ManipalCigna Health Insurance Company Limited
Fraud Monitoring Framework and Policy

Owner: Fraud Monitoring Unit

Approver: ManipalCigna Board of Directors

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Review History

Date of Review	Changes to Section	Review initiated by	Review signed off by	Review Approved by	Version Number	Effective from
NA	New Policy	Fraud Management Unit	Chief Compliance and Governance Officer	Board	1.0	1st April 2026
29th July 2026	Annual Review – Change in Version	Fraud Monitoring Unit	Chief Compliance and Governance Officer	Board	1.1	06th Aug 2026

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1. Introduction

This Fraud Monitoring Framework and Policy (" Policy") is created considering the nature of business size, risk profile, overall business strategy, products, distribution channels, technology infrastructure, with the objective to deter, prevent, detect, report and remedy fraud risks effectively. It establishes a foundation for promoting ethical conduct, accountability, and transparency across all operations. Through clearly defined principles, processes, and controls, the framework ensures that fraud risks are identified, assessed, and mitigated in a consistent and effective manner.

This Policy strengthens the organization's resilience by minimizing exposure to fraud-related incidents and enabling a swift and coordinated response when issues arise. Through active participation from leadership, employees, and stakeholders, the framework helps safeguard organizational resources and reinforces trust in its operations.

IRDAI vide its circular no IRDA/IID/GDL/MISC/112/10/2025 dated 9th October 2025 has issued guidelines to provide regulatory framework on measures to be taken by Insurers and Distribution Channels to address and manage risks emanating from fraud. The aforesaid guidelines upon coming to effect on April1, 2026 shall repeal the Insurance Fraud Monitoring Framework issued vide ref: IRDA/SDD/MISC/CIR/009/01/2013 dated 21st January 2013. Accordingly the existing Fraud Monitoring Policy and Framework of the Company will be replaced by this Policy and will be effective from 1st April 2026. Anything done or any action taken or purported to have been done or taken in respect of the repealed Insurance Fraud Monitoring Framework shall be deemed to have been done or taken under the corresponding provisions of this Policy.

1.1. Scope and applicability

ManipalCigna Health Insurance Company Limited (herein after referred to as "The Company") shall place high emphasis on prevention, detection, control and deterrence through below mentioned elements

- Create an environment and culture of honesty and high ethics through fraud risk and control
- Implementation of processes, procedure and controls to identify, assess and mitigate fraud risk and reduce the opportunity of fraud

This Policy shall be applicable to all employees, contractual staff and of the Company as well as the agents, distribution channel partners, intermediaries, vendors, contractor, consultants, policy holders, third-parties, Third-Party Administrators, effective from 1st April, 2026.

The FMU will be independent from Internal Audit, to support the FMC in discharging its functions and effective implementation of measures suggested by the FMC.

This Policy should be read in conjunction with applicable policies of the Company including Code of Conduct, AML policy, Risk management policy, Whistle blower policy, Anti- Fraud policy, Information Security and Cyber Security policy.

1.2. Objectives

To establish a comprehensive framework in order to deter, prevent, detect, report and remedy fraud risks effectively across the Company. These guidelines aim to enhance the sector's resilience against fraud,

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foster a culture of integrity, protect policyholders' interests, safeguard financial stability and maintain public trust.

1.3. Key Terms Used

- IRDAI – Insurance Regulatory & Development Authority of India
- TPA – Third Party Administrator
- FMU – Fraud Monitoring Unit
- FMC – Fraud Monitoring Committee
- CRO – Chief Risk Officer
- RMC – Risk Management Committee
- F&I – Fraud and Investigation
- IIB – Insurance Information Bureau

2. Definition

IRDAI vide its circular no IRDA/IID/GDL/MISC/112/10/2025 dated 9th October 2025 defined the following terms:

(i) Insurance Fraud means an act or omission intended to gain advantage through dishonest or unlawful means, for a party committing the fraud or for other related parties; including but not limited to:
- Misappropriating assets
- Deliberately misrepresenting, concealing, not disclosing one or more material fact relevant to the financial decision, transaction or otherwise
- Abusing responsibility, position of trust or fiduciary relationship.

(ii) Red Flag Indicator means a possible warning sign, that points to a potential fraud and may require further investigation or analysis of a fact, event, statement, or claim, either alone or with other indicators.

(iii) Cyber or New Age Fraud means any insurance fraud carried out using digital or new age technologies.

(iv) Distribution Channels shall have the same meaning assigned to it under sub clause (8) of clause 5 of IRDAI (Protection of Policyholders' Interests and Allied Matters of Insurers) Regulations, 2024.

2.1 Classification of Fraud

Fraud can be broadly categorised into the below mentioned categories:

(i) **Internal Fraud**: Fraud/ misappropriation against the Company involving its Director, Manager and/or any other officer or staff member (by whatever name called)
(ii) **Distribution Channel Fraud**: Fraud involving distribution channels.
(iii) **Policyholder Fraud and/or Claims Fraud**: Fraud involving any person(s), in obtaining coverage or payment during the purchase, servicing, or claim of insurance policy.
(iv) **External Fraud**: Fraud involving external parties' / service providers / vendors etc.

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(v) **Affinity Fraud or Complex Fraud**: Fraud involving collusion among one or more fraud perpetrators in the above categories

2.2 Zero Tolerance Policy

The Company has adopted Zero tolerance policy for fraudulent activities or attempts to commit a Fraud. Prompt and strict action shall be taken against perpetrators attempting/supporting/committing Fraud or concealing instances of Fraud.

2.3 Governance

The Company shall follow high standards of integrity and honesty by encouraging transparency and openness at all levels of hierarchy to prevent fraud or concealment of fraudulent practices.

Regular communication for creating awareness amongst employees, policy holders, and the general public will be maintained through training programmes, emailers or through any other appropriate forums/modes

3. Fraud Risk Management Framework

Fraud Management Framework lays down the key activities for, identifying, investigating, monitoring and reporting of Frauds committed or suspected fraudulent activities by internal and external stakeholders such as employees, directors network hospitals, distribution channels, TPAs, external vendors, policyholders etc.

3.1 Fraud Risk Identification, Mitigation and Monitoring

The Department Heads i.e. the first line of defence will continue to monitor the activities of the department and exercise necessary controls from a fraud mitigation perspective. The Risk Management Committee (RMC) shall be responsible for effective implementation and oversight of the fraud risk management framework

Fraud Monitoring Unit (FMU) while investigating reported matters, may decide to perform transaction review, data analysis, tracking business trends from distribution channels, grievance / complaints/ claims pattern recognition, and anomaly detection, if required.

FMU may use internal data and Insurance Information Bureau (IIB) intelligence for threat indicators, blacklists, and industry-wide patterns for their investigation. FMU may also receive all fraud-related alerts, complaints, RFIs, whistleblower reports, and internal referrals and get them evaluated accordingly. Further, FMU may classify matters reported to them into required fraud category and maintain incident database.

FMU may prioritize cases based on severity, risk exposure, regulatory relevance, and potential customer impact. Conduct fraud-sensitive audits for compliance with Fraud Risk Monitoring Framework, monitoring vendor activities for compliance with fraud prevention measures and contractual obligations.

Identification and mitigation of claims related Fraud will be primarily carried out by the Claims Investigation and Loss Minimisation team as part of day-to-day claims evaluation/processing and specific trends to be reported to FMU as may be deemed necessary for further investigation.

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In order to prevent Cyber or New Age fraud the Company shall establish and implement a robust cybersecurity framework to protect against evolving cyber frauds or threats and continuously monitor and strengthen systems and processes for fraud risk management, such as incident databases, customer verification, and access control. The Company has a separate Information Security policy named Information and Cyber Security Policy which caters to prevention of cyber or new age frauds. The Company will utilize relevant risk and technological expertise to manage cyber fraud risks across various insurance business lines.

FMU shall support the FMC for discharging its functions and effective implementation of measures suggested by FMC.

FMU will be responsible for operationalizing the Fraud risk management framework, centralized monitoring and oversee activities, as appropriate, to ensure fraud deterrence, prevention, detection, remedying and reporting of frauds and operationally maintaining the Anti-Fraud Policy. Specifically, it will involve:

- Maintaining Fraud incident related records
- Identify potential vulnerabilities and assesment across business lines to identify Fraud • Spreading awareness regarding fraud prevention

3.1.1. Fraud Monitoring Committee (FMC)

Fraud Monitoring Committee will be constituted of (i) Chief Compliance & Governance Officer,(ii) Chief Risk Officer,(iii) Chief Operating Officer/Head of Business Operations,(iv) Chief Distribution Officer, (v) Chief Human Resource Officer,(vi) Chief Financial Officer,(vii) Head of Legal and other members on invitation. Chief Compliance & Governance Officer will be the head of the Committee and convenor of the meetings of the Committee. Committee will have a minimum quorum of 3 members. The Committee will be held quarterly or whenever necessary.

The FMC will be responsible for:

a) recommending and regularly updating, based on experiences, appropriate measures on fraud risk management to various functions.
b) overseeing prompt responses on instances or suspicions of Fraud
c) maintaining all relevant details pertaining to each instance of Fraud
d) facilitating collaboration with industry peers / bodies, law enforcement agencies and regulatory bodies to pursue cases of Fraud and share information / intelligence on known Fraud schemes and perpetrators.
e) conducting an Annual Comprehensive Fraud Risk Assessment to identify potential vulnerabilities across business lines and activities for Fraud, using past experiences, emerging trends & Red Flag Indicators (RFIs). A illustrative list of RFIs is attached hereto as Annexure 2.
f) identifying areas for improvement and adaptation of the Fraud Risk Management Framework.

3.2 Fraud Control/ Prevention Mechanism

The Company shall be proactive in reducing the opportunities for Fraud by putting in place adequate internal control measures to prevent and detect fraud incidents at an early stage. Management shall

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ensure effective and appropriate internal controls are implemented, which include a well-developed control environment, an effective and secure information system, to reduce & eliminate Fraud risks like:

a) Ensuring compliance with the Code of Conduct, collecting conflict of interest disclosures; commission/incentive governance for channels.
b) Distribution partner due diligence, onboarding and periodic reviews and ensuring the Distribution Channels comply with the applicable regulations, anti-fraud policies, procedures and controls and put in place a mechanism to inform any suspicion of Fraud which may impact the Company and comply with the requirements.
c) Provider management (hospitals/garages/TPAs): review of performance SLAs and tariff governance.
d) Establishing and implementing robust cybersecurity framework to protect against evolving cyber frauds or threats
e) Due diligence procedures for staff recruitment and vendor engagement.
f) Review processes to identify missed insurance fraud detection opportunities.
g) Analyse customer grievance and complaints to detect and prevent fraud.

The Whistle Blower complaints shall be handled as per the Company's Whistle Blower Policy, which includes Whistle Blower protection,

3.3 Reporting Requirements

3.3.1. Internal Reporting

a) submit quarterly reports to the RMC on its activities, findings, and recommendations including the financial impact of fraud on the Company.

b) submit report of the Annual Comprehensive Fraud Risk Assessment before the Board of Directors through RMC.

c) report to the Audit Committee, in addition to the RMC, in case of all internal frauds.

3.3.2 Insurance Information Bureau (IIB)

a) Company shall participate in the Fraud Monitoring Technology Framework made available by IIB to ensure that the data available with the Company is effectively utilized to prevent frauds in insurance sector and to combat fraud and protect policyholders and all stakeholders.
b) Relevant departments will share to IIB the details of distribution channels, hospitals, third party vendors and fraud perpetrators blacklisted by the Company.

3.3.3 Reporting to Authorities

The Compliance Function of the Company is responsible to submit all the regulatory reports pertaining to frauds to external authorities in the prescribed format within the applicable timelines as prescribed by the respective Authorities from time to time. Relevant data required for reporting will be provided by the FMU.

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3.4 Training, Education and Awareness

Regular awareness programs to educate policyholders and the general public about the risk of fraud and how to prevent and protect against it.

Periodic training programs, as appropriate for employees and senior management (including Board Members) and distribution channels.

4. Roles & Responsibilities

FMU: FMU will coordinate with all the Heads of Department to ensure fraud management procedures are implemented across the Company. In this regard, this Policy and the Anti-Fraud Policy should be made available on the Company's employee portal, for the employees to make themselves aware of such policies.

Business/ Departmental Heads – The Departmental heads will be primarily responsible to ensure fraud vulnerabilities in their respective departments are proactively identified and mitigating controls are implemented. The Departmental heads must encourage the personnel to report instances/indications of fraud to the Seniors in the team. Fraud Risk areas must be included as part of RCSA registers for respective functions.

HR/Training Department: The HR/Training departments should incorporate the relevant aspects of the policy in the training manual and induction program for new employees.

5. Review of the Policy

To ensure compliance with the regulatory guidelines, this Policy shall be reviewed at least once in a year and changes if any submitted to the Board of Directors for approval.

In view of modifications to regulatory requirements, suitable addendums should be issued within the company to communicate the revised guidelines.

6. Annexure

Annexure 1 - Contact Person

Name	Designation	Email ID
Deepak Yadav	Senior Manager- Fraud Monitoring Unit	fmu@manipalcigna.com
Sangeeta Menon	DVP-Legal and Fraud Monitoring Unit	fmu@manipalcigna.com

Annexure 2

Red Flag Indicators (RFI)

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The RFIs listed herein are illustrative and not exhaustive. The RFI inventory shall be periodically reviewed and updated based on inputs received from respective departments, emerging risk trends, regulatory guidance, audit observations, and industry intelligence.

Red Flag Indicators for Fraud detection	
Internal Frauds (*including Employees, management, internal stakeholders*)	Misappropriating funds.
	Fraudulent financial reporting.
	Fraudulently collecting premium in personal account
	Overriding decline decisions to open accounts for family/friends
	Inflating expense claims / over-billing
	Paying false or inflated invoices (self-prepared or via collusion with suppliers)
	Permitting special prices or privileges to customers, or granting business to favoured suppliers for kickbacks/favours.
	Forging signatures
	Removing money from customer accounts
	Falsifying documents
	Selling insurer's assets below true value in return for payment
	Taking kickbacks for empanelment of hospital, approval of claims etc
	Suppression or delay in escalation of issues flagged by systems
Distribution Channel Fraud (*Including Agents, Bancassurance, Brokers, Web Aggregators, IMFs*)	Premium diversion-Intermediary takes the premium from the purchaser and does not pass it to the insurer
	Inflating the premium, remitting only the correct amount to insurer and keeping the difference.
	Non-disclosure or misrepresentation of risk to reduce premium.
	Commission fraud: ensuring non-existent policyholders, paying first premium to earn commission and annulling the insurance by ceasing further premium payment
Policy holder Fraud and/or Claims Fraud (*including Customers or insured persons*)	Exaggerating damages/loss
	Staging the occurrence of incidents
	Reporting and claiming fictitious damage/loss.
	Medical claims fraud

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	Fraudulent death claims.
	Insured residence far from hospital
	Vitals inconsistent with medical condition
	Inflated or forged medical bills/reports.
	Inconsistent treatment dates or missing signatures.
	Mismatched patient details across documents.
	Duplicate claims submitted to multiple insurers.
External Fraud (*including Vendors, Hospitals, TPAs, Diagnostic Centres, Service Providers*)	Vendor with common directors linked to existing blacklisted vendors
	Incomplete KYC or refusal to share financial statements
	High claim frequency from specific hospitals/providers.
	Unusual billing patterns compared to peers.
Affinity Fraud or Complex Fraud (*Collusion across multiple parties – internal, intermediaries, customers, externals*)	Collusion indicators: Same provider linked to multiple suspicious claims.
	Inputs from IIB / industry sources indicating collusion networks

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