Cooperative Alliance for Responsive Endeavor

Mutual Benefit Association (CARE MBA), Inc.

Office Address	:	39 Ilang-ilang St., Zaballero Subd., Brgy. Gulang-gulang, Lucena City
Contact Number	:	(042)373-7789
E-mail Address	:	mbacare@yahoo.com.ph
SEC Reg. #	:	CN200818098
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Nature of Business	:	Microinsurance

CARE MBA, INC.
ANTI-FRAUD MANAGEMENT PLAN

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I. Introduction

Cooperative Alliance for Responsible Endeavour Mutual Benefit Association, Inc., hereinafter referred to as **CARE MBA, INC.** for brevity, is at firm belief that most of our members and claimants are honest people who deserve to have their legitimate covered losses paid promptly. Similarly, our employees, trustees, partners and service providers, are honest people simply doing their job each day. But when someone has purposely set out to conceal the truth, extensive investigations often are necessary: a tedious, time-consuming and financially expensive process, but one that is necessary to protect the interests of our honest members, partners and our association.

CARE MBA, like all organizations, is faced with risks from wrongdoing, misconduct, dishonesty and fraud. As with all business exposures, we must be prepared to manage these risks and their potential impact in a professional manner.

The impact of misconduct and dishonesty may include:

- the actual financial loss incurred
- damage to the reputation of our organization and our employees
- negative publicity
- the cost of investigation
- loss of employees
- loss of members and partners
- damaged relationships with our partners and service providers
- litigation
- damaged employee and trustee morale

Our goal is to establish and maintain a micro-insurance business environment of fairness, ethics and honesty for our employees, our members, clients, partners, service providers and anyone else with whom we have a relationship. To maintain such an environment requires the active assistance of every employee, manager, trustee and partners every day.

CARE MBA is committed to the deterrence, detection and correction of misconduct and dishonesty. The discovery, reporting and documentation of such acts provides a sound foundation for the protection of innocent parties, the taking of disciplinary action against offenders up to and including dismissal or expulsion from employment or membership, wherever is appropriate, the referral to law enforcement agencies when warranted by the facts, and the recovery of assets.

Fraudulent acts are perpetrated by people from all walks of life. While fraud may never be completely eliminated, it can be decreased when existing and prospective insured and others who may be tempted to commit fraud learn that we have the personnel and skills to recognize these claims, and that such personnel are able to separate honest claims from suspicious ones.

II. Purpose

The purpose of this document is to communicate CARE MBAI policy regarding the deterrence and investigation of suspected misconduct and dishonesty by employees and others; and to provide specific instructions regarding appropriate action in case of suspected violations, such as but not limited to:

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. Functioning 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.

III. STATEMENT OF POLICY

Cooperative Alliance for Responsible Endeavour Mutual Benefit Association, Inc.(CARE MBAI) ***does not tolerate fraud or any misconduct and dishonesty***, whether carried out by the CARE MBAI's members or by outsiders/non-members, it's trustees, management or staff, or by its partners, consultants or service providers. As appropriate, CARE MBA 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 CARE MBAI will take action based on the gravity of the offense or even take legal action including reporting the infraction to proper authorities in order to get conviction, recover assets or obtain compensation for loss.

Being a mutual benefit association CARE MBAI existence is based upon reciprocal contracts and requires that a member receive benefits as a matter of right.

For purposes of this policy, misconduct and dishonesty include but are not limited to:

* Acts which violate the CARE MBAI's Code of Conduct;
* Theft or other misappropriation of assets of CARE MBAI, our customers, suppliers or others with whom we have a business relationship;
* Misstatements and other irregularities in CARE MBAI records (financial or organizational), including the intentional misstatement of the results of operations;
* Profiteering as a result of insider knowledge of CARE MBAI activities;
* Disclosing confidential and proprietary information to outside parties;
* Forgery or other alteration of documents;
* Accepting or seeking anything of value from claimants, contractors, vendors or other persons providing services/materials to CARE MBAI;
* Fraud and other unlawful acts;
* Any similar acts.

CARE MBAI specifically prohibits these and any other illegal activities in the actions of its employees, managers, executives and others responsible for carrying out the organization's activities, as well as members and claimants.

Management is responsible for the detection and prevention of fraud, misconduct, dishonesty, and other irregularities. Each member of the management team will be familiar with the type's of improprieties that might occur within his or her area of responsibility, and be alert for any indication of irregularity.

Any employee or member of CARE MBAI who suspects dishonest or fraudulent activity will notify CARE MBAI general manager, or directly to the Compliance Officer/Anti-Fraud Coordinator immediately, and *should not attempt to personally conduct investigations or interviews/interrogations* related to any suspected fraudulent act (see **Reporting Fraudulent Activity .Suspected Fraud** section below).

The Special Investigation Unit (SIU) treats all information received confidentially.

Investigation results *will not be disclosed or discussed* with anyone other than those who have a legitimate need to know. This is important in order to avoid damaging the reputations of persons suspected but subsequently found innocent of wrongful conduct and to protect CARE Mailroom potential civil liability

IV. WHAT IS FRAUD?

CARE MBAI adopts the following definition and characterization of fraud:

i. 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 (Merriam Webster Dictionary).

ii. Fraud, as defined 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.

iii. Fraud is a form of dishonesty, involving false representation, failing to disclose information or abuse of position, undertaken in order to gain or cause loss to another and Theft is dishonestly appropriating property belonging to another with the intention of permanently depriving the other of it.

iv. For practical purposes of the application of this policy, fraud may be defined as the use of deception with the intention of:

a) gaining an advantage, financial or otherwise, personally and for family or friends;
b) avoiding an obligation; or
c) causing a financial loss to CARE MBAI.

v. A fraudulent act can take many forms, for example, theft – removal or misuse of funds, assets or cash; false accounting - dishonestly destroying, defacing, concealing or falsifying any account, record or document required for any accounting purpose, with a view to personal gain or gain for another, or with the intent to cause loss to the MBA'S or furnishing information which is or may be misleading, false or deceptive; or abuse of position – abusing authorities and misusing MBA'S resources or information for personal gain or causing loss to the MBA.

vi. Those engaged in fraud can include an employee, officer, trustee or director, any person acting on behalf of the MBA i.e. our partners, individuals or organizations who authorize someone else to carry out these acts, government or public officials whether foreign or domestic.

V. OVERSIGHT AND OPERATIONAL RESPONSIBILITIES OVER THE ANTI-FRAUD PLAN

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

b. The Board of Trustees, acting through the Treasurer, 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 Compliance Officer is designated by the Management as the Anti-Fraud Officer 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.

VI. CATEGORIES OF FRAUD

a. Member/Policyholder Fraud and/or Claims Fraud

This involves fraud in the application by, and enrolment 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 CARE MBAI's cooperative partners, collection agents, insurance/ CARE MBAI 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/Management that has terms and conditions highly disadvantageous to the members or to the Association.

VII. Prevention and Detection of Fraud

Membership Enrolment

a. The business model of micro-insurance CARE MBAIs involves partnership with Cooperatives institutions which are the source of members for CARE MBAI and which provide various services such as collection of CARE MBAI contributions, facilitating the reporting and validation of claims and disbursement of insurance benefits. Thus, for administrative and cost reasons, CARE 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) and age(s) of legal spouse/dependents

b. As co-owners of the CARE MBAI, all members recognize that they play an important role in fraud prevention. Before an applicant is allowed to join CARE MBAI Cooperative partner to which the applicant is a member screen the applicant's background and determine if he/she will be qualified for membership to CARE MBAI.

c. Apart from the assessment made by Cooperative partner, CARE MBAI 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 CARE MBAI.

d. The CARE MBAI Membership Enrolment 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).

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e. The CARE MBAI Membership Enrolment 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.

	Membership
Member	• Falsification of application documents of applicant, dependent and 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 enrolment date to avail of continuous benefit • Adjustment of dates to make a member qualified • Padding of number of membership enrolment to qualify for cash incentives • Distribution of member quota to share incentives • Consolidation of member quota to share incentives • Submission by cooperative of fictitious data on non-existent members and/or spouse and dependents which data will eventually be used to claim insurance benefits; • Submission by cooperative 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

As additional preventive measure, and in view of Insurance Commission Circular Letter No. 2016-50, the CARE MBAI will request approval from the Insurance Commission to include in staff orientation and communicate with partner organization:

> **"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."**

Collections

a. CARE MBAI Finance is in charge of receiving collections of CARE MBAI contributions remitted by the Cooperative partner, organized group and other intermediaries. Collection reports sent by the Cooperative partner, organized group and other intermediaries are regularly reconciled against bank deposits of CARE MBAI to determine if there was any misappropriation of collections.

b. CARE 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. CARE 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. CARE MBAI Finance coordinates the regular reporting to the Management/Board of Trustees by the membership enrolment, MIS, and claims departments on new members gained or lost, status of membership, claims submitted/in-process/denied/paid, etc.

e. Some instances of possibility of fraud are:

	Collection
Member	• Insists of payments not made • Intentionally unrecorded collection from other group members • Purposeful non-remittance of collection ("hold-up me")
Intermediary	• Deliberate *non-remittance or partial remittance* of collection to Cooperative/ banks • Deliberate non-issuance of provisional receipt/passbook/collection sheet • Misappropriation of funds (e.g. contribution intended for payment of MBA insurance applied to loan/savings , 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 member 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.

	MIS
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 CARE MBAI Coordinator / CARE field staff / Cooperative partner 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 Enrolment /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 (SIU), the Claims Section/Department will report it to the Anti-Fraud Coordinator who will, together with Internal Audit, conduct a full investigation. The investigation will include, among others, the cause of death, and 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 Section/Department requires the submission of a statement of account showing the amount of original loan, repayments made and outstanding (unpaid) principal balance. CARE MBAI settles the outstanding principal balance and pays the remaining amount (if any) to the borrower's beneficiary.

i. To aid the Claims Section/ 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;
- CARE MBAI 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, CARE MBAI shall release 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. *(Please refer to the exact wordings shown in the Membership Enrolment section of this Plan).*

	CLAIMS
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 • coordinator asks for "processing fee" to hasten the claims benefit acquisition

Internal Audit

a. Internal Audit performs audit and operational reviews of the CARE MBAI'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 shall hold 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 CARE MBAI'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 Enrolment, MIS, Finance and Claims and other processes that likewise have significant risk exposures for the association i.e. backlogs, overtime pay, under time, etc., as these areas normally have significant risk exposures to fraudulent activity. Among other audit steps, the auditor reviews transactions on audit sampling basis, reviews membership enrollment for completeness of required information, traces contributions, and reviews changes in members' records and claims payments if properly authorized.

C. It is important for 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, inclusion of non-existent members and erroneous posting of wrong contributions; 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.

Compliance Officer

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, Bureau of Internal Revenue, 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 Compliance Officer/Anti-Fraud Coordinator also heads the SIU, with assistance from the Head of Internal Audit. As SIU Head, he/she reports to the Board of Trustees through the Treasurer, in proper coordination with the MBA General Manager.

Internal Control and Financial Management

a. The MBA should practice sound financial management to include the following:
    1. Projected Financial Statement and Performance Objectives
    2. Investment Plan
    3. Monthly Financial Statements
    4. Annual External Audit
    5. Recording of Financial Transactions
    6. Annual Budget

b. It is of utmost importance that XYZ MBA maintains at all times the trust of its members. Thus, the goal of the Association is to prevent and detect 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 the common fraudulent acts related to internal control and financial management:
    1. Window dressing/false reporting

2. Receiving gifts, favours or benefits in cash or in kind from suppliers (optional) that may affect decisions
3. Conflict of interest such as acquisition of assets, services that constitute conflict of interest for decision makers
4. Theft and misappropriation of funds and other assets (e.g. cash advance use for other purposes)

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

e. Following are some of the internal controls implemented by CARE MBAI:

- 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 Php 500.00.
- 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.
- Signatories in the bank account of CARE MBAI to withdraw from bank accounts or issue Checks up to Php 30,000.00 should be signed by any one of Set A-signing officers which is the cashier or finance officer and countersign by any one of Set B- which is the General Manager or the BOT Treasurer.
- For the amount Php 30,000.00 and above, signatories in the bank account of CARE MBAI to withdraw from bank accounts or issue checks should be signed by any one of Set A-signing officers which is the General Manager or the BOT Treasurer and countersign by any one of Set B- which is the President or Vice-president.
- 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.

Education and Training

g. Applicants for membership in CARE MBAI are required to attend the Orientation Seminar (OS). 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. Through this seminar, the Association widens its anti-fraud prevention network by involving members in screening applicants and providing community-based claims validation. More so, regular updating of anti-fraud policies should be included in the re-orientations.

h. In order to keep the Membership Enrolment, 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.

i. CARE MBAI 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.

j. 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.

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

l. CARE 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.

m. This Anti-Fraud Plan, including the reporting policies contained herein, shall be maintained in the office of the Compliance Officer/Anti-Fraud Coordinator and shall be open for inspection by the Insurance Commission. CARE MBAI shall also maintain appropriate records to determine the effectiveness of this Anti-Fraud Plan.

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 or directly to the Compliance Officer/Anti-Fraud Coordinator or Board of Trustees, through personal appearance using incident report form, or email to CARE MBAI Email address: mbacare@yahoo.com.phor call to (042) 373 7789.

b. In case any member sees or suspects a fraudulent activity is happening, he/she must report it to his/her general manager, or directly to the Compliance Officer/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 Compliance Officer/Anti-Fraud Coordinator.

c. The Compliance Officer/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.

9. Special Investigation Unit (SIU)

a. The SIU is headed by the Compliance Officer/Anti-Fraud Coordinator who will report directly to the Board of Trustees through the Board Treasurer. 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 investigative team 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 investigating team 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.

10. Reporting and Monitoring Results of Investigation

a. The SIU will issue an initial briefing report to be distributed to the following: MBA 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 General Manager, Treasurer and Audit Committee which will further report to the Board 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.

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 microfinance 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.

Cooperative Alliance for Responsive Endeavor Mutual Benefit Association (CARE MBA), Inc.

ANTI-FRAUD MANAGEMENT PLAN

ADOPTION

This manuscript entitled "**CARE MBAI ANTI-FRAUD MANAGEMENT PLAN**" is hereby adopted as CARE MBAI Anti Fraud Policies, Guidelines and Procedures. All other necessary implementing procedures to be made shall be in accordance with this document.

Adopted by the CARE MBAI Board of Trustees this 31st day of August 2017 at Lucena City.

ATTY. JORGE B. VARGAS
President

DOMINADOR S. TAMAYO
Vice President

CRISELDA R. ABUEL
Treasurer

ERLENE E. BARANDINO
Secretary/Independent Trustee

MELODY L. BRINGEL
Trustee

PAZ L. BOBADILLA
Trustee

RAMON M. MARTINEZ
Independent Trustee