EXAMINING FRAUDULENT CLAIMS THROUGH AFCA'S EYES

AFCA's Approach

It is widely known that AFCA is not bound strictly by legal principles or precedent. Indeed, this approach to decision-making is enshrined in AFCA's Complaint Resolution Scheme Rules at Rules A.14.2 and A.14.3 which state:

> *A.14.2 When determining any other complaint, the AFCA Decision Maker must do what the AFCA Decision Maker considers is fair in all the circumstances having regard to:*
>
> *a) legal principles,*
>
> *b) applicable industry codes or guidance,*
>
> *c) good industry practice and*
>
> *d) previous relevant Determinations of AFCA or Predecessor Schemes.*
>
> *A.14.3 An AFCA Decision Maker is not bound by rules of evidence or previous AFCA or Predecessor Scheme decisions.*

Additionally, since the costs and speed of running a complaint through AFCA result in significantly more complaints being run through AFCA than through Court, it is important to understand how AFCA interprets key principles. With this in mind, we focus on AFCA's interpretation of claims made fraudulently and highlight the principles that should be considered when conducting a claims assessment.

As we can see in the table below, the number of complaints relating to fraudulent claims for life insurance products that reach final determination is very small.

Life Insurance Complaints for period 1 July 2022 to 30 June 2024	
Total Complaints to AFCA	**Total Determinations about fraudulent claims**
1828	6

AFCA's Principles

Examining cases dealing with various life insurance products, AFCA's approach becomes apparent about what it assesses to determine if a claim was made fraudulently.

Two prominent cases, Cases 798098 and 824100, provide a useful summary of the various principles that AFCA assess. Both of these cases look at a claim for IP benefits, but the outcomes are contrasting – AFCA determined the claim in Case 798098 was made fraudulently, while it did not find fraud in Case 824100.

From these two cases, we can see that that AFCA takes uses the following principles when assessing if a claim has been made fraudulently:

- AFCA will not lightly find fraud.
- Fraud must be proved to the reasonable satisfaction of the Tribunal.
- Fraud is a serious allegation that requires clear and cogent evidence. It is not sufficient to rely on inexact proofs, indefinite testimony or indirect inferences.

- The onus is on the insurer to prove fraud.
- Fraud is satisfied if the insured had a dishonest intent to induce a false belief in the insurer for the purpose of obtaining payment or some other benefit under the policy. As such, fraud can be found even in circumstances where the insurer was not mislead by the dishonest statement.
- Consideration must be given to the seriousness of the allegation, the inherent unlikelihood of an occurrence, and the gravity of the consequences flowing from a finding.

AFCA has also made it clear in Cases 902656 and 892036 that allegations about the alleged fraud must be put to the complainant.

Ways to improve your processes

Given that AFCA's views are reasonably clearly set out from its determinations, which in these cases are consistent with leading Court decisions, we recommend that you:

- Ensure you collect clear and direct evidence about the alleged fraudulent conduct.
- Communicate your concerns to the claimant and allow them an opportunity to respond.
- Train your teams and keep updated with the latest determinations and cases.