POLICY

NATCCO MBAI does not tolerate fraud, whether carried out by the Association's members or by outsider/non-members, its trustees, officers, management or staff, or its cooperative partners, consultants or suppliers. As appropriate, NATCCO MBAI will investigate any suspected or actual fraud including but not limited to insurance claims, benefits, premiums, contributions or misappropriation of assets. If there is probable cause, the NATCCO MBAI will take action based on the gravity of the offense or even take legal action including reporting the fraud to the proper authorities in order to get conviction, recover assets or obtain compensation for loss.

SECTION 4. PURPOSE OF THIS ANTI-FRAUD PLAN

This Anti-Fraud Plan aims to do the following:

a. Define the procedures involved in preventing, detecting, reporting, and investigating suspected or actual cases of fraud involving members, intermediaries and internal staff, in the areas of membership enrolment, collection of contributions, claims and handling of assets.

b. Confirm the Management's overall responsibility for the Association's anti-fraud efforts.

c. Identify the Anti-Fraud Coordinator directly responsible for, and the procedures involved in, the following anti-fraud efforts:
   i. Development, implementation, review, and maintenance of the Anti-Fraud Plan;
   ii. Function of the Special Investigation Unit (SIU).

d. Identify the member of the Board of Trustees tasked with oversight responsibility over the Anti-Fraud Plan.

e. Confirm the Association's commitment to develop a program to provide continuing anti-fraud education and training for members and staff.

SECTION 5. OVERSIGHT AND OPERATIONAL RESPONSIBILITIES

a. As a matter of policy, all officers and staff of the Association are responsible for preventing and detecting insurance fraud in their respective areas of operation.

b. The Board of Trustees, acting through the Audit Committee, has *oversight responsibility* over the Association's anti-fraud efforts.

c. The Management has the *overall responsibility* for the development, implementation and regular review of the Anti-Fraud Plan.

d. The Anti-Fraud Coordinator is responsible for the continued maintenance of the Anti-Fraud Plan. He/she is also designated as the Head of the Special Investigation Unit (SIU), in charge of coordinating any investigation of actual or suspected fraud, with assistance provided by Internal Audit. He/she is also in charge of contacting the police and law enforcement authorities whenever appropriate

e. The Auditor is not part of Claims or Underwriting Department.

SECTION 6. CATEGORIES OF FRAUD

a. Member/Policyholder Fraud and/or Claims Fraud

This involves fraud in the application by, and enrollment of, members and dependents, and in the purchase and/or execution of an insurance product, including claims and benefits.

b. Intermediary Fraud
This includes fraud committed by the Association's cooperative partner, collection agents, insurance/MBA coordinators and other intermediaries.

c. Internal Fraud
This group of fraud includes misappropriation of cash/assets by any of the Association's trustees, managers or staff. This also includes fraud at governance level, e.g., creation of a loan facility for the Trustees, Officers, and Management that have terms and conditions highly disadvantageous to the members or to the Association.

SECTION 7. PREVENTION AND DETECTION OF FRAUD

SOURCES OF FRAUD:

Membership Enrollment

a. The business model of microinsurance MBAs involves partnership with cooperative institutions which are the source of members for NATCCO MBAI and which provide various services such as collection of MBA contributions, facilitating the reporting and validation of claims and disbursement of insurance benefits. Thus, for administrative and cost reasons, NATCCO MBAI principally relies on the cooperative partner to do the verification of member's personal circumstances such as identity, age, source of income, home/business address and name(s) of legal spouse/dependents.

b. As co-owners of the Association, all members recognize that they play an important role in fraud prevention. Before an applicant is allowed to join a local group/center/unit, existing members of the group/center/unit screen the applicant's background and determine if he/she will be an asset or a liability to the group.

c. Apart from the assessment made by existing members, the Association also requires prospective members to fill up a membership application form in fulfillment of the know-your-customer (KYC) requirement. This is done through the cooperative partner as part of the support services provided by it to the Association.

d. The Membership Enrollment staff, having been trained to watch out for fraudulent applications, will examine the application form by checking the completeness of answers and the consistency of application information (such as name, date of birth, etc.) with information stated in civil documents (e.g., birth certificate, marriage contract), or alternative / substitute documents (e.g.,

Indigenous Persons Certification) or, if available, government-issued identification documents (e.g., Driver's license).

e. The Membership Enrollment staff have been given examples of fraudulent acts that they should watch out for. The examples listed below are not intended to be exhaustive but are rather meant to be instructive and serve as a guide for the detection of member- and intermediary-related fraudulent activity.

	SOURCES OF FRAUD
Member	• Falsification of application documents of applicant, dependent or beneficiaries • Falsification of applicant's age in order to qualify for membership and insurance coverage • Inclusion of over-age or otherwise ineligible dependents • Misrepresentation of relationship (by blood or by law) to overcome the lack of insurable interest
Intermediary	• Intentional acceptance of false member information • Manipulation of enrollment date to avail of continuous benefit • Adjustment of dates to make a member qualified • Padding of number of membership enrollment to qualify for cash incentives • Distribution of member quota to share incentives • Consolidation of member quota to share incentives • Submission by MFI of fictitious data on non-existent members and/or spouse and dependents which data will eventually be used to claim insurance benefits; • Submission by MFI of request for credit life insurance covering a fictitious loan.
Internal	• Intentional acceptance of fabricated documents • Collusion with the intermediary for groups to qualify for incentives

Collections

a. NATCCO MBAI Finance is in charge of receiving collections of MBA contributions remitted by the MFI partner and the issuance thereof. Collection reports sent by the MFI partner are regularly reconciled against bank deposits made by the MFI partner to determine if there was any misappropriation of collections.

b. NATCCO MBAI Finance is in charge of posting members' payments to the members' corresponding subsidiary ledgers. Control totals of subsidiary ledgers

are generated, both before and after making the ledger postings. The change in control totals should correspond to the total payments made. Similarly, withdrawals from members' ledgers due to death, resignation or retirement are reconciled. This ensures that all movements in ledger balances are fully accounted for, with audit trails as reference.

c. NATCCO MBAI Finance regularly reconciles the members' subsidiary ledgers against the general ledger. Member subsidiary ledgers include: basic life premiums, equity values, credit life premiums, retirement fund contributions, etc.

d. NATCCO MBAI Finance coordinates the regular reporting to the Management/Board of Trustees by the Membership Enrollment, MIS and Claims Sections on new members gained or lost, status of membership, claims submitted/in-process/denied/paid, etc.

	SOURCES OF FRAUD
Member	• Insists that payments not made • Intentionally unrecorded collection from other group members • Purposeful unremittance of collection to branch ("hold-up me")
Intermediary	• Deliberate *non-remittance or partial remittance* of collection to branch • Deliberate non-issuance of provisional receipt/passbook/collection sheet/center logbook • Misappropriation of funds (e.g. contribution intended for payment of MBA insurance applied to loan/savings of MFI, advanced MBA contribution of a member used to pay other member's unpaid contribution) • Tampering of original payment made in the original receipt • Imitating bank deposit formats and layout to prove that payments are made • Intentional double recording of collections
Internal	• Manipulation of collection posting

MIS

a. Management Information System (MIS) is a series of processes and actions which capture raw data and then process the data into usable information, so that this information can be disseminated to users in the form needed. The MIS should be able to maintain databases of members and dependents, products, payment or transactions, and claims, at the minimum.

b. The purpose of the MIS is to support effective and efficient management as well as facilitate good governance on the part of the Board of Trustees.

c. MIS is in charge of safekeeping member records. MIS staff are not allowed to do postings, withdrawals or any changes to member records in order to ensure segregation of duties/responsibilities between Finance (account updates) and MIS (safekeeping).

d. There are audit trails on any changes in the members' database and a defined hierarchy of positions who are authorized to make changes or to view records.

	SOURCES OF FRAUD
Intermediary	• Deliberately encoded false entry of member details, payments, and claims • Forced balancing on records/remittances
Internal	• Manipulation of client's account/records which may include equity value, retirement savings fund and premiums (e.g. encoding of payments which is not made) • Creation of fictitious clients' records • Unauthorized deletion and addition of information • Connivance of management and claimants

Claims

a. Once an insurance claim is filed by a beneficiary, the MBA Coordinator / MBA field staff / MFI field staff will conduct on-site validation. Claims staff relies on the submitted validation report and other necessary documents such as the following (as applicable):
   - Death certificate;
   - Birth or baptismal certificate;
   - Marriage contract;
   - Police report;
   - Hospital records;

b. Claims staff also validates insurable interest issues. If there is no insurable interest, Claims Department denies the claim and notifies the claimant accordingly.

c. The Claims Department will also coordinate with Membership Enrollment /MIS or Finance in order to confirm if the coverage is in force / within the grace period / lapsed.

d. The one-year contestability period provides some measure of protection from uninsurable applicants especially if death occurs within a relatively short period after acceptance of membership. If death is due to a pre-existing health condition, the Association pays a lower amount of benefit according to a pre-defined benefit schedule.

e. If the Claims staff suspects fraud was committed (especially in case of death due to accident), a *cost-effective investigation* is initiated to gather evidence including police report, hospital/medical clinic record, and interview of witnesses.

f. If the initial investigation points to a need for a deeper investigation by the Special Investigation Unit, the Claims Department will report it to the Anti-Fraud Coordinator who will, together with Internal Audit, (as the head and member, respectively, of the Special Investigation Unit) conduct a full investigation. The investigation will include the cause of death, place of death, financial and medical circumstances of the insured, and his/her relationship to the beneficiary.

g. If the insurance coverage or policy is already incontestable, the Claims Department verifies only the needed information (in-force or within the grace period) before approving payment of the claim.

h. In case of a claim filed by a cooperative partner for Credit Life benefits, the Claims Department requires the submission of a statement of account showing the amount of original loan, repayments made and outstanding (unpaid) principal balance. The Association settles the outstanding principal balance and pays the remaining amount (if any) to the borrower's beneficiary.

i. To aid the Claims Department in validating the claim, following are some examples of "red flags" that may trigger further investigation (these "red flags" are also included in the claims procedure manual).
   - Death happened outside of the country;
   - Cause of death is "undetermined";
   - Dates on submitted documents are conflicting;
   - Death certificate looks irregular;
   - MBA is notified of the death claim only after burial.

j. Examples of fraudulent acts:
   - Submission of fake death claim documents by beneficiary;
   - Submission of fake resignation / retirement documents;
   - Submission by a non-member / outsider of fake membership documents.

K. To raise anti-fraud awareness and to help deter claims fraud, the Association has released appropriate Advisories addressed to members, intermediaries and internal staff, respectively, regarding the anti-fraud warning stated under the aforementioned Circular Letter No. 2016-50. The anti-fraud warning will, henceforth, also be included in all claims notices/forms.

	SOURCES OF FRAUDS
Member	• Submission of fake

	death/disability/hospitalization claims' documents (e.g. fake police report, death certificate, medical certificate, incident report, and blotter report from the barangay) • Tampering of death/disability/hospitalization documents • Manipulated cause of death (whether or not natural death or accidental death)
Intermediary	• Payment of unqualified claims due to sympathy • Intentional tampering of documents to qualify as beneficiary • Account officer aid in the processing of fictitious claims to benefit from the claims proceeds • Account officer forge the signature of inactive member to withdraw members' equity value and retirement savings fund, if applicable • Payment of understated benefit to the beneficiary
Internal	• Process a fictitious claim in order to benefit from the claims proceed • MBA coordinator asks for "processing fee" to hasten the claims benefit acquisition

PREVENTIVE AND DETECTIVE CONTROLS:

Education and Training

a. Applicants for membership in NATCCO MBAI are required to attend the Pre-Membership Education Seminar (PMES). Among the topics included in the seminar are anti-fraud policies and procedures, duties and responsibilities, anti-fraud awareness, claims fraud prevention and the negative effects of fraud on the institution's solvency. As additional preventive measure, and in view of Insurance Commission Circular Letter No. 2016-50, the Association will include in its Training and Education Program the following anti-fraud warning:

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

Through this seminar, the Association widens its anti-fraud prevention network by involving members in screening applicants and providing community-based (informal) claims validation. More so, regular updating of anti-fraud policies should be included in the re-orientations.

b. In order to keep the Membership Enrollment, Claims, Internal Audit and Compliance staff up-to-date on insurance claims handling and fraud investigation, the Association requires the aforesaid staff to attend regular training, conferences / seminars on the subject. Training also covers fraud "red flags" as well as high profile current events and topics related to insurance fraud.

c. The Association requires all new/existing staff including managers to read and follow this Anti-Fraud Plan. Management emphasizes the importance of strictly following the policies, procedures and internal controls laid out in the Plan in order to discourage fraud and to increase the staff's awareness of suspicious acts.

d. From time to time and as necessary, the Association shall revise procedure manuals and internal controls in order to incorporate improvements to policies and procedures.

e. To further strengthen awareness of policies, applicable information, education and communication materials should contain anti-fraud provisions/briefer.

f. NATCCO MBAI in coordination with the intermediary should conduct fraud awareness orientation to all its staff and concerned stakeholder. Further, anti-fraud advisories or memos should be made available/visible in the respective offices. Regular skills training on fraud identification handling and reporting should also be conducted to update and refresh knowledge of the staff.

g. This Anti-Fraud Plan, including the reporting policies contained herein, shall be maintained by the Anti-Fraud Coordinator and shall be open for inspection by the Insurance Commission. The Association shall also maintain appropriate records to determine the effectiveness of this Anti-Fraud Plan.

Internal Control and Financial Management

a. The NMBAI should practice sound financial management to include the following:
   - Projected Financial Statement and performance objectives
   - Investment plan
   - Monthly Financial Statements
   - Annual external audit
   - Recording of financial transactions
   - Annual budget

b. It is of utmost importance that NATCCO MBAI maintains at all times the trust of its members. Thus, the goal of the Association is to detect and prevent at the earliest possible time any theft of cash, investment collections, padding of expenses and other forms of misappropriation of assets. Any actual or suspected internal fraud committed by staff, management or trustees, calls for immediate investigation by the Anti-Fraud Coordinator and/or Internal Audit.

c. These are common fraudulent actions related to internal control and financial management:
- Window dressing and false reporting
- Receiving of gifts, favors, or benefits in cash or in kind from supplier that may affect decisions.
- Acquisition of assets, services that constitutes conflict of interest for decision makers
- Theft and misappropriation of funds and other assets (ex. Cash advance used for another purpose)

d. In order to prevent or detect fraud, the Association has implemented measures and internal controls such as proper segregation of duties, setting of approval limits, and designation of authorized check authorized signatories.

e. Following are some of the internal controls implemented by NATCCO MBA:
- Staff cannot approve his/her own expenses.
- Managers, depending on job function, are authorized to approve only those expenses within their area of responsibility.
- Maximum amount of expense allowed to be paid from the petty cash fund is Php5,000.00.
- All requests for payment either through the petty cash fund or in check must be properly supported by invoice, receipts, statement of account, etc.
- Expenses for travel, accommodation, entertainment, representation must be reviewed for compliance with the Association's guidelines before payment.
- Checks of Php 5,000.00 and up should be signed by authorized signatories.
- Unbudgeted payments/expenses must be approved by Board of Trustees, covered by a Board Resolution.
- Bank reconciliations are regularly prepared to detect any forged/fraudulent checks paid, collections not deposited, unauthorized debits to bank account, etc.
- Cash advance limits and liquidation period.
- Purchasing policy
- Budgeting and approval process
- Periodic review and analysis of financial reports
- Policy manuals are made available to all employees
- Development of code of conduct

f. If any employee notices a fraudulent activity, he/she must first report it to the his/her immediate supervisor or the next higher authority, who will then report it to the Anti-Fraud Coordinator who shall take the necessary action in accordance with his/her role as head of the SIU.

Anti-fraud Coordinator

a. The Compliance Officer works with the individual departments to ensure compliance with rules and regulations issued by the Insurance Commission and other regulatory bodies such as the Anti-Money Laundering Council, Securities & Exchange Commission, BIR, CIC, etc. Compliance Unit also provides advice to management on conduct of insurance business and other compliance issues.

b. While the Management has overall responsibility over the Association's anti-fraud efforts, the Compliance Officer, as the Anti-Fraud Coordinator, has the direct responsibility for the development, implementation, review, and maintenance of the Anti-Fraud Plan and the functioning of the Special Investigation Unit (SIU).

c. The Anti-Fraud Coordinator heads the SIU. As SIU Head, he/she reports to the Board of Trustees, in proper coordination with the MBA General Manager.

Internal Audit

a. Internal Audit performs audit and operational reviews of the Association's functional areas based on the amount of risk exposure of the area and also based on available resources. These audits aim to identify weakness in internal controls, pinpoint responsibility for non-compliance to procedures and make recommendations for operations improvement. At the end of the review, Internal Audit holds an exit meeting with the Management to discuss findings and agree on corrective steps or improvements in processes and procedures. To ensure independence with respect to its own audit function, Internal Audit directly reports to the Audit Committee of the Board.

b. As Internal Audit is not involved in the line operation of the Association's insurance business, Internal Audit is in a distinct position to do audit reviews covering all of the three (3) abovementioned categories of fraud. In particular, Internal Audit pays special attention to Membership Enrollment, MIS, Finance and Claims, and other processes that likewise have significant risk exposures to fraudulent activity. Among other audit steps, the auditor reviews transactions on audit sampling basis, reviews membership enrollments for completeness of required information, traces contributions, and reviews changes in members' records and claims payments if properly authorized.

c. It is the responsibility of Internal Audit to distinguish between errors or omissions in insurance operations due to incompetence, lack of training, lack of supervision, etc., and those that are due to fraudulent activity. Such as, claims payment on fictitious records, erroneous posting of contributions, non-existent member. These may have been made erroneously due to wrong posting of contribution; on the other hand, the payment may have been made as a result of fraud/collusion among staff in charge of membership records and claims by creating fictitious records on non-existent members and proceeding to process fake insurance claims. In the former case, Internal Audit proceeds with its usual review, while in the latter, the auditor will discuss it with the Anti-Fraud Coordinator to determine if there is a need for a deeper investigation by the Special Investigation Unit.

SECTION 8. Reporting Fraudulent Activity / Suspected Fraud

a. In case any member sees or suspects a fraudulent activity involving any co-member, management or staff, he/she should report it immediately to the proper authority (i.e. General Manager, Anti-Fraud Coordinator, Compliance Officer) through personal appearance, snail mail, email, or SMS message.

b. In case any staff sees or suspects a fraudulent activity is happening, he/she must report it to his/her manager, or directly to the Anti-Fraud Coordinator in case his/her manager is involved, using Incident Report Form. In turn, any manager who receives such report must immediately notify and forward the Incident Report Form to Anti-Fraud Coordinator.

c. The Anti-Fraud Coordinator will make a preliminary evaluation as to whether the matter appears to be fraudulent. If fraud is detected, he/she will initiate a full internal investigation. (*Refer to the section on Special Investigation Unit*) and notify the following, as applicable: MBA President/General Manager, Internal Audit, HR / Legal. The report should be treated with utmost confidentiality.

See Attachment on Reporting Process flow.

SECTION 9. Special Investigation Unit (SIU)

a. The SIU is headed by the Anti-Fraud Coordinator who will report directly to the Board of Trustees through the Audit Committee. He/she is assisted by the Internal Audit in the functioning of the SIU and in undertaking fraud investigations.

b. The SIU shall determine if an internal investigation is sufficient or if an external resource is needed to conduct the investigation. Each reported case of fraud or suspected fraud will be handled in a way suitable to its size and nature.

c. The SIU expects full cooperation from specific staff or departments who have responsibility over the matter being investigated. The SIU will interview, as necessary, those individuals with knowledge or information related to the suspected fraud and will review pertinent documents. Each staff or member of management is required to cooperate fully with the investigation process and shall not in any way hinder the investigation. Pertinent records will be made easily available to the SIU. The investigative team should observe procedural fairness and due process.

d. As earlier stated, all claims submitted within the Basic Life's contestable period are initially investigated by the Claims Department. If fraud is suspected, the investigation is placed under the guidance of the Anti-Fraud Coordinator. The SIU will call upon the departments and specific individuals whose responsibilities are important to the investigation and may also request help from an outside investigator, if necessary, for external investigations.

SECTION 10. Reporting and Monitoring Results of Investigation

a. The Anti-Fraud Coordinator will issue an initial briefing report to be distributed to the Board of Trustees following: MBAI General Manager, Treasurer, and the Audit Committee of the Board of Trustees. This report will provide a summary of the issue, an outline of procedures for the investigation, liaison with or notification to the proper authorities, other areas of the business for which the fraud might be relevant, the reporting timetable of the investigation and any other relevant information.

b. Upon completion of the investigation, the SIU will issue a final report to the Board of Trustees covering all aspects of the case. This will serve as formal record of the case including action taken. Contents of this report will include the following:
   - Facts and circumstances of the fraud and its discovery;
   - Procedures and findings;
   - Damage inflicted whether financial or non-financial in nature;
   - Amount involved;
   - Recommended sanctions (based on Staff/Employment Manual) for erring staff or member of management;
   - Recommended corrective action to improve procedures;
   - Recommendation, if any, to pursue legal action.

c. The Anti-Fraud Coordinator given a specific timeframe shall ensure that the recommended sanctions, corrective actions, and the pursuit of legal action once deemed necessary, is enforced.

SECTION 11. Referral for Legal Action

a. The Board of Trustees will make the final decision regarding the cost-effectiveness and practicality of pursuing legal action against prosecuting the ones who committed the fraud.
   - The decision to institute legal action / prosecute depends not only on the amount of loss/fraud involved but also in instances wherein the Association's interest will benefit from showing the case as an example of the Association's non-tolerance of fraud, especially if staff or management are involved.
   - If the case involves members, the decision shall take into account possible negative effects against the Association's reputation including loss of members' trust.
   - If the case involves the cooperative partner, the decision shall take into consideration all factors involved including ramifications of any action.

b. If the decision is to pursue legal action, the Anti-Fraud Coordinator will coordinate to the proper authorities, and the Insurance Commission, if deemed necessary. The Association shall fully cooperate with law enforcement authorities in any criminal investigation.

Annex 1 – Examples of Fraudulent Activity

Intermediary Fraud

- Cooperative partner creates a fictitious loan to a member, insures with the Association the credit exposure, pays for the insurance premiums and collects insurance benefits.
- Cooperative field staff files fictitious claims.
- Cooperative partner inflates its membership roster and subsequently claims insurance benefits in behalf of non-existent members.
- Cooperative partner's account officer/loan officer creates a fictitious Center or Member Cluster/Group and subsequently claims insurance benefits.
- Kiting or lapping of collections by cooperative partner.
- Connivance by MBA Coordinator with other parties (e.g., the member, account officer/loan officer) in filing fraudulent claims.

Internal Fraud

- Internal staff creates fictitious membership records, pays for the regular contributions, and after some time claims the insurance benefits.
- Internal staff processes fictitious claims and finds a way to claim the benefits.
- Internal staff manipulates membership/premium records to pay a claim for the benefit of a family, relative or friend.
- Board of Trustees/Directors/ Management misappropriate assets by ratifying and implementing policies for their own undue benefit.