PGA Sompo Insurance Corporation

ANTI-FRAUD PLAN

Effective September 01, 2017

V2020.2

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I. POLICY STATEMENT

PGA Sompo Insurance Corporation (the “Company”) promotes an anti-fraud culture. This Anti-Fraud Plan has been drawn up and shall be used for the purposes of preventing, detecting and investigating suspicious or actual acts of insurance fraud perpetrated against the Company.

The Company does not tolerate any level of fraud, whether carried out by the customers, intermediaries, adjusters, suppliers, contractors, including officers and employees of the Company.

The Company is determined to prevent and detect all forms of fraud perpetrated against it by internal or external parties. The Company will fully investigate all instances of actual, attempted and suspected fraud committed by staff, officers, intermediaries, suppliers and or other third parties to recover funds and assets lost through fraud. Perpetrators will be subjected to disciplinary action.

II. PURPOSE

The purpose of the Company’s Anti-Fraud Plan is to define responsibilities and actions in promoting and observing the Company’s policy on fraud; and to set out guidance to officers, employees, and business partners on how they prevent, detect and report fraud, in particular, and how to recognize and deal with fraud in general.

III. WHAT IS FRAUD?

For purposes of this Anti-Fraud Plan, fraud is defined as the use of deception by an individual with the intention of obtaining an advantage for himself or herself or for a third party or parties, avoiding an obligation, or causing loss to another party.

The term fraud is issued to describe offenses such as, but not limited to, deception, bribery, forgery, extortion, corruption, theft, conspiracy, embezzlement, misappropriation, false presentation, concealment of material facts, and illusion.

This Anti-Fraud Plan shall apply to the following types of fraud:

a. **Policy Fraud and/or Claims Fraud** - external fraud perpetrated by an insured against the company in the purchase and/or execution of an insurance product, including fraud at the time of making a claim;

b. **Intermediary Fraud** - external fraud perpetrated by an insurance agent/general agent, insurance broker, or adjuster against the insurer and /or policyholders;

c. **Third-Party Fraud** – external fraud perpetrated by third parties, such as a supplier, contractor, or other external party against the insurer and/or policyholder;

d. **Internal Fraud** – fraud/misappropriation against the insurer by its director, manager and/or any other officers or employees.

Examples of the above-mentioned types of insurance fraud are shown in **Annex A.**

IV. HOW FRAUD OCCURS?

Fraud arises because of lack of proper or ineffective internal control policies and procedures, failure by staff to observe existing internal control or inadequate separation of duties.

Four basic elements are usually present when fraud occurs:

- Individual(s) to carry out the fraud – inside or outside of the organization
- Assets to be acquired, used or disposed of fraudulently
- Intent to commit the fraud
- Opportunity to do so

Managers must ensure that the opportunities for fraud are minimized. A high probability of being caught will deter those who might otherwise engage in fraud. Opportunities to commit fraud may be reduced by ensuring that a sound system of internal control that is proportional to risk has been designed and implemented and is functioning as intended.

V. FRAUD PREVENTION

The Board of Directors and senior management are primarily responsible for the prevention of fraud and other irregularities in the Company through the enactment of policies which would address fraudulent practices. Members of the management team are expected to be familiar with the types of fraud that might occur within their area of responsibility, and be alert for any indication of irregularity.

Internal controls are set-up in the various operational activities-from acceptance of insurance application up to servicing of policy-and various support to minimize the risk of fraud.

Employees have a responsibility as well as an obligation in the management of fraud risk by conducting themselves with integrity, demonstrating awareness of the importance of ethical practices in their day to day work, and adhering to established internal control procedures. The Company provides educational trainings to employees in critical positions to equip them with knowledge in order to prevent and detect fraud.

All brokers and agents distributing the Company's products are independent contractors. In signing an Agreement with the Company, these independent insurance contractors agree to abide the terms and conditions, which sets forth the responsibilities and limitations of authority as representative of the Company. As a requirement for securing an insurance brokerage or agency license from the Insurance Commission ("IC"), the Company's broker and agents must undergo insurance training course(s) which is/are intended to educate them on various non-life insurance products and related matters including insurance fraud. To help prospective agents prepare for IC licensing and to provide updates to various insurance fraud schemes, the Company provides in-house training courses at least annually.

VI. FRAUD DETECTION

Functional areas in the Company have established policies and procedures with embedded checks and balances to deter and promptly detect suspected fraudulent acts. All employees are required to adhere to these procedures.

Management will assign third-party auditor/examiner to act as the Internal Auditor of the Company under special engagement. The third-party auditor will conduct systematic review of all the functional areas to determine adequacy and effectiveness of internal controls and subsequently updates policies and procedures when the need arises. Likewise, the third-party auditor will conduct surprise audit which will help deter fraudulent employee behavior. This review may uncover irregularities which, upon establishing their certainty, are immediately handled in accordance with the established procedures in investigating and reporting incidents of fraud.

VII. REPORTING ALLEGATION

All employees, including consultant and project-based employees, should be aware of the potential for fraud, and should report any suspected incidents of fraud or fraudulent activities. Concerns which should be reported include, but are not limited to, officers or employees committing or attempting to commit any fraudulent act such as:

- Forgery or alteration of documents or accounts;
- Misappropriation of funds, supplies or other assets;

- Gross negligence in handling or reporting of money or financial transactions;
- Abuse of authority in allowing unauthorized transactions for personal gain or for third party's advantage;
- Unauthorized disclosure of official activities on information for personal advantage;
- Attempt to achieve personal gain from third parties by virtue of official position or authority;
- Theft, misuse, or destruction of property, facilities or services.

External party actions which should be reported by employees include:

- Being offered a bribe or incentive to favor client, claimant, intermediary, adjuster, contractor, supplier or other external parties;
- Receiving fraudulent invoices (i.e. intentionally inaccurate, rather than erroneous) from supplier, contractor, adjuster or claimant;
- Known instances of corruption, deception or misuse by a client, claimant, intermediary, adjuster, contractor, supplier or other external parties.

If employees become aware of a suspected fraud, they should never attempt to investigate it themselves but immediately report the same on a confidential basis through the following channels, in order of preference, depending on the circumstances of who is thought to be involved in the suspected fraud:

a. The Employee's Immediate Superior or Manager
b. The Head of Human Resources Department
c. The Vice-President and Chief Finance Officer and/or Compliance Officer
d. The President and CEO
e. The Chairman of the Board of Directors

Employees can also report directly, anonymously should they wish, to anti-fraud email address *report@pgasompo.com*. The email hotline is exclusively accessed and managed by the Vice-President and Chief Finance Officer.

All reports received on suspected fraud must be communicated to the designated Special Investigation Unit. Allegations, whether made anonymously or not, must be supported by documentary evidence or statement of the witnesses for the investigation to proceed. Without such evidence the investigation cannot take place.

All reports on suspected fraud will be treated seriously, systematically and confidentially. If an allegation is determined to have been made maliciously or in bad faith for personal gain or revenge, disciplinary action will be taken against the person making such an allegation.

VIII. SPECIAL INVESTIGATION COMMITTEE

All investigation concerning reports shall be conducted on an internal basis under the direction of the Investigation Committee headed by the Compliance Officer. Being a department which does not have any operational responsibility in the Company, the Compliance Section is designated as the fraud special investigation unit, which has the primary responsibility for the investigation and reporting of all suspected fraudulent acts to the Investigation Committee as defined in the policy.

The Special Investigation Committee is composed of the following members:

1. Compliance Officer;
2. Vice-President and Chief Finance Officer;
3. Head of the Internal Audit; and
4. Head of the Human Resources Department.

IX. FRAUD INVESTIGATION AND REPORTING

Upon receipt of the report, the Compliance Officer will make an initial assessment to determine whether the facts presented warrant a full investigation.

If the Compliance Officer determines that a report of suspected fraud warrants full investigation, or an instance of suspected fraud has been detected, evaluated and found to warrant a full investigation, he/she will communicate immediately to the Special Investigation Committee.

The committee will conduct immediately a full investigation of each suspected fraud in a manner appropriate to its size and nature. The committee may, in the conduct of the investigation, require the submission of documents or evidence, the taking of statements from persons with personal knowledge of the incidents, and such activities as may be necessary in order to complete the investigation.

At the conclusion of the investigation, the committee will issue a formal report to the President and CEO and other designated members of senior management to update them of the results of the investigation. Content of the report will include among others the circumstances of the fraud and its recovery, the amounts involved, the recommended controls to stop the future abuse and the commitment of relevant departments to implement the recommendations.

The Compliance Officer will submit a report of Negative List of Employees and Agents to the Insurance Commission for the Company's employees, officers and intermediaries found guilty on fraud.

X. DISPOSITION OF FRAUD CASES

The Chairman of the Board and/or the President and CEO will decide on the final disposition of fraud cases, including seeking restitution for monies/assets lost and /or prosecution of the offending party or referring the results of committee's examination to appropriate law enforcements and/or regulatory agencies for independent investigation.

XI. ZERO TOLERANCE POLICY

The Company does not tolerate any unethical or dishonest behavior. Extensive investigation will be conducted without regard to the suspected fraudster's length of service, title or position, or relationship to the Company.

Violators will be dismissed from the employment and/or prosecuted, and referred to appropriate authorities.

XII. ANTI-FRAUD EDUCATION AND TRAINING

The Company recognizes that the credibility and success of the Anti-Fraud plan is dependent, to a large extent, on how effectively it is communicated throughout the organization. To this end, details of the plan will be provided to all officers, employees, intermediaries and third parties working on behalf of the Company.

The Company will ensure that all officers and employees are aware of their responsibilities for fraud control and ethical behavior. Once approved, the Anti-Fraud Plan will be disseminated to all employees and to all members of the Board of Directors. Training will be conducted for those who occupy positions tasked with implementing this Plan. Targeted training will be provided for new staff and fresher training for current staff. Training will include among others the following subject areas:

1. Definition of fraud and examples to illustrate external and internal fraud;
2. The need for ethical behavior and the employee's responsibility in fraud prevention;
3. Details of Company's Anti-Fraud Plan such as:
    - Red flags that could indicate that the fraud may have been committed.
    - Steps to take if fraud is reasonably suspected.
    - Responsibilities for handling allegations and inquiries into cases of fraud in the Company.

- Correlation of the Anti-Fraud Plan with the Company's Code of Conduct.
- The role of Special Investigation Committee.
- Available remedies and measures to be applied when fraud is established.
- Measures to ensure that third parties are aware of the Company's Anti-Fraud Plan.

XIII. ADMINISTRATION OF THE ANTI-FRAUD PLAN

The Compliance Officer is responsible for the administration, revision, interpretation, and application of this plan. The plan will be reviewed annually and revised as needed.

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Approved by:

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Annex "A"

EXAMPLES OF INSURANCE FRAUD

a. **Buyer Insurance Fraud -** A type of insurance fraud committed by the insured party wherein the buyer bends the process to obtain more coverage, or claim more cash, than he or she is rightly entitled to

b. **Hard Fraud -** Deliberate orchestration of loss in order to receive payment for damages

   Examples: organized collisions, auto-theft, arson, murder for proceeds, suicidal accidents and faking one's death

c. **Soft Fraud (opportunistic fraud) -** Exaggeration of loss by the policyholders of otherwise legitimate claims

d. **Premium Theft or Premium Diversion** - Insurance Representatives accept premiums but do not remit or submit them to the Insurance Companies. Sometimes, the premiums collected are higher than the premiums remitted to the Insurance Company

e. **Unauthorized Insurance Agents/ Brokers** - The Insurance Agents/Brokers misrepresent themselves as authorized by the Insurance Companies

f. **Fee Churning** - An insurance representative advises the customer to cancel, renew and open new policies in a way that is beneficial to him or her instead of making sure it will be beneficial to the client

g. **Over or Under Coverage Insurance Policy** - Insurance representatives may convince customers to buy coverage that they don't need, or sell a lesser policy while representing it as a complete policy, thereby making the insured pay for either an over or under coverage insurance policy

h. **Concealment** – An Intentional and fraudulent omission to communicate information Material to Insurer

i. Fraud or Material misrepresentation

j. Breach of Warranty with fraud

k. A fraudulent claim in non-life insurance policy

l. Presenting or causing to be presented any fraudulent claim or Fraudulently preparing, making or subscribing any writing with intent to present or use the same, or allowing it to be presented in support of any such claim