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COLLEGE OF BUSINESS AND ECONOMICS

DEPARTMENT OF MANAGEMENT

THE EFFECT OF MOTOR INSURANCE FRAUD RISK MANAGEMENT PRACTICE ON PERFORMANCE: THE CASE OF ETHIOPIAN INSURANCE CORPORATION

BY: KASSAHUN KEBEDE ESHETE

A RESEARCH REPORT SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF BUSINESS ADMINISTRATION (MBA) IN INSURANCE

ADVISOR: ASRES ABITIE KEBEDE (PhD)

APRIL 2022

ADDIS ABABA, ETHIOPIA

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Declaration

I, Kassahun Kebede, hereby declare that this research paper entitled “**The Effect of Motor Insurance Fraud Risk Management Practice on Performance: The Case of Ethiopian Insurance Corporation**” submitted by me is my own original work and I have authenticated that to say, it has not been formed by any other educational institutions for any other requirements in any form. In order to attain this paper, I recognize all sources of information that I used to prepare the study.

Kassahun Kebede Eshete (Ato)

The Researcher Signature _____ Date _____

Certification

This is to certify that the thesis work entitled “**The Effect of Motor Insurance Fraud Risk Management Practice on Performance: The Case of Ethiopian Insurance Corporation**” is a genuine work of Kasshaun Kebede Eshete who carried out this research under my supervision and is submitted for examination with my approval as a research project

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This is to certify that the research entitled, **“The Effect of Motor Insurance Fraud Risk Management Practice on Performance: The Case of Ethiopian Insurance Corporation”** was carried out by **Kassahun Kebede Eshetie** under the supervision of **Asres Abitie Kebede, (Ph.D)** submitted in partial fulfillment of the requirements for the degree of Master of Business Administration fulfills with the regulations of the University.

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Abstracts

Insurance fraud is one of operational risk challenging almost all insurance companies. In Ethiopian Insurance Corporation fraud has evolved over time from inflating of legitimate claim submitting fake accident report and fraud perpetrated on both claim and policy underwriting process. The objective of the study is to examine and analyze the nature and status of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation. The study was descriptive and explanatory research design was used for the study with a target population of 243 respondents and a sample size of 151. From the study findings, it was found that the type of motor insurance fraud was claim and underwriting fraud are predominating and mainly perpetrated by internal and external bodies through collusion. Additionally, most claim lodged were inflated that was caused as a result of lack of appropriate punishment to fraudsters, poor internal controls and greed. Moreover, the study was indicated that the company's strategic approach to motor insurance fraud management is passive.

The study concluded that based on multiple regression analysis, 49.6 % variation in organizational performance is explained by the employed explanatory variable i.e. preventive fraud management practice, detective fraud management practice, and responsive fraud management practice. However, the major proportion that is 50.4 % variation in organizational performance not explained. This indicates that additional elements, such as financial and non-financial considerations, were not included in the study.

The study achieves that preventive fraud management practice, detective fraud management practice, and responsive fraud management practice are the key factors that affect the performance of the company in the Ethiopian Insurance Corporation. Furthermore, the study recommends that the company should create consolidated central database of all motor policies in order to identify suspected fraudulent claims

Key words: EIC, Motor Insurance Fraud, Risk Management Practice, Company Performance

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List of Abbreviations and Acronym

AAA:	American Accounting Association
ABI:	Association of British Insurer
ACFE	Association of certified fraud examiners
AEI:	Association of Ethiopian Insurer
APA	Auditor of public accountant
BI	Bodily Injuries
CA	Control activity
CAIF:	Coalition Against Insurance Fraud
CE	Control environment
CFI:-	Corporate Finance Institute CII
Chartered Insurance Institute	CMTF
Compulsory Motor Third party	
COSO:-	Committee of the Sponsoring Organization
DCEO:	Deputy Chief Executive Officer
EIC:	Ethiopian Insurance Corporation
FDP	Fraud detection and prevention
FDRE	Federal Democratic Republic of Ethiopian
FDT	Fraud Diamond Theory
FTT	Fraud Triangle Theory
IC	Information and Communication
ICAE	Institute of chartered accountant of England
ICS	Internal control system
IFRS:	International Financial Reporting Standards
IRC:	Insurance Research Council

ISA	International standard of auditing
ISO:	International Organization for Standardization
KPMG	Is a multinational accounting and auditing firm, providing three main business services - audit, advisory and tax services
MTPL:	Motor Third Party Liability
NBE:	National Bank of Ethiopia
RA	Risk assessment
SPSS	Statistical Package for Social Science
UK:	United Kingdom
VIATPR:	Vehicle Insurance Against Third Party Risk

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Over the last few decades, the growth of the world economy has been quite positive, and there have been improvements in the economic well-being of most countries. However, this growth has been accompanied by some negative developments (Kratcoski & Edelbacher, 2018). The growth in economic crime has become a global problem, and there has been a strong increase in activity by international criminal organizations. Financial and tax fraud and corruption have shown strong increases (Kratcoski & Edelbacher, 2018).

The insurance industry is one of the largest industries worldwide and the interdependencies with other industries are not to be underestimated. However, it is facing the pressure of intensified competition as banks and other financial players continue to move onto their territory, providing financial alternatives to traditional insurance (Viaene & Dedene, 2004).

It has allowed us to cope with increasingly complex and uncertain circumstances. The business's core functions are collection, accumulation and management of contractual capital savings have made into very important institutional investors and key players on the international financial markets (Viaene, & Dedene, 2004).

According to Vaughan (2007), risk can be defined as a condition of the real world in which there is an exposure to adversity. More importantly, risk is a condition in which there is a possibility of an adverse deviation from a desired outcome that is expected or hoped for. Hence, insurance is one of the risk transfer mechanism from the insured to insurer. This transfer of risks to insurance companies has practiced in our country to protect the whole society from adverse financial loss.

National Bank of Ethiopia Annual Report, 2020/21 confirmed that, the number of insurance companies stood at 18, whose branches rose to 632 after they opened 27 new branches. About 54.6 percent of total insurance branches were situated in Addis Ababa. 85.8 percent were private insurance companies. Insurance companies increased their total capital by 14.7 percent to Birr

11.1 billion whose share of private insurance companies was 73.6 percent and that of public insurance company was 26.4 percent

In the general insurance industry's major portfolio sector is motor insurance. This type of business generates around 46% of total non-life output income/GWP. However, the vehicle insurance industry in Ethiopia is not as appealing or profitable. Almost all government and private insurance companies declare that motor insurance is consistently a bad performance result in their annual reports (Ayele, 2014).

1.1.2 Motor Insurance in Ethiopia

Motor Insurance originated in U.K. where the first motor insurance policy was introduced into England in 1894 to cover third party liabilities and in 1899 the policy was extended to cover the accidental damage similar to what is known as comprehensive policy (Gupta, P. K. (2008).

Different studies show that four-wheel motor vehicle has entered in Ethiopia in 1907 GC for the first time. This vehicle laid a foundation for the modern road transport service in the country. Starting from then the number of vehicles moving on roads increased.

Car or automobile is the most widely owned major asset in Ethiopia. It is also one of the chief sources of economic loss. The ownership or operation of an automobile exposes the individual to many sources of loss: a person may be killed or injured while operating a car, or may be struck by one, with resulting medical expenses and loss of income; one may be held legally liable for injuries to others or for damage to the property of others; the car may be damaged, destroyed, or stolen.

Automobile physical damage coverage insures against loss of the policyholder's own automobile and it is optional the contract concluded by the free consent of the insured with an insurer. The coverage is chosen by the insured whether it is comprehensive, Third party fire and theft or Third party only. However, Due to the occurrence of accidents caused by vehicles are escalating from time to time; and the loss of lives, bodily injuries and damages to properties caused by vehicle accidents are creating social problems, the Federal Democratic Republic of Ethiopian (FDRE) enacted proclamation No. 559/2008 and has introduced Vehicle Insurance Against Third Party Risks, which requires owner of vehicle to have a minimum third party motor insurance that

provides compensation to victims of road traffic accidents. The Act provides that no motor vehicle can be used in a public place unless there is in force insurance policy in relation to vehicle issued by an authorized insurer. This policy covers the insured person's liability in the event of death, bodily injury of certain persons or damage to property of third party.

The main objective of motor insurance in Ethiopia is to cover losses to third party liability to persons and property as well as accidental own damage to the same due to overturning or collision depending upon the type of cover. The subject matter in motor insurance is motor vehicle. A motor vehicle is defined by VIATPR Act of Ethiopia –vehiclell means any wheeled motor vehicle, semi- trailer or trailer for use on the road with the exception of wheelchair and bicycle; "motor vehicle" means a vehicle moving on a road by mechanical or electrical power.

1.1.3 Insurance Fraud

What is Insurance Fraud?

Insurance fraud is when someone takes advantage of an insurance policy in order to gain profit from the insurance fund. It not only puts an insurer in jeopardy, but it also has a negative impact on its value chain, the financial sector, and might be exceedingly damaging to existing social and economic systems. And also thought that to have a significant impact on the cost of insurance premiums and as a result become a danger to lead the industries out of market (ACFE, 2019)

1.1.4 Background of the Organization

The Bank of Abyssinia (Habesha Bank) started rendering modern insurance service for the first time in Ethiopia in 1905 as an agent for a foreign insurance company. The business led by, a foreigner opened a full-fledged insurance branch in Addis Ababa as an intermediary for –Balois Fire Insurance Companyll.

During the Italian occupation only Italian companies were allowed to operate in Addis Ababa and other central regions of the country and in Eritrea. After World War II several British and other overseas companies provided insurance service until 1950. In 1951, the Imperial Insurance Company was established by some open-minded Ethiopians.

This development encouraged Ethiopians and consequently some 18 companies were established in 1954 with branches and agents in Addis Ababa, Asmara, Dire Dawa, Massawa, Assab and Dessie. In 1970, the first proclamation on licensing and supervision of insurance services, proclamation NO.281/70 was enacted and an office for the supervision of insurance business was established under the Ministry of Trade and Industry. The office licensed only 15 companies.

In 1974, the Provisional Military Administration Council (PMAC), came into with the new economic system called socialist or command economy. Accordingly, in December 1975, being after the thirteen private Insurance Companies state-owned, the Provisional Military Administration Council enacted Proclamation and Ethiopian Insurance Corporation (EIC) was established in 1976 by proclamation No.68/1975.

On January 1, 1975 all these 13 insurance companies were nationalized in accordance with the proclamation of the provisional military government. The Government merged the 13 companies and, by proclamation 26/1975, established the Ethiopian Insurance Corporation as a monopoly in insurance business. The Ethiopian Insurance Corporation functioned as a monopoly for nearly two decades until 1994.

Currently, EIC has 106 direct market place to provide insurance services for public including six districts "A" and eight districts "B" each have 75 branches and 17 satellite offices through the country.

1.2 Statement of the Problem

Every business is affected by fraud losses. Increased consumer inconvenience, opportunity costs, excessively high prices, and criminal actions supported by false gains are all expenses that are passed on to society.

Motor or auto insurance is the most common type of insurance in the world, and it is the largest non-life insurance market in Ethiopia. Despite the fact that currently, motor insurance accounts 35% market share of all general insurance premiums, it is said to be a loss leader for most insurers. This is the major economic difficulty that Ethiopian insurance companies face: improve the profitability of the motor class of business while growing the business (Hailu, 2017)

Insurance fraud is a real problem that leads to significant financial, societal and humanitarian costs (Palasinski, 2009). Insurance fraud is a more complex and multi-sided phenomenon. It occurs when an insurance company, intermediary, loss adjuster, customer, victims of accident or insurance employee commits an intentional dishonesty act in order to obtain an illegal financial benefit during the process of buying, using, selling insurance policy.

Insurance fraud is a growing concern in Ethiopia. Currently, although a separate record doesn't exist to fraudulent claims and analyses their real impact, it is known that it affects individuals, consumers, different stakeholders and organizations in various ways. Fraud usually lowers organizations' net income to recover these costs, consumers and individuals must pay more for goods and services.

Fraud affects innocent policy holders, affects insurance demand, as these claims force insurance premiums to escalate. For instance, to see some regional trends, the East Africa Insurance Fraud Risk survey conducted by KPMG, one of the largest professional services companies in the world, in 2015 confirmed that fraud in the region exists both in underwriting and claims. For example, in Uganda the detected claims were valued at USD 10,000.00 was considered that the total cost of claims fraud was USD 500,000.00 (Fikru T. 2015).

Among many factors escalation of claim costs may be an indicator of claims leakage. For instance, the net claims incurred by insurance industry have risen from ETB 1.9 billion in 2013 to ETB 2.5 billion in 2015. In motor insurance which takes up to 72% of the claim costs of the industry, there is a possibility that fraudulent claims may be lodged. It may be in the form of faking accidents, exaggerating the claim amounts, cost of spare parts and producing false accident evidence.

According to Corporate Finance Institute (2021), each insurance company sets its own loss ratio target, which is based on the expense ratio. In general, a loss ratio of 60 percent to 70 percent is considered appropriate.

Regarding, the current Ethiopian Insurance Corporation Financial Report on motor insurance claims ratio, which shows that 77%. In addition, when we evaluate all government owned and private motor insurance companies' loss ratio was 71 % (National Bank of Ethiopia, 2021). Hence, this indicate that there was a claim leakage in motor insurance and Ethiopian Insurance

Corporation is no exception to this. Based on the report of the National Bank of Ethiopia, there is an indication of high claims cost and needs further research.

Many researchers had assessed the effect of fraud and the role of in the bank industries and public sector such as ethio-telecom, Ministry of Revenue in our country and globally, (Miheret, S 2021) the role of internal audit on fraud detection and prevention in the case of Ethiopian Ministry of Revenue, (Alemayehu, E 2016); The role of internal audit in detecting fraud: the case of Ethiopian budgetary public sector; (Fikeru, 2018). The Effectiveness of Internal Control System in Detection and prevention of Fraud in Ethiopian Banking Industry and (Njuguna, W. 2019), conducted a research motor insurance fraud in Kenya. The above reviewed studies have conducted, both local and at the regional level has facets of bank and public sector fraud. Therefore, seek to fill this research area gap the researcher has motivated to investigate by focusing on motor insurance fraud linked with the EIC performance.

1.3 Objectives of the Study

1.3.1 General Objectives

The general objective of this study is to examine and analyze the nature and status of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation.

1.3.2 Specific Objectives

- i. To identify the major incidence of fraud in the insurance business;
- ii. Identify the nature and status of motor insurance fraud;
- iii. Identify the major factors that can encourage fraud risk
- iv. Examine the effect of fraud risk management practices on the performance of the company;

1.3.3 Research Questions

1. What are the major incidence of motor fraud in the insurance business?
2. What are the nature and status of motor insurance fraud?
3. What are the major factors that can encourage motor fraud risk?
4. What are the effects of motor fraud risk management practices on the performance of the company;

1.4 Significance of the Study

This study contributes to the scarce empirical data on the risk management practice of motor insurance fraud in the insurance industries. Because it is one of the insurance business that had negative growth on general insurance and not frequently profitable. The study was also have a significant input to evaluate the performance of the company by risk management practice to curb insurance fraud. Additionally, the finding of the study was assist the company stakeholders to meet their business strategic objectives in order to take deterrent methods by implementing appropriate prevention approaches and other alternative solutions.

The contribution of this study to academic is also not in doubt as it provides a good premise for future research. It also adds to existing literature on the contribution of risk management to

detering insurance fraud. The study was also having a contribution to the policy makers such as the regulator of the industry (National Bank of Ethiopia) and different parts of the government in laying down the foundation for the growth of the insurance sector in the economy

1.5 Scope of the study

The scope of this study contextually limited to analysis of motor insurance fraud and risk management practice of EIC in respect to its performance. The research is concerned in analyses of the main incident, nature, major factors that encourage fraud risks and to examine the effect of fraud risk management practices on the performance of the company. It has been done from the understanding and context of different category of insurance employees on underwriting and claim process operational activities located at Addis Abeba.

The population consists of in the study area key informants such as: Chief Executive Officer, Deputy Executive Officers, Directors, Team Leaders, Principal and Senior Officers, Auditors, Ethics and anti-corruptions officers and risk management officers of five district –All main branches, one district –BII branches and branch I and branch II managers located at Addis Ababa.

1.6 Definitions of Terms

According to, H. W., Rubin (2000) insurance terms defined as:-

Adverse selection a process in life insurance by which an applicant who is uninsurable, or is a greater than average risk, seeks to obtain a policy from a company at a standard premium rate. Life insurance companies carefully screen applicants for this reason, since their premiums are based on policyholders in average good health and in non-hazardous occupations.

Agent:- One who negotiates contracts of insurance or reinsurance as an insurance company's representative i.e. the agent's primary responsibility is with the insurance carrier and not the insurance buyer.

Asymmetric information is a term that refers to when one party in a transaction is in possession of more information than the other. In certain transactions, sellers can take advantage of

buyers because asymmetric information exists whereby the seller has more knowledge of the good being sold than the buyer.

Excess or Deductible:- The amount or proportion of some or all losses arising under an insurance contract that the insured must bear.

First Party - In an insurance contract, the first party refers to the person who buys the insurance. Thus, the car owner is referred to as the first party in a car insurance policy.

Hazards:- are the conditions that increase the severity of loss or the conditions affecting perils. These are the conditions that create or increase the severity of losses.

Insurable Interest:- The Insured must have an insurable interest in the subject matter of insurance, that, he/ she must benefit by its safety or be prejudiced by its loss. It an interest accepted and protected by law arising out of financial and legal relationship.

Insurance broker:- a representative of an insured, not of an insurance company. Acts of a broker are not the responsibility of the company, and notice given by an insured to a broker is not the same as notice to the company. The broker searches the insurance marketplace for a company in which to place the insured's business for the most coverage at the best price. The broker is not restricted to placing business with any one company.

Insured:- a person who has been insured by an insurance company or underwriter against loss.

Insurer: - a company who has been providing the insurance cover.

Material misrepresentations is a falsification of a material fact in such a manner that, had the insurance company known the truth, it would not have insured the risk. A material misrepresentation gives an insurance company grounds to void a contract

Moral hazard refers to the increase in the probability of loss that results from dishonest tendencies in the character or behavior of the insured person.

Moral hazards:- circumstance which increases the probability of loss because of an applicant's personal habits or morals; for example, if an applicant is a known criminal.

Peril refers to the prime cause of an accident loss or the contingency that may cause a loss. In literary sense, it means the serious and immediate danger. Perils refer to the immediate causes of loss.

Physical hazard consists of those physical properties that increase the chance of loss from the various perils.

Premium the payment, or one of the periodical payments, a policyholder agrees to make for an insurance policy.

Premium:- Amount payable by the insured or reinsured in order to obtain insurance or reinsurance protection.

Reinsurance refers to An agreement to indemnify a primary insurer by a reinsurer in consideration of a premium with respect to agreed risks insured by the primary insurer. The enterprise accepting the risk is the reinsurer and is said to accept inward reinsurance. The enterprise ceding the risks is the cedant or ceding company and is said to place outward reinsurance.

Risk:- There is no single definition of risk. Economists, behavioral scientists, risk theorists, statisticians, and actuaries each have their own concept of risk. However, risk historically has been defined in terms of uncertainty and it refers to the possibility that something unpleasant or dangerous might happen. It is a condition in which there is a possibility of an adverse deviation from a desired outcome that is expected or hoped for.

Second party: - refers to the car insurance company that protects the vehicle and compensates for the losses or damages to the car

Third Party: "third party" means any person other than the insured person, member of the insured person's family, the driver or employee of the insured person to which an insurance policy applies at the time when vehicle accident occurred giving rise to liability under such insurance policy;

Underwriting refers to The process of reviewing applications submitted for insurance or reinsurance coverage, deciding whether to provide all or part of the coverage requested and determining the applicable premium.

Warranties: a promise which shall be done or not done during the currency of insurance policy. There are two types of warranties: express and implied. Express warranties are written into the contract and become a condition of the coverage relating to potential causes of an insured event. Whereas implied warranties not written on the policy but it is applied impliedly.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1 Introduction

This chapter includes both theoretical and empirical literature on motor insurance fraud and the concept of risk management practice. The purpose of this chapter is to clearly indicate how insurance fraud is a serious problem globally in the insurance industry.

2.2 Theoretical Literature Review

According to *Black's Law Dictionary* Insurance is defined as: a conditional contract that involves an insurer and insured where one of them agrees to compensate the other for a loss of a conditional element through specified perils in their agreement. The –insurer‖ is the company who pays the compensation fees at the time of claim to the person –insured‖. The insurer is also named to as the –underwriter‖ that concluded the contract. The consideration between the individuals is called –premium‖, and it is a sum of money payable at the time of an agreement. This entire consent is confirmed in a document called the –insurance policy‖ (Garner, B. A. 2004).

According to Vaughan, and et al. (2007) insurance contract is a conditional contract, which means the conditions of the contract are considered a part of the consideration (premium) by the insured. The insurer is obligated to fulfill its promises only if the insured has fulfilled his or her promises. At the same time, if the conditions are unmet, they may be prevented from collecting in the event of a loss. Additionally, insurance contract is a contract of *adhesion* that is prepared by the company and accepted or rejected by the insured.

The contract of insurance also *aleatory* contract that means a contract where performance of the promise is dependent on the occurrence of a fortuitous event and the outcome is affected by chance and the number of money in terms of premiums given up by the contracting parties will be unequal. The insured pays the required premium, and if no loss occurs, the insurance company pays nothing. If a loss does occur, the insured's premium is small in relation to the amount the insurer will be required to pay.

Due to the nature of insurance contract certain legal characteristics are unique to insurance covenants notably; *Utmost Good Faith, Indemnity, Insurable Interest, Proximate Cause, Subrogation, and Contribution*. The principles have evolved from practices adopted during the development of insurance over a period of several hundred years, and have been upheld by courts of law and stated in our commercial code.

According to Gupta, P. K. (2008) the six doctrine of insurance defined as:-

- i. **Utmost Good Faith (*uberrimae fidei*)** :- Under the contract of insurance, the insured is duty bound to disclose all material facts relating to the risk to be covered. Utmost good faith is a positive duty voluntarily to disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not.
- ii. **Indemnity**. The principle of indemnity maintains that individuals should not be permitted to profit from the existence of an insurance contract but should be restored to the same financial condition that existed prior to the occurrence of the loss.
- iii. **Insurable Interest** The most important legal doctrine giving substance and support to the principle of indemnity is that of insurable interest. An insurance contract is legally binding only if the insured has an interest in the subject matter of the insurance and this interest is insurable.
- iv. **Contribution Condition** is a corollary to the Principle of indemnity. If an insured obtains more than one policy covering the same risk, he cannot recover the same loss from more than one source so that more than 'Indemnity' does not benefit him.
- v. **Subrogation:-** in general, means the legal right of one person, having indemnified the other in a contractual obligation to do so, to stand in the place of another and avail of all the rights and remedies of the another, whether enforced or not.
- vi. **Proximate Cause:-** It is defined as the active efficient cause not a remote cause and a chain of concurrent events that causes a loss or damage to the subject matter of insurance must be an insured peril;

2.2.1 Fundamental Concepts of Insurance Fraud

Fraud is defined as applying the methods of deception or any device that would culminate in an individual or groups gaining advantages over others, by making wrong suggestions or not telling

the truth which includes all surprises, tricks, cunning or dissembling, in any unfair way (Albrecht et al., 2012).

Insurance fraud has significant financial, societal and humanitarian costs, its complex, multi-sided phenomenon, and has many types of insurance fraud, which include offences of individuals against individuals, individuals against companies, companies against individuals and companies against other companies, therefore it is definitely affecting the insurance companies' earnings, reserve deficiencies, rising loss costs and other insurance expenses, as well as pricing difficulties, for example, fraud in motor insurance is historically one of the most costly fraud scandals in the world, according to (Coalition Against Insurance Fraud, 2012) in the United States this type of fraud is costing the average household \$950/year, which means that around 10-20% of all motor insurance claims filed are fraudulent.

According to Hoyt et al. (2006) indicated that fraud increases the cost of insurance, impends the financial strength of insurers and negatively affects the accessibility of insurance, Hence, fraud, arising from illegal claims inflate the costs of the premium. What further worsens the case is the difficulty involved in detecting and preventing fraud as it results from asymmetric information between the insurers and their customers (Cawley and Philipson, 1999).

Fraud has grown rapidly over the last few years, and there is a growing trend for large organizations to consider hiring professionals such as forensic accountants to reduce the pressure and potential of occupational, financial frauds (Mansor & Abdullahi, 2015).

In Insurance fraudulent activity on behalf of any of the transacting parties generally requires the presence of the following elements: (1) material misrepresentation that is in the form of concealment, falsification or lie, (2) intent to deceive, and (3) aim of gaining an unauthorized benefit. The absence of one or more of these key elements makes an undesirable activity at most qualify as so-called abuse of insurance (Viaene, & Dedene, 2004).

Viaene, & Dedene, (2004) indicted that, there are three commonly encountered functional classifications of insurance fraud are: (1) internal 2) external, (3) underwriting (3)claim, and (4) soft (5) hard fraud.

Internal fraud is committed by insiders of the insurance industry professional employees, insurance intermediaries such as agents, brokers, managers. This includes, for example, selling insurance without a proper license, embezzlement of insurance funds.

External fraud is fraudulent activity on the part of outsiders of the insurance industry such as applicants, policyholders and claimants, sometimes perpetrated in collusion with insiders such as agents or brokers, or third-party service providers such as nominated motor vehicles repairs, garages. Intermediary fraud. These activity done by intermediaries such as agents and brokers against the insurer or policyholders.

Outsiders in the insurance sector, such as applicants for insurance, policyholders, and claimants, engage in fraudulent behavior, which is sometimes carried out in conjunction with insiders, such as agents or brokers, or third-party service providers (i.e. vehicles repairers garages) and conspiracy with employee.

Fraud committed via intermediaries. Intermediaries, such as agents and brokers, engage in this activity on behalf of the insurer or policyholders.

This covers, amongst others, providing false statements and submitting bogus claims. It also includes cases of professional providers of services (to insurers, middlemen, garages, suppliers billing insurance for non-existent services; misrepresenting services provided; and charging insurance for the same services more than once.

2.2.2 Motor Insurance Fraud

Motor insurance fraud ranges from misrepresenting facts on insurance applications and inflating insurance claims to staging accidents and submitting claim forms for injuries or damage that never occurred, submitting false traffic police reports for vehicles accidents.

According to IRC, (2012) Fraud accounted for between 15 percent and 17 percent of total claims payments for auto insurance bodily injury. The study estimated that between \$5.6 billion and \$7.7 billion was fraudulently added to paid claims for auto insurance bodily injury payments in 2012, compared with a range of \$4.3 billion to \$5.8 billion in 2002.

Given the high prevalence of organizational fraud, as reported by the Association of Certified Fraud Examiners (ACFE), companies have strong incentives to invest in fraud auditing capabilities both internal and independent (external) audits (Mark Lowers, 2015). Detecting fraud is a high priority in the audit profession. Leaders argue that the future demand for audits was depend largely on auditors' detect and deter fraud (Wilks and Zimbelman, 2004).

Insurance fraud is a deliberate deception perpetrated against or by an insurance company or agent for the purpose of illegitimate financial gain. Fraud may be committed at different points in the transaction by applicants, policyholders, third-party claimants, or professionals who provide services to claimants. Insurance agents and company employees may also commit insurance fraud.

1) Underwriting Fraud

This will happen during the offer and acceptance of risks and it includes fraudulent acts perpetrated at renewal of the insurance contract and concealment of information during application to obtain coverage or a lower premium, intentional disguise of existing insurance contracts and underwriting coverage for fabricated risks. Since the principle of utmost good faith obliges the policyholder to report any new or altered information that comes to his attention during the course of the contract and is likely to affect the insured risk.

2) Claim fraud

It is most prevalent fraud in insurance companies which refers to deliberately inflated, false or fictitious claims. It has two types:-

Soft fraud:- refers to claimants seizing an opportunity to inflate the damages or legitimate claim. The label “_soft” tends to be broadly associated with unwanted opportunistic behavior of normally frank people. What behavior exactly falls under this category is not always made explicit and depends on the stakeholder using the vocabulary, but it generally includes claimants seizing an opportunity to inflate the damages of an otherwise legitimate claim such as claim padding or build-up.

Hard fraud:-It refers that to a carefully planned and minutely executed to rip off insurance. The soft fraud is opportunistic fraud however; hard fraud is planned one. The terminology “_hard

fraud“ is often reserved for criminal offences (Derrig and Krauss, 1994). For instance, hard fraud includes, filing claims for bogus or staged injuries and accidents.

2.2.3 Risk Management

Risk management is a scientific approach to the problem of risk that has as its objective the reduction and elimination of risks facing the business firm. Risk management evolved from the field of corporate insurance buying and is now recognized as a distinct and important function for all businesses and organizations (Vaughan, E. et al (2007). The definition of the process of risk management is:

Risk management is a scientific approach to dealing with risks by anticipating possible losses and designing and implementing procedures that minimize the occurrence of loss or the financial impact of the losses that do occur.

Risk Management has been as a group of actions that are integrated within the wider context of a company or organization, which are directed toward assessing and measuring possible risk situations as well as elaborating the strategies necessary for managing them (Hopkin 2010). Risk management encompasses; identifying and assessing risks inherent to an organization and then responding to them in a manner that was reduce their impact and maximize the shareholder value (Ouma, 2014). It comprises the activities and actions taken to ensure that an organization is conscious of the risks it faces, makes informed decisions in managing these risks, and identifies and harnesses potential opportunities.

2.2.4 Fraud Risk Management

Managing the risk of fraud requires the same process as managing other business risks. The guidelines on risk management are available in the ISO 31000 (2010) and the COSO framework (2013). Fraud risk management refers to any activities planned and actions taken to minimize risk arising from the potential and actual cases of corporate fraud. The COSO framework recognizes the fact that all organizations require a formal internal control procedure and recommend that adequate measures are used in evaluating whether objectives are met or not.

Different literatures indicated that an effective fraud risk management approaches encompasses controls and measures that can be grouped into three broad dimensions: preventives, detectives, and responsive measures (ACFE, 2015)

Current researches on fraud and the management of fraud mainly focus on detection and preventive approach. These proactive approaches aim at averting and detecting fraud at an early stage and in line with firm's strategic objectives to tackle the fraud before it occurs. However, responsive measures are no doubt need equal focus to manage residual fraud risks. Thus, an effective business driven fraud risk management approach is one that is focused on three aspects: detection, prevention, and response (Boateng et al., 2014)

Preventive Fraud Risk Management means avoiding the occurrence of fraud. It involves the efforts to reduce the frequency of fraud occurrence to zero. Prevention and deterrence measures are less costly than the time and expense required for fraud detection and litigation (Sanusi, Rameli & Isa, 2015).

The best practice fighting fraud is to curb it from happening in the first place and preventing it is mostly on improving the key business processes (Albrecht et al., 2012) . Prevention of fraud starts with the identification of the weakness in the current systems of an organization and the enforcement of controls if introduced, will reduce the opportunities for fraud and warns potential fraudsters that organization is aggressively monitoring the business and that in turn deters fraud.

Detective Fraud Risk Management

Fraud detection involves identifying fraud as quickly as possible once it has been perpetrated. Fraud detection strategies are plans implemented to efficiently and promptly identify frauds that have by-passed the preventive measures so that an organization can take proper corrective action (Australian Standard, 2008).

Burnaby et al. (2009) in detecting fraud by the organization revealed that review of access control, physical securities and test of controls to the analysis of risk are the most effective means of fraud detection.

Responsive Fraud Risk Management

Organizational responses to fraud vary significantly from sector to sector and across countries. According to ACFE (2010), having numerous ways and mechanisms of reporting fraud incidences in an organization leads to effective control of fraud. Organizations should recognize the establishment of fraud response strategy. The tone at the top should define multiple ways of reporting fraud incidences on detection or suspicion (Biegelman & Bartow, 2012).

Performance of an Organization

It can be defined in many ways. For example, Antony and Bhattacharyya (2010) defined performance as the measure that is used to assess and evaluate the success of an organization in creating and delivering value to its external as well as internal customers. Firm performance can also be seen as an assessment of whether strategic goals are being achieved or not. Some view performance from objective measures (financial) while others from subjective measures (non-financial), (Aliyu, Jamil, & Mohamed, 2014) , with the most common indicators being yearly profit, return on investment and revenue growth.

Globally, studies have explored the relationship between fraud risk management and organizational performance. Empirical evidence indicates that it has positive relationship between fraud risk management and firm performance in various organizational setting and in several countries (Furlan, Vasilecas & Bajec, 2011)

2.3 Overview of Motor Insurance

Widespread use of the automobile began after the First World War in the cities. Cars were relatively fast and dangerous by that stage, yet there was still no compulsory form of car insurance anywhere in the world. This meant that injured victims could often not get any compensation in an accident, and drivers often faced considerable costs for damage to their car and property (CII, 2010).

According to CII, (2010) Insurance policies originated in 17th century London coffee houses which became the place for sharing information on agreements of pooled risks between merchants, ultimately leading to the formation of Lloyds of London.

A compulsory car insurance scheme was first introduced in the United Kingdom with the Road Traffic Act 1930. This ensured that all vehicle owners and drivers had to be insured for their liability for injury or death to third parties whilst their vehicle was being used on a public road. Germany enacted similar legislation in 1939.

It also known as auto/car or motor insurance is an insurance purchased for cars, trucks, and other road vehicles. Its primary use is to provide protection against physical damage and bodily injury resulting from traffic accidents and against liability that could arise from the use of vehicle. Motor insurance is all about protecting against financial losses arising out of the usage of vehicles. In exchange for premium, motor insurance was pay valid claims resulting from accidental loss or damage and liability. (CII, 2020)

Motor Insurance (or Auto Insurance) provides protection for vehicle against the financial loss and liability that could result as a part of accident or theft. The policy scope of cover includes the mandatory Vehicles Insurance Against Third Party cover and optional, Third Party Only Cover, Third Party, Fire & Theft Cover and Comprehensive Cover.

2.3.1 Nature of Motor Insurance

The main purpose of motor insurance is mainly to cover losses to third party liability to person and property as well as accidental own damage to the same due to overturning or collision depending upon the type of cover. The subject matter in motor insurance is motor vehicle.

Motor insurance is divided into two main categories, the private motor insurance and commercial motor insurance that is given for private automobile and commercial vehicle cover respectively. Private vehicle is used solely for private purpose and not used for commercial activity.

On the other hand, commercial vehicles are goods carrying vehicles as well as passenger carrying vehicles for commercial purpose. It is used to describe different types of vehicles that are intended or designed to carry goods and passengers. It ranges from trucks, busses to small goods caring delivery vans and small mini buses. Such vehicles can be used for carriage of goods and people for hire or reward and carriage of own goods pulse own service.

General Cartage: these are types of vehicles that are intended or designed to carry goods. It ranges from trucks to small goods carrying delivery vans. Such vehicles can be used for carriage of goods for hire or reward and carriage of own goods.

Passenger Carrying Vehicles: This group includes vehicles such as taxis, minibuses, buses, etc. Generally, it is divided into public service vehicles and own service vehicles. **Public service vehicles** are vehicles used for the carriage of passengers for hire or reward. These include public hire vehicles, private hire vehicles and buses. On the other hand, **own service vehicles** are vehicles used for the carriage of passengers not for hire or reward. These include organizations employee transport services.

Vehicles of **Special Construction:** such vehicles are designed or constructed to perform specific purposes such as mobile cranes, fire trucks, breakdown vehicles, dumpers dozers graders etc.

Agricultural and Forestry Vehicles: This group includes tractors, trailers, and balers and combined harvester. Motor cycles: This group is two or three wheeled vehicles used for personal or business purposes (EIC manual, 2011).

Vehicle Classification/Graphical Presentation

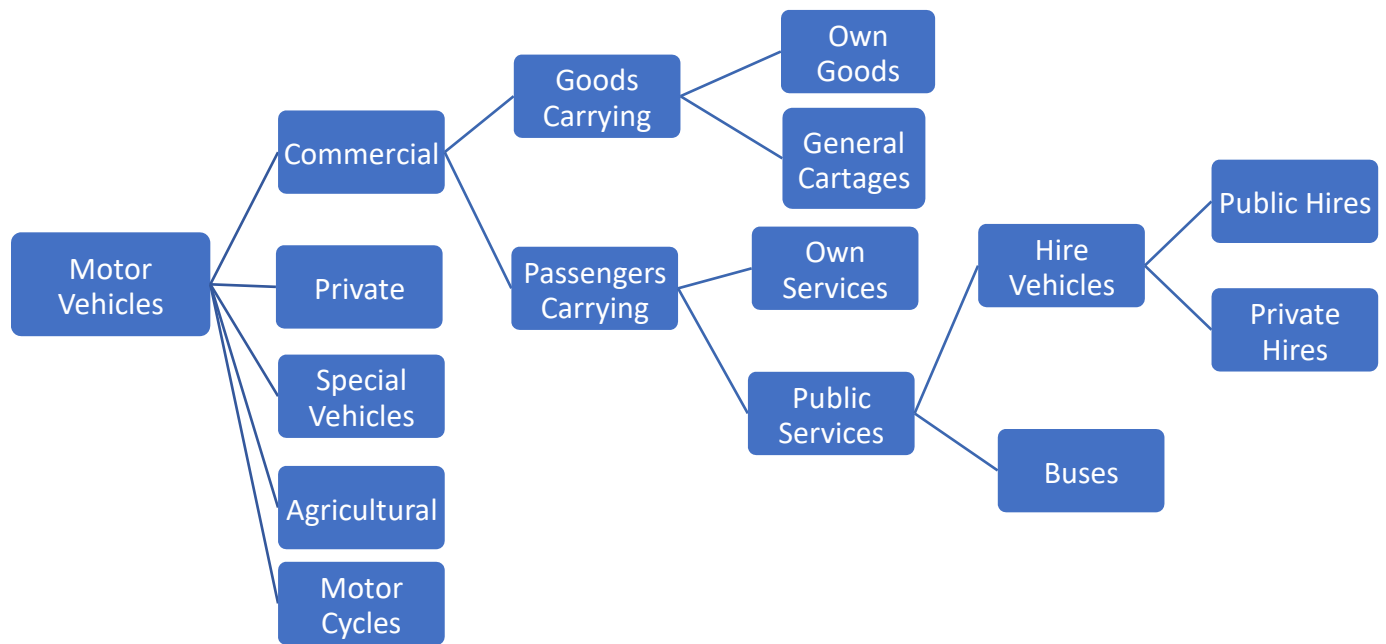


Figure 1. Vehicles Classification/ Graphically Adopted from, Chartered Insurance Institute

2.4 Theory of Fraud

This research was premised on three theories namely fraud triangle theory, the Fraud Management Lifecycle theory and deterrence theory. The aim of the research was to analyse motor insurance fraud and the risk management practice within the company.

2.4.1 Fraud Triangle Theory

Many of the world's most prominent companies have faced large-scale frauds. These frauds have had an effect on our world's economy in addition to contributing to unnecessary economic failure.

Cressey D, (1950) In his fraud triangle theory, he explains it and emphasizes its significance. He was a criminologist who sought to learn more about the fundamental incentives for fraud, which he detailed in his classic fraud theory, the fraud triangle theory.

His study looked into what motivates people to break trust. Over the course of five months, he interviewed 250 criminals whose actions fit two criteria: (1) the person must have accepted a position of trust in good faith, and (2) the trust must have been abused.

He discovered that three factors must be present for a person to violate trust and was able to conclude that: they committed the crime while under financial duress to meet their basic needs, they had knowledge or awareness that this problem could be secretly solved by breaching their position of trust, and they were able to apply this knowledge or awareness to their own conduct in that situation (Kassem & Higson (2012).

Cressey listed three factors: –financial difficulties, the opportunity to commit a trust violation, and the trust violator's rationale. When it comes to financial problems, Cressey revealed that persons breach their trust when they have faced or have incurred financial duties which are considered as it must be satisfied by a private or undisclosed means (Cressey, 1950).

He also noted that a perceived opportunity emerges when a fraudster finds a method to address a financial problem by using their position of trust, knowing that they are unlikely to be detected. In terms of rationalization, Cressey believes that the majority of fraudsters are first-time offenders who have never been convicted of a crime.

They believe this because they are honest individuals who are in a difficult situation. This allows individuals to rationalize the crime in their own minds, making it acceptable or justified.

Cressey's idea has evolved into what is known as "the fraud triangle," as seen in Figure 2 below, over many decades. The first side of the fraud triangle reflects pressure or motivation to commit fraud, the second side provides a perceived opportunity, and the third side represents rationalization. (Wells 2011).

Cressey, –combined these elements into a hypothesis known as the Fraud Triangle and defines a model that contains three elements|| such as:-

- ✚ **Pressure:** The motivation behind the crime: for example, –I have overwhelming debt and can't see my way clear.||
- ✚ **Opportunity:** The ability to use a position of trust with little perceived risk of being caught: –I'm a long-term employeell; –My performance is above reproach.||
- ✚ **Rationalization:** Justification of the crime based on personal ethical values: –I'm borrowing the money||; –I need it for my family||; –The work this company does is harmful to...|| (Donald R. Cressey, 1950)

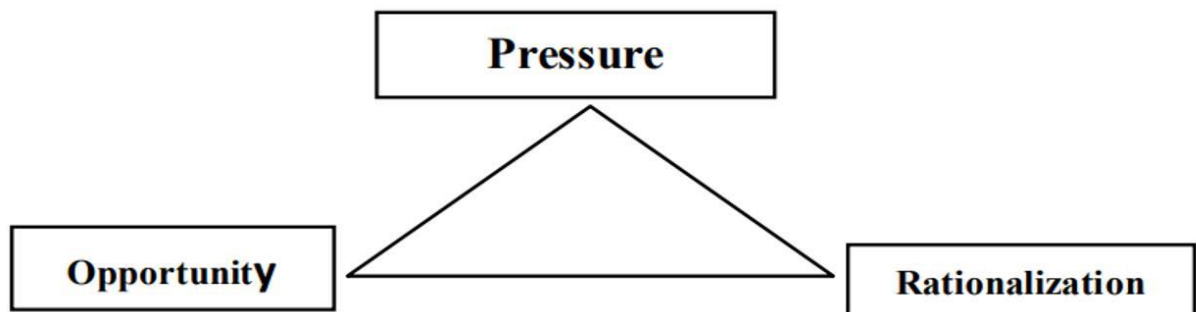


Figure 2. Fraud Triangle

Source: Wells, JT., 2005

2.4.2 The Fraud Management Lifecycle Theory

Fraud risk management life cycle is dynamic, evolving and have eight stages that are: described with the following fraud management lifecycle theory. (Wilhelm, W. K. 2004).

- i. **Deterrence:** it is the first stage, by measures and activities aimed at stopping or preventing fraud before it occurs; that is, to turn away or discourage even the attempt at fraud through, for example, card activation programs. The second stage of the Fraud Management Lifecycle,
- ii. **Prevention:** it involves actions and activities to stop fraud from occurring.
- iii. **Detection:** the intent of detection is to uncover or reveal the presence of fraud or a fraud attempt such as: statistical checking programs are used to identify and locate fraud prior to, during, and subsequent to the completion of the fraudulent activity.
- iv. **Mitigation:** by blocking an account, we can prevent losses from occurring or continuing, and/or we can prevent a fraudster from continuing or finishing the fraudulent conduct.
- v. **Analysis,** by using analysis approaches we can identify the root cause of losses that occurred despite deterrent, detection, and prevention measures to understand the reasons that contributed to the loss situation.
- vi. **Characterized by activities** to develop, assess, explain, and help in the implementation of policies aimed at reducing fraud.
- vii. **Collecting enough evidence** and information to detect fraud, recover illegitimate assets, or achieve restitution, as well as proof and assistance for the successful prosecution and conviction of the fraudsters (Wilhelm, W. K. 2004).

2.4.3 Deterrence Theory

According to Scholtz, (1997). Fraud Deterrence theory assumes that, customers and any contracting party in insurance policy conduct crimes based on calculations about imagined personal benefits, and the possibility of legal sanctions deters people for fear of punishment,

Deterrence through contract design and auditing are the two main ways found in the theoretical literature on insurance fraud. These two approaches tackle insurance fraud, which can be caused by two types of asymmetric information: adverse selection and moral hazard.

Adverse selection occurs when an insured in an insurance contract has information about the insured subject matter that the insurer does not. Adverse selection happens in this case when

asymmetric information is utilized, causing the prudent insurer without important knowledge to make decisions about whether or not to accept the risk. Morale hazard is the behavior and attitude of an insured's that has an influence on the risk covered by the policy after it has been signed (Yusuf, 2009).

2.4.4 Deterrence through Contract Design

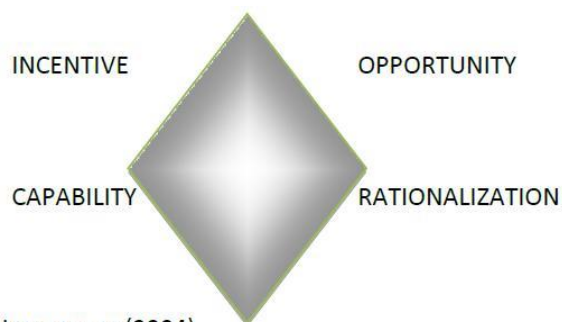
J. Schiller, (2003) suggested that policyholders may be able to utilize their information advantage about the knowledge of the subject matter insured loss report that did not exist.

Townsend (1979), on his landmark contribution to theories on insurance fraud, describes an insurance contract with deductible (i.e. the first part of the claim that must be paid by the policy holder) as an optimal contract in the presence of costly state verification problems. Such contract would minimize claim costs and guarantee insurance protection against large losses to risk-averse policyholders. It would also reimburse the total reported loss less the deductible when the reported loss is above the deductible. Hence, in the contractual agreement (i.e. in an insurance policy) Excess or deductible clause can minimize insurance fraud.

2.4.5 Fraud Diamond Theory

Wolfe and Hermanson (2004) proposed in the Fraud Diamond that the Fraud Triangle can be extended by adding a fourth aspect termed capability after evaluating the four characteristics of fraud. Position and proper knowledge are two capabilities that can be connected to the offender.

According to Dorminey et al. (2010), the ability to open the door to fraud, pressure, and justification get the perpetrator closer to the door, but the perpetrator must be able to recognize the presence of the chance to go through the door and perform fraudulent acts.



Source: Wolfe and Hermanson (2004)

2.4.6 Summary of Theory of Fraud

The evolution of fraud theory discusses how the characteristics of fraud perpetrators and the environment in which they operate have changed over time. This theory is being developed in order to capture reality and provide an alternate answer to fraud concerns. The study of fraud in the modern era cannot be limited to a single discipline. Fraud research is a multidisciplinary endeavor. It requires economic, psychological, sociological, criminological and political approaches in order to be able to capture the fraud phenomenon comprehensively.

This theoretical reviews on the existing literature on frauds for the purpose of discussing the fraud triangle theory of Cressey (1950). The level of fraud concealed and its cost is expected to rise over time. In order to proactively address the fraud risk factors, the anti-graft bodies have to clearly understand the fundamental elements which contribute to fraudulent acts. Violations of trust are motivated by one's perceived risk of the surrounding and the temptations to benefit from the situation.

Regarding on the theory of Fraud Management Lifecycle confirmed that the successful identification of the presence of the fraud reinforces the belief that effective fraud management balances the activities in each stage of the Fraud Management Lifecycle.

In order to deter insurance fraud deterrence through contract design has a special role and by imposing excess and deductibles in the policy condition expressly can curb an insurance fraud.

2.5 The Effect of Motor Fraud Risk Management

Insurance fraud is a misconduct crime that costs insurance company, policyholders, and society as a whole and causes considerable financial and personal damages. It affects people of all ages, races, and genders. Because of the massive losses that occur inside the insurance sector, the cost of insurance to customers continues to rise year after year. Insurance fraud frequently goes undetected because the perpetrators involved in a clandestine felony that can be committed by either an insurer or an insured (ACFE, 2019)

Insurance fraud is committed by a variety of people, ranging from skilled criminals to average consumers and even insurance business staff. It is becoming an increasingly costly burden on a

country's economy, diverting valuable resources away from businesses, law enforcement, the civil justice system, and regulatory agencies.

Consumers are harmed by insurance fraud because premiums and the costs of various goods and services rise. Insurance firms are forced to pass on the expenses of false claims, resulting in higher rates. The actual extent and cost of insurance fraud remain hard to quantify with precision. There are several obstacles to its measurement. The first, particular to the nature of fraud itself, is the fact that it is set up as a covert operation and, as such, is not self-revealing. Fraud is not a static phenomenon either. It is as dynamic as the business environment itself and swiftly capitalizes on the latest opportunities (Dionne, 2000).

Best practices in risk management are meant to keep flaws in companies from causing damage or even bringing the company down. Effective strategic risk management methods and practices, on the other hand, become more difficult to execute as businesses expand, become more complicated, operate in several locations, and branch out into new areas of business.

2.6 Major Factors Encouraging Fraud

The availability of an economic motivation, opportunity, and the unavailability of skilled guardians are two main variables that encourage fraud. (Cohen and Felson, 1979).

Fraud also follows opportunity (Felson and Clarke, 1998). Insurance, by its very nature, is especially prone to fraud. Due to information unevenness, the players have no choice but to trust each other throughout transaction time. It is lack of perfect knowledge, numerous situations develop where one or more of the persons involved has a clear economic motivation to conduct fraud, whether deliberate or opportunistic.

2.7 The fraud Risk Management Practice on Detering Insurance Fraud

Fraud is not a new phenomenon: it can be traced back to the early of our world's history, when men used tactics, manipulation, and deception to obtain money, land, goods, or trust, all with the goal of generating a profit. In economic history, the development of accounting and auditing is linked to a desire, particularly on the side of the state and the church, to prevent theft and misrepresentation in their finances.

Biegelman, M. T., & Bartow, J. T., (2012) outlines five key important principles of fraud risk management process and suggests solutions for boards, senior management, and internal auditors to improve fraud risk management effectiveness. The following are the five principles:

Principle 1: A fraud risk management program should be in place as part of an organization's corporate governance structure, including an expressed policy that communicates the board of directors' and senior management's expectations for managing fraud risk.

Principle 2: The organization's fraud risk exposure should be examined on a regular basis to identify particular potential schemes and occurrences that need to be avoided or to mitigate.

Principle 3: wherever possible, prevention methods to avert probable important fraud risk events should be devised to mitigate the organization's potential impacts.

Principle 4: when preventative measures fail or unmanaged hazards are realized, detection mechanisms should be devised to uncover fraud events.

Principle 5: To ensure that potential fraud is appropriately dealt with in a timely manner, a reporting process should be in place to solicit input on potential fraud, and a coordinated approach to investigation and corrective action should be used.

2.8 Review of Empirical Studies

Mihert S, (2021) conducted a descriptive survey on the role of internal audit was undertaken using a cross-sectional survey to explore the function of internal audit on fraud detection and prevention. The investigation identified a lack of proper organization setup and undefined scope of internal auditors in the organization, as well as a lack of competence and independence of auditors in fraud detection, and an issue with the efficacy of internal audit work in identifying and preventing fraud. According to the findings the Ethiopian Ministry of Revenue's internal audit staff lacks the necessary knowledge and independence to prevent and detect fraud and the office does not employ fraud risk assessment activities. The study concluded that, internal audit has played a little role in the prevention and detection of fraud in the past.

Alemayehu E. (2016) conducted a research regarding internal audit's function in detecting fraud. He confirmed that internal audit is important as an essential internal assurance mechanism in controlling fraud in any sector, according to the study, which used a cross sectional survey and descriptive statistics to investigate the role of internal audit. He concluded that internal audit is important as an essential internal assurance mechanism in controlling fraud in any sector. He discovered in the study's findings that there is a problem with auditors' competency and lack of independence when it comes to the value of internal audit work in detecting and preventing fraud.

Kassem & Higson, (2012) explored the Cressey's model of fraud triangle theory, with an emphasis on a problem that receives a lot of attention from regulators, auditors, and the general public. External auditors are increasingly being asked to play a key role in assisting organizations in preventing and detecting fraud. Detecting fraud is a difficult endeavor that necessitates a full understanding of the nature of fraud, as well as how it can be committed and concealed. Their research attempts to increase external auditors' understanding of fraud and why it occurs. They explain and demonstrate the significance of Cressey's fraud theory, offer various fraud models, and propose a new fraud triangle model for external auditors to consider when assessing the risk of fraud.

Fikeru, (2018), did a study on the Effectiveness of Internal Control Systems in Detecting and Preventing Fraud in the Ethiopian Banking Industry, and he noted that frauds are something that

banks and other companies must deal with. In the Ethiopian banking business, the survey looks at the concerns of effective internal control vs. fraud detection and prevention.

Internal control systems at Ethiopian banks have benefited in combating or preventing fraud in the banking industry, according to the study's findings. Internal control techniques used by banks to prevent fraud were found to be effective, but some improvements were noted, and the study's final conclusion was that there is a significant relationship between internal control system components (control environment (CE), risk assessment (RA), and control activity (CA)).

Njuguna, W (2019) conducted a research on auto insurance fraud in Kenya: An evaluation of the legislative and institutional framework's effectiveness in preventing insurance fraud. The main objective of the study was to assess the efficiency of Kenya's current legal and institutional framework in combating insurance fraud.

The study determined if there was a need to examine the current Insurance legal and institutional framework as a whole, and whether the insurance-related amendments were sufficient. According to the findings, the legislative structure in place before to the enactment of the Insurance Act had modestly succeeded in reducing insurance fraud. The study concluded that more attention should be paid to the institutional structure in order to effectively combat insurance fraud.

Chepkoech & Rotich, (2017) conducted a descriptive research and applied fraud management lifecycle theory, collective risk theory and new institutional economic theory in describing the relationship between risk management process and motor insurance fraud.

The general objective of the study was to establish the effect of risk management process on motor insurance fraud in Kenya. The study found that there was significant relationship between risk identification, risk assessment, risk mitigation, risk monitoring and Motor Insurance fraud in Kenya.

The study concluded that all the dependent variables influence Motor Insurance fraud in accordance to regression results. From the finding and conclusions, the study recommends that organizations should carefully consider the extent to which they adopt the various risk management strategies, since it has been established from the study that they affect motor

insurance fraud differently and recommends that risk management strategies should be made a core business process by insurance companies and should be planned systematically and accordingly in the context of risk identification.

Bashir, et al (2013) conducted a research and stated that insurance fraud is continually growing concerns among insurance companies and authorities in India, according to a study, due to enormous losses caused to businesses every year. This type of insurance, which accounts for nearly a third of all non-life insurance in India, is particularly vulnerable to fraud.

The study demonstrates that there is a scarcity of research on such a topical subject in developing countries like India, and it advises that insurance companies should discuss the effects of insurance fraud on the business in order to combat the problem.

Rawashdeh & Singlaw (2016) carried out a descriptive study on the existence of fraud indicators in the insurance industry: the case of Jordan. The study looked at the possibility of fraud indicators in this market and picked four variables: effective internal systems, probable fraudulent acts by insured parties' middlemen or brokers, and complementary service providers.

Viaene and Dedene (2004) confirmed that a policy holders may conduct fraud or engage in fraudulent actions, particularly if they have had an unfavorable experience with the insurance relationship, such as delays in indemnifications or underpayment of compensations.

2.8.1 Summery of Empirical Literature Review

Regarding the findings from different literature revealed that insurance companies had different types of fraud indicators and vulnerable to fraud. Despite the fact that numerous studies have been undertaken globally on insurance fraud and its regulation, and numerous recommendations have been made. However, I was unable to find any empirical research in our country.

Hence, the researcher decided to survey this critical area and it would have given an opportunity for the company and as a whole in the insurance industry. Therefore, intent of this research to assess the motor insurance fraud and the role of risk management practice of EIC in deterring this killer operational risk and to fill the knowledge gap that exists in the area by providing evidence from the finding of this study.

2.9 Conceptual Framework

The researcher believes that when analyzing motor insurance fraud and its risk management practice in the performance of the company. As per the theoretical and empirical literature review this study come up with the following conceptual framework. Thus, the researcher selects performance of the company as dependent variable and fraud risk management practices as independent variables i.e. Preventive practice, detective practice and responsive practice.

Fraud Risk Management Practice

Independent Variable

Dependent Variable

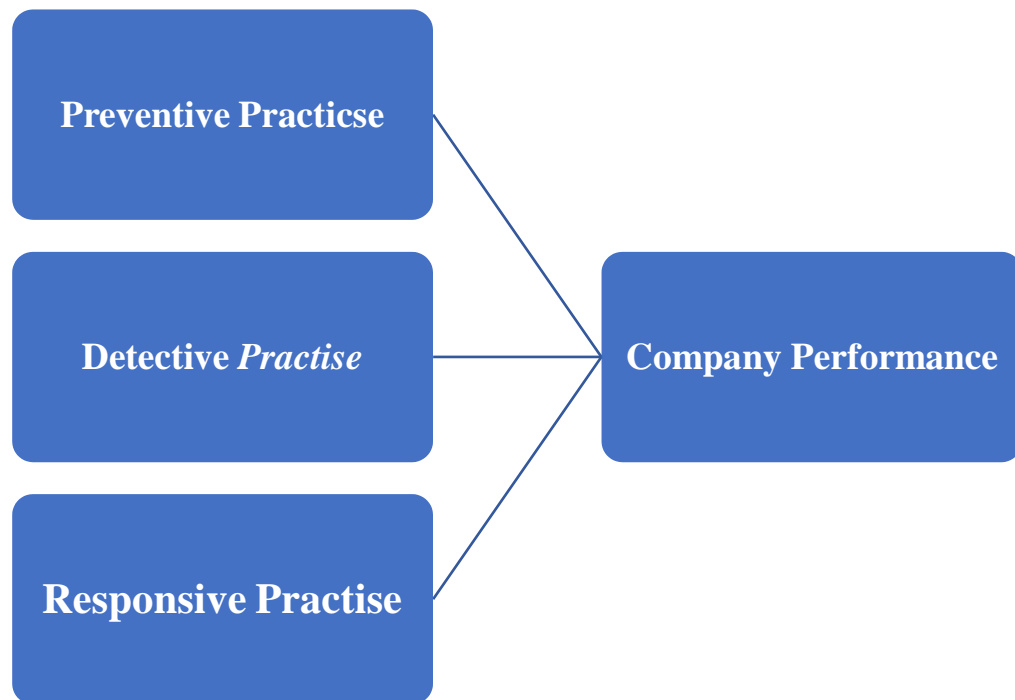


Figure 3. Conceptual Framework

Source: Different Literature

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter emphasizes on the research design and methodology used to explore the status of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation. The main purpose is to provide the setting and contextual background for the in-depth analysis of issues to be dealt with in the chapters that follow. Detailed accounts of methods involved in data generation and techniques employed in processing and analyzing the data will also be dealt with.

3.2 Research Approach

To better understand the nature and status of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation. The research approach is a quantitative method that was employed.

It attempts to precise measurement of the findings. The quantitative methodologies usually measure the respondent's behavior, knowledge, opinions, or attitudes. Such methodologies answer questions related to how much, how often, how many, when, and who. (Cooper & Schindler, 2008)

3.3 Research Design

Research design is a comprehensive plan for data collection in an empirical research project. It is a –blueprint‖ for empirical research aimed at answering specific research questions. Hence, the study used descriptive explanatory research type. This method is best suited for studies that have individual people as the unit of analysis (Anol B (2012). Explanatory research attempts to explore and explain while providing additional information about the topic and it uses to define situations, problems, events, situations or any other characteristics that has not been clearly defined in terms of the reasons why it takes place. It is a research methodology that aims to define the –why‖ behind a certain phenomenon. It uses reasoning and connects different ideas to define a cause and effect based relationships that highlight the factors or reasons behind the happening of a certain event. This relationship based understanding helps in identifying pain points to solving specific issues. (Thornhill, et al 2003).

To explore a contemporary and little-understood phenomenon within its real-life context (Yin, 2018) and changes observed over time, a descriptive and explanatory survey design was employed. The choice of the descriptive survey design allows a picture of a situation as it occurs in natural setting (Creswell, 2014). This study focuses mainly on the nature and status of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation. The Ethiopian Insurance Corporation was selected on the basis of its relevance for the study.

A questionnaire survey was employed to investigate the major incidence of fraud in the insurance business, the nature and status of motor insurance fraud, the major factors that can encourage fraud risk, and the effect of fraud risk management practices on the Ethiopian Insurance Corporation. Hence, the qualitative and quantitative data complement each other to provide a full picture of the study issues.

3.3.1 Sources of Data

Data were collected from both primary and secondary sources. Information such as the major incidence of fraud in the insurance business, the nature and status of motor insurance fraud, the major factors that can encourage fraud risk, and the effect of fraud risk management practices on the performance of Ethiopian Insurance Corporation was collected from different secondary sources. Primary data were collected on a range of variables important for answering the research questions of this study. Secondary data were collected mainly from motor insurance policy and practice documents and annual report.

The researcher used quantitative data. This involves the use of descriptive analysis. The descriptive statistics incorporates the use of tables and percentages.

3.3.2 Sampling Technique & Procedure

In order to infer about the population, it was necessary to include sample from all classes. Accordingly, the sample has been selected using random sampling technique. In this regard, the total numbers of samples considered for this study were selected employees of the corporation located in Addis Ababa area from Head Office and level –A|| Districts, one District –B||, Three Branch I and twelve branch II senior officers, principal customer care officers, managers, district directors, team leaders and key informants from internal audit directorate, business development

and risk management directorate and ethics and anti-corruption work unit total number of populations are 243 population. Due to the large size of population it is difficult to survey all population.

As per the data obtained from Human Resource Management Directorate of the Corporation, the total number of employees as of September, 2021 reached 1,767 among these number 243 insurance operational employees are working in Head Office, District -A, District -B and Branches. The target population selected for this study was, however, limited to all operational employees and management members by taking their nature of operations, and frequent interaction with customers during insurance policy underwriting and claim handling process. Table 1. Shows the total number of target population found in Ethiopian Insurance Corporation, Addis Ababa and the nature of operations for this study.

Table 1. Distribution of Samples in the Study

Position	CEO Top Management	DCEO Top Management	Director Middle Management	Team Leader Middle Management	Manager Lower Management	Principal Lower Management	Senior Officer (Non-Management)	Officers	Auditors
Head Office	1	4	10	4		5			15
District "A"	-	-	6	11		42	50	10	-
District "B"	-	-	-	1		1			
Branch I	-	-	-	-	15	4	8	5	-
Branch II	-	-	-	-	13	13	20	5	-
	1	4	16	16	28	65	78	20	15
Total									243

In terms of sample size, the study used a simplified method developed by Yamane (1967) to establish the minimal sample size required at a 95 percent confidence level with a 5 percentage point error. The formula is as follows:

$$n = \frac{N}{1 + Ne^2}$$

Where n = no is the sample size

N= is the population size, and

$$n = \frac{243}{1+243(0.05)^2}$$

e = is the level of precision or sampling error

$$n = \frac{243}{1.6075}$$

Therefore, sample size was 151 respondents

3.4 Methods of Data Collection

For data collection, questionnaires and document review were employed. The details are presented below.

3.4.1. Questionnaire

Data were collected through survey in Ethiopian Insurance Corporation, Addis Ababa. The survey was conducted with the use of Google form that is easy to interface and integration almost easy to use and user friendly. Additionally, time efficient, labor costs, accurate recapitulation of respondents' answers.

The main information collected during the survey will centered on the major incidence of fraud in the insurance business, the nature and status of motor insurance fraud, the major factors that can encourage fraud risk, and the effect of fraud risk management practices on the Ethiopian Insurance Corporation. Survey data were collected with the help of a structured questionnaire administered to selected employees of the corporation such as: Chief Executive Officer, Deputy Executive Officers (i.e. Top Management), Directors and Team Leaders (i.e. Middle Management), Principal Officers and Managers (i.e. Lower Management) and Senior Officers and Officers (i.e. non-management) by Google form online with close supervision of the researcher.

3.4.2. Document Review

To enhance the reliability of data and complement the information missing from the survey and relevant information was collected from the motor insurance policy and practice documents and annual report of the Ethiopian Insurance Corporation.

3.5 Method of Data Analysis

In order to organize, analyze and interpret the data gathered through quantitative and qualitative research methods, two data analysis approaches were used. First, quantitative data were analyzed using different descriptive and inferential statistical techniques. The procedure is that the collected quantitative data was first entered into SPSS version 26 using the pre-coded variables of the respondents. Then, results of descriptive statistics (frequencies, percentages, mean, and cross-tabulations) were presented in the form of tables, charts and other appropriate data displaying tools.

Second, qualitative data were analyzed using thematic and textual analysis tools focusing on the characteristics of certain keywords/phrases used by the informants. Also, themes that emerged during conversations with the study participants will provide the basis for undertaking the qualitative data analysis. Finally, interpretations and explanations of the data were integrated and conclusions are drawn.

3.5 Model Specification

Based on the developed conceptual of the expressed study, figure no 3 mathematically the relationship between selected independent variable and dependent variable is expressed in the multiple regression equation. Multiple regression analysis is a popular statistical technique for predicting unknown values of variables based on known values. It's also about developing a model and discovering a relationship between variables. This study's model is based on three factors or predictors that have an impact on company performance.

Based on the conceptual frame work the following model mathematically expresses the relationship between selected independent variable and dependent variable in the multiple regression equation.

Multiple regression analysis is a popular statistical technique for predicting unknown values of variables based on known values. It's also about developing a model and discovering a relationship between variables.

This study's model is based on three factors or predictors that have an impact on company performance.

Where Y is the dependent variable and the independent variables are those which explain the response ranges from X1 to X3.

Where: Y= Company Performance

X1= Responsive fraud risk management practice

X2= Preventive fraud risk management practice

X3= Detective fraud risk management practice; are the coefficients and
the error term

Table 2. Model Specifications

N₀	Independent variable	Beta Coefficients (β)	Independent variable assigned by X
1	Responsive fraud risk management practice		X ₁
2	Preventive fraud risk management practice		X ₂
3	Detective fraud risk management practice		X ₃
3	Constant		1
	Dependent variable		Variable assigned by Y
1	Company Performance		Y

3.5.1 Reliability Test

As shown in table 3, below, all of the latent variables and their accompanying indicator variables were multi-item questions. Dependability is calculated in such a way that it shows the reliability of the mean of the items, not the reliability of any single item.

According to Gliem and Gliem (2003), as compared to summated multi-item questions, a single item question is not as dependable to conclude. Based on the study, the sum of the variables has an average Cronbach's alpha value of (= 0.811), and the study's reliability test is in the "very Good" range.

Table 3. Reliability Test of Variable's Using Cronbach's Alpha

Reliability Statistics					
N_o	Variable Name	Cronbach's Alpha Value	Cronbach's Alpha based on standardized items	N_o of items	(α) reliability ranges
1	Preventive Fraud Management	0.625	0.726	9	Good
2	Detective Fraud Management	0.802	0.785	7	Very Good
3	Responsive Fraud Management	0.585	0.582	8	Good
4	Organization Performance	0.649	0.640	4	Good
	Overall	0.811	0.855	28	Very Good

Source: SPSS Version 26 Computation, 2021

3.6 Ethical Issues

In any research involving human subjects, ethical considerations are imperative (Creswell, 2014; Monette et al., 2005). Therefore, the researcher had an obligation to respect the rights, needs, and values of participants and ensure their information is confidential. Each potential participant was informed of all aspects of the study relevant to the decision to participate (Monette et al., 2005).

In this study, participants, prior to the study were informed that the purpose of the research was purely academic and the findings from the research would be disseminated in the development field. Consent to participate was obtained orally. Participants were also informed the data collected will be used anonymously with no names to protect their identity.

3.7 Limitation of the Study

The researcher encountered various challenges that tended to hinder access to information due to the escalation of COVID-19 PANDAMIC during data collection of the study. Moreover, to achieve the maximum result from the study, it would have been better if it had been studied in a comparison way between EIC and any of other 17 private insurance companies to have a complete picture of the analysis of motor insurance fraud and their risk management practice. But due to the COVID-19 pandemic and budget constraint brings a burden to limit this study just on a single insurance company, EIC.

Finally, due to the absence of empirical studies related with the motor insurance fraud in our country may affect the comprehensiveness of the study.

CHAPTER FOUR

4. DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.1 Introduction

This section summarizes and explains the information gained from the analysis. The findings have been assessed in light of the study's specific objectives and divided into two sub-sections that have detail demographic information's of respondents and the objectives' findings. The purpose of this study is to look into and assess the type and state of motor insurance fraud and risk management practice in Ethiopian Insurance Corporation.

4.1.1 Questionnaire Data of Survey Respondents

A total of 151 questionnaires were sent to respondents through Google form online interactive self-administered survey, with 137 (90.72%) of them being filled out correctly. However, 14 (9.28%) of the questionnaires were not returned. The dataset was double-checked to confirm that the data entered was correct.

To discover any irregular or unexpected data values, the lowest and maximum data values on each variable associated to each instance were evaluated. As a result, questionnaires with a response rate of 90.72 percent were utilized in the analysis, as Mugenda (2003) said that a respondent rate of 50 to 70% is sufficient for a study.

Table 4. Gender of Respondents

Item	Categories	Frequency	Percent
Gender of Respondents	Male	90	65.7
	Female	47	34.3
	Total	137	100.0

As shown in the above Table 4, 65.7 % or (n=90) of employees participated in the study are male and 34.3 % or (n=47) are female. This shows that the male respondents formed majority of the target population.

Table 5. Age of Respondents

Item	Categories	Frequency	Percent
Age of Respondents	18 and more	1	.7
	20-29	27	19.7
	30-39	62	45.3
	40-49	30	21.9
	50 and more	17	12.4
	Total	137	100.0

The sample population is predominantly dominated by respondents aged 30-39 years, that accounts for 45.3 percent (n=62), followed by respondents aged 40-49 years, accounts for 21.9 percent (30), and respondents aged 20-29 years, account for 19.7 percent (n=27) of the total number of respondents.

Table 6. Education Level of Respondents

Item	Categories	Frequency	Percent
Education level	Diploma	3	2.2
	First Degree	57	41.6
	Master's Degree	77	56.2
	Total	137	100.0

Regarding the education level of participant's majority of them have master's degree 56.2 % (n=77) followed by first degree 41.6 % (n=57).

Table 7. Experience of Respondents

Item	Categories	Frequency	Percent
Work experience of Respondents	Bellow 5	27	19.7
	Between 6-10	30	21.9
	Between 11-15	33	24.1
	Above 15	47	34.3
	Total	137	100.0

The preceding table 7. also shows the respondents' employment experience. 34.3 percent (n=47) have worked for the company for more than 15 years, followed by 24.1 percent (n=33) who have worked for 11–15 years, and 21.9 percent (n=30) who have worked for 6–10 years. Hence, the majority was above 15 years' experience and the result shows that they are familiar with the causes of fraud and the organization's fraud management practices.

Table 8. Work Position of Respondents

Item	Categories	Frequency	Percent
Position in the organization operational activity	Non-Management	58	42.3
	Lower Management	49	35.8
	Middle Management	25	18.2
	Top Management	5	3.6
	Total	137	100.0

Regarding the work position in the organization operational activity majority of the respondents were in non-management member 42.3 % (n=58) followed by lower management level 35.8 % (n=49) middle management level 18.2 % (n=25) and top management 3.6%.

Table 9. Place of Work of Respondents

Item	Categories	Frequency	Percent
Place of work in the organization	Both Underwriting and Claims	79	57.7
	Human Resources	2	1.5
	Insurance support Back Office	10	7.3
	Finance and Investment	5	3.6
	Audit Directorate	10	7.3
	Business Dev't and Risk	13	9.5
	Information Technology	15	10.9

Item	Categories	Frequency	Percent
	Management		
	Legal Services	3	2.2
	Total	137	100.0

Source: SPSS Version 26 Computation, 2021

According to the demographic information provided above, the majority of the respondents worked in both underwriting and claims (57.7% (n=79), which is the fundamental operational activity performed and where the majority of insurance fraud is alleged.

These work areas stated they had good information about the occurrence of motor insurance fraud, followed by Information Technology Management (10.9 percent, n=15), Business Development and Risk Management (9.5 percent, n=13), and the Audit Directorate (7.3 percent) (n 10).

4.2 Cause and Types of Motor Insurance Fraud

4.2.1 Types of Motor Insurance Fraud

The study also sought to establish the types of motor insurance fraud in the organization. The results are presented

Table 10. Types of Motor Insurance Fraud

Statement	Mean	Std. Deviation
Internal Fraud (staff)	2.51	1.451
Policyholder or Claimant Fraud	3.36	.961
Intermediary fraud	3.11	.975
Policy Underwriting Fraud	2.40	1.060
Claim Process Fraud	3.62	1.170

The study's findings on table 10 shows that the majority fraud occurred during the claim process that was (Mean = 3.62 SD =1.170), caused by a policyholder or claimant reveals that (Mean=3.36, SD =0.961) and Intermediary Fraud (3.11, SD =0.975) are the two most common types of motor insurance fraud. Internal fraud (Mean = 2.51, SD =1.451) was also mentioned by

several respondents as a sort of motor insurance fraud that occurred in the organization. As a result of the findings, claim fraud is of a high degree.

When it comes to sorts of fraud, various experts have proven that claims fraud can occur when policyholders and service providers collude (e.g., car repairers, loss adjusters, etc). These were concluded by research done (Rawashdeh & Singlawi 2016) that shows the existence of fraud.

The study concluded that fraud exists as a result of ineffective internal systems that provide opportunities for fraudsters. This result is consistent with previous studies such as (Yusuf and Babalola, 2009). In addition, insurance companies have faced fraudulent practices committed by policyholders and claimants. Hence, the study finding is consistent with the findings of (Dean, 2004) who investigated insurance fraud from the perspective of the insured party.

4.2.2 The Effect of Motor Insurance Fraud on Company Performance

The study sought to determine the effect of motor insurance fraud on organization. The finding presented below.

Table 11. Effect of Motor Insurance Fraud on Company Performance

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Highly Prevalent	60	43.8	43.8	43.8
	Occasionally Prevalent	39	28.5	28.5	72.3
	Moderately Prevalent	31	22.6	22.6	94.9
	Has never occurred	7	5.1	5.1	100.0
	Total	137	100.0	100.0	

According to the results in table 11, the majority of respondents (43.8 percent) believe that motor insurance fraud has had a negative impact on their organization, while other respondents believe that 28.5 percent of motor vehicle fraud has occurred on occasion. Also, 22.6 percent of respondents said that auto insurance fraud was moderately common at the firm. As a result,

various publications and experts have concluded that the incidence of insurance fraud has a significant impact on a company's performance and increases the expense of investigating suspected frauds, resulting in higher premiums for honest consumers. Investigating fraud has an influence on insurers' capacity to respond rapidly to legitimate claims.

4.2.3 Causes of Motor Insurance Fraud

Table 12. Causes of Motor Insurance Fraud

Statements	Mean	Std. Deviation
Greed	3.56	1.006
Poor Record keeping	3.27	.951
Poor internal Controls	3.74	.963
Poor salaries	3.19	1.004
Lack of appropriate punishment to fraudsters	3.77	1.007
Dissatisfied staff	3.20	.917

According to the findings of the study, motor vehicle fraud is caused by poor internal controls (Mean = 3.74, SD = 0.963), while greediness is another element that leads to insurance fraud (Mean = 3.56, SD = 1.006). The results also show that the company is vulnerable to fraud due to a lack of appropriate penalty for fraudsters (Mean = 3.77, SD = 1.007) and insufficient staff to effectively handle the motor vehicle segment.

Fraud is the result of both motive (i.e. a supply of motivated criminals) and opportunity (i.e. the availability of eligible targets and the absence of capable guardians), that confirmed by (Viaene, S., and Dedene, G. 2004) scholar's literature. Additionally, Cohen and Felson, (1979) stated that Economic incentive is by far the most common reason for deception.

Almost every fraud story has an explanation based on greed or (perceived) financial strain. Fraud also follows opportunity (Felson and Clarke, 1998). Hence, the finding shown on table 12 has supported by different literature.

Table 13. Insurance Company Strategic Approach to Fraud Detection

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Proactive	10	7.3	7.3	7.3
	Reactive	45	32.8	32.8	40.1
	Passive	82	59.9	59.9	100.0
	Total	137	100.0	100.0	

As per the table above majority of the respondents were indicated that the company strategic approach to motor insurance is passive (59.9 %) on the opinion that the insurance company strategic approach to motor insurance fraud detection and followed by reactive (32.8 %) and proactive (7.3 %). Hence, the study revealed that the company fraud risk management practice is passive.

According to the table 13 above, the majority of respondents believe that the insurance company's strategy approach to motor insurance fraud detection is passive (59.9%), followed by reactive (32.8%) and proactive (32.8%). (7.3 percent). As a result, the researcher concluded that based on the investigation discovered that the company's fraud risk management strategy is inactive.

M. T. Biegelman and J. T. Bartow (2012), confirmed that organizations should be proactive in reducing fraud opportunities by (1) identifying and measuring fraud risks, (2) taking steps to mitigate identified risks, and (3) implementing and monitoring appropriate preventive and detective internal controls and other deterrent measures in order to prevent fraud.

The study also sought to establish the types of motor insurance fraud in the organization. The results are presented below.

Table 14. Type of Fraud Committed by Internal Staff

Statement	Mean	Std. Deviation
Underwriting Insurance policy without a proper insurable interest	2.59	.944
Collusion with external bodies	3.08	1.037
Embezzlement of insurance funds	2.87	.984
Attaching fake claim documents	2.97	1.007

From the study findings indicated that internal employees committed the majority of fraud cooperation with external entities (Mean = 3.08, SD = 1.037), followed by attaching bogus claim documents (Mean = 2.97, SD = 1.007) and embezzlement of insurance funds (Mean = 2.87, SD = 0.984).

According to a survey by (Yusuf and Babalola, 2009), dishonest applicants overstate real claims to defraud insurance firms. They have used a variety of strategies, including submitting bogus claims using fake documents with the knowledge or collaboration of service providers such as mechanics, lawyers, and loss adjusters.

The commission of fraud can sometimes take the form of coordination with members of the insurance company's staff who advise the inexperienced claimant on what to write on the claim forms and also provide official support to legitimize the fraud. As a result, the conclusions of the study on insurance fraud were backed up by the aforementioned scholars.

Table 15. Type of Fraud Committed by External Body

no	Committed fraud by external/policy holder	Mean	Std. Deviation
1.	Notification of lapsed policy claim	2.80	.956
2.	Providing fake accident police report	3.23	.965
3.	Inflation or exaggeration of genuine claim	3.82	.899
4.	Providing Unauthorized driving license	3.39	.926
5.	Causing deliberate accidental damage	2.79	.919

6.	Creating an entirely fictitious event	2.70	.886
7.	Providing untruthful or incomplete information regarding claim	3.30	.926

From findings, majority of the respondents were agreed on Inflation or exaggeration of genuine claim (Mean = 3.82, SD = .899), Providing Unauthorized driving license Mean =3.39, SD = 926), providing fake accident police report (Mean 3.23. SD =.965), providing untruthful or incomplete information regarding claim (Mean = 3.30, SD = .926)

The above study finding implies that in the company underwriting and claim handling work has been exposed for various causes of motor insurance fraud such as: committed by external body ranging from exaggeration or build up genuine claim and providing fake or illegal documents such as notification of lapsed policy claim (Mean =2.80, SD =.956), Causing deliberate accidental damage (Mean =2.79, SD =.919), Creating an entirely fictitious event (Mean =2.79 SD =.886).

4.2.4 Fraud Management Practices

In this section, the study determines the effectiveness of fraud risk management practices in the organization. The respondents were requested to indicate their level of agreement on the following statements in relation to budget monitoring. The responses are rated on a five point Likert scale where: Where, 5 = greatly; 4 = considerably; 3= moderately; 2 = remotely; 1= Not all

Table 16 Preventive Fraud Management

Items	Mean	Std. Deviation
Establishment of strong internal control	3.44	.984
Establishment of effective code of conduct and related standards	3.55	.939
Targeted training on fraud prevention and	3.09	.935

Items	Mean	Std. Deviation
management		
Employment of screening techniques of potential policy holders	3.75	1.117
Employment screening	2.99	1.115
Reward to whistle blowers	4.39	.957
Establishment of Fraud Department	3.70	.770
Employment of support programs	2.78	1.386
Adoption of information technology	2.52	1.600

The findings of the study suggest that the most essential preventive fraud risk management measures are rewarding whistleblowers (Mean = 4.39, SD = 0.957), employing possible policyholder screening techniques (Mean = 3.75, SD = 1.117), and establishing a fraud department (Mean = 3.75, SD = 1.117).

Additionally, the study's findings revealed that establishing an effective code of conduct and related standards (Mean = 3.55, SD = 0.939), establishing strong internal control (Mean = 3.44, SD = 0.984), and providing targeted fraud prevention and management training (Mean = 3.09, SD = 0.935) are all important fraud risk management practices in the organization.

Other fraud risk management measures include employment screening (Mean = 2.99, SD = 1.115), the use of assistance programs (Mean = 2.78, SD = 1.386), and the use of anti-fraud technology (Mean = 2.78, SD = 1.386).

Detective Fraud Management Practices

Detective fraud management practices are aimed at identifying the occurrence of fraud in cause of insurance firm operation. The result on detective fraud risk management practices are presented in the following table.

Table 17 Detective Fraud Management Practices

Items	Mean	Std. Deviation
Management Review of Process	3.13	1.063
Proactive data analysis	3.07	1.045
Establishment of monitoring system to detect fraud	3.30	.995
Monitoring system aimed at detecting fraud	3.76	.743
Fraud risk awareness training	3.06	.968
Internal Audit	4.26	.697
External Audit	4.15	.812

Regarding detective risk management practice the findings of the study implies that internal audit (Mean = 4.26, SD = 0.697) and external audit (Mean = 4.15, SD = 0.812) are considerably important detective fraud risk management practice in the organization.

In addition, as per the result monitoring system aimed at detecting fraud (Mean = 3.76, SD = 0.743), proactive data analysis (Mean = 3.07, SD = 1.045), fraud risk awareness training (Mean = 3.06, SD = 0.968) and management review of process (Mean = 3.13, SD = 1.063) are moderately important detective fraud risk management practice in the organization.

Moreover, proactive data analysis (Mean = 3.07, SD = 1.045), fraud risk awareness training (Mean = 3.06, SD = 0.968), and management review of process (Mean = 3.13, SD = 1.063) are moderately important detective fraud risk management practices in the organization, according to the result monitoring system aimed at detecting fraud (Mean = 3.76, SD = 0.743).

Responsive Fraud Management Practice

Responsive fraud risk management practice is other fraud management strategy considered in the study. This practice mainly focused on handling procedures a fraud after being detected. The result presented in the following table.

Table 18. Responsive Fraud Management Practice

Items	Mean	Std. Deviation
Disclosing internal investigation result	3.92	.849
Conducting internal investigation	3.59	1.088
Prosecution both internal and external offenders	3.61	1.456
Communication to the employees of the action taken by the management	3.31	1.365
Public disclosure of fraud and misconduct	3.63	.728
Recovery of stolen assets	3.74	.770
Remedying the harm caused	3.77	.697
Strengthening internal controls	3.93	.495

The study's findings revealed that strengthening internal controls (Mean = 3.93, SD = 0.495), disclosing internal investigation results (Mean = 3.92, SD = 0.849), resolving the harm caused (Mean = 3.77, SD = 0.697), and recovering stolen assets (Mean = 3.74, SD = 0.770) are all nearly as important as responding to fraud risk management practices.

Furthermore, according to the findings, public disclosure of fraud and misconduct (Mean = 3.62, SD = 0.728), prosecution of both internal and external offenders (Mean = 3.31, SD = 1.635), internal investigation (Mean = 3.59, SD = 1.088), and communication to employees of management's action (Mean = 3.31, SD = 1.365) are moderately important responsive fraud risk management practices.

4.2 Descriptive Statistics of Dependent and Independent Variables

In this part, the study sought to decide the effectiveness of the frauds management practices engaged by the company. Three insurance fraud management practices assessed include preventive, responsive and detective practices. As a result, the researcher investigated the effectiveness of the various fraud management practices and the findings presented on table 19.

As presented in the table below shows the descriptive statistics of preventive fraud management practice, detective fraud management practice and responsive fraud management practice, and the dependent variable of organizational performance. The underneath table shows that responsive fraud management practice had the greatest overall mean score of 3.68, followed by detective fraud management practice with an overall mean score of 3.53, and preventative fraud management practice with a comparatively low overall mean score of 3.53. In terms of the dependent variables, summary statistics show that organizational performance has the highest mean score of 3.76.

Table 19. Descriptive Statistics

Descriptive Statistics					
	N	Minimum	Maximum	Mean	Std. Deviation
Preventive F	137	1.67	4.56	3.3560	.55802
Detective F	137	2.29	5.00	3.5318	.61828
Responsive F	137	2.38	4.75	3.6880	.49796
Performance	137	2.50	5.00	3.7664	.47473

Source: SPSS Version 26 Computation, 2021

4.3 Correlation Analysis

Correlation matrix depicts the association between the variables that determines non-performing loans. The correlation matrix helps to detect multicollinearity amongst the variables. The values reveal the intensity of the correlation and the sign gives the direction of the association between the variables. The value of the correlation coefficient varies between +1 and -1 (Cohen & West, 2003). The Pearson's correlation coefficient analysis aided to understand whether there was a positive relationship, negative relationship, or no correlation between the variables. Thus, the

strength and direction of relationship between variables was able to be analyzed by the researcher using Pearson correlation coefficient analysis.

Table 20. Correlation Matrix of Dependent and Independent Variables

Correlations					
		Performance	Preventive F	DetectiveF	ResponsiveF
Performance	Pearson Correlation	1	.454**	.499**	.547**
	Sig. (2-tailed)		.000	.000	.000
	N	137	137	137	137
PreventiveF	Pearson Correlation	.454**	1	.419**	.202*
	Sig. (2-tailed)	.000		.000	.018
	N	137	137	137	137
DetectiveF	Pearson Correlation	.499**	.419**	1	.222**
	Sig. (2-tailed)	.000	.000		.009
	N	137	137	137	137
ResponsiveF	Pearson Correlation	.547**	.202*	.222**	1
	Sig. (2-tailed)	.000	.018	.009	
	N	137	137	137	137
**. Correlation is significant at the 0.01 level (2-tailed).					
* . Correlation is significant at the 0.05 level (2-tailed).					

Source: SPSS Version 26 Computation, 2021

Table 20 shows that the correlation analysis performed on all variables in order to determine correlation coefficients using a two-tailed significance test. Preventive fraud management practice, detective fraud management practice, and responsive fraud management practice are the recognized independent variables that contribute to organizational success.

Organizational performance is the dependent variable in this case and there is a strong positive correlation coefficient between organizational performance and responsive fraud management practice ($r = 0.547$, $P\text{-value} = 0.000$), as well as a strong positive correlation coefficient between

detective fraud management practice and organizational performance ($r = 0.499$, $P\text{-value} = 0.000$). The correlation coefficient $r = 0.454$ between preventive fraud management practice and organizational performance is positive and statistically significant at the 1% level of significance.

4.4 Regression Analysis

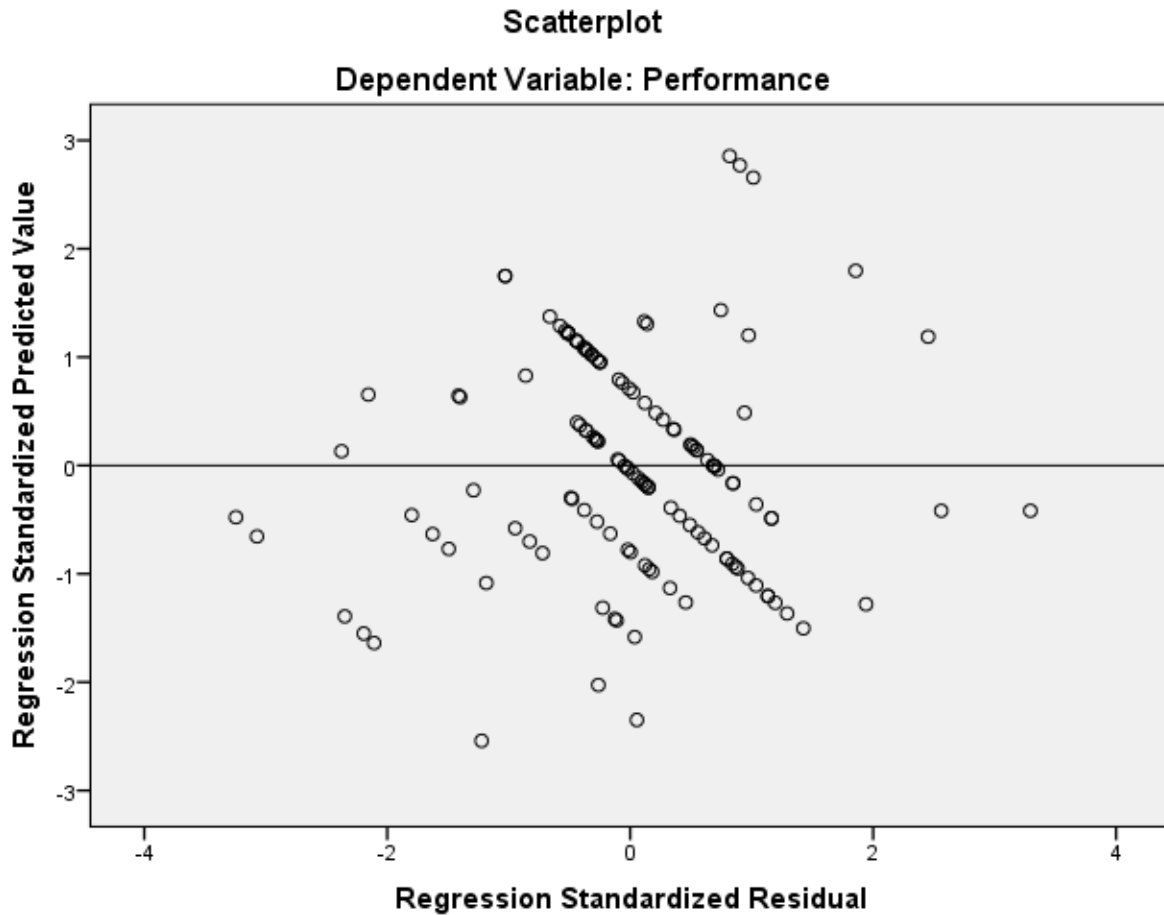
Regression analysis is a statistical measurement used for estimating the relationships among the dependent and independent variables. It enables to determine the strength of the relationship between variables and the predictive power of the independent variables on the dependent variable. In short, regression helps a researcher understand to what extent the change of the value of the dependent variable causes the change in the value of the independent variables, while other independent variables are held unchanged. Regression analysis is a way of statistically sorting out the variables that have indeed an impact. While there are many types of regression analysis, at their core they all examine the influence of one or more independent variables on a dependent variable. Therefore, Multiple Regression Analysis was applied to analyze the result of fraud risk management practice on organizational performance.

4.4.1 Diagnostic Tests

The researcher ran diagnostic tests before beginning regression analysis and include Multicollinearity, normalcy, and heteroskedasticity test.

4.4.2 Homoscedasticity Test

This assumption of homoscedasticity is central to the linear regression model. Assumptions checked by a scatter plot diagram. This indicate that the case as the residuals are randomly spread around the center line; the test is presented in the following figure.



SPSS Version 26 Computation, 2021

Figure 4. Homoscedasticity Test

4.4.3 Autocorrelation Test

Durbin-Watson statistic is used to test for the presence of serial correlation among the residuals. The residuals are not correlated if the Durbin-Watson statistic is about 2, and an acceptable range is 1.50 - 2.50. As it can be shown from the table below the Durbin-Watson statistics value is 2.028 and this value almost approaches 2 therefore, there is no autocorrelation problem in this model.

Table 21. Autocorrelation Test

Model Summary					
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.704 ^a	.496	.484	.34093	2.028
a. Predictors: (Constant), ResponsiveF, PreventiveF, DetectiveF					
b. Dependent Variable: Performance					

Source: SPSS Version 26 Computation, 2021

4.4.4 Multicollinearity Test

The term Multicollinearity indicates the existence of high correlations or linear associations between two or more independent variables in the regression model. If there is multicollinearity in the model, the regression coefficients of the independent variables may be undetermined with immeasurable standard errors (Gujarati, 2004). There after a problem of multicollinearity can be observed if the presence of large correlations (0.8 or larger) among pairs of independent variables is observed. The rule of thumb is that if VIF of variables exceed 10, the variable is said to be highly collinear (Robert, 2006). Based on the table 23 there are no multicollinearity problems in this study since, all variables were under 10 VIF. The VIF display how much the tolerance of the coefficient estimate is being inflated by multi co linearity. Using VIF as indicator of multi co linearity, some authors stated that the larger value of VIF more collinear with the variable. As rule of thumb, if the VIF of variables exceeds 10 the independent variable would be highly collinear (Robert, 2006). Because all of the variance inflated factor (VIF) values are less than 10 and all of the tolerance values are more than 0.1, there is no major multicollinearity concern in this model. Multicollinearity problem it is not a matter of existence rather it is a matter of degree.

Table 22. Test of Multicollinearity

Model		Collinearity Statistics	
		Tolerance	VIF
1	(Constant)		
	Detective F	.805	1.242
	Preventive F	.812	1.231
	Responsive F	.936	1.068

Source: SPSS Version 26 Computation, 2021

4.4.5 Normality Test

Normal distribution of error terms is among the assumption of ordinary least square regression model. The assumptions guarantee that the error term has zero mean and a constant variance σ^2 .

This assumption is essential in order to perform statistical tests concerning the estimated parameters using the normal distribution. However, the normal distribution has impact on hypothesis testing for inference; it doesn't affect the estimation of parameters. Normality can also be checked with the decision is gained by looking at the normal probability plots, that is from the points where the data points form a linear pattern, so that it can be considered as consistent with a normal distribution. The result of the tests is presented in the figure below.

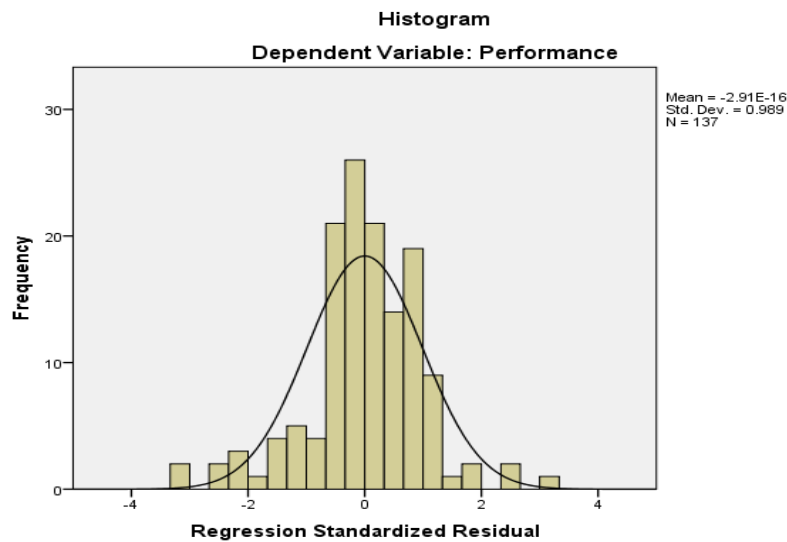


Figure 5. Normality Test

Source: SPSS Version 26 Computation, 2021

4.5 Regression Result and Discussion

The findings of the regression output will be presented in the following section, which will be used to examine the impact of fraud risk management practices on organizational performance. The regression model was created using multiple linear regression analysis to establish the model summary, ANOVA, and Beta coefficient.

4.5.1 Output Model Summary

The R value correlation coefficient between the dependent and independent variables is represented. The correlation coefficient (R) for a set of independent variables (preventive, detective and responsive fraud management practice) with the dependent variable (organizational performance) was 0.704, shown on table 23 model summary.

As a result, the independent factors and the dependent variable had a strong positive association. The coefficients of determination and R square are both 0.496 in Table 23. Thus, the employed explanatory variable, i.e. preventive, detective and responsive fraud management practice, explains 49.6% of the variation in organizational performance. This indicates that there are other factors that account for 50.4 percent of the variance not considered in the study.

Table 23. Model Summary

Model Summary ^b				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.704 ^a	.496	.484	.34093
a. Predictors: (Constant), ResponsiveF, PreventiveF, DetectiveF				
b. Dependent Variable: Performance				

Source: Own computation using SPSS and survey, 2021

4.6 ANOVA Test

In this investigation, analysis of variance was conducted to see if the model was a good match for the data. The data in Table 24, the F value of the test is 43.568. The p-value is connected with a F value of.000, which is less than the alpha of 0.05. Furthermore, the ANOVA table 24

shows that the independent variables had a substantial impact on the dependent variable, and the model used was highly suitable for predicting the dependent variable.

Table 24. ANOVA Test

ANOVA ^a						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	15.192	3	5.064	43.568	.000 ^b
	Residual	15.459	133	.116		
	Total	30.651	136			
a. Dependent Variable: Performance						
b. Predictors: (Constant), ResponsiveF, PreventiveF, DetectiveF						

Source: Own computation using SPSS and survey, 2021

Table 25. Regression Output

Coefficients ^a						
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.745	.267		2.784	.006
	DetectiveF	.232	.053	.302	4.404	.000
	PreventiveF	.205	.058	.241	3.521	.001
	ResponsiveF	.411	.061	.431	6.771	.000
a. Dependent Variable: Performance						

Source: own computation using SPSS 26 and survey, 2021

Standardized Beta Coefficient: It is the coefficients that can explain the relative importance of explanatory variables. These coefficients are obtained from regression analysis after all the explanatory variables are standardized. Table 25 above shows the standardized coefficient of responsive fraud management practice is the largest value followed by detective fraud management practice and preventive fraud management practice. The larger the standardized coefficient, the higher is the relative effect of the factors to the organizational performance.

To know about the effect of independent variable on organizational performance multiple regressions was used as a model. It allows us to compare the predictive ability of particular independent variables and to find the best set of variables to predict a dependent variable. As depicted below from the unstandardized coefficient values listed as β , the study constructs the following regression equation: The study determined the relationship between organizational performance and independent variables.

Standardized Beta Coefficient: the coefficients that can explain the relative relevance of explanatory factors are known as the Standardized Beta Coefficient. After all of the explanatory variables have been normalized, regression analysis yields these coefficients. Table 25 demonstrates that responsive fraud management practice has the highest standardized coefficient, followed by detective fraud management practice and preventive fraud management practice.

The higher the standardized coefficient, the greater the elements' relative impact on organizational success. Multiple regressions were employed as a model to determine the effect of independent variables on organizational performance.

It enables us to examine the prediction capacity of different independent variables and choose the optimal combination of factors for predicting a dependent variable as table 21 shows the results of the study.

Unstandardized Beta Coefficient (β): As it is defined in chapter three, the unstandardized coefficients (β_1 up to β_3) are the coefficients of the estimated regression model. Hence, by including the error term (ϵ), the model for organizational performance can be written as;

The intercept (β_0) is the point on the vertical axis where the regression line crosses the Y axis. The value of β_0 is 0.745 which means the expected value of organizational performance is 0.745 when all the three explanatory variables assume zero value.

Out of three variables all factors found to be a statistically significant effect on organizational performance. The significant variables are preventive fraud management practice, detective fraud management practice and responsive fraud management practice.

4.4.1 Discussion of the Regression Result

The research was approved in order to classify and analyze the impact of fraud management practices on EIC's organizational performance. The findings of this study reveal that preventive fraud management, detective fraud management, and responsive fraud management practices all have a significant impact on organizational performance.

The researcher triangulates the study regression result with other researchers stated below. For instance, Furlan, Vasilecas, and Bajec (2011) carried out a research on the motor insurance fraud management system in the United States revealed a significant positive relationship between detective fraud risk management and profitability of the company.

According to Kinyua and et al, (2015) conducted their research on Kenya's Securities Exchange at Nairobi, and confirmed that there is a strong link between fraud risk management and the financial performance of Nairobi security exchange.

Preventive Fraud Management Practice

The result of the study properly addressed based on the previous studies that has preventive fraud risk management has less costly than the time and expense required for fraud detection and litigation (Sanusi, Rameli, & Isa, 2015). It is the best approach to fighting fraud from happening in the first place and preventing it is mostly on improving the key business processes (Albrecht *et al.*, 2012). It involves by different activities such as: by involving human, technical, and improving policies of an organization. Human intervention that include surprise audit, fraud prevention training, employee counseling programs. While, the technological methods employed in preventive fraud includes updating the technologies employed periodically (Halbouni et al., 2016). In addition, on policy intervention, improving policies of an organization such as reporting policies and procedures employed, and communicate them to employees, anti-fraud policy, fraud vulnerability reviews, whistle-blowing policy, ethics policy, increased the role of

audit committee, and imposing a penalty and disciplinary action are among the effective fraud prevention mechanisms (Halbouni et al., 2016).

As per the regression output of model this study table 25 above mentioned that the coefficient of preventive fraud management practice is 0.205. The coefficient is positive and has statistically significant effect on organizational performance at one percent level of significance. The coefficient of preventive fraud management practice interpreted as holding constant other explanatory variables when preventive fraud management practice increased by one unit, the level of organizational performance is increased by 0.205 units. Therefore, the study failed to accept the null hypothesis that preventive fraud management practice has a negative effect on organizational performance. This means, there is enough evidence to support the positive relationship between organizational performance and preventive fraud management practice. The relationship is positive as expected.

The coefficient of preventive fraud management practice is 0.205, according to the regression result of model table 25. At a 1% level of significance, the coefficient is positive and has a statistically substantial effect on organizational performance. When the degree of organizational performance is increased by 0.205 units, the coefficient of preventive fraud management practice is read as holding other explanatory factors constant.

As a result, the null hypothesis that preventive fraud management has a detrimental impact on organizational performance was rejected. This indicates that there is sufficient data to demonstrate a beneficial association between organizational performance and fraud prevention practices. As anticipated, the association is positive.

Responsive Fraud Management Practice

Organizational replies to fraud vary significantly from different business sector and across countries. They have numerous ways and mechanisms of reporting fraud incidences in an organization leads to effective control of fraud. Organizations should recognize the establishment of fraud response strategy ACFE (2010).

The most effective means of fraud response reported by Kapardis, and Papastergiou (2016) includes internal enquiry, referred to the appropriate authority, reviewed by the audit committee, voluntary resignation or retirement, civil action for recovery warning or reprimand, settled before the courts, immediate dismissal, and disciplinary action. Fraud investigation as a response mechanism may involve law enforcement teams and or internal fraud investigators (KPMG, 2006).

The coefficient of responsive fraud management practice is 0.411, according to the regression result of model table 25. At a 1% level of significance, the coefficient is positive and has a statistically major result on organizational performance. When responsive fraud management practice improved by one unit, while maintaining other explanatory variables constant, the level of organizational performance increased by 0.411 units.

As a result, the null hypothesis that responsive fraud management has a detrimental impact on organizational performance was rejected. This indicates that there is sufficient data to demonstrate the beneficial association between organizational performance and fraud management practices that are responsive. As expected, the association is positive.

Detective Fraud Management Practice

According to Australian Standard, (2008) fraud detection involves identifying fraud on time once it has been committed. Fraud detection strategies are plans implemented to efficiently and promptly identify frauds that have by-passed the preventive measures. Most of the fraud is carried out by insiders as such it takes a longer time to be detected (KPMG, 2017b).

Burnaby et al. (2009) revealed that review of detecting fraud by the organization access control, physical securities and test of controls to the analysis of risk are the most effective means of fraud detection. Among the essential method of detecting fraudulent transactions is an efficient and effective internal control system requires a proper control environment. This is confirmed from the survey by (KPMG in 2013).

In this study the coefficient of detective fraud management practice is 0.232, according to the regression result of model table 25. At a 1% level of significance, the coefficient is positive and has a statistically major outcome on organizational performance.

When detective fraud management practice grew by one unit, the level of organizational performance increased by 0.232 units, according to the coefficient of external factor, which is understood as maintaining other explanatory variables constant. As a result, the null hypothesis that detective fraud management practice having a detrimental impact on organizational performance was rejected.

This indicates that there is sufficient data to demonstrate the link between organizational success and detective fraud management practice. As predictable, the association is positive.

CHAPTER FIVE

5. SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This chapter summarized the study findings and generated conclusions and forward policy ideas with recommendations for best practice of fraud risk management for improvement and future research.

5.1 Summary of Findings

The main goal of this study is to examine and analyze the nature and status of motor insurance fraud and risk management practices in Ethiopian Insurance Corporation using a questionnaire that included 151 questionnaires were distributed to respondents via a self-administered survey in the company.

Three independent variables constructed such as: Preventive, responsive, and detective variables that have been established based on the literature review presented in chapter two. The descriptive section of the research revealed that the majority of the total respondents (65.7 percent) are male and that 34.3 percent of the respondents are female.

Before moving on to the primary analysis of the study, a reliability test was run to see if the questionnaire was trustworthy. As shown in Table 3, all of the questionnaires were reliable and acceptable, based on the overall Cronbach's Alpha result. 811.

The result from Pearson coefficients implies the independent variables such as: preventive, detective, and responsive fraud management practice are contributing to dependent variable organizational performance. The purpose of the study was to determine the impact of motor insurance fraud on organizations, and respondents stated that the company was negatively affected by the fraud.

The study sought to determine the effect of motor insurance fraud on organization performance and respondents revealed that the company performance adversely affected by Motor Insurance Fraud.

From the study findings, it is found that motor vehicle fraud as a result of Poor Internal Controls, greed, lack of appropriate punishment to fraudsters and insufficient staff to handle the motor vehicle segments are the cause of insurance motor fraud. Regarding to motor insurance fraud detection in the organization majority of the respondents were indicated that the company strategic approach to motor insurance is passive on the opinion followed by reactive and proactive.

Findings from the multiple regression analysis depict, 49.6 % variation in organizational performance is explained by the employed explanatory variable i.e. preventive fraud management practice, detective fraud management practice and responsive fraud management practice. This thus shows that there are other causes that the research did not cover that explain 50.4 % variation in organizational performance.

The standardized coefficient of responsive fraud management practice is the largest value followed by detective fraud management practice and preventive fraud management practice. The larger the standardized coefficient, the higher is the relative effect of the factors to the organizational performance.

5.2 Conclusions

To realize the objectives of the study, four research specific objectives were generated, and correlation and multiple regression method were employed to meet the research objective: To address the problem the study aim to find to meet the following basic research objectives.

- i. To identify the major incidence of fraud in the insurance business;
- ii. Identify the nature and status of motor insurance fraud;
- iii. Identify the major factors that can encourage fraud risk
- iv. Examine the effect of fraud risk management practices on the performance of the company;

Thus, on the base of research objectives the following conclusions were made.

Motor insurance fraud ranges from misrepresenting material facts during an insurance applications and inflating insurance claims at the time of accident. The type of fraud varies from exaggeration of legitimate accidents and submitting false claim documents for injuries or damage

that never occurred and providing false traffic police reports for the accidents during claim process.

This research work can justify that preventive fraud management practice, detective fraud management practice and responsive fraud management practice has positive relationship and impact with organizational performance.

The model met the multiple regression expectations of heteroskedasticity, autocorrelation, multicollinearity, and normality tests. The results of the ANOVA test in the model revealed that the R and R² values reported in the model summary section were positively and statistically important and generally significant.

A multiple linear regression analysis of the independent factors and dependent variables in the model revealed that all three independent variables have a positive and statistically significant impact on organizational performance.

Based on the findings, the researcher concludes that preventive fraud management, detective fraud management, and responsive fraud management are the key factors and important aspects that affect the Ethiopian Insurance Corporation's performance.

5.2 Policy Recommendation

From the conclusion made based on the major findings of the research the following recommendations are suggested. Based on the findings the researcher came up with the following possible recommendations to the in Ethiopian Insurance Corporation.

- The company should create consolidated central database of all motor policies in order to identify suspected fraudulent claims. Additionally, the establishment of dedicated fraud department that charged with deterring fraud by using information technology, database, record keeping and fraud detection software solutions in order to *'flag'* suspected claim
- Management should ensure that proper internal control system is developed and ensure their full implementation to reduce chances of fraud commission and an integrated effort between management and employees can deter the incidences of fraud.

- Regulatory authorities (i.e. National Bank of Ethiopia) should develop and promote voluntary best practice' guidance that enhance the effectiveness of insurance companies to tackle fraud and improve fraud fighting by securing consistency across insurance markets increase the efficiency and effectiveness of anti-fraud framework.
- An organization should formally document the techniques developed and implemented to prevent fraud. This includes documenting and good record keeping processes used to monitor the performance of fraud preventive controls or to indicate when such controls are ineffective.
- The study recommends that the organization shall apply detective fraud risk management practices since detective practice has significant effect on organizational performance.
- The company management should fully support insurance fraud risk responsive policies by allocating resource to ensure that there is regular review. The study recommends the reinforcement of the controls that will enhance fraud risk detection.
- The researcher recommends that these research findings have analyzed motor insurance fraud and risk management practice of EIC on its performance. However, the study has been conducted only on a single insurance company (i.e. EIC). Hence, the researcher recommends that the theoretical contribution of these research helps for future research should be undertaken in order to generalize the motor insurance fraud status of other private insurance companies.

References

- Alan Doig (2012) *Fraud : The Counter Fraud Practitioner's Handbook*: Routledge. 2012. eBook., Database: eBook Collection (EBSCOhost)
- Albrecht, W. S., Albrecht, C. O., Albrecht, C. C., & Zimbelman, M. F. (2012). *Fraud Examination*. South-Western Cengage Learning. Mason, OH.
- Alemayehu E. (2016) *The role of internal audit in detecting fraud: the case of Ethiopian budgetary public sectors*.
- Aliyu, N. S., Jamil, C. Z. M., & Mohamed, R. (2014). The mediating role of management control system in the relationship between corporate governance and the performance of bailed-out banks in Nigeria. *Procedia-Social and Behavioral Sciences*, 164, 613-620.
- Anokye M. Adam, A. M. (2020). Sample size determination in survey research. *Journal of Scientific Research and Reports*, 90-97.
- Anol, b. (2012). *Social Science Research, Principles , Methods and Practices*. Florida.
- Antony, J. P., & Bhattacharyya, S. (2010). Measuring organizational performance and organizational excellence of SMEs–Part 2: an empirical study on SMEs in India. *Measuring business excellence*.
- Artís, M., Ayuso, M., & Guillén, M. (2002). Detection of automobile insurance fraud with discrete choice models and misclassified claims. *Journal of Risk and Insurance*, 69(3), 325-340.
- AYELE, L. (2014). *An Assessment if Sales Promotion Practice: The Case of Awash Insurance Company SC*. St Mary's University
- Bartow, J. T., & Biegelman, M. T. (2012). *Executive roadmap to fraud prevention and internal control: Creating a culture of compliance*. John Wiley & Sons.
- Bashir, I., Madhavaiah, C., & Naik, J. R. K. (2013). Motor Insurance Frauds in India: Detection and Control Mechanisms. *Srusti Management Review*, 6(2), 27.
- Bhattacharjee, A. (2012). *Social science research: Principles, methods, and practices*. University of South Florida.
- Boateng, A. A., Boateng, G. O., & Acquah, H. (2014). A literature review of fraud risk management in micro finance institutions in Ghana. *Research Journal of Finance and Accounting*, 5(11).
- Boulescu, M. (2003). *Financial Audit and Financial Control National Normative Benchmark*, Ed. Economica, Bucuresti.

- Boyer, M. and Peter, R. (2018) Insurance Fraud in a Rothschild–Stiglitz World *The Journal of Risk and Insurance*. Volume 87 XX, No. XX, no 1–26 (2018).
- Bryman, A. (2008). *Social Research Methods*. 3rd Edition. New York, United States of America: Oxford University Press.
- Burnaby, P., Howe, M., & Muehlmann, B. W. (2011). Detecting fraud in the organization: an internal audit perspective. *Journal of Forensic & Investigative Accounting*, 3(1), 195-233.
- C.R. Kothari (2004) *Research Methodology Methods & Techniques* 2nd edition. New edge International Publisher, India
- Cawley, J., & Philipson, T. (1999). An empirical examination of information barriers to trade in insurance. *American Economic Review*, 89(4), 827-846.
- CFI (2021), Retrieved October 18, 2021 from <https://corporatefinanceinstitute.com/resources/knowledge/other/loss-ratio/>
- Chali, A. (2016). An Integration of Prediction Model with Knowledge Base System for Motor Insurance Fraud Detection. ADDIS ABABA UNIVERSITY, ADISS ABABAETHIOPIA.
- Chepkoech, F., & Rotich, G. (2017). Effect of risk management process on motor insurance fraud in Kenya. *International Journal of Social Sciences and Information Technology*, 3(3), 1934-1951.
- CII, 2020 The Chartered Insurance Institute
- Cohen, L. E., & Felson, M. (1979). Social change and crime rate trends: A routine activity approach. *American sociological review*, 588-608.
- Cohen, M. B., Gibbons, P. B., Mugridge, W. B., Colbourn, C. J., & Collofello, J. S. (2003, November). A variable strength interaction testing of components. In *Proceedings 27th Annual International Computer Software and Applications Conference. COMPAC 2003* (pp. 413-418). IEEE.
- Cooper, D. R., & Schindler, S. P. (2008). *Business research methods*, 12.
- Cressey, D. R. (1950). –The criminal violation of financial trust. *American Sociological Review*, 15 (6), pp.738-743, October, 2021, pp.1-15. Retrieved from www.JSTOR.org
- Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches*. Sage publications.
- Crocker, K. J., & Tennyson, S. (2002). Insurance fraud and optimal claims settlement strategies. *The Journal of Law and Economics*, 45(2), 469-507.

- Cummins, S Tennyson Moral hazard in insurance claiming: evidence from automobile insurance - Journal of Risk and Uncertainty, 1996
- Derrig, R. A., and L. Krauss, 1994, First Steps to Fight Workers Compensation Fraud, Journal of Insurance Regulation, 12: 390-415
- DESALEGN, A. (2014). Assessment of Motor Insurance Business on Financial Performance of Insurance Company, The Case of Awash Insurance Company (Doctoral dissertation, St. Mary's University).
- Dionne, G. (Ed.). (2000). *Handbook of insurance* (pp. 155-183). Boston: Kluwer Academic Publishers.
- Doig, A. (Ed.). (2016). *Fraud: The counter fraud practitioner's handbook*. CRC Press.
- Dornyei, Z. (2007). *Research Methods in Applied Linguistics: Quantitative, qualitative, and Mixed Methodologies*. New York: Oxford University Press.
- Dudley, J. (2005). *Research Methods for Social Work: Becoming Consumer and Producer of Research*. Boston: Pearson.
- Felson, M., & Clarke, R. V. (1998). Opportunity makes the thief. *Police research series, paper, 98(1-36)*, 10.
- Fikru T. (2015) Ethiopian Business Review. <https://ethiopianbusinessreview.net/insurance-fraud/>
- Fikru W (2018) The Effectiveness of Internal Control System in Detection and prevention of Fraud in Ethiopian Banking Industry.
- Fraud (2021) Retrieved October 12, 2021, from Abdi Chali (2016) an Integration of Prediction Model with Knowledge Base System for Motor Insurance Fraud Detection: The Case of Awash Insurance Company S.C
- Furlan, Š., Vasilecas, O., & Bajec, M. (2011). Method for selection of motor insurance fraud management system components based on business performance: Technological and economic development of economy, 17(3), 535-561.
- Garner, B. A. (2004). *Black's law dictionary*.
- Gujarati, D. N., & Porter, D. C. (2004). Chapter 10–Multicollinearity: What happens if the regressors are correlated?. *Basic Econometrics*, The McGraw-Hill, 341-386.
- Gupta, P. K. (2008). *Fundamentals of insurance*. Himalaya Publishing House.
- Handbook, I. F. (2019). Association of Certified Fraud Examiners. *Austin, TX, USA*.

- Hopkin, P. (2018). *Fundamentals of risk management: understanding, evaluating and implementing effective risk management*. Kogan Page Publishers.
- Hoyt, R. E., Mustard, D. B., & Powell, L. S. (2006). The effectiveness of state legislation in mitigating moral hazard: evidence from automobile insurance. *The Journal of Law and Economics*, 49(2), 427-450.
- Insurance Information Institute (2021) accessed 18th October 2021
<https://www.iii.org/article/background-on-insurance-fraud>
- Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research*, 1(2), 112-133.
- Julian Dosset (2020) Fact-checked with HomeInsurance.com. julian post
<https://www.coverage.com/insurance/motor/motor-insurance-fraud/>
- Kassem, R., & Higson, A. (2012). The new fraud triangle model. *Journal of emerging trends in economics and management sciences*, 3(3), 191-195.
- Kinyua, J. K., Gakure, R., Gekara, M., & Orwa, G. (2015). Effect of internal control environment on the financial performance of companies quoted in the Nairobi Securities Exchange. *International Journal of Innovative Finance and Economics Research*, 3(4), 29-48.
- Koletar, J. W. (2003). *Fraud exposed: What we don't know could cost wer company millions*. John Wiley & Sons.
- Kratcoski, P. C., & Edelbacher, M. (Eds.). (2018). *Fraud and corruption: Major types, prevention, and control*. Springer.
- Lowers, B (2015): The Essential Role of Internal Audits in Fraud Control. Accessed on October 21, 2021 from <https://blog.lowersrisk.com/internal-audits-fraud-control/>
- M Mohamed (2013) Countering fraud in the insurance industry: a case study of Malaysia.
- Mansor, N., & Abdullahi, R. (2015). Fraud triangle theory and fraud diamond theory. Understanding the convergent and divergent for future research. *International Journal of Academic Research in Accounting, Finance and Management Science*, 1, 38-45.
- Martin Boyer, M., & Peter, R. (2020). Insurance fraud in a rothschild–stiglitz world. *Journal of Risk and Insurance*, 87(1), 117-142.
- Maxwell, J. A., (2005). *Qualitative research design: An interactive approach* (2nd ed.). London: Sage.

- Michael Clarke (1989) INSURANCE FRAUD: The British Journal of Criminology, Winter 1989, Vol. 29, No. 1 (Winter 1989), pp. 1-20
- Michael Poll : Motor Claim (2011) Chartered Insurance Institute United Kingdom
- Mihert S, (2021) the role of internal audit on fraud detection and prevention in the case of Ethiopian ministry of revenue Master's thesis Addis Ababa University
- Mirchaye Mulugeta (2015) Predictive Model for Medical Insurance Fraud Detection: The Case of Ethiopian Insurance Corporation
- Mohamed, M. (2013). *Countering fraud in the insurance industry: a case study of Malaysia* (Doctoral dissertation, University of Portsmouth).
- Monette, D., Sullivan, T., & Dejong, C. (2005). *Applied social research: A tool for the human services* (6th ed.). Austria: Thomson Brooks/Cole.
- Mugenda, O. M., & Mugenda, A. G. (2003). *Research Methods: Sample size determination*. African Centre For Technology Studies.
- National Bank of Ethiopia, 2013, Report on Insurance: NBE
- Njuguna, W (2019) Motor Insurance Fraud in Kenya: An analysis of the effectiveness of the legal and intestinal framework in curbing insurance fraud.
- Ouma, P. A. (2008). *The relationship between value chain and competitive advantage in the Insurance Industry in Kenya* (Doctoral dissertation, University of Nairobi).
- Palasinski, M. (2009). Testing assumptions about naivety in insurance fraud. *Psychology, Crime & Law*, 15(6), 547-553.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods*. 3rd ed. (Sage Publications: Thousand Oaks).
- Proclamation No. 799-2013 Vehicle Insurance Against Third Party Risks proclamation
- Purdy, G. (2010). ISO 31000: 2009—setting a new standard for risk management. *Risk Analysis: An International Journal*, 30(6), 881-886.
- Rawashdeh, F. M., & Al Singlawi, O. (2016). The Existence of fraud indicators in insurance industry: case of Jordan. *International Journal of Economics and Financial Issues*, 6(6S), 168-176.
- Richard A. Derrig, Daniel J. Johnston, Elizabeth A. Sprinkel (2006) Auto insurance fraud: measurements and efforts to combat it *Risk Management and Insurance Review*, 2006, Vol. 9, No. 2, 109-130

- Riedinger, D. R., & Major, J. A. (2002). EFD: A HYBRID KNOWLEDGE/STATISTICALBASED SYSTEM. *The Journal of Risk and Insurance*, 69(3), 309-324.
- Robert W. Emerson (1992) Insurance Claims Fraud Problems and Remedies, 46 U. Miami L. Rev. 907 Available at: <https://repository.law.miami.edu/umlr/vol46/iss4/3>
- Sanusi, Z. M., Rameli, M. N. F., & Isa, Y. M. (2015). Fraud schemes in the banking institutions: prevention measures to avoid severe financial loss. *Procedia economics and finance*, 28, 107-113.
- Schiller, J. (2006). The impact of insurance fraud detection systems. *Journal of Risk and Insurance*, 73(3), 421-438.
- Scholz, J. T. (1997). Enforcement policy and corporate misconduct: the changing perspective of deterrence theory. *Law and Contemporary Problems*, 60(3), 253-268.
- Sharon Tennyson and Pau salsas-forn (2002) –Claims auditing in automobile insurance: fraud detection and deterrence objectives| *The journal of risk and insurance*, 2002, vol. 69, no. 3, 289-308 claims
- Slovin, E. (1960). Slovin’s Formula for Sampling Technique.[Paper reference 1].
- Standard, A. Fraud and Corruption Control, AS 8001-2008 (2008).
- Stijn Viaene and Guido Dedene. Insurance Fraud: Issues and Challenges. *The Geneva Papers on Risk and Insurance Vol. 29 No. 2 (April 2004) 313-333*
- Vaughan, E. J., & Vaughan, T. (2007). *Fundamentals of risk and insurance*. John Wiley & Sons.
- Viaene, S., & Dedene, G. (2004). Insurance fraud: issues and challenges. *The Geneva Papers on Risk and Insurance-Issues and Practice*, 29(2), 313-333.
- Wells, J.T. (2011). *Corporate Fraud Handbook: Prevention and Detection*. 3rd edition, Hoboken, New Jersey, John Wiley & Sons, Inc., pp.1-40
- Wilhelm, W. K. (2004). The fraud management lifecycle theory: A holistic approach to fraud management. *Journal of economic crime management*, 2(2), 1-38.
- Wilks, T., and M. Zimbelman (2004) Using game theory and strategic reasoning concepts to prevent and detect fraud *Accounting horizons*, CFI (2021) Retrieved October 18, 2021 from <https://corporatefinanceinstitute.com/resources/knowledge/other/loss-ratio/>
- Yin, R. K. (2018). *Case study research and applications: Design and methods*. Sage publications.

Yusuf, T. O., & Babalola, A. R. (2009). Control of insurance fraud in Nigeria: an exploratory study (case study). *Journal of Financial Crime*.

Appendix I Cover Letter to Respondents

**Addis Ababa University College of
Business and Economics
Department of Management
Masters of Business Administration (MBA)
Questionnaires**

Dear Respondents,

My name is Kassahun Kebede, a student at Addis Ababa University College of Business and Economics, Department of Management pursuing a Masters of Business Administration (MBA).

This questionnaire is designed to gather data about **Analysis of Motor Insurance Fraud and Risk Management Practice: The Case of Ethiopian Insurance Corporation**. The information that we offer me with this questionnaire was be used as primary data in my study which I would be conducting as partial fulfillment of the requirements for the degree of Master of Business Administration (MBA) at Addis Ababa University. The research output was used to mitigate one of an operational risk that affect the performance and profitability the company.

Therefore, I kindly and earnestly request we respond to all questions contained in this questionnaire by giving wer honest answers. I want to assure we that this research is only for the academic purpose authorized by Addis Ababa University. No other person could access the collected data. Wer response is handled confidentially and interpreted impartially. In the end, I would like to express my deep appreciation for wer generous time and prompt responses.

Contact Address:-

Telephone -09111 38 26 47

Email: kkebede51@gmail.com

Appendix II Questionnaire

PART ONE

Demographic Data of the Respondent

(Please put any sign/mark on the number from alternatives that best describes your choice)

Personal information of the respondent

SECTION A: DEMOGRAPHIC INFORMATION

Kindly indicate your gender.

1-Male [] **2-Female** []

2. Please indicate the highest level of education we have ever attained

1-College Diploma/Levels [] **2-First Degree** []

3- Master degree level [] **Ph.D. level** [] **If any other** []

3. Age

1- 18 and more [] **2- 20—29** [] **3- 30—39** [] **4 -40—49** [] **5- 50 or more** []

4. Experience in years

1-Below 5 [] **3-Between 11-15** []

2-Between 6-10 [] **4-Above 15** []

5. What is your position in the organization operational activity?

[1] Non –Management [] **2. Lower Level Management** [] **3. Middle Level Management** []

4. Top Management []

6. Place of work in the organization

1-Both Underwriting and Claims [] **2-Human Resources** [] **3-Insurance support Back Office** []

4-Finance and Investment [] **5-Audit Directorate** [] **6-Business Dev't and Risk Management** [] **7-Information Technology Management** [] **8-Legal Services** [] **If any other** []

SECTION B: Cause and Types of Motor Insurance Fraud

1. What are views on the following statements regarding the types of motor insurance fraud in the Ethiopian Insurance Corporation? (Circle the number closest to wer view)

Use a scale of 1 to 5 where 5= highly frequent, 4=frequent, 3=less frequent, 2=rarely frequent, 1= not frequent

No	Types of fraud	5	4	3	2	1
1.	Internal Fraud (staff)					
2.	Policyholder or Claimant Fraud					
3.	Intermediary fraud					
4.	Underwriting Fraud					
5.	Claim Fraud					

2. **B2** -How adversely has the company been affected by Motor Insurance Fraud? Fraud is ...

- a) Highly prevalent [1] b) Moderately Prevalent [3]
 b) Occasionally Prevalent [2] c) Has never occurred [4]

3. **B3**- The following are some of the common causes of motor vehicle fraud. Please indicate the prevalence of each of them:-

5= to a very large extent, 4= Large extent, 3= Moderate extent, 2= small extent, 1 very small extent

	Causes of Motor vehicle fraud	5	4	3	2	1
1.	Greed					
2.	Poor Record keeping					
3.	Poor internal Controls					
4.	Poor salaries					
5.	Lack of appropriate punishment to fraudsters					
6.	Dissatisfied staff					

4. **B4** In wer opinion, generally, what is the insurance company strategic approach to motor insurance fraud detection?

- a) Proactive [1] b) Reactive [2] C) Passive [3]

5. B5- What are wer views on the following statements regarding what type of fraud committed by internal staff?

Use a scale of 1-5 where 5=very great extent; 4=Great extent; 3=Moderate extent; 2=Low extent and 1=Very low extent. (Circle the number closest to wer view)

	Type of fraud Committed by internal staff	5	4	3	2	1
1.	Underwriting insurance policy without a proper insurable interest					
2.	Collusion with external bodies					
3.	Embezzlement of insurance funds					
4.	Attaching fake claim documents					

6. B6 What type of motor insurance fraud committed by external in EIC?

Use a scale of 1-5 where 5=very great extent; 4=Great extent; 3=Moderate extent; 2=Low extent and 1=Very low extent. (Circle the number closest to wer view)

	Committed fraud by external/policy holder	5	4	3	2	1
1.	Notification of lapsed policy claim					
2.	Providing fake accident police report					
3.	Inflation or exaggeration of genuine claim					
4.	Providing Unauthorized driving license					
5.	Causing deliberate accidental damage					
6.	Creating an entirely fictitious event					
7.	Providing untruthful or incomplete information regarding claim					

C- Section C: To what and how the motor insurance frauds affect the EIC?

Use a scale of 1-5 where 5=very great extent; 4=Great extent; 3=Moderate extent; 2=Low extent and 1=Very low extent. (Circle the number closest to wer view)

	Fraud Risk Management Practice	5	4	3	2	1
	The three					
1.	Higher premiums for honest customers					
2.	Increasing costs of consumer goods and services.					
3.	Affect profitability an Insurance Company					
4.	Negative impact on insurers‘ ability to deal with genuine claims quickly					
5.	Insurance fraud funds facilitates other serious crime					

SECTION D : Motor Insurance Fraud Risk Management Practice at EIC

1. Comment which of the following components of fraud risk management practices in improving company motor insurance business performance
 1. Not effective 2. Uncertain 3. effective 4. very effective 5. Extremely effective

	Motor Insurance Fraud Risk Management Practice	5	4	3	2	1
1.	Preventive Practice					
2.	Detective Practice					
3.	Responsive practice					

2. D-Insurance Fraud Risk Management practices and its effect in the Motor Insurance business in EIC

Please Show the extent to which the below insurance fraud management practices are practiced in your organization. Using the following rating;

Where, 5 = Greatly; 4 = Considerately; 3= Moderately; 2 = Remotely; 1= Not all

	Preventive Fraud Management	5	4	3	2	1
1.	Establishment of strong internal control					
2.	Establishment of effective code of conduct and related standards					
3.	Targeted training on fraud prevention and management					
4.	Employment of screening techniques of potential policy holders					
5.	Employment screening					
6.	Reward to whistle blowers					
7.	Establishment of Fraud Department					
8.	Employment of support programs					
9.	Adoption of information technology					
	Detective Fraud Management	5	4	3	2	1
1.	Management Review of Process					
2.	Proactive data analysis					
3.	Establishment of monitoring system to detect fraud					
4.	Monitoring system aimed at detecting fraud					
5.	Fraud risk awareness training					
6.	Internal Audit					
7.	External Audit					

Responsive Fraud Management		5	4	3	2	1
1.	Disclosing internal investigation result					
2.	Conducting internal investigation					
3.	Prosecution both internal and external offenders					
4.	Communication to the employees of the action taken by the management					
5.	Public disclosure of fraud and misconduct					
6.	Recovery of stolen assets					
7.	Remedying the harm caused					
8.	Strengthening internal controls					

Section E. Organization Performance

1. Indicate the extent of influence to which the motor insurance fraud management practices has had on wer organization performance?

Where. 1 = Not at all; 2= Remotely; 3= Moderately; 4 = Considerately; 5= Greatly

Organization Performance		5	4	3	2	1
1.	Fraud management practices positively affects the company internal process					
2.	Fraud management practices influences company customer's relationship with the firm					
3.	Fraud management practices has had positive effect on firm financial performance					
4.	Fraud management has had a positive effect on the firm learning and growth capacity					

If we have any further comments and suggestions regarding motor insurance fraud and its risk management Practice?