11
Claims

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Learning objectives

After studying this chapter, you should be able to:

- define a claim;
- identify the different types of claims;
- discuss the requirements of a valid claim;
- recognise invalid claims;
- list the documents required to be submitted to settle a death claim;
- describe early death claims;
- explain the process of settling maturity, survival and death claims;
- recall the IRDA guidelines pertaining to the settlement of claims;
- state the consequences of settling a fraudulent claim;
- distinguish between contracts that are void and voidable;
- explain the indisputability clause in life insurance.

Introduction

When making a decision on buying life insurance, clients will take a number of factors into account. These include the:

- pricing of the product;
- features of the product;
- likely returns that will be offered by the product compared to other insurance and investment products;
- flexibility offered in terms of plan term, premium payments, liquidity etc.;
- tax benefits offered by the product; and
- level of customer service provided by the company.

All these factors play an important role, but one very important aspect, which few people pay attention to, is how the insurance company handles and settles claims. What good is an insurance product during the lifetime of a policyholder, if the nominee/beneficiary/assignee is not able to receive the claim from the insurance company in a reasonable time and with ease? The real test of an insurance company and an insurance policy comes when the policy becomes a claim. People take out insurance because they worry about the possibility of misfortune. Ultimately, the 'value' of insurance will be judged, by most individuals, on the way in which their claim is handled.

While the IRDA has laid down broad guidelines for claims settlement, it depends on individual companies and their claims handling staff how quickly and efficiently they respond to a claim when it arises and how soon they settle it. The claims settlement ratio (how many claims are settled to every 100 claims arising) is also one of the benchmarks on which an insurance company is judged. So claims handling and settling assumes a great deal of significance.

In this chapter you will learn all about claims, their types and their settlement. You will learn about valid and invalid claims and what you should do when one of your clients' policies becomes a claim.

Key terms

This chapter features explanations of the following terms and concepts:

Claims	Maturity claims	Survival benefit payments	Death claims
Valid claims	Policy not in force	Breach of policy condition	Fraudulent claims
Claim documents	Early death claims	Presumption of death	Void contracts
Voidable contracts	Indisputable contracts	Claimant's statement	Rider benefits
Return of premium (ROP)	Terminal bonus		

A Requirements for a valid claim

Before discussing the requirements for a valid claim let's look at what a claim is and what the different types of claims are.

A1 What is a claim?

A claim is a demand that the insurer redeem the promise made in the contract. The insurer then has to perform its part of the contract, i.e. settle the claim, after satisfying itself that all the conditions and requirements for the settlement of the claim have been complied with.

We will look at three main types of claim in this section – **maturity claims**, **death claims** and **rider benefits**.

A2 Maturity claims

Some life insurance plans, such as endowment plans and whole life plans, promise to pay the insured a specific amount at the end of the plan, if they survive for the plan's entire term. This amount is known as the maturity benefit amount or the maturity claim amount. The amount payable on maturity is the sum insured plus any accumulated bonuses, minus any outstanding premiums and interest thereon.

In some cases the premiums paid over the tenure of the plan are returned on maturity. These plans are termed as '**return of premium**' (**ROP**) plans by some insurers.

Example

Ajay has bought a participating endowment plan with a sum insured of Rs. 25 lakhs that will run for 30 years. Under the terms of this plan, if Ajay survives until the end of the 30 years, and has paid all the premiums, the insurance company will pay him the maturity benefit amount or maturity claim of Rs. 25 lakhs along with the accumulated bonuses (if any).

On maturity the insurance company may also pay Ajay a one-time terminal bonus in addition to the accumulated bonuses that are declared year after year. This bonus is paid to encourage policyholders to continue with the policy for the full term and to pay the premiums regularly on time.

The terminal bonus is also known as the final additional bonus (FAB) or loyalty or persistency bonus. It may be fixed by some insurance companies at the beginning of the policy, or alternatively it will depend on the financial performance of the insurance company over the life of the policy. It is paid provided the premiums have been paid for a specified period (usually at least 15 years).

In the case of ULIPs, the insurance company pays the fund value (or in some cases the fund value and sum insured) as the maturity claim, at the end of the plan's term or, in the case of a money-back policy, minus the survival benefits received during the term of the policy.

A2A Survival benefit payments

For money-back policies the insurance company makes specific payments to the policyholder at specific times during the term of the policy. These payments are known as survival benefits.

Example

Ajay has bought a money-back policy with a sum insured of Rs. 20 lakhs for 20 years, which promises to pay 25% of the sum insured every five years as survival benefit. In this case the insurance company will pay Ajay Rs. 5 lakhs at the end of the 5th, 10th, 15th and 20th years, as a survival benefit. If the policy is a participating policy, the insurance company will also pay the accumulated bonuses along with the last payment at the end of the 20th year.

Consider this…

How is a survival claim different from a maturity claim? Think of some examples of the types of policies in which the two claims arise.

A2B Reduced sum insured (paid-up value)

Sometimes during the tenure of a policy the policyholder may face financial problems and may not be in a position to continue paying the premiums. During such times rather than surrendering the policy, the policyholder has the option to convert it into a paid-up policy. On the maturity of such policies, the proportionate reduced sum insured is paid out by the insurance company.

A2C Discounted claims

Discounted claims are those options which are exercised by the policyholder within one year of the maturity date of the policy.

A2D Commutation of instalments

For annuity plans, before receiving regular/periodic annuity payments, the individual can make a lump sum withdrawal. This is known as commutation. Insurance companies normally allow the individual to make withdrawals of up to a third of the accumulated fund. The remaining two thirds must be used to buy the annuity payments for the individual.

A2E Annuity payments at the time of vesting

In the case of annuities, on vesting, the regular annuity payments start to be made by the insurance company to the annuitant. The payments may be made to the annuitant on a monthly, quarterly, semi-annual or annual basis depending on the plan's terms and conditions.

A3 Death claim

A death claim is where the life insurance company pays the sum insured to the nominee/ beneficiary on the death of the insured during the term of the plan. For whole life policies, the benefit is paid on death, regardless of when this occurs, i.e. there is no fixed term. If the policy is a participating policy, the insurance company will also pay the bonuses accumulated until then. If the policyholder had taken out any loans, then the outstanding amount of the loan, the interest and any outstanding premium and interest thereon will be deducted before the final amount is paid.

Example

Ajay has bought a term insurance plan with a sum insured of Rs. 25 lakhs for 25 years. He dies in the 13th year of the policy. In this case the insurance company will pay Ajay's nominee/beneficiary Rs. 25 lakhs as a death claim.

Be aware

In the case of an ULIP, should the insured die, the insurance company pays the higher of the sum insured or the fund value (or, in the case of some insurance companies, both the fund value and the sum insured is paid).

There are certain policies where the benefit is not paid on death but on a specified date as chosen by the life insured when taking out the policy. For example, for a policy where the objective is to provide for a lump sum amount for a daughter's marriage or a son's higher education, the amount is not paid on the death of the life insured but becomes payable on the date specified, for example:

- when the son/daughter reaches the age of 18 or 21.

This is, of course, as per the terms and conditions of the policy and the option exercised by the proposer.

A4 Rider benefit

A payment under a rider is made by the insurance company on the occurrence of a specified event according to the rider terms and conditions. For example:

- under an **accidental death benefit (ADB)** rider, in the event of the death of the insured, the additional sum insured under this rider is paid;
- under a **critical illness (CI)** rider in the event of diagnosis of a critical illness, a specified amount is paid as per the rider terms and conditions. The illness should be covered in the list of CIs specified by the insurance company (the list may differ among insurers);
- under a **'hospital care'** rider the insurance company pays the treatment costs in the event of hospitalisation of the insured, subject to the terms and conditions of the rider.

To refresh your knowledge of riders, refer back to chapter 7, section B3.

A5 Valid claim

Once an insurance company receives notification of a claim it will want to be sure that the claim is valid before it makes a payment. It will do this by checking the following:

- Was the insurance policy in force when the event occurred?
- Has the insured event taken place?
- Have the original policy document, a completed claim form and all the other required documents been submitted?
- Has the policyholder performed their part with regards to age admission and the disclosure of material facts relevant to the policy? These will be investigated by the insurance company as part of its claim settlement process.

Example

The insurance company will investigate whether the policyholder declared their correct age and supported it with valid age proof documents. If it is an early claim (death happening within 2 to 3 years of buying the policy or revival of the policy) the insurance company will investigate whether the insured suppressed any material facts (for example something related to their health or about a pre-existing illness) in order to get insurance on better terms. (If you want to refresh your knowledge of material facts, we discussed these in chapter 3, part 1.)

- Did the claim demand come from the right person(s), i.e. the person(s) who is entitled to receive the claim amount? This can be the nominee, the legal heir or the assignee etc.
- Have all the other formalities that are required for a claim to be valid been fulfilled?

Suggested activity

Find out from your family or friends if any of them has ever made a claim on a life insurance company. Ask them about the claims procedure and the documents that they were required to submit to settle the claim.

Question 11.1

What are the three main types of claim?

B Why a claim may be invalid

Once an insurance company has completed its investigations it may conclude that it does not need to make a claim payment because the claim is invalid. There are three main circumstances in which this may arise:

The policy is not in force:	If the policy was not in force when the event occurred, the insurance company will reject the claim.	Example: Ajay has taken out a term plan for 20 years. He pays the annual premium on the 1st of April every year. In the 3rd year he suffers a severe heart attack. Due to financial problems because of huge hospital bills, Ajay is not able to pay the premiums on time. His financial problems continue for a longer time than expected and he is not able to pay the premium even during the grace period. At the same time Ajay's health deteriorates and he dies on 15th May. Ajay's nominee files a claim with the insurance company but the company rejects the claim as the policy was not in force due to premiums not being paid, even during the grace period.
Excluded conditions apply:	If the death is caused by something excluded from cover under the policy, the claim will not be met.	Example: Insurance policies exclude death due to suicide in the first year of the policy, therefore the death claim for a policyholder who commits suicide during that first year, will be rejected by the insurance company.
The claim is fraudulent:	If, during its investigations, the insurance company finds out that a material fact was deliberately suppressed by the insured then it will reject the claim.	Example: If the insurer finds out that the age declared by the insured at the time of taking out the policy was wrong or the insured was suffering from some illness that was deliberately not disclosed, then the insurer can reject the claim on the grounds of misrepresentation.

Suggested activity

Search the internet and find out about some life insurance cases where the insurance company rejected the claim because it was of the opinion that the claims were invalid due to various reasons. Study those cases.

C Duties after death and documentary evidence

Clearly, unless the insurance company knows about the death, it will not pay out the sum insured. Therefore the first thing that must happen, after the death of the life insured, is for the insurance company to be advised that the death has taken place. The notification may be sent by the nominee, assignee, relative, the individual's employer or the insurance agent. However, notification of the death is not enough – the insurance company will need proof, not just that the death actually took place, but that the life was insured by the company. Therefore, the next duty for the claimant is to ensure that the insurance company receives the following documents:

- The policy document (see section E on lost policies).
- Deeds of assignments/reassignments: if the policy has been assigned, then the insurance company needs to know this so that it can make the payment to the correct person. (See chapter 3, part 2, section H4B to refresh your knowledge of assignment.)
- Proof of age, if age is not already admitted.
- The death certificate (proof of death).
- The claimant's statement.
- Legal evidence of title, if the policy is not assigned or nominated.
- The discharge form, sent by the insurance company, must be executed and witnessed and returned to the insurance company.

C1 Early death claims

If the claim occurs within three years from the date of risk, or from its revival, insurance companies normally classify it as an early death claim. In such cases insurance companies will carry out a detailed investigation. Additional documents may be called for in order to make certain that material facts were not suppressed at the time of proposal/revival. These documents include:

- a statement from the last medical attendant to attend the deceased before death, giving details of their last illness and the treatment given;
- a statement from the hospital, if the deceased had been admitted to a hospital;
- a statement from the person who attended the last rites and had seen the dead body; and/or
- a statement from the employer (if the deceased was employed) showing details of leave taken.

If the life insured had an unnatural death, such as an accident, by suicide or by an unknown cause, the following will also be looked into:

- Police first information report (FIR);
- panchanama (inquest);
- forensic report;
- post mortem report; and
- Coroner's report.

Depending on the initial evidence, a special inquiry may be ordered.

Example

Ajay has bought an endowment insurance plan with a cover of Rs. 25,00,000 for a term of 25 years. Let's see how the claim will be handled in various scenarios:

a) Ajay dies within the first three years of buying the policy. His death is treated as an early death claim by the life insurance company. The insurance company carries out a more detailed investigation than usual before settling the claim. In addition to seeing the usual required documents and the completed claim form, in order to settle the claim it may ask for information from the last doctor who treated Ajay before his death.

b) Ajay pays all the premiums regularly on time and he dies in the 7th year of the policy. The life insurance company will treat his death as a normal claim. Ajay's nominee/legal beneficiary will be required to submit the regular set of documents along with the completed claim form. The insurance company will settle the claim in a reasonable period of time without going into a detailed investigation, provided the claim is valid.

c) Ajay is unable to pay the premium in the 5th year of the policy and the policy lapses. He revives the policy in the 6th year and dies in the 7th year. The treatment of the claim will be different from a normal death claim. Even though death has happened in the 7th year of the policy, the life insurance company will still treat the claim as an early death claim as death happened one year after the policy's revival. The insurance company will carry out a more detailed investigation than normal before settling the claim as in scenario a).

D Settling claims

In section A we looked at maturity and death claims and in this section we will look at how these are settled in more detail. Before we do so, however, we will consider the guidelines laid down by the IRDA about how all claims should be handled, as these provide the framework.

D1 IRDA guidelines for claim settlement

In the introduction to this chapter we stated that the IRDA has laid down guidelines for the settlement of claims. These are included in the **IRDA (Protection of Policyholders' Interests) Regulations 2002** and are as follows:

Claims procedures in respect of a life insurance policy

1. A life insurance policy shall state the primary documents which are normally required to be submitted by a claimant in support of a claim.
2. A life insurance company, upon receiving a claim, shall process the claim without delay. Any queries or requirement of additional documents, to the extent possible, shall be raised all at once and not in a piecemeal manner, within a period of 15 days of the receipt of the claim.
3. A claim under a life policy shall be paid or be disputed giving all the relevant reasons, within 30 days from the date of receipt of all relevant papers and clarifications required. Where in the opinion of the insurance company the circumstances of a claim warrant an investigation, it shall initiate and complete such investigation at the earliest, in any case not later than 6 months from the time of lodging the claim.
4. Subject to the provisions of section 47 of the Act, where a claim is ready for payment but the payment cannot be made due to any reasons of a proper identification of the payee, the life insurer shall hold the amount for the benefit of the payee and such an amount shall earn interest at the rate applicable to a savings bank account with a scheduled bank (effective from 30 days following the submission of all papers and information).
5. Where there is a delay on the part of the insurer in processing a claim for a reason other than the one covered by sub-regulation (4), the life insurance company shall pay interest on the claim amount at a rate which is 2% above the bank rate prevalent at the beginning of the financial year in which the claim is reviewed by it.

Now that we have established the framework within which all claims must be handled, we can go on to consider the individual types of claim.

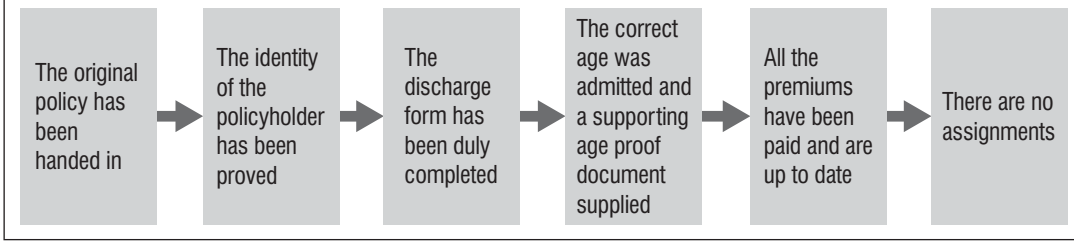
Question 11.2

What documents are required in support of a death claim?

D2 Maturity claim

Action on maturity claims is normally initiated by the insurance company itself. It will know from its records which policies will mature each month and will normally send an advance notification to the person insured. The insured will then take the steps described in section C. Then, before making the payment, the insurer will satisfy itself that:

Figure 11.1



The insurer is expected to make the payment on the maturity date. Post-dated cheques are usually sent a few days in advance of the maturity date, provided a signed discharge form has been received.

If the policy is reported lost, then the insurer may settle on the basis of indemnity (see section E). This is possible because no further obligations remain under the policy.

Assigned policies

Be aware

In the case of an absolute assignment, the claim payment will be made to the assignee.

If the assignment is conditional, reverting to the policyholder on maturity, the insurance company can make the payment to the policyholder. It will be prudent, however, to first check that the assignee has no outstanding claims.

Be aware

Settlement option: Some maturity claims (for example in case of ULIPs) may be payable, not on the date of maturity as chosen by the policyholder, but later and in instalments, not as a lump sum. This is known as the settlement option. The policyholder needs to exercise such an option in advance before the policy matures for payment. While the decision to settle may be taken before the maturity date, the settlement process will continue for a few years after the maturity date.

D3 Survival benefit payments

When it comes to making survival benefit payments, the procedure is similar to the payment of maturity claims. Action will be initiated by the insurer and post-dated cheques will be sent in advance.

If the policy is reported to be lost, a duplicate policy may be provided on which an endorsement will be made regarding the settlement of the survival benefits. See also section E below on fraudulent claims.

D4 Death claims

Unlike the first two types of claim, the process here is started by the claimant, who will advise the insurance company of the death of the life insured. The insurance company will then wait for the relevant documentation (see section C), check it, and carry out any further investigations that it deems necessary. Once it is satisfied that the claim is a valid one, it will send the sum insured to the nominee or beneficiary within a reasonable timeframe, i.e. it will settle the claim.

Question 11.3

According to IRDA guidelines, how long does an insurance company have to complete its investigation of a claim?

E Fraudulent claims

Insurance fraud is a deliberate attempt to use insurance for unjustified financial gain. Insurance fraud includes bogus claims and the misrepresentation of facts.

Be aware

Loss of policy

Insurance companies take the utmost care when settling maturity claims. Sometimes the original policy is reported as lost. Caution must be exercised to ensure that there is no attempt to defraud, for example it could have been pledged elsewhere for a loan. But if the loss of policy is genuine, it is possible to settle the claim on the basis of an indemnity accompanied, as a precaution, by an advertisement in the newspapers.

The indemnity is in the form of a statement, signed by the claimant, stating that should the original policy come to light and evidence of ownership by another party is provided, then the claimant will reimburse the insurance company for any claim payments made to them.

E1 Consequences of fraud

If fraud is not detected and a fraudulent claim is paid, there are direct consequences for the insurer, their insureds and on the fraudulent claimant, as follows:

Consequences of fraud from the insurer	• Individual insurers that do not take the detection and prevention of fraud seriously will see the result of this in a fall in their profits. Their claims costs will rise and this will have an impact on premiums, making them less competitive in the market. • In addition, by word of mouth it may become known among fraudsters which insurers do not carry out adequate checks before paying claims, leading to even more claims of this sort.
Consequences of fraud for the insured	• Insured people who do not act fraudulently will also suffer as a result of fraudulent claims being paid. • This happens because the increase in premiums will affect all policyholders, not just those who have made fraudulent claims. You will remember that the insurer tries to make sure that each insured person brings a fair premium to the pool for the risk presented. This will be distorted by fraudulent claims.
Consequences of fraud for the fraudulent claimant	• The consequence on the claimant of a fraudulent claim being paid is clear. If the claimant has succeeded in receiving monies in respect of a fraudulent claim, there will be a temptation to continue this practice in future.

E2 Caution points at the time of handling death claims

Death claims are where most fraud occurs, and therefore insurers tend to be more cautious when handling them. The following are some indications that a death claim may be fraudulent:

- If the notification of death is received from a stranger, there is reason to ask: 'Why has it not come from a family member or a relative?'
- Too many enquiries about progress in the settlement of the claim should raise doubts.
- If the notification of death is received three years after the date of death, there is reason to be suspicious. In such a scenario, investigation in the same way as for an early death claim would be desirable in all cases, to rule out the possibility of a fraud. If the reasons for the delay in making the claim are not fully satisfactory, the plea that the claim is 'time barred' can be made.

While insurers, as a matter of good faith, should expedite claims settlement, as a trustee of the policyholder's premiums and their company's finances they should always act to prevent fraud. This balance has to be maintained.

E3 Presumption of death

Proof of death is essential for a claim to be settled. However, sometimes a person is reported missing without any information about their whereabouts. What happens to the life insurance of such an individual – can a claim be made or would an insurance company be suspicious that all such claims were fraudulent?

Sections 107 and 108 of the **Indian Evidence Act 1872** deal with presumption of death; under this Act if an individual has not been heard of for seven years they are presumed to be dead. This has the following effect on the actions of the life insurance company:

- If the nominee or heirs claim that the life insured is missing and must be presumed to be dead, insurers insist on a decree from a competent court.
- However, the insurer may also act on its own, without a decree of the court, if reasonably strong circumstantial evidence exists to show that the life insured could not have survived a fatal accident or hazard.
- It is necessary that the premiums should be paid until the court decrees presumption of death; although insurers may, as a concession, waive the premiums during the seven year period. This is at the discretion of the individual insurance company.

F Void and voidable contracts

One reason why a claim may be rejected by an insurance company is because the original contract of insurance has been found to be invalid, or **void**, or has become **voidable** and the insurance company chooses to set it aside for some reason. We will describe what these two terms mean, and the difference between them, in this section.

A contract may not be valid or fully valid in law for a number of reasons. A void contract has no binding effect on either party because a void contract is no contract at all (the expression is really a contradiction in terms). Circumstances that will render a policy void include the following:

Mistake	If there is a fundamental mistake that goes to the root of the contract, there has been no meeting of minds and, therefore, no valid contract exists.	Example: A life insurance contract entered into with a drunken person or person who is not of sound mind at the time of entering into the contract, will not be valid as the person is not in a state of mind to understand the contract's terms and conditions.
Illegitimate/unlawful circumstances	If the insurance has been taken out in support of some illegitimate (unlawful) activity, it will be void.	Example: A person taking out life insurance with the intention of committing suicide or a husband taking life insurance on his wife's life with the intention of killing her and claiming the money from the insurance company.
Lack of insurable interest	If there is no insurable interest attaching to a policy, it would be declared null and void.	

A voidable contract is binding unless and until one of the parties chooses to set it aside. Insurance contracts may be voidable on a number of different grounds. Examples are:

- **Breach of good faith** – misrepresentation or non-disclosure will allow the insurer to treat the policy as void.
- **Breach of warranty** – this will entitle the insurer to treat the policy as void.

However, in Indian law there is an exception to the insurance company's right to declare a policy void on the grounds of misrepresentation or non-disclosure. This is important, so we will consider it now.

F1 Indisputable contracts

As we have just seen, if the proposer has made any untrue or incorrect statements at the time of proposal, either in the proposal form or in the personal statement, or they have not disclosed some material information, the policy contract becomes void *ab initio*. This means that all the benefits under the policy cease and all monies paid in premiums are forfeited.

Be aware

Ab initio is a Latin term which means 'from the beginning'. A policy contract which is declared void *ab initio* means that the policy was null and void from the beginning and since the contract is not legally enforceable, the insurer is not required to pay the claim.

However, this penalty is subject to section 45 of the Insurance Act 1938. Under this section, a policy which has been in force for two years cannot be disputed on the grounds of incorrect or false statements in the proposal and other documents, unless it is shown to be on a material matter and was fraudulently made. This provision is meant to protect policyholders from suffering for minor inaccuracies on stated facts.

Section 45

No policy of life insurance shall after the expiry of two years from the date on which it was effected be called in question by an insurer on the ground that statement made in the proposal or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made by the policyholder and that the policyholder knew at the time of making it that the statement was false or that it suppressed facts which it was material to disclose.

Key points

The main ideas covered by this chapter can be summarised as follows:

Requirements for a valid claim

- A claim is the demand that the insurer should redeem the promise made in the contract.
- A maturity claim is the sum insured, plus any accumulated bonuses. It is paid to the insured or the proposer (if the proposal is on the life of another person, say, key man insurance, partnership insurance etc.) or the assignee if the policy was assigned absolutely for valuable consideration, at the end/maturity of the plan, if they survive the entire term of the plan.
- A terminal or final additional bonus may be paid.
- In money-back policies the insurance company makes specific payments to the policyholder at specific periods during the term of the policy. These payments are known as survival benefits.
- The sum insured paid by a life insurance company to the nominee/beneficiary/assignee in the event of the death of the insured during the term of the plan, is known as death claim.

Why a claim may be invalid

- An insurer may refuse to pay the claim because:
  - the policy is not in force;
  - an exclusion condition applies; or
  - the claim is found to be fraudulent.

Duties after loss and documentary advice

- The claimant needs to inform the life insurance company of the death of the life insured and submit the necessary documents to settle the claim.
- In the case of an early death claim, additional documents are required over and above the documents usually required for a normal death claim.

Settling claims

- For maturity claims the process is initiated by the insurance company well in advance of the maturity date.
- In cases of absolute assignment the payment is made to the assignee.
- For survival benefit payments the action is initiated by the insurance company and post-dated cheques are sent to the policyholder well in advance.
- The IRDA has laid down guidelines for the settlement of claims in **IRDA (Protection of Policyholders' Interests) Regulations 2002**.

Fraudulent claims

- Insurance fraud is a deliberate attempt to use insurance for unjustified financial gain.
- If fraud is not detected and the fraudulent claim is paid, there are direct consequences for the insurer, their insureds and the fraudulent claimant.

Void and voidable contracts

- A void contract has no binding effect on either party.
- Circumstances that will render a policy void include the following:
  - a mistake;
  - illegitimate/unlawful circumstances; or
  - a lack of insurable interest.
- A voidable contract is binding until one of the parties chooses to set it aside.
- Under section 45 of the **Insurance Act 1938**, a policy which has been in force for two years cannot be disputed on the ground of incorrect or false statements in the proposal and other documents, unless it is shown to be on a material matter and was fraudulently made.