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KWAZULU-NATAL

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**A criminological inquiry into life insurance fraud in
KwaZulu-Natal: An exploratory study.**

By

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Thesis submitted in fulfilment of the requirements for the degree of

**Doctor of Philosophy
Criminology and Forensic Studies
University of Kwazulu-Natal**

Supervised by Dr Sazelo Mkhize

2023

DECLARATION

I, Nomathamsanqa Mthethwa, student number (211535116), solemnly declare that:

- (i) The research reported in this thesis and that is submitted for the degree Doctor of Philosophy: Criminology and Forensic Studies, titled “*A Criminological inquiry into life insurance fraud in Durban: An exploratory study*”, is my own original work and has not been submitted for examination to any other institution of higher education.
- (ii) All the sources that I have used or quoted have been properly cited in-text and acknowledged in the comprehensive list of references.
- (iii) I also declare that the figures configured in this study some were adopted, and some have been created by the researcher using SmartArt. Those that adopted have been referenced accordingly.

Signed: Nomathamsanqa Mthethwa

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Date: 30 December 2023

DEDICATION

This thesis is dedicated to:

My late father **Blessing Muzokhona Mthethwa** and brother **Mvuselelo Mthethwa**, whose memory has been the greatest source of my inspiration. I hope you both are proud of me, and I dearly wish you were here to share this great achievement with me.

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ABSTRACT

Life insurance is a financial safeguard designed to provide individuals and families with a sense of security, assuring them that their loved ones will be financially protected in the event of an unforeseen circumstance. However, there exists a dark side to this industry the realm of life insurance fraud, which has become vulnerable to the intricate web of fraudulent activities.

The reality is that innocent people are killed solely to cash in on life insurance money. Life insurance fraud has become pervasive and is on the upsurge within the insurance sector in South Africa, particularly in the province of KwaZulu-Natal. with a major financial impact on insurance companies and policyholders. While life insurance fraud is not a new problem in South Africa, it has gained increased media attention in recent years, highlighting its importance as a critical subject. However, very little data on this phenomenon is available in local and international literature. Hence, this study aimed to contribute to this knowledge by exploring the *Modus Operandi* used by policyholders or beneficiaries to commit life insurance, the motivating factors and the detection and prevention strategies employed by insurance companies, using those who have first-hand experience and knowledge.

To ensure that the aim of this study was achieved, a qualitative research design was utilised which assisted the researcher in focusing on the criminological inquiry of life insurance fraud in KwaZulu-Natal. Data collection was achieved employing semi-structured interviews and key informant interviews (KIIs) that involved a total of twenty (20) participants comprising of Directorate for Priority Crime Investigation (DPCI) members and Assupol forensics investigators. A set of pre-determined questions were used, these enabled the researcher to explore themes and elicit data that focused on achieving the objectives of the study. The fraud triangle and routine activities theory were used as theories in support of this study.

The findings of the study revealed that life insurance fraud takes on various forms, with policyholders and beneficiaries engaging in deceptive practices such as faking their deaths or orchestrating the death of others to secure a pay-out. The study uncovered that the occurrence of death in rural areas, similar to other settings, can be vulnerable to life insurance fraud when individuals or beneficiaries attempt to deceitfully claim life insurance benefits for someone who passed away months or even years ago. Additionally, the study uncovered a chilling trend in the manipulative exploitation of life insurance policies through the use of hired dead bodies. This modus operandi goes beyond mere deception, delving into the horrid realm of utilising actual deceased individuals to fabricate deaths

and illegally claim insurance benefits. In essence, the findings depicted that life insurance fraud costs the lives of innocent people, as people are murdered for the sole purpose of obtaining a life insurance pay-out.

The findings also revealed that the insurance sector employs various strategies; however, challenges that were exposed include a lack of cooperation from South African Police Services officials, a basic understanding deficit regarding what constitutes life insurance fraud, limited public awareness, and reluctance of informants to cooperate in criminal investigations. Moreover, the research revealed that the Directorate for Priority Crime Investigation (DPCI) tends to respond reactively rather than proactively in cases of life insurance fraud. Consequently, the responsibility for proactivity is perceived to lie with the insurance industry. This underscores the argument for enhanced collaboration between the South African Police Services and the insurance industry to formulate strategies to proactively address the rising trend of life insurance fraud in the study area.

Keywords: *Insurance fraud; life insurance fraud; mundus operandi; policyholder; beneficiary; fraudulent claim.*

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LIST OF ACRONYMS

ASISA Committee	Association for Savings and Investment South Africa Forensics Standing
BI	Notification of death/still-birth
CAIF	Coalition Against Insurance Fraud
DPCI	Directorate of Priority Crimes Investigation
FTT	Fraud Triangle Theory
ICB	Insurance Crime Bureau
KII	Key Informant Interviews
MO	Modus Operandi
NIOS	National Institute of Open Schooling
RAT	Routine Activity Theory
SA	South Africa
SAPS	South African Police Services
US	United States
KZN	KwaZulu-Natal

CHAPTER ONE: GENERAL ORIENTATION

1.1 Introduction

Life insurance is a vital financial instrument that provides individuals with peace of mind, financial security, and protection for their loved ones in the event of their death. However, like many countries around the world, South Africa is not immune to the problem of life insurance fraud. Life insurance fraud in South Africa poses a significant challenge to the insurance industry, policyholders, and society. Hence, the researcher endeavours to conduct an explorative analysis of life insurance fraud. The rationale that prompted the researcher to embark on a study of this nature is that life insurance fraud is an increasing problem in South Africa and internationally with major financial, societal, and humanitarian impacts. In addition, the amount of research available on this phenomenon is extremely limited, particularly in South Africa. This chapter will provide an introduction and background to the study, problem statement, research aim, objectives, and research questions. It further highlights the definitions of key concepts, as well as the value of the study. Finally, the chapter provides a preview of the entire study by highlighting the aspects covered in each section of the chapter.

1.2 Rationale for the Study

A research study should be useful and valuable to the proposed target group (De Vos, Strydom, Fouche & Delport, 2011). “Good research demonstrates its relevance in terms of existing knowledge that contributes something to existing theories, the way it addresses practical problems and the timeliness thereof” (Denscombe, 2002:43). Hence, the rationale that prompted the researcher to undertake a study of this nature is that firstly, life insurers are in constant risk of life insurance fraud being perpetrated upon them by their policyholders and claimants and secondly; the amount of research available on this phenomenon is extremely limited, particularly in Africa and South Africa. In contrast, research into insurance fraud prevention, risk management of insurance fraud, claims fraud prediction and customer perception and tolerance of insurance fraud has been prioritised, while exploratory studies of life insurance fraud have been largely neglected in South Africa. Thus, the researcher decided to embark on this study.

Limited criminological literature explicitly includes insurance fraud as a subject of analysis. Furthermore, there do not appear to be any criminological studies specifically addressing life insurance fraud as a particular form of insurance fraud (Longino, 2015). The systemic prevalence and impact of policyholder’s /beneficiary committing life insurance fraud is not better understood

and reported in more depth, instead of it is sporadically mentioned in articles, television, internet and social media when a perpetrator is involved and has been found guilty and sentenced, following the conclusion of criminal prosecution. The coalition against insurance fraud (2017), shares a similar option with Longino (2015), stating that there appears to be much less emphasis on fraud within life and disability insurance. Limited research has been conducted to understand the severity of fraud in these specific sectors and to examine the measures taken by government and insurers to combat fraudulent activities in life and disability fraud (Coalition Against Insurance Fraud, 2017). Thus, this study finds its premise within this gap. More research needs to be done on life insurance fraud from a criminological perspective in South Africa.

There are several valuable studies on insurance fraud (Geldenhuys, 2018; Gupta & Venugopal, 2011; Legotlo, 2018), all of which present evidence of fraudulent activities across the entire insurance industry. However, none of these studies specifically addresses life insurance as a criminological phenomenon in South Africa. It is asserted that special investigation units play a crucial role in the investigation of insurance fraud. Thus, there is a need for further research to explore the perceptions and working of these units (Chudgar, 2015). The current research aimed to fill this gap by interviewing Directorate for Priority Crime Investigation (DPCI) investigators as an investigation unit that plays an important role in the investigations of life insurance fraud in KwaZulu-Natal. While there has been some research on fraudulent activities related to insurance fraud (Miyazaki, 2009; Sarvamangala, 2016; Swaby, 2011), limited research is available specifically on the understanding of the violence of life insurance fraud in South Africa. This study aims to contribute to this research gap by exploring the *modus operandi* (MO) used by perpetrators (policyholders and beneficiary) to commit life insurance fraud and motivating factors in the study area. An exploration of MO of life insurance fraud is necessary for assisting insurance companies and the South African Police Services in detecting and investigating fraudulent claims in life insurance.

After the completion of the exploration of life insurance fraud, this study and its results could, if incorporated, firstly be to the advantage of insurance companies to be more vigilant and to strengthen their detection and preventative measures. Insurance companies encounter numerous fraudulent death claims that are being approved for perpetrators who have found ways to defraud the system. Consequently, forensic / fraud investigators could gain comprehensive and precise insights into the factors that drive such fraud. This study could serve as a management tool, a basis for future advancements, and an opportunity to address deficiencies, including enhancing collaboration among stakeholders and implementing training interventions for investigators of life insurance fraud. Secondly, this study and its findings could, if incorporated, prove beneficial for the entire forensic

investigation division. Thirdly, the general public could also benefit from this study and its results, as it has the potential to enhance public awareness regarding life insurance fraud. Fourthly, the academic community could also gain from this study, as its findings could be utilised in related studies and academic research. In addition, this research will contribute to the academic literature and help explain the motivating factors of the perpetrators in perpetrating life insurance fraud. It will provide researchers and life insurers with a new lens through which to investigate the phenomenon of life insurance fraud. This research will further create interest and opportunities for future research on this topic, both on an international scale and, notably, within local contexts. In conclusion, this study will contribute to the existing body of knowledge, particularly given the scarcity of research on this topic. This study stands as one of the few research studies that have delved into this subject in the context of South Africa.

1.3 Background of the study

Insurance is a crucial component of the financial services sector, a pillar of our economy, and vital for the well-being of the public. “Businesses, institutions, government departments and individuals worldwide make use of insurance as a means to protect themselves and/or their assets against the risk of some unforeseen future event that could cause loss or damage” (Grant, 2012:1-34). “Insurance is thus seen as a mechanism that affords protection to victims of accidents, crime, and natural and/or man-made disasters to the extent that they are insured” (Insurance Europe, 2012:5), while some well-mobilise it for personal gain at the expense of others. The escalating rate of life insurance fraud, both in terms of monetary cost and prevalence is a severe problem in South Africa (SA) which has been regularly in the news over the past few years. Similarly, Shah (2014), reported that there is a consensus in the industry that insurance fraud cases have been significantly increasing. Consequently, Bali, Singh, Parekh and Indge (2010), highlights that insurance companies are increasingly recognising that insurance frauds are elevating the overall costs for insurers and premiums for policyholders. This realisation poses a potential threat to their viability and could significantly impact their profitability. In addition, Ayboga and Ganji (2021), alluded that insurance companies compensate for the losses incurred by fraud by setting higher premiums for policyholders. It is in the interest of all policyholders that insurance companies have effective and efficient strategies to combat insurance fraud, particularly life insurance fraud, which tragically claims the lives of many innocent people.

Insurance fraud is a major problem facing the insurance industry (Derrig, 2002); it is a real crime which undermines the whole insurance system and has an impact on insurers, policyholders,

businesses, society, and the economy in general (Al-Rawashdeh1 & Al Singlawi, 2016). Therefore, discovering effective ways to reduce and deter life insurance fraud is crucial for the insurance industry. According to (Black, 2005:1; Muscat, 2013), “insurance fraud affects many types of insurance policies, including non-life insurance, life and protection insurance, and health insurance”. The nature of these frauds can range from a minor exaggeration of the claim's value to a completely fabricated claim where damages never really occur. However, Huneberg (2017) argues that a significant proportion of the overall fraudulent claims amount occurs in the life insurance sector. Similarly, Chudgar and Asthana (2013), noted that life insurance fraud stands out as one of the most serious challenge facing insurers, insurance consumers, and regulators. Insurance fraud is estimated to cost South African insurance companies approximately R 4 billion per year (Du Toit, 2013). According to the Association for Savings and Investment South Africa (ASISA), “South African life assurers reported significant increases in dishonest and fraudulent long-term insurance claims for 2016” (Herman, 2018:1). The latest insurance fraud statistics released by the (Association for Savings and Investment South Africa, 2022), in 2020, a total of 3186 cases (compared to 2837 in 2019) of fraudulent and dishonest claims with a value of R587.3 million (compared to R537.1 million in 2019) were recorded. Further, de Klerk (2018), stated that estimates of fraudulent claims in South African insurance could amount to as much as 32% of all claims submitted in any year. Consequently, the increasing rate of life insurance fraud in South Africa is a cause for grave concern as insurance companies and the public are vulnerable to the threat of life insurance fraud.

Most fraudulent insurance activities are perpetrated by the public, often under the belief that there is little harm in slightly exaggerating their losses or significantly altering essential facts (Baldock, 1997). Recently, Muscat (2013), aptly stated that insurance fraud can be perpetrated by a policyholder or a third party claiming an insurance policy. In addition, Tessier (2013), revealed that these individuals may feel compelled or enticed to engage in insurance fraud for a variety of reasons, including extraordinary circumstances. Karstedt and Farrall (2006) also found that insurance fraud is a substantial issue, and a notable number of ordinary individuals perceive it as acceptable. Silverstone, Sheetz, Pedneault and Rudewicz (2012:32) agree with the above authors, by stating that “society perceives fraud to be a victimless crime and that governments and businesses are so wealthy that the money taken fraudulently will not be missed”.

To fight life insurance fraud, it is imperative to know the motivating factors for perpetrators to commit this crime. O’Brien (2021) states that some people may commit insurance fraud due to financial pressure for example greed or addiction. The most shocking reality of life insurance fraud is the fact that greedy fraudsters even murder people so that they can get their life insurance money

(du Preez, 2022). du Preez (2022) further mentions that as long as there is life insurance, there will be fraud, and fraudsters will keep getting more and more innovative in committing their crimes. Furthermore, Sarvamangala (2016) argued that little focused on establishing effective fraud control mechanisms for life insurance fraud or strategies to effectively mitigate fraudulent activities. Hence, the researcher seeks to explore the strategies that companies use to detect and prevent life insurance fraud and their effectiveness.

Insurance companies are hesitant to publicise their defences or disclose those they apprehend, as doing so may create the impression of a perceived lack of a capable guardian (Button, Pakes & Blackburn, 2016). The reasons for this reluctance include “first, the fear of bad publicity, which could lead to competitor advantage; second, the fear of putting ideas into policyholders’ heads” and third, the fact that, although there may be a strong suspicion that a fraud has been conducted, it is often difficult to prove” (Clarke, 1989: 4). This underpins the importance of acquiring the perspective of the insurance industry on life insurance fraud on public awareness. Hence, little is known about the public awareness of life insurance fraud and the *modus operandi* used by perpetrators in perpetuating life insurance fraud in the study area. Therefore, the researcher argues that this is a poor base on which to build effective prevention strategies.

While it is acknowledged from the outset that the findings of this study may not be generalised, it will undoubtedly contribute to the existing pool of knowledge by providing valuable insights for life insurance fraud investigators. To achieve this goal, the study (a) determines the *modus operandi* used by policyholders (beneficiaries) to commit life insurance fraud, (b) identifies the key motivating factors for committing life insurance fraud (c) explores the strategies that companies use to detect and prevent life insurance fraud and their effectiveness.

1.4 Problem statement

Welman, Kruger and Mitchell (2005:13), define a research problem as “a process involving narrowing down the researcher’s general interest in a research topic to focus on a particular research problem that is small enough to be investigated. Consequently, once a research problem has been identified, the researcher collects applicable information to solve the problem (Leedy & Ormrod, 2013). Bless and Higson-Smith (2005:21) support the above-mentioned authors’ statements by stating that the investigation into a well-chosen problem should satisfy as many as possible of the following criteria:

- It should be timely.
- Relate to practical problems.

- Relate to a wide range of the population.
- Relate to an influential or critical population.
- Fill research gaps.
- Permit generalisations to broaden the principles of social interaction or general theory.
- Sharpen the definition of an important concept or relationship.
- Have many implications for solving a wide range of practical problems.
- Create or improve an instrument for observing and analysing data.
- Provide possibilities for a fruitful exploration using known techniques.

This research study adheres to established standards in terms of the chosen problem area and the methodology utilised to conduct the study in the following manner:

- The research was timely as the rate of life insurance fraud across South Africa has increased. Furthermore, life insurance fraud is often viewed as a victimless crime. However, the consequences of this crime are often serious and deadly.
- The research related to an influential population drawn from the SAPS DPCI commercial crimes unit and Assupol forensic investigation department. Unfortunately, the objective of selecting an ideal participant sample for this study was not achieved entirely (refer to paragraph 4.7). However, despite these limitations, the selected sample included participants who were all available for interviews and were familiar with the topic under investigation.
- The findings of this study filled a gap in knowledge in the field of social sciences and criminology and forensics studies both locally and internationally. This was achieved by using a unique methodology to study life insurance fraud in the study area.

Considering the above, the problem investigated in this study was confined to life insurance fraud in KwaZulu-Natal. The pivotal problem statement was thus as follows:

International studies have revealed that insurance fraud is one of the most serious problems which poses a significant risk to insurers, insurance consumers and regulators (Lesch & Brinkmann, 2011; Swaby, 2011; Tseng & Kuo, 2014). These risks manifest in the form of high claim costs for insurance, reduced profits due to paying out fraudulent claims and delays in claims settlement processes (Kamiya, Schmit & Rosenberg, 2012). Globally, it is estimated that 10% of all insurance claims made by consumers are fraudulent, while just one-fifth of these fraudulent claims are detected by the insurer (Ishida, Chang, & Taylor, 2016). Krawczyk (2009), clarifies that fraudulent claims by policyholders (claimants) are one of the major concerns in the insurance industry. While life insurance fraud can

be found around the world, it varies across countries due to social and cultural differences (Tonenciuc, 2015).

The South African Police Service crime statistics reveal that commercial crimes have consistently ranked highest compared to other serious crimes in South Africa since 2017. The South African Police Service (SAPS) encounters challenges in fulfilling its mandate to address this specific crime in the country. The data presented in Table 1.1 corroborate this problem statement.

Table 1.1: Comparative data on other serious crimes in South Africa over five years.

CRIME	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	COUNT	% CHANGE
CATEGORY							DIFF
OTHER SERIOUS CRIMES							
ALL THEFT NOT MENTIONED ELSEWHERE	302 656	300 457	282 817	224 345	249 215	24 870	11.1%
COMMERCIAL CRIME	73 277	83 823	83 869	82 890	102 057	19 167	23,1%
SHOPLIFTING	62 180	60 167	59 883	47 331	42 549	-4 782	-10,1%

Source: SAPS annual report 2019/2023

Available statistics on other serious crimes indicate that commercial crime remained high over five years (2017 to 2022), with high peaks in 2021 and 2022. Although the reasons for this increase were beyond the scope of the study, it is undeniable that life insurance fraud in South Africa has negatively impacted the insurance industry as life insurance fraud which is considered a victimless crime does not only have financial implications for innocent parties, but victims may also be harmed physically and emotionally.

Considering the above figures, the enormity of commercial crime and its infiltration into society, government, and the business sector cannot be denied. In addition, “fraud cases, especially in the commercial crime unit sector in South Africa (SA), are growing daily and it has been observed that law enforcement agencies are unable to manage these types of crimes and fraud” (Statistics South Africa, 2017:1). Statistics South Africa (2017) revealed that fraud committed by consumers ranks as the second most reported crime in SA. Hence, based on the endemic and increasing cases of fraud, it may be argued that the fraud phenomenon is continuously becoming a major concern in KwaZulu-Natal, especially for insurance companies. Nevertheless, it is important to highlight that the South African Police Services does not record statistics specifically for life insurance fraud. In South Africa,

life insurance fraud is not officially recognised as an independent criminal offence; instead, it is classified under commercial crimes. Consequently, there is an absence of data specifically related to life insurance fraud. However, despite the absence of official statistics, a report from Savings and Investment South Africa (2022) uncovered that instances of life insurance fraud indeed take place within the insurance industry in South Africa.

Statistics by the Association for Savings and Investment South Africa (2022) revealed that KwaZulu-Natal accounts for 31% of all fraudulent and dishonest claims when compared to the Eastern Cape, which accounts for 16% and Gauteng with 15%. Amidst these glaring statistics, consumers bear the greatest burden as they are most vulnerable to life insurance fraud. Simelane (2019), revealed that it is much more difficult for life insurance companies to verify and investigate claims in provinces with vast rural areas like Eastern Cape and KwaZulu-Natal. In addition, (Bugra & Merkin, 2012); (Geldenhuis, 2019), state that the true impact and cost of fraudulent life insurance claims are not quantifiable as they extend far beyond payments of inappropriate claims, especially in cases where lives are lost for insurance policy pay-outs. Despite the enormity of the financial loss stemming from insurance fraud, the public remains unaware of the social and economic implications of this crime. In support of the above statement, Geldenhuis (2019), argue that in the event of life insurance fraud, there is a large societal impact for which the insurance industry must take responsibility. Moreover, Alfejeva (2011); and Remli, Salleh and Arifin (2021), highlight that public tolerance against fraud increases its prevalence, reduces the likelihood of fraud detection, and reduces the level of penalties.

The high incidents of insurance fraud are a cause for grave concern for both the insurance sector and the public. Ogunbanjo and van Bogaert (2014), highlighted that insurance fraud encompasses a wide range of illicit practices and illegal acts involving intentional deception or misrepresentation. Further, Remli, Salleh and Arifin (2021), share the same sentiment with the above authors by stating that although insurance fraud is considered a non-violent economic crime, it can lead to, or be part of, violent activities illegal. Similarly, Johan Steyn from the Insurance Crime Bureau recognised that the biggest problem in South Africa is that the crimes tend to involve a level of physical violence in both the short-term industry as well as the life and funeral industry, where there is an increase in the number of 'murder for money' syndicates (Geldenhuis, 2019). Additionally, Lopes and Carvalho (2022) aptly noted that while most people recognise the negative financial implications of insurance fraud, many do not realize that it can also be a violent crime involving murder, personal injury, and serious property damage. For example, a woman from Mpumalanga hired a hitman to murder her husband for his life insurance (Francke, 2023).

The case of Rosemary Ndlovu opened the eyes of many South Africans, as it brought attention to fraudulent life insurance claims. Ndlovu was found guilty of orchestrating the murder of her close relatives and the father of her child to benefit from funeral and life insurance pay-outs to the amount of R 1.4 million from Assupol, Clientele limited, 1 Life insurance and Old Mutual (Makgatho, 2021). A recent investigation by the Insurance Crime Bureau uncovered similarities to the Rosemary Ndlovu case. “In this instance, the alleged claimant obtained life and funeral policies on her spouses and family members. She then made use of hit men to commit the murders for insurance payouts. Claims were submitted on four of her spouses and two on her stepsons, all of whom were shot, and nothing was taken from them. One of the deceased was run over by a vehicle upon his release from hospital and was shot and killed within an hour” (Insurance Crime Bureau, 2023:1). The above-quoted cases expose the deadly side of life insurance fraud and how easy it is to take out a life policy on individuals without their knowledge or consent. In addition, Longino (2015) argues that a better understanding of this crime may lead to changes in policing and legislation that could decrease the prevalence of this crime and the perceived reward to the criminals who perpetrate it. Thus, the researcher decided to embark on a study of this nature to investigate the nature of life insurance fraud and determine the *modus operandi* of life insurance fraud used by perpetrators. Understanding the *modus operandi* of life insurance fraud is an essential component of a comprehensive strategy to prevent, detect, and address fraudulent activities. Hence, recognising patterns will enable the development of proactive strategies to deter potential fraudsters.

In an economic downturn, the incentive or pressure to commit fraud is increased as, inter alia, financial pressures increase. This may result in the fraudster defrauding insurance companies for their benefit. Slow economic growth and unemployment have increased fraudulent insurance claims (Booyesen, 2018). In South Africa, this has become more prevalent with Covid-19 regulations that left many retrenched and unemployed. According to Shabangu (2006), unemployment breeds poverty, which consequently breeds criminality. Consequently, the COVID-19 pandemic resulted in a lengthy and peculiar journey for most of the financial crime compliance industry in South Africa (Wesso & Hamman, 2022). Colquitt and Hoytt (1997), aptly stated that insurance frauds were higher in the states where unemployment was high. The convenor of the Association for Savings and Investment South Africa Forensics Standing Committee (ASISA), Megan Govender, stated that the surge of fraud is not startling because the hard-hitting economic circumstances have caused temptation for deceitful syndicates and policyholders to attempt obtaining insurance payouts (BusinessTech, 2021). Therefore, it is crucial that extensive research to understand the motivating factors for perpetrators to perpetuate life insurance fraud. This, therefore, highlights the urgency to

investigate and understand the nature of life insurance fraud in South Africa due to the current continuous low economic growth.

De Klerk of the Insurance Crime Bureau stated that the economic fallout from the COVID-19 epidemic has caused an increase in the number of “walking dead”, as well as other false insurance claims and scams (Geldenhuis, 2020). “Walking Dead” is the nickname in the insurance industry for those people who either fake their deaths or do not know that someone has “killed” them off for financial gain. For example, I am claiming my grandmother, but she is not dead; she is hidden away in some remote area (Geldenhuis, 2020). This is also evident in the following cases: it is reported that two suspects appeared in the Durban regional court for insurance fraud after a policyholder with the beneficiary, faked his death to claim life insurance. The 33-year-old suspect applied for R6.5 million life cover, three months later the 45-year-old beneficiary submitted a claim alleging that the insured person died when he was indeed alive (Singh, 2022). Recently, a couple was arrested as the husband and wife conspired to fake the death of the husband to cash in on a life insurance claim worth R1.7 million from Old Mutual (van Zyl, 2022). Chris, the husband is believed to be Robbie Smith, a man who died in a car crash 23 years ago in Gauteng. As it turns out, Robbie did not die but allegedly faked his death, and assumed a new identity as Chris Boshoff (van Zyl, 2022). Based on the above-quoted cases, it is evident that fraud in insurance is one of the most significant challenges to the insurance industry.

Despite all the knowledge about the problem of insurance fraud, there also remains a gap in knowledge of life insurance fraud. To date, in Africa and South Africa, there have been very limited studies that focused on life insurance fraud in criminology literature. Kiragu (2019:3) emphasised that there is less emphasis by researchers on insurance crimes, and this makes it difficult for criminologists to properly estimate the extent and cost of crime in society at the individual, institutional, and national levels. It is in this context where the following research becomes relevant because it will cover the existing gap in the literature which addresses life insurance fraud, particularly in South Africa.

This is a cause for concern [in] a country such as South Africa with such high rates of insurance crime”. In support of the above statement, Stokes (2010) asserted that death and funeral policies continue to be the primary source of fraudulent insurance claims in South Africa. Thus, it was against this background that the researcher deemed it necessary to study and explore life insurance fraud, with a specific focus on KwaZulu-Natal. To fill this gap in criminological literature, the current study aims to examine life insurance fraud from a criminological perspective and offer empirical knowledge of this understudied crime. Further, relevant recommendations emerging from this study

will attempt to address this gap. Moreover, it was argued that the findings would create awareness among the public and the insurance industry on how to protect themselves and minimise the risk of becoming victims of this crime.

1.5 Research aim

The aim of the research is “to discover answers to questions through the application of scientific procedure” (Pandey & Pandey, 2021:9). The specific purpose of this study was to achieve new insights into the phenomenon of life insurance fraud in South Africa. Therefore, the aim was to explore life insurance fraud in KwaZulu-Natal from the perspective of forensics and fraud investigators. This knowledge can be valuable in detecting fraudulent claims, can assist the insurance industry in identifying irregularities in claims decreasing the rate of cases that go undetected and, lastly, assist in improving the current preventative strategies used by insurance companies and South African Police to help them one step ahead of the perpetrators.

1.6 Research objectives

Research objectives must be developed to fulfil the study's aim. According to Farrugia, Petrisor, Farrokhyar & Bhandari (2010:3), “Research objectives address the specific topics that the researcher wants to investigate and should thus be articulated and precise in character”. Study objectives are more specific than the aim and relate directly to the research question (Grove & Burns, 2014; Parahoo 2014). Considering the above requirements, the key objectives of this study were the following:

1.6.1 To determine the *Modus operandi* used by policyholders (beneficiaries) to commit life insurance fraud in KwaZulu-Natal.

1.6.2 To identify the key motivating factors for committing life insurance fraud.

1.6.3 To explore the strategies that companies use to detect and prevent life insurance fraud and their effectiveness.

Achieving the aim and objectives as set out above required the researcher to elicit authentic information and knowledge regarding life insurance fraud, the *modus operandi* of life insurance fraud and the motivating factors were explored. Because the study area and participant sample were relatively small, it is reiterated that the findings may not be generalised to the entire South Africa or areas outside its borders. However, the nature and execution of the study elicited noteworthy findings that may contribute not only to local knowledge about life insurance fraud, but also to other regional, national, and international areas where this crime is rife.

1.7 Research questions

“Research questions help narrow the purpose statement into predictions regarding what will be learned in the study or the questions to be answered” (Creswell, 2014:139). Research questions play a crucial role as they direct the selection of methodology, methods, sample, sample size, data collection instruments, and data analysis techniques (Lipowski 2008). They provide a framework while specifying the data that will be required (Punch, 2013).

The researcher focused on the following key questions to guide the research study:

1.7.1 What is the *modus operandi* used by policyholders (beneficiaries) to commit life insurance fraud in KwaZulu-Natal?

1.7.2 What are the motivating factors for committing life insurance fraud?

1.7.3 What are the strategies that companies use to detect and prevent life insurance fraud and their effectiveness?

1.8 Conceptualisation and Operationalisation

Keywords are a list of approximately half a dozen words that describe the primary areas of interest in one's research (Silverman, 2013). Key concepts are elucidated to provide a clear understanding for both the researcher and the reader, ensuring a specific comprehension of what each concept means.

The key concepts central to this study are as follows:

1.8.1 Life insurance policy

“A life insurance policy promises that the insurer would pay to the policyholder a certain sum of money if the person insured dies or any other specified contingency happens” (Insurance Institute of India, 2007:2). In this study, life insurance refers to a way of saving money for the benefit of the selected beneficiary, upon the death of the insured.

1.8.2 Life insurance fraud

Life insurance fraud is when someone deceives an insurance company for personal gain (Shoenthal & Shih, 2022). According to Nealon (2022:3), “life insurance fraud occurs when an individual or group is dishonest with an insurance company to benefit financially”. In this study, life insurance

fraud refers to a misrepresentation of facts done with the intent to unlawfully deceive the insurance companies for financial gain.

1.8.3 Modus operandi

Marais and Van Rooyen (1990:66) explain that “*modus operandi* is derived from a Latin term which means conduct, manner of conductor operational method of procedure”. Furthermore, Canter and Young (2009:94) mention that “modus operandi can be observed as the behavioural style or pattern that is more fixed in nature and unveil a particular general style of an offence when crime is committed”. Zinn (2002:83) emphasises that “modus operandi comprises, for example, signs or indications of a particular classification or category of criminals who commit crimes together on certain targets in a certain location”. For this study, modus operandi refer to scams used by perpetrators to commit life insurance fraud.

1.8.4 Policyholder

A “policyholder is the person who owns the insurance policy. In most cases, the policyholder is the only person who can change the policy. The policyholder is also the person that is responsible for making sure premium payments are up to date” (Pope, 2023:1). “Policyholder” means the person who for the time being is the legal holder of the policy for securing the contract with the insurer” (Insurance Regulatory Authority, 2012:2). For this study, a policyholder is the one who purchases the insurance coverage from an insurance company, pays the premiums, and is entitled to the benefits outlined in the policy.

1.8.5 Beneficiary

“The person or persons designated by the policy owner to receive the benefits of an insurance policy upon the death of the insured. Also known as the primary beneficiary” (Yates, 2022:1). For this study, a beneficiary is a person nominated by the policyholder as the person to receive the pay-out from an insurance policy.

1.8.6 Claimant

“Means a person who has a right to a settlement arising from a contract of insurance” (Insurance Regulatory Authority, 2012:2). For this study, a claimant is a person who makes an insurance claim.

1.8.7 Perpetrator

“The classification of a person as a perpetrator depends on whether his conduct satisfies all the elements of an offence. A perpetrator can, therefore, be defined as a person who complies with all the requirements of the offence” (Joubert, 1999:97 as cited in Pardhoothman, 2015:8). For this study a perpetrator refers to the individual/ individuals (policyholder/beneficiary) that intentionally commit life insurance fraud intending to collect life insurance or other financial benefits. The researcher uses this term to refer to policyholder and beneficiary as perpetrators of life insurance fraud.

1.8 Research Methods

To respond to the research questions that gave direction to the study, the researcher utilised a qualitative research design. The qualitative approach was best suited to carry out this research as the researcher intended to obtain practical answers and real-life examples from the forensic and fraud investigators tasked with investigating life insurance fraud. The researcher conducted (10) in-depth, -semi-structured interviews and (10) key informant interviews with participants who were selected using purposive sampling techniques. This technique was chosen because it was envisaged that the recruited participants would possess rich information regarding the topic under study and that their experiences and understandings would elicit important data. To analyse the data that were provided by the participants, the researcher used thematic analysis. Using this method meant identifying key themes (or patterns), and this elicited pivotal discussion points as uncovered by the participants’ views and experiences related to the phenomenon under investigation. A more detailed discussion of the research methods is presented in (Chapter Four) of this thesis.

1.9 Structure of the Thesis

Chapter 1: General Orientation

This chapter serves as an introduction and background to the study. It provides a rationale for the study, introduces the background of the study, and problem statement, presents the aims and objectives of the research, and outlines the research questions. The chapter further explains the research methodology and study design, briefly touches upon ethical considerations, provides the definition of the concept, discusses the data collection instrument, and highlights the significance of the study.

Chapter 2: Literature Review

This chapter presents a review of related literature. Which was reviewed to explain the phenomenon of life insurance fraud.

Chapter 3: Theoretical Framework

This chapter illuminates the relevant theories that underpin this study. This study comprised two theories that are related to the topic under investigation namely: The fraud triangle theory (FTT) and the Routine activities theory (RAT). These theories relate to the motivating factors of committing life insurance fraud by policyholders.

Chapter 4: Methodology

This chapter expounds on the qualitative research methodology employed in the study. It details the study procedures, the chosen data collection method, its processes, and procedures. The chapter also provides an elaboration on the data analysis and the processes involved in analysing the data. Various measures taken to provide clear direction and impetus to the study are described and explained.

Chapter 5-7: Presentation of findings

This chapter offers a critical evaluation of the collected data, providing a comprehensive analysis and interpretation of the information gathered from the participants. Furthermore, the presentation of the findings is segmented into three chapters (5, 6, & 7), delineating the discussion of the findings for each objective. It addresses the accomplishment of the research objectives and answers the research questions by integrating insights from the literature and theory covered in the preceding chapters.

Chapter 8: Conclusion and Recommendations

In the final chapter of the thesis, an integrative discussion and main conclusions are presented, derived from the researcher's evaluation of the most significant data emerging from the study. The chapter concludes with a concise section outlining general recommendations and suggestions for future studies.

1.10 Chapter Summary

Chapter One provided an orientation to the phenomenon under study, delineating and elaborating on the statement of the problem and background of the study. The significance of the study paved the way, outlining the necessity and rationale for conducting the current study. Concepts used in the study were clearly defined, and research questions and objectives were stipulated. The theoretical

framework underpinning the study was highlighted, and methodological justification identified the most appropriate approach for this study. Lastly, chapter outlines revealed the overall structure of the thesis. The next chapter is a review of the literature relating to this inquiry.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of previous research whose findings are relevant to the topic under study. Several disciplines, ranging from economics to criminology, sociology, and psychology, have endeavoured to elucidate fraudulent behaviours in the realm of insurance (Ribeiro, Silva, Pimenta & Poesch, 2019). Nevertheless, an exhaustive review of the international literature on life insurance fraud has yielded limited information (Levi, 2008). The scant information available reveals that the dearth of life insurance fraud research transpires not only in South Africa but also internationally, underscoring the significance of this research. Nevertheless, several authors (Lesch & Brinkmann, 2011; Palasinski, 2009; Smith, Button, Johnston & Frimpong, 2010), exert a dominant presence in the field of international insurance fraud research and have published insightful articles on topics such as consumer insurance fraud, tolerance of fraud, strategies to address it, and the exploration of consumer perceptions. However, there has been very little research into the *modus operandi* of life insurance fraud and the motivating factors that contribute to life insurance fraud, specifically within the South African context. Consequently, Miyazaki (2009) appealed to academics to conduct more research on insurance fraud given the importance of the insurance sector and the devastating effects insurance fraud could have on this sector. This study is therefore aimed at addressing the deficiency of life insurance fraud research, particularly in South Africa. It seeks to contribute valuable insights to the existing body of knowledge within the field of criminology and forensic studies. This chapter will explore the research on the element of insurance, the cost of insurance fraud, types of insurance fraud and prevention strategies. It will also look more deeply into the *modus operandi* of committing life insurance fraud as well as the motivating factors for committing life insurance fraud. By the end of the chapter, it hopefully enables a better understanding of the severity of life insurance fraud as one of the biggest problems facing the insurance industry and the public.

2.2 Element of Insurance

Risk is part of everyday life, which creates insecurity and uneasiness in society (Reinecke, Van der Merwe & Van Niekerk, 2002). Some of these risks can be prevented, others can be minimized, and yet most are entirely unforeseeable. Garg (n.d.:11) defined risk as the

“possibility of occurrence of an unfavourable deviation from the expected”. When an unexpected event occurs, there is invariably a sense of loss, which may or may not be measurable in terms of money (Garg, n.d.). “Risk can manifest itself in different forms, including natural disasters, biological disasters, technological disasters, political risks, economic risks demographic risks, or a combination of these” (Insurance Europe, 2012:3; UNEP Finance Initiative, 2014:1). According to Garg (n.d.), the awareness of risk and its potential for causing loss generates uncertainty and fosters a sense of insecurity, leading to concerns among individuals. Thus, a certain level of comfort and peace of mind is important in personal and business life. The need for peace of mind and protection from various forms of risks gave birth to the concept of insurance (UNEP Finance Initiative, 2014:1). However, it is important to note that “insurance cannot prevent a risk from occurring, but instead enables society to transfer their risk to a third party, thereby relieving themselves from the financial or physical burden they may incur when risks materialise” (Grant, 2012:3; Insurance Europe, 2012:5; Muscat, 2013). Following the above-mentioned authors, Alfejeva (2011:13) stated that “insurance is a social process that affects essential interests of individuals by providing safety and stability, it is a type of legal transaction, whereby a transfer of risk takes place in return for a consideration”. Alfejeva (2011) states that its economic substance is in the form of risk management to guard against the negative consequences of risk occurrence and receiving loss compensation from a special fund held by the insurer. Similarly, Kathanga, Awino, and Kabiru (2016) alluded that an insurance buyer pays a predetermined premium in return for the commitment to receive compensation in the event of a specified loss. According to (Havenga, 2006) premium is one specific requirement for a valid insurance contract. Furthermore, Section 1 of the Short-Term Insurance Act explicitly defines a premium as the “consideration given or to be given for an undertaking that provides policy benefits” (Havenga, 2006:12). Therefore, in the event of a loss, the insurer disburses a sum calculated based on an agreed-upon basis. The amount of premium paid by the policyholder is determined by the type of risk and the level of protection required. (Gill, 2001).

Insurance is commonly described as the pooling of risks, where individuals contribute to a shared fund through premiums. The fortunate individuals who do not experience a loss assist those less fortunate who suffer a loss during a defined insurance period (Irukwu, 2009). In addition, Muscat (2013:18) shares the same sentiment by stating that the “main principle of insurance is the spread of risk to a pool. It is this pooling of risk that enables an insurance company to operate profitably while at the same time being able to pay for claims that will or

may arise during the period of insurance”. However, Alfejeva (2011:15) argued that “the nature of insurance is often misinterpreted by the public, as the immediate result is not visible upon purchasing insurance services. Sometimes insurance is expected to perform a typical task, such as solving social problems”. It is noteworthy that in South Africa, a significant portion of available insurance falls under the categories of short-term and long-term insurance, encompassing coverage for motor, health, property, disability, and life (Rangarajan, 2006). These products are designed to offer financial benefits during retirement and provide financial compensation to beneficiaries in the event of an accident, illness, or death (Association of British Insurers, 2014:10, Grant, 2012:8). For the purposes of this study, the researcher will focus primarily on long-term insurance, with a specific emphasis on life insurance.

2.3 Life Insurance Policy

As “Benjamin Franklin once said, nothing is certain but death. There is no exact way of predicting when one is to die. Therefore, people need to be financially prepared for such occasions otherwise their dependents’ financial security could be at risk as it not only affects emotionally but financially too” (Muscat, 2013:19). Further, Parvathy and Rajalakshmi (2021) believe that a life insurance policy is widely utilised to accommodate subordinate relatives in the occurrence of sudden passing. In addition, it aims to support certain objectives, for example, a kid or grandkid’s future education (Parvathy & Rajalakshmi, 2021).

Various forms of life insurance contracts exist; some offer indemnification upon death, while others provide a return on the investment if it proves successful. Alternatively, the policyholder may receive benefits if they survive up to a pre-defined age (Muscat, 2013). The market provides a diverse range of life insurance products, each with distinct terms and conditions of coverage. Each type of product is designed to meet the specific demands or needs of consumers.

According to Viaene and Dedene (2004:13), “life insurance is a financial cover for a contingency linked with human life, like death, disability, accident, and income protection”. However, Hollard (2015); and BrightRock (2021), argue that many individuals and sometimes even experts use the term ‘life insurance’ to refer to funeral cover and life cover collectively. Autogen (2022:1) shares the same sentiment with the above authors, by stating that “life cover and funeral cover are two products that can support your family after death but are frequently mistaken for one another”. Consequently, this can cause a lot of confusion for a layperson without the knowledge of the difference between these products, as this can cost consumers

money (Kagura, 2017). In support of the above authors Thiye (2021), revealed that more than 7 million South Africans have funeral policies in place for themselves and their families and a far lower number have taken out life insurance policies the reason might be that many people who already have a funeral policy believe a life insurance policy is similar and therefore unnecessary. Therefore, for this study, it is important to understand the difference between life and funeral cover. Both life and funeral policies are paid out for one's death, but the two products serve very different purposes. Funeral policies provide a lump sum that can be used to pay for costs associated with the funeral, for example, costs of a burial or cremation, grocery purchases, airtime and other funeral costs. Funeral covers can be taken on the lives of any of your family members, including extended family (Autogen, 2022; Hollard, 2022:1). Life insurance, however, offers a wider range of protective cover for beneficiaries and insured policyholders in the event of life-changing circumstances, such as a sudden loss of income, the onset of a severe disease or disability, or loss of life, ensuring the ability to fulfil financial responsibilities to oneself and dependents. Life covers can only be taken for yourself or your spouse, in some instances on other lives where a clear insurable interest exists (Autogen, 2022; Hollard,2022:1).

Life insurance is a long-term contractual arrangement between a policyholder and an insurer, necessitating public trust in effectively managing protection and savings prepared in the case of death of the policyholder (Adinugroho, Rauf & Sucipto, 2022; Choudhary, 2014). Furthermore, Muscat (2013), believes that life insurance is deemed the simplest, most popular, and cost-effective method of safeguarding one's own family or mortgage in the event of one's death. Beyond providing benefits to one's family in the event of death, life insurance can also serve as an investment for the policyholder. Similarly, Murphy (2010), stated that a life insurance policy involves the payment of premiums at a certain percentage on the condition that, if the person named should die before a specified time, his or her heirs would receive the amount of the principal for which the premium was paid. A life insurance contract must involve three parties: the insurer, an insured, and a beneficiary (Muscat, 2013). The beneficiary can either be the insured himself, in which case the life assurance would be taken on his own life or else as desired by the policyholders. For instance, it includes (Muscat, 2013:7)

- Spouse's life
- Life of Children
- Employer and employee

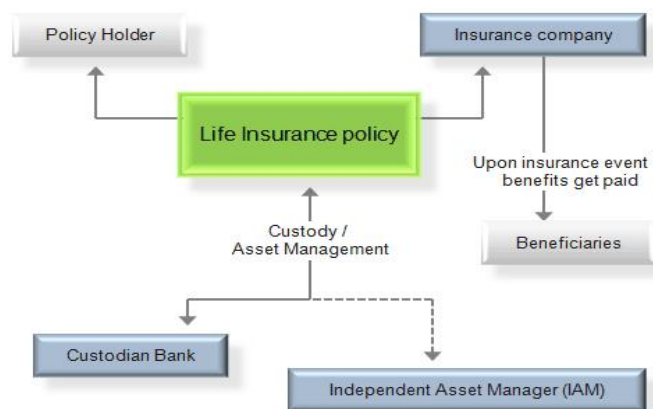
- Creditor and debtor
- Business Partners

According to Discovery (2022), life insurance policies ensure that the policyholder and their family are financially protected in the event of a death, disability, severe illness, or loss of income, as it guarantees to pay a stated sum to a family on the death of its income earner(s). In so doing, it affords families a measure of protection against the adverse financial consequences of premature death, gives individuals a greater sense of economic security, and can help reduce worry and distress and thereby increase initiative (United Nations Conference on Trade Development, 1982). Thus, this type of policy is a very important part of personal financial planning because it is a rapidly available source of financial support for a person’s dependents upon the insured’s death.

However, according to Alfejeva (2011:15), “the nature of insurance is often misinterpreted by the public, as the immediate result is not visible upon purchasing insurance services. Sometimes insurance is expected to perform a typical task, such as solving social problems. The myth of social problem-solving with the help of insurance is maintained by public relations campaigns organised by the insurers themselves”. Further, Kingree and Tanner (1994:1) aptly stated that “life insurance purchased to insure the life of another can have the unintended effect of tempting a murderous beneficiary to kill the insured to obtain the insurance payout”. Nevertheless, in developing countries life insurance has become an important instrument of mobilizing long-term funds. The savings component of the policy puts the life insurance in direct competition with other financial institutions and savings instruments (Rangarajan, 2006).

Figure 2.1, illustrates conceptually how a life insurance policy is structured.

Figure 2.1: Chart of life insurance



The researcher opines that, from the literature above, it is evident that insurance is designed to protect individuals against significant but uncertain losses through the pooling of risk. However, life insurance fraud undermines this pooling system because it diminishes the funds paid in by honest policyholders to cover genuine losses. Policyholders and beneficiaries misuse this amazing system to finance their lavish lifestyles.

2.3.1. Insurable interest as a requirement for life insurance policy

According to Havenga (2006), in South Africa, there is a legal provision to take out an insurance policy on someone else's life. However, you need to prove that 'insurable interest' exists. In essence, you must be able to prove that the policyholder would suffer a financial loss if the insured person were to be deceased. Chriscoe (2017), simply stated that a life insurance policy excludes a person from being beneficiary to a life insurance policy covering the life of another person unless he has a sufficient relationship with the insured life to constitute an insurable interest. Kingree and Tanner (1994) assert that an insurable interest is regarded to "prevent" the murder of the insured. However, Havenga (2006) argue that it should be made clear that the requirement cannot prevent the murder of the life insured and that it can at most serve as a deterrent against murder. In American law, for example, it is generally stated that an insurable interest serves as a deterrent against murder (Havenga, 2006). The irony, at least for American law, is that since spouses are usually deemed to have an insurable interest in each other's lives and in that of their children, a life insurance contract with an insurable interest does not seem to deter or prevent the life insured from being murdered. On the contrary, it may even be possible that the existence of a life insurance contract with an insurable interest encourages murderers. Nevertheless, (Havenga, 2006) acknowledges that since an insurable interest need only exist at the time of conclusion of the life insurance contract a beneficiary may be motivated to murder the insured life to obtain the insurance money. In essence, a person can take out life insurance on his own life, to which he has an insurable interest, that in the event of death, his dependants are taken care of by being compensated the benefits of the life insurance contract. Furthermore, he can take out life insurance on the lives of other persons related to him to which he also has an insurable interest.

2.4 Definition of fraud

Before estimating the extent of the global life insurance fraud problem, it is necessary to define what constitutes fraud. The legal definition varies depending on the jurisdiction. In South Africa, fraud is defined under common law. According to Van Der Merwe & Du Plessis (2004:483), fraud encompasses any unlawful act made with the intention to defraud, under which a misrepresentation is made that causes actual prejudice or which is potentially prejudicial to another. The South African Police Service (SAPS) (2016:115) defines fraud as “the unlawful, intentional distortion of the truth, calculated to prejudice another”.

2.5 Insurance Fraud

Despite the valuable contribution that insurance brings to societies, especially in mitigating financial losses, the reality is that the industry has itself fallen victim to the scourge of crime manifested in the form of insurance fraud (Morley, Ball and Ormerod, 2006:163-164; Tennyson, 2002:289). According to (the Association of British Insurers (ABI), 2012:3; Association of Certified Fraud Examiners, 2014:12; Schiller, 2006:421), insurance fraud remains a significant risk plaguing the insurance industry, and the frequency, methods and financial impact of insurance fraud remain a growing concern for insurers all over the world. Dean (2004:67), reported that insurance fraud is the second-largest white-collar crime in the United States (US) in terms of monetary value.

Definitions of insurance fraud are important in determining its causes, prevalence, social impact, and other elements and also for providing the research (Alfereva, 2011). Consequently, Pimenta and Afonso (2014), provide a more comprehensive explanation by defining insurance fraud as “any intentional act by persons, individual or collective, perpetrated with deception that causes, effectively or potentially, advantages for someone or damage to others and which violates either good social practices or the law” in an insurance matter. Moreover, it is important to note that a common definition of insurance fraud does not exist among the several definitions. However, this dissertation endorses the one by Lesch and Byars (2008:412), who defined insurance fraud as the “deliberate deception perpetrated against an insurance company or agent for financial gain and includes illegitimate claims, claims exaggeration and reporting fake incidents”. Hence, insurance fraud is not only an economic, legal, and social issue but also a moral or psychological problem, depending on the context.

Insurance fraud can be committed at any stage of the insurance lifecycle from the policy inception stage up to the claims stage, and in various ways (Insurance Fraud Taskforce, 2016:5; Miyazaki, 2009:589). All insurance product lines, including household, motor vehicle, and life, are all at risk and other commercial insurance products, are susceptible to insurance fraud (Miyazaki, 2009:589). Similarly, the Insurance Information Institute (2015), is of the view that insurance 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.

The term ‘insurance fraud’ basically means the exploitation of insurance contracts through illegal means for financial enrichment. The mere concept of insurance i.e., protection against eventual risks is exploited. Although many cases of insurance fraud by insurers have been recorded, major cases of fraud reported are committed by the policyholders who malign the insurance contracts by attempting to make more money through exaggeration and disillusion of claims (Khatua, 2020).

The following are reasons why insurance fraud is increasing so drastically (Coalition Against Insurance Fraud, [s.a.]

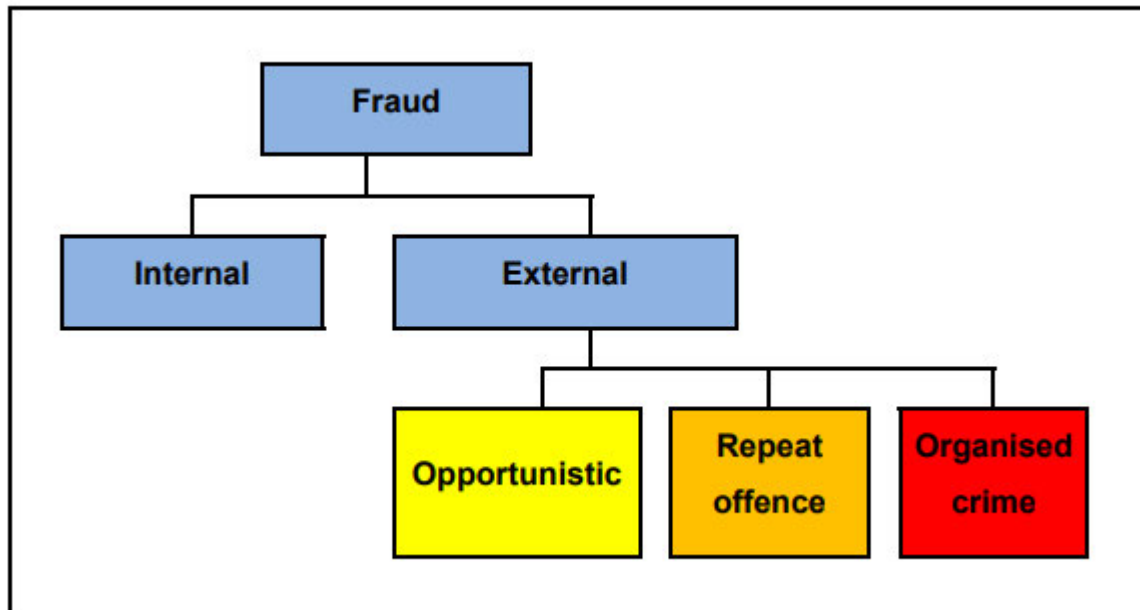
Some insurance companies unconsciously encourage fraud by settling suspicious claims easily. They believe that it is cheaper to pay the claim than to fight it in court or to face lawsuits due to bad faith.

- Some policyholders believe that insurance fraud is a low-risk crime with a high financial benefit in comparison to crimes such as armed robbery or drug trafficking.
- Investigating officers do not understand the short-term insurance industry and it is therefore difficult for them to investigate cases of insurance fraud.
- Prosecutors give priority to more serious crimes and sometimes believe that insurance crimes are too complex and technical to successfully prosecute.
- People tend to have a tolerance for insurance fraud and many policyholders believe that insurance fraud is justified.

It is well-known that insurance fraud comprises several situations: fraud committed by insurance customers toward insurer companies or by insurer companies toward consumers; fraud perpetrated by intermediaries toward insurers and/or policyholders; fraud carried out by

insurer employees with or without the collusion of others; fraud involving organized crime and gangs (Insurance information institute, 2015). This study focuses on insurance fraud, specifically life insurance fraud which is committed by policyholders (claimants) against insurance companies. Figure 2.2 depicts the types of fraud.

Figure 2.2: Chart of the different types of insurance fraud



Researchers and academics (Insurance Europe 2013:7; Tseng & Su, 2013:38), separate fraud into two categories, namely planned fraud, and opportunistic fraud. Moreover, planned, and opportunistic fraud is also known as hard and soft fraud respectively (Goel, 2014). However, some research studies classify insurance fraud into three commonly encountered classifications depending on the intentions of the perpetrator: (1) soft vs hard, (2) internal vs external, (3) underwriting vs claims. Nevertheless, this study seeks to unpack soft vs hard, and internal vs external, these two forms are discussed below.

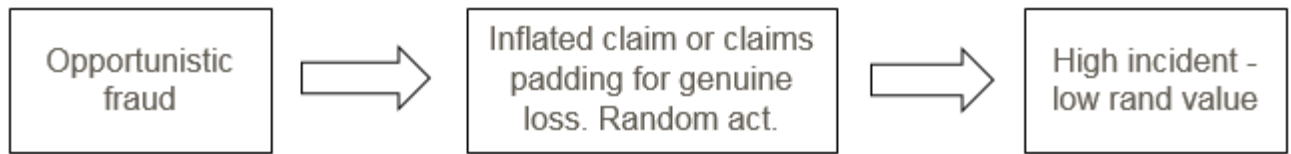
2.5.1 Opportunistic (soft) fraud

The first type of insurance fraud is commonly referred to as opportunistic fraud, which is usually perpetrated by an individual who inflates or exaggerates the value of a valid or legitimate loss suffered. Haithem, Ayisi, and El-Hedhli (2014:317) and Viaene and Dedene (2004:316), on the other hand, describe this type of insurance fraud as soft fraud.

The above authors report that soft fraud occurs when “claimants seize an opportunity to inflate the damages of an otherwise legitimate claim (claim to pad or build up)” (Haithem, Ayisi, and El-Hedhli, 2014:317; Viaene and Dedene, 2004:316). Further, they concur that the term “soft” and “opportunistic” can be used interchangeably. According to (Goel, 2014; Haithem et al., 2014:318; and the Insurance Information Institute, 2015), opportunistic (soft) fraud is commonly unplanned, and it arises when the opportunity presents itself, to obtain a better financial benefit than the actual loss suffered. Further, Clarke (1990) highlighted that opportunistic fraud is a significantly more prevalent form of insurance fraud in the non-life or general insurance business. Yusuf and Babalola (2009) share the same sentiment as Clarke (1990) by stating that this type of fraud occurs in the retail and commercial non-life insurance market. Hence, the researcher argues that life insurance fraud is planned fraud, which typically involves intentional actions and schemes where individuals deliberately deceive the insurance company for financial gain. This can include actions such as providing false information on insurance applications, staging accidents, or even faking one's death.

According to Tennyson (2008), soft fraud can be viewed as unethical and abusive behaviour, whereas hard fraud is criminal fraud that can be prosecuted. This type of fraud is undertaken by individuals who experience a loss and attempt to shift the costs to the insurance system. Furthermore, Miyazaki (2009:589), refers to this type of insurance fraud as claims padding and describes it as the “purposeful inflation or overstatement of the actual value when making a claim”. In addition, (Viaene, Derrig & Dedene, 2009), shares a similar point of view that opportunistic fraud is often characterized by claims exaggeration, and may be undertaken by the insured alone or with the help of a service provider or legal professional. Miyazaki (2009:589) and Tennyson and Salsas-Forn (2002:289) reported that opportunistic insurance fraud is the most common, widespread, and costly type perpetrated by policyholders against insurers. These authors report that the prevalence of opportunistic insurance fraud is related to consumer attitudes because consumers do not perceive the conduct as fraudulent or unethical. There is support for the views expressed by Miyazaki (2009:589) and Tennyson (2002:36) in Coalition Against Insurance Fraud (1997:11, 2008:5) findings, which revealed that a large percentage of consumers in the United States considered opportunistic insurance as acceptable.

Figure 2.3: Process relating to opportunistic fraud.



Source: Chetty (2020:50)

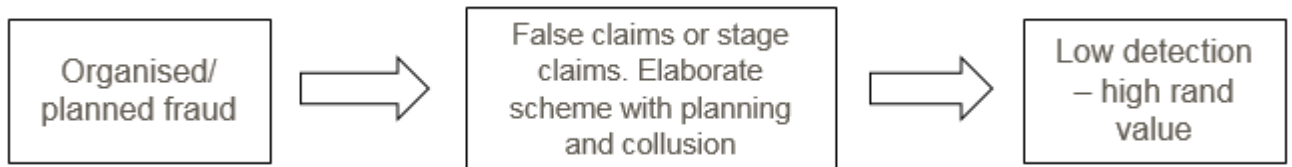
2.5.2 Organised (Hard) Fraud

The “label “hard” tends to be associated with carefully premeditated and minutely executed scams to off insurance, hard fraud is often reserved for criminal offences” (Haithem et al., 2014:317). This fraud takes planning and scheming by organised criminal gangs or cartels with or without someone inside the insurance company to help get money from an insurer (Coalition Against Insurance Fraud, 2015; Viaene & Dedene, 2004). Following the above-mentioned, Longino (2015:1) stated that “one alarming aspect of insurance fraud is the involvement of organised criminal groups. These organised criminal enterprises are formed for the sole purpose of defrauding the insurance industry”.

In addition, Haithem et al. (2014:317) and Viaene and Dedene (2004:316), describe organised fraud as “carefully premeditated and minutely executed scams to rip off insurance”. The authors do agree that the terms “hard” and “planned” have a similar meaning. Claims for bogus or staged injuries, accidents, burglaries, and fires are some examples of “hard fraud” listed by these authors. An example of hard fraud would be getting into an accident on purpose so that you can claim the insurance money or intentionally inflating claims to benefit from the insurance contract (Saylor, 2023:2). In addition, Angima and Omondi (2016) are of the view that planned fraud may be undertaken by an individual on a one-time basis or may be carried out by professionals in a systematic effort to profit from the insurance system. Committing life insurance fraud is far from a spontaneous act. Tennyson (2002) reports that this type of fraud manifests itself by falsifying of claims where the insured event did not happen, but a claim is still submitted. Essentially, perpetrators submit false claims to insurance companies. Hence, unlike impulsive decisions, fraudulent activities within the realm of life insurance involve intricate schemes that necessitate careful orchestration. Individuals or syndicates contemplating such actions must invest time and effort into planning every detail to avoid detection. Consequently, the researcher believes that life insurance fraud is categorized as hard

fraud because the syndicates or individuals involved are highly organised, well-planned, and correctly resourceful.

Figure 2.4: Process relating to organised/planned fraud.



Source: Chetty (2020:51)

2.5.3 Internal vs External

Internal Fraud: Internal frauds are those perpetrated against a company or its policyholders by agents, managers, executives, or other employees (Viaene & Dedene, 2004). An internal fraud often involves theft of proprietary information, improper relationships with vendors or consultants involving conflicts of interest, diversion of policyholder or company funds by employees, use of confidential information for investment purposes, intentional misrepresentation by agents to prospective customers about the characteristics or future of company products and any other unethical activity that might put the business interest at risk.

External Fraud: External frauds are directed against the company by individuals or entities as diverse as medical providers, policyholders, beneficiaries, vendors, and career criminals. External fraud can involve such schemes as fraudulent automobile, life, health or disability claims, the use of tax-advantaged insurance products for concealing the origins of illicit funds, or the negotiation of counterfeit checks (Viaene & Dedene, 2004). Thus, this study is more focused on external fraud, specifically fraud committed by policyholders (beneficiaries).

In considering the above classification of fraudsters, Chetty (2020) argued that it is possible in certain circumstances that there would be a progression of insurance fraud from opportunistic insurance fraud to planned insurance fraud and ultimately to organised insurance fraud. “She further explains that this will occur where the fraudster who initially committed opportunistic insurance fraud progresses to more planned forms of fraud for greater returns, and thereafter more organised insurance fraud, which yields the greatest returns” (Chetty, 2020:16). This

progression could be influenced by the poor control environment, the belief of low detection and the financial gain.

2.6 Life Insurance Fraud

According to reviewed literature insurance companies are not the only ones facing the consequence of insurance fraud. i.e. life insurance fraud. It is important to note that due to this type of crime policyholders are forced to bear the financial burden of insurance fraud through increase of premiums (Insurance Fraud Taskforce, 2016; Tennyson, 2008) and declining quality of products and services due to lengthy assistance, regular inspections or by diminishing risk protection (Ribeiro, Silva, Pimenta & Poeschl, 2019). Choudhary (2014) asserts, that life insurance fraud is more than just a financial crime that harms individuals, businesses, and the government. But it can also be an aggressive crime, including murder, personal injury, and serious property damage. Life insurance fraud also forces other personal risks such as disrupted lives, families, dishonour, sadness, financial failure and lost jobs (Choudhary, 2014) Moreover, researchers (Insurance Fraud Bureau, 2012; Ernst & Young, 2011; Association of British Insurers, 2012) share the same sentiment with Choudhary (2014), by stating that frauds and fraudulent practices in life insurance frequently put people's lives in danger and infringe painful, invasive and unnecessary procedures. Insurance fraud puts pressure on insurance companies, and legal public services and erodes societal trust. Therefore, apart from the financial impacts of this phenomenon, insurance fraud has also major societal impacts, contributing to the deterioration of social relations based on trust and ethical values (Pimenta & Afonso, 2014) cited in (Ribeiro, Silva, Pimenta & Poeschl, 2019). The researcher argue that life insurance fraud not only undermines the integrity of insurance systems but also poses significant dangers to family members. Moreover, the betrayal of trust inherent in insurance fraud can erode familial relationships, leading to strained dynamics and emotional distress within the household.

Insurance fraud imposes personal costs such as disrupted lives and families, humiliation and depression, lost jobs, and bankruptcy (Mutua, 2017). In life insurance, insurance abuses may be carried out to obtain indemnity through the persons who deceased in the past or lost or who is of unsound mind (Polat1, Zeynep & Reva, 2018).

2.7 The cost of life Insurance fraud

Globally, it is estimated that 10% of all insurance claims made by consumers are fraudulent while just one-fifth of these fraudulent claims are detected by the insurer (Ishida, Chang & Taylor, 2016). Despite the fact that insurance fraud can be found around the world, it varies across countries due to social and cultural differences (Tonenciuc, 2015). Although it is almost impossible to determine the costs of insurance fraud precisely (Association of British Insurers, 2009b), the Coalition Against Insurance Fraud (2015) estimates the cost of insurance fraud to be at least \$80 billion per year, across all types of insurance. In 2011, it was estimated that about £1.9 billion of insurance fraud in the UK went undetected, while the value of detected insurance fraud increased to £983 million; a seven percent increase from 2010 (ABI, 2012:5; Insurance Europe, 2013:9). Many fraudulent claims that slip through the insurers' counter fraud controls. Tennyson (2008) alluded that the process of measuring fraud is difficult and prone to error as it is difficult to know how much remains undetected. Measuring insurance fraud has proven difficult due to the subjective nature in assessing a case.

Ericson and Doyle (2000:539), reported that, in Canada, insurance fraud is the second greatest generator of criminal proceeds, after drug dealing, and that about 10% to 20% of claims are fraudulent. Furthermore, Research by Ericson and Doyle (2004) acknowledges that the actual cost of insurance fraud may be twice the estimated cost of 10 percent, as this crime also goes undetected. Although these studies reflect different measures of incidence, they indicate that insurance fraud does occur and should be addressed. As mentioned above life insurance fraud is a problem that occurs internationally, South Africa is also one of the country that is experiencing this problem. Therefore, it is imperative to discuss the extent of life insurance fraud from a South African perspective.

A review of the sparse literature on insurance fraud in South Africa (SA) indicates that no attempt has yet been made to quantify the costs associated with life insurance fraud. The costs are mostly based on estimates, which are reported in various online media articles. The lack of credible sources in SA to prove the costs of life insurance fraud is a major obstacle for the insurance industry to convince the government to intervene with regulations to prevent life insurance fraud. Further, Viaene and Dedene (2004:19) argue that obtaining "accurate and reliable statistics on insurance fraud costs would help elevate the problem through the availability of credible information".

There is also no readily available information on life insurance fraud cases reported to the South African Police Services (SAPS), as these cases are clustered under commercial crime in police crime statistics (SAPS, 2016:70-72). There is limited data from the insurance companies on the number of reported criminal cases to SAPS, leaving only media reports as a source of information (COVER, 2015; eNCA, 2013; Wood, 2017).

The Association for Savings and Investments South Africa (ASISA) (2016) reported that the value of fraudulent claims in the long-term insurance industry increased from R755.2 million in 2014 to R870.7 million in 2015. Furthermore, the ASISA, reported that there has been a massive increase in fraudulent death claims in South Africa which costs the combined insurance industry billions of rand each year (Association for Savings and Investments South Africa, 2016). The statistics show that in 2017, claims to the value of R1.13 billion were made against life insurers. In total, 2111 fraudulent death claims were reported, compared to only 444 in the previous year (Insurance Crime Bureau, 2020). In 2018, life insurers rejected 1915 funeral claims worth R176.4 million of which 1127 were found to involve fraudulent documentation. Another 156 fraudulent claims showed syndicate involvement and in seven cases beneficiaries were found to have caused the death of the policyholder (Business Insider SA, 2019).

Irrespective of the methods used or concerns raised about the accuracy of these estimates, there is consensus amongst the various sources that incidents of life insurance fraud are widespread and the associated costs are substantial. Which will remain a challenge for insurance companies both locally and internationally to effectively address and manage (Ai, Brockett, Golden, & Guillén, 2013:122; Dionne & Wang 2013:68; Miyazaki, 2009:589; Ormerod, Ball & Morley, 2012:371; Tennyson, 2008:1184-1186). Thus, this global scale indicates that life insurance fraud is a complex phenomenon that calls for insurance companies to have prevention strategies that will be holistic and specifically designed to bring relief to life insurers.

The following is a discussion on the motivating factors for committing life insurance fraud.

2.8 Motivation for Committing Life Insurance Fraud

There are various contributing factors which lead to life insurance fraud (Chudgar & Asthana, 2013). Similarly, Wells (2005:13), argued that there is no single reason why people commit fraud. Coalition Against Insurance (2020), also added to this by stating that the causes of insurance fraud vary but are usually centred on greed and holes in the protection against fraud, often those who commit insurance fraud view it as a low-risk and lucrative business. Omar, Nawawi and Puteh Salin (2016:1539) found that some of the causes of fraud include social factors like lifestyle and financial pressure due to a low income as well as unplanned financial needs. This corroborates findings by Schich (2010) that insurance policyholders defraud funds from insurers to maintain or return their previous standard of living.

However, Ishak, Baker and Zakaria (2020) argue that regardless of the impact of crime on others, the primary goal of criminals is financial gain. Further, Kavanagh (2018), aptly noted that the most obvious incentive for committing insurance fraud is financial gain either through paying less premium or increasing the amount paid by an insurer for a claim. Additionally, The SEMutual Insurance (2018) stated that insurance fraud can result in death or physical injury, as well as emotional and psychological impairment to the members of the public.

Hence, a weakness in the legal system, such as minimal punishment for those caught committing insurance fraud, means that those who want to commit fraud have a starting advantage (Cartwright & Roach, 2016). In essence, determining the possible motivating factors of life insurance fraud would help to develop or improve anti-fraud strategies within the organization. This is supported by Murdock (2008:81); (Skiba & Disch, 2014:14), who stated that when designing or improving anti-fraud strategies, organisations need to understand the reasons why fraud is perpetrated against them. Following the above mentioned, (the Association of Certified Fraud Examiners, 2016) clarifies that detecting fraud is not an easy task and therefore requires knowledge about the nature of fraud, why it is committed and how individuals engage in insurance fraud. Moreover, Chetty (2020) assert fraudster's reasons for committing fraud are best dealt with within the criminology realm. Because criminology is the study of crime, the causes of crime (aetiology), crime typology, the meaning of crime in terms of law, rates, or incidences of crime, and community reaction to crime (Ramamoorti, 2008:523). Furthermore, Chetty (2020) stated that the first step in combatting fraudulent and dishonest claims is understanding why they occur and who is responsible. The researcher argues that without a clear understanding of what motivates perpetrators to commit life

insurance fraud, it is impossible to expect the insurance industry to have well-rounded proactive preventative and detection strategies for life insurance fraud. Ramamoorti, Morrison and Koletar (2009:7-10) alluded that, “because fraud is committed by human beings, it is important when developing anti-fraud strategies to understand the reasons why the fraud was committed; they stress that exploring other disciplines that focus on understanding human behaviour is a vital component to the success of anti-fraud strategies”. Thus, this study aims to fill this gap in life insurance fraud literature.

2.8.1 Fraud Triangle

There is no one reason for committing fraud, thus the fraud triangle, which consists of motivation, opportunity, and rationalisation, offers a useful solution in developing an anti-fraud programme (Lees, 2012:5) posits that, because. Based on the research done by Donald Cressey and his theory of the fraud triangle, it is believed that fraud is likely to result from a combination of three factors, namely, motivation, opportunity, and rationalisation (Muscat, 2013). Chetty (2022) share the same sentiment by stating that much of the rise in fraudulent and dishonest claims has been driven by the three factors collectively called the fraud triangle. However, Kakati and Goswami (2019:4) argue that the “motives, rationalisation and opportunity to commit fraud differ, depending on which interested party or combination of interested parties are involved in the fraudulent activity”.

The following is a discussion of the elements of the fraud triangle.

2.8.2 Motivation/ Financial pressure:

This is based on greed or needs, for example, resulting from financial difficulties (Sujeewa, Yajid, Azam & Dharmaratne, 2018). According to Chetty (2022) the economic difficulties borne of Covid-19, left people feeling the financial pinch to commit insurance fraud. Moreover, Murdock (2008:81) explained that financial pressure is created through problems caused by immoral personal behaviours such as gambling, drugs, extramarital relationships, or the need to live lavishly. In addition, a study conducted in 2013 in the United Kingdom (UK) by the Association of British Insurers (ABI) showed that 42% of the participants admitted to considering insurance fraud an easy way to “make a quick buck” (Ribeiro, Silva & Poeschl, 2020). Hickling (2021) highlighted that industry statistics suggest that people are more likely to commit insurance fraud in times of economic hardships. Stokes (2022) is of the same view as Hickling (2021) by stating that the level of fraud and dishonest claims tends to increase

during tough economic times, as individuals succumb to the financial pressure, they find themselves under.

2.8.3. Opportunity:

According to Chetty (2022), fraud cannot happen without an opportunity to take advantage of it. Unfortunately, these opportunities can be difficult to mitigate and even harder for insurers to stay on top of them. For example, the claimant may inflate a genuine claim and falsify certain details for financial gain. Claims processes, which have been implemented by insurers to speedily assist policyholders in claims settlement, are being exploited by criminal syndicates (Chetty, 2022). In addition, the KPMG Malaysia Fraud, Bribery, and Corruption highlighted that the most influential opportunities are loopholes in internal control, inadequate competency to detect fraud by the internal audit team, and insufficient training to give awareness on fraud (Said, Alam, Ramli & Rafidi, 2017).

2.8.4. Rationalisation:

This is when the actions taken are assumed necessary for the business, harmless because the victim is large enough to absorb the impact or justified because the wrongdoer feels aggrieved (Sujeewa et al, 2008). Similarly, Chetty (2022:2), stated that rationalisation refers to the justification which is advanced to support unethical or bad behaviour. He further mentioned that a person's ethics plays an important role in understanding their motivation to employ rationalisation techniques. Chetty (2022:2) highlighted that people filing dishonest or fraudulent claims often rationalise this fraudulent behaviour by "tricking" themselves into believing that filing fraudulent claims is a victimless crime as no one gets hurt. While not only explaining the driver behind why people commit insurance fraud, the "fraud triangle" also explains the primary motivations behind why insurance crime is trending upward (Chetty, 2022). Unfortunately, Kassem and Higson (2012:191), argue that the fraud triangle in isolation cannot explain fraud because rationalisation and pressure are factors that cannot be observed. Morley, Ball and Ormerod (2006:163) suggest that "motivations to commit fraud vary". Brinkmann and Lentz (2006:322) explain that opportunistic individuals may perceive insurance fraud as being a victimless crime and would therefore indulge in submitting a fraudulent claim as a means of recovering their premiums.

In addition, Chudgar and Asthana (2016:), conducted quantitative research to identify various drivers of life insurance fraud, and it was found that broadly there are four drivers which contribute to the fraudulent activity in life insurance fraud, namely:

2.9. Fraudster's Attitude (I can get away with it)

One of the drivers is the fraudster's attitude which compels him/her to commit life insurance fraud. Based on the conducted survey by Chudgar and Asthana (2016), more than 55 per cent of respondents believe insurance fraud occurs because people believe they can get away with it and that they need money. This indicates that the fraudster's attitude is driving up the insurance fraud. The negative attitude of fraudsters thinking they can get away with life insurance fraud is a serious concern that needs to be taken into consideration by the insurance industry as this implies that they might be aware of the loopholes in their systems. Tennyson (2002) examined whether consumers level of experience with insurance was related to their attitudes toward insurance fraud. Survey data showed that the respondents who owned more types of insurance and those who had recent insurance claiming experience were less likely to find insurance fraud to be acceptable.

2.9.1 Poor Control

Poor control refers to the customer service and the internal process of the insurer. From the survey conducted by Chudgar and Asthana (2013), it was found that more than half that is 55 % of the respondents believe that poor control is responsible for driving insurance fraud. A study conducted by Akomea-Frimpong, Andoh and Ofosu-Hene, (2016), on the causes, effects, and deterrence of insurance fraud in Ghana. The study found that Weak internal controls in the insurance companies were the next talked-on causes of internal fraud in Ghana. This happens when managers or employees wield too much power or authority with no controls or supervision and ill-crafted internal controls. Weak internal controls are also the floodgates through which all forms of attacks are mounted on the financial strength of organizations (Daniela & Attila, 2013).

2.9.2 Difficult Economy

According to Alfejeva (2011) during an economic recession the number of fraud cases increased, "the Association of British Insurers found that there were clear signals indicating that the recession leads to an increasing volume of insurance fraud, as well as an increased number of cases" (Alfejeva, 2011:16), In addition, Alfejeva (2011) further argued that insurance fraud is perceived to be a relatively simple way to improve one's financial situation with a relatively low risk of being caught, it is especially committed at times of

economic recession when the financial stability of individuals and businesses is significantly reduced. Colquitt and Hoytt (1997) evaluated the reasons given by insurers for resisting fraudulent claims. Findings suggested that frauds were higher in the states where unemployment was high and where public attitudes to accept the fraud were higher. Schich (2009) further added that insurance policyholders defraud funds from insurers to maintain or return their previous standard of living. Similarly, Smith (2015) stated that the worsening social and economic circumstances in South Africa may attract more individuals to crime.

However, Tennyson (2008) opines that even in the narrowest economic sense insurance fraud has negative consequences for society. The researcher believes that, from the literature above, it is evident that perpetrators of life insurance are more likely to commit insurance fraud due to the economic depression that results in people losing jobs or being retrenched. The researcher is of the view that the economic hardship in South Africa has pushed many perpetrators to commit life insurance fraud. In addition, Omar, Nawawi and Puteh Salin (2016:1539) conducted a study on the causes of employee fraud and it was found that some of the causes of fraud include social factors like lifestyle and financial pressure due to a low income as well as unplanned financial needs.

2.9.3 Consumer's Attitude (Fraud is unacceptable)

The last driver is the consumer's attitude. To measure the customer's attitude respondents were asked how the acceptability for people to commit life insurance fraud. Only 24% of the respondents believed it is acceptable for people to commit life insurance fraud (Chudgar et al, 2016). Policyholders consider it to be normal when the amount of insurance indemnity claimed is greater than the losses incurred by the insurer, or when the circumstances of the injury are "somewhat" changed to receive insurance indemnity. There is also evidence to suggest that the public is much more open to the idea of committing insurance fraud compared to other crimes and frauds (Gill, Woolley & Gill 1994; Dodd, 1998).

Similar research conducted by Karstedt and Farrall (2006) also found that 22% of those surveyed in England and Wales stated that they would consider filing a fraudulent insurance claim. There is therefore evidence that life insurance fraud is a substantial problem and that many ordinary people consider it acceptable. Silverstone, Sheetz, Pedneault and Rudewicz (2012:32) agree with the above statement, by stating that society perceives fraud to be a victimless crime and that governments and businesses are so wealthy that the money taken

fraudulently will not be missed. It is also perceived that fraud is an easy way to get money without receiving severe punishment.

A study conducted by Chudgar (2015:2) found that people commit insurance fraud because of the following reasons:

- Fraudsters think they can get away with insurance fraud.
- Fraudsters need money.
- Fraudsters think they are paying excessively for insurance.
- Fraudsters want to compensate for the deductible expenses they would have to pay.
- Their insurance agents, friends, family, or doctor(s) influence.
- Insurers make undue profits.
- Everybody lies on applications, or everybody is not honest with their applications.

Bologna and Shaw (1997:2) emphasise the fact that fraud is most likely to occur in environments where motives, opportunities, means and methods flourish. Bologna and Shaw believe that the following conditions offer exposure of risk for fraud to occur (Bologna & Shaw, 1997:2):

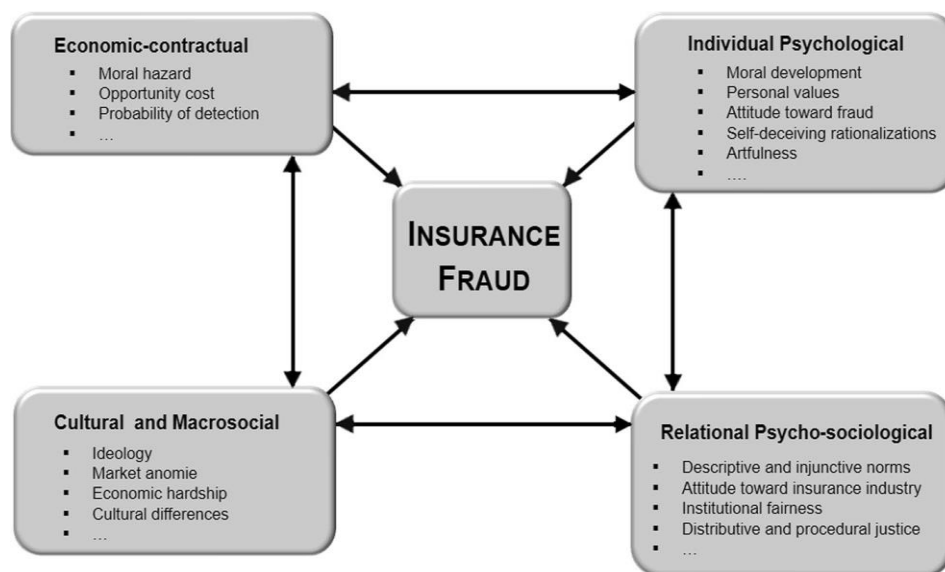
- Internal controls are absent, weak, or loosely enforced.
- Employees are hired without due consideration for their honesty and integrity.
- Employees are poorly managed, exploited, abused, or placed under great stress to accomplish financial goals and objectives.
- Management models are themselves corrupt, inefficient, or incompetent.
- There are employees with financial problems, such as alcoholism, drug abuse, gambling, or expensive tastes.
- A history or tradition of corruption exists within the environment.
- The company has fallen on hard times and is losing money.
- Internal audit and security resources are inadequate.

2.10 Theoretical approaches to insurance fraud

According to Tennyson (2008), several disciplines have contributed to the understanding of the different determinants of unethical consumer behaviour in insurance, for example, economics, business, ethics, sociology, law, psychology, philosophy, marketing, political science, and criminology. However, a majority of conducted studies that document or measure fraud usually adopt an economic frame of reference (Tennyson, 2008). Yet the many avenues through which fraudulent insurance claims may arise are mirrored by the large variety of theoretical perspectives in modelling its causes.

The work of Tennyson (2008) highlights the theoretical and conceptual approaches to insurance fraud, each of them pointing out different but complementary approaches to understanding and combat fraud: a) the economic-contractual; b) the individual psychological; c) the relational psycho-sociological; and d) the cultural and macrosocial.

Figure. 2.5: Theoretical approaches to insurance fraud



Source: Ribeiro, Silva, Pimenta and Poeschl (2019)

2.10.1 Economic-contractual approaches consecutively

Tennyson (2008) sees insurance fraud as an economic response to the contractual relationship between insurers and policyholders, and it is analysed based on the theories of moral hazard. For example, in opportunistic insurance fraud, insured consumers may take advantage of an

accident by exaggerating the amount of loss claimed or by presenting fictitious claims (Tennyson, 2008:3). The decision to file a fraudulent insurance claim is based on the expected gains concerning its perceived costs, i.e. the size of the penalties from an unsuccessful claim and the probability of detection (Müller, Schmeiser & Wagner, 2011). Thus, policyholders perceive insurance fraud as a low opportunity cost, being driven by principles of efficiency and gain to the detriment of axiological references.

The most common incentive for committing insurance fraud is financial gain either through paying less premium or increasing the amount paid by an insurer for a claim (Müller et al., 2011). A significant deterrent is the fact that individuals know that insurance fraud is a crime or that it is simply an unethical and/or immoral thing to do (Ishida et al., 2016). However, weaknesses in the system, such as minimal punishment for those caught committing insurance fraud, mean that those who want to commit fraud have a starting advantage (Cartwright & Roach, 2016). According to a study conducted by Chudgar (2015), it was also found that consumers agree that people are more likely to commit insurance fraud during economic downturns. According to IOL (2021), industry statistics suggest that people are more likely to commit insurance fraud in times of economic hardship. As seen from the Association for Savings & Investment SA (ASISA) statistics above, over the past year, insurers have experienced a dramatic rise in fraudulent behaviour, indicating that the tough economic conditions have led more people to commit some form of insurance fraud. The Covid-19 pandemic has made it worse. Desperation due to job losses is driving more people to resort to crime while the pandemic has also resulted in a significant increase in deaths, which makes it easier to source dead bodies from flooded mortuaries for fraudulent claims (Association for Savings & Investment SA, 2021). According to ASISA, approximately 70% of individuals who commit insurance fraud do so because of desperate circumstances and financial pressure due to loss of income attributed to job losses (Buthelezi, 2013).

2.10.2 Criminal View

According to Tennyson (2008:) when insurance fraud is viewed as criminal behaviour, “the moral hazard framework must be modified by the potential for criminal penalties, including fines, imprisonment, and loss of reputation”. Traditional economic theories of crime suggest perpetrators of insurance fraud evaluate the magnitude of the potential gain from a successful filing against the magnitude of penalties from an unsuccessful filing and the probability of detection (Becker, 1969) as cited in Tennyson (2008). If the expected gain from successful

fraud outweighs the expected penalties, then the fraudulent claim will be filed. Siegel (2011:84) agrees by stating that before deciding to commit a crime, the reasoning perpetrator evaluates the risk of apprehension, the seriousness of expected punishment, the potential value or benefit of the criminal enterprise, his or her ability to succeed, and the need for criminal gain". Tennyson (2008) revealed that making penalties/ consequences of insurance fraud large enough can eliminate incentives for crime.

2.10.3 Individual psychological approaches

The economic model of balancing financial gain/loss with the possibility of detection or penalties overlaps with the individual psychological approaches insofar as individuals are motivated to maximize self-interest (Baker, 2010). However, the psychological approaches also take other motivations and psychological determinants into account. Personality traits such as risk aversion/propensity, levels of moral development, self-control, or personal values are powerful individual determinants of behaviour (Picard, 2000). In a study conducted by Brinkmann (2005) analysing different scenarios of dishonesty in insurance, it was found that the willingness to misrepresent facts to obtain insurance coverage and/or to deliberately exaggerate an insurance claim was related to the level of morality of individuals. Other studies also show a positive association between acceptance of insurance fraud and fraudulent claiming, although positive attitudes are only necessary but not sufficient conditions for behaviour to occur (Dean, 2004). Moreover, attitudes toward fraud vary with sociodemographic, cultural, or institutional characteristics (Dean, 2004). It can therefore be argued that policyholders make a rational choice to commit insurance fraud after weighing the potential costs and benefits.

2.10.4 Cultural and macro social approaches

Karstedt and Farrall (2006), stated that consumers' insurance fraud falls into a category of acts defined within a grey zone of legality and morality. "They consider these crimes of everyday life the result of the cultural changes associated with the transition to neo-liberal economies in the twentieth century, characterized by economic models of behaviour regulated by self-interest and profit-seeking" (Garland · 2000:2). These values are not specific of the economic sphere, as they have spread to other sectors and vital institutions of society. The emergence of a "syndrome of market anomie" may explain according to these authors the willingness of consumers to engage in unethical practices in the marketplace (Karstedt, 2006). The syndrome

of market anomie is characterized by a lack of trust in businesses and others in general; fear of becoming a victim of others' unrestrained self-interest pursuits, accompanied by feelings of insecurity and vulnerability; and legal cynicism, when legal norms are perceived as having no validity for themselves and others (Karstedt, 2006).

2.10.5 Relational psycho-sociological approaches

According to Little (2014), the psycho-sociological approaches emphasize the role of social relations and social norms in fraudulent behaviour. Social norms have been proven to be a concept more useful than individual attitudes to explain that behaviours are regulated by social influence. Insurance Europe (2013); and Tennyson, 2008 further commented that perceiving insurance fraud as common or accepted by others in their social groups, contributes to viewing fraud as an acceptable behaviour and raising the likelihood of enacting a fraudulent behaviour. Using data from the European Social Survey, Lopes (2010) suggested that fraudulent behaviours are driven by feelings of economic hardship. On the contrary, in countries where fraudulent behaviour is more generalised, opportunity plays a determinant role in facilitating fraudulent behaviour. Tennyson (2008:1192) alluded that, "the social dimension of fraud decisions depends on consumer attitudes toward insurance fraud. Holding constant the financial costs and benefits of fraud, consumer attitudes may affect the rate of fraud by creating social stigma or psychic costs of engaging in fraud". Tennyson (2008) further highlighted that theories of the development of social norms emphasize peer group or network influences. To the extent that individuals learn their attitudes from others, if insurance fraud is accepted by one's peers, then one will be more likely to also find fraud acceptable. Thus, higher public tolerance for fraud or the perception that fraud is commonplace will in turn lead to more accepting attitudes and lower social costs of engaging in fraud. In support of the above statement Aker (2002) states that social learning theory puts forth that criminal behaviour is learnt through close contact with others who behave criminally.

Contrary to the above argument, some theories suggest that individuals with (positive or negative) perceptions of an institution will affect their attitudes toward honest dealings with it (Axelrod, 1986). This implies that consumers with negative perceptions of insurance companies and consumers who have had negative interactions with insurance companies will be more accepting of insurance fraud. Research has shown that general insurance education both improves knowledge of insurance and results in more positive attitudes toward insurance

institutions (Barrese, Gardner, & Thrower, 1998), and this may be one avenue for changing attitudes toward insurance fraud.

An overview of the modus operandi of committing life insurance fraud follows for discussion.

2.11 The modus operandi of committing life insurance fraud.

There is an immense need to examine the modus operandi (MO) in white-collar crimes, such as fraud, because fraudsters tend to change their pattern of behaviour in response to new opportunities (Tupman, 1998). *Modus operandi* is a Latin term that means “method of operating” (Zinn & Dintwe, 2015:447). In essence, it refers to the way a crime has been committed and includes the choices and behaviours that are intended to assist the perpetrator in the executing of a crime (Cioaca, 2020). This information may also reveal the motive for committing a criminal offence.

In addition, Bennett, and Hess (2013:35) explicate that MO refers to the characteristic way a criminal successfully commits a specific type of crime. “Knowledge of the modus operandi of criminals and methods of their apprehension skill, patience, tact, industry, and thoroughness will be everlasting primary assets in crime investigation” (O’Connell & Soderman, 1936:1). Therefore, the use of MO information during the investigation of life insurance fraud within the insurance industry is becoming increasingly significant. Perpetrators commonly utilise more proficient and effective ways when committing crimes. Once a perpetrator is successful with the first attempt, for example, murder for money, they would often repeat the same method with confidence because of not being detected. However, Burger (2014), proclaim that investigators lack proper training on the use and value of MO information in fraud investigations.

The consequence of the failure of investigators to use MO information effectively is that suspects cannot be identified and linked, resulting in perpetrators committing further crimes repeatedly without being noticed. This is evident in the recent case of Rosemary Ndlovu, who managed to repeatedly submit over four fraudulent claims on her family members across various insurance companies without being detected. Committing life insurance fraud is a deliberate and calculated act that requires careful planning. The complexity of the schemes, the need for strategic deception, navigating legal measures, collaboration among perpetrators, and meticulous financial calculations all contribute to the deliberate nature of life insurance fraud.

Thus, understanding the premeditated nature of such fraudulent activities becomes crucial for prevention and legal consequences.

Being alert about the perpetrator's MO can assist investigations in the following manner (College of Policing, 2017):

- Recognising how a specific crime has been committed, the type of material that could have been generated in the commission of the offence and the whereabouts of this material.
- Detecting a linked series of crimes committed with the same MO.
- Identifying links between crimes and known offenders who make use of the same MO.
- Predicting imminent crime patterns, enhancing the possibility of apprehending offenders.

According to (Govender, 2020:25) investigators can effectively investigate and link fraudulent claims using several of the following techniques:

- Following the discernible pattern utilised by the fraudster to falsify documents submitted for the claim.
- Discovering similarities in descriptions of events provided.
- Repeated use of the same cell phone number, street address, postal address, bank account or email address.
- Location of crime or where the fraud is committed.
- Handwriting.
- Voice identification.
- MO.

Like other crimes of insurance fraud, there is a variety of MO's perpetrators utilise when committing life insurance fraud. Similarly, Geldenhuys (2020) stated that insurance fraud comes in all shapes and sizes and there are countless ways in which to commit life insurance fraud. Life insurers have reported that underwriting fraud is the most severe form of fraud perpetrated against them (Coalition Against Insurance Fraud, 2017). In support of the above statement, Progressive (2022:1) alluded that, life insurance fraud can range from intentionally

withholding or misrepresenting information to full-blown life insurance scams, including but not limited to policies on fake individuals, impersonating a proposed insured or applicant and even intent to murder the insured to profit from the life insurance policy. According to Garth de Klerk, CEO of the Insurance Crime Bureau (ICB), insurance fraud is committed in two ways: those who take out policies disingenuously intending to steal; and those with existing policies who pretend either something was stolen when it was not or who over-inflate the values in their claims when something has legitimately been stolen (De Klerk, 2018). It is therefore deemed appropriate to understand in depth the MOs employed by the perpetrators to commit life insurance fraud as this can add value to the prevention and detection strategies of insurance fraud, specifically life insurance fraud.

The following methods by Ben-David (2011:40) are believed to be ways fraudsters use to commit life insurance fraud:

2.11.1 Fake death

While death is a serious subject, some may view it as a creative solution to escape their problems. To illustrate this point, Harman (2020:1) states when “the economy is lagging and unemployment is on the rise, it is common for people to fall behind on rent, car payments and other debts. Thus, the pressure can lead individuals to find new ways to pay for these responsibilities. Which can result in some sort of insurance fraud such as faking their death”. Faking one’s death is not inherently illegal, however, it may be part of fraudulent or illicit activity such as tax evasion and insurance fraud (Greenwood, 2016:1). “Faking death to defraud an insurer has been popular in Ghana, Syria, the Philippines, Chile, Jamaica, Iraq, Afghanistan, Pakistan and eastern European countries” (Coalition Against Insurance Fraud, 2017:6). However, the researcher argues that faking death can be generalised to all insurance companies worldwide, as life insurance fraud is a universal problem. However, to date, most reports of fake deaths occur in the United States although some have an international aspect to them (Coalition Against Insurance Fraud, 2017).

According to Coalition Against Insurance Fraud (CAIF) (2017:6), it is important to note that “faking one’s death to cash in on a life insurance policy is a long, time-honoured practice. Similarly, Kohn (2019); and Reese (2018), stated that deaths have been faked since ancient times, but the rate increased significantly in the middle 19th century, when life insurance fraud became more common. In 2016, the Coalition Against Insurance Fraud conducted a survey in

which insurance companies were asked if the faking death problem was slight, moderate, or severe. According to Dennis Jay executive director of CAIF, he stated that faking death is moderate, however, it happens more than the insurance carriers are comfortable admitting (Pierce, 2017). In addition, Dennis highlighted that suspicious deaths occur in undeveloped countries, where fraudulent death certificates are more easily obtained (Pierce, 2017). While South Africa may be a developed country, it still faces the challenges of fraud and corruption. Today corruption in South Africa is a serious problem affecting all sectors of society and the most common form of corruption is bribery (Newham, 2014). The researcher argues obtaining a fake death certificate in South Africa for the purpose of committing life insurance fraud, can also be relatively easy due to perpetrators bribing home affairs officials.

According to Progressive (2022); and Impactlaw (n.d), the insured fakes their death to collect their life insurance death benefit. Insurance money can be claimed on a person who is still alive or never existed (Nealon, 2023); Sheridan, 2013). Garth de Klerk CEO of the ICB assert that the economic fallout from the COVID-19 pandemic has caused an increase in false insurance claims, and scams as well as the number of “walking dead” (Geldenhuis, 2021). The term “walking dead” according to the insurance industry refers to people who have either faked their death or do not know that someone has “killed” them off for financial gain (Geldenhuis, 2020). For example, people submit false death claims for people who have been hidden away in remote areas. In addition, de Klerk stated that been an increase across the board in the number of fake retirement claims, disability claims, credit loss and life covers (Geldenhuis, 2020).

Many individuals buy life policies solely to commit this scam, while others have long-time existing policies, and perhaps face financial hardship or just see an opportunity to cash in on the policy (Muscat, 2013). In addition, (Nealon, 2023), highlighted that such a scam is quite sophisticated and involves elaborate planning in staging the fake death with accomplices, oftentimes family members. Hence, the researcher is of the view that the success of life insurance fraud relies on strategic deception. Perpetrators need to create an illusion of genuine circumstances, requiring thoughtful planning to fabricate events or situations that align with faking death for a fraudulent claim. This deliberate deception is not a result of spontaneous actions but rather a preconceived strategy. Further, funeral home directors also have been convicted of aiding such scams. In one elaborate scam, a couple in Texas in 2005, exhumed a corpse, placed it in their car and set it afire. The wife claimed the corpse was her husband and sought to collect on the life insurance policy (Coalition Against Insurance Fraud, 2017). In addition, Geldenhuis (2020), highlighted an important point that the hardest part for people

who fake their death is to 'stay dead'. Similarly, Sheridan (2013:1), also echoed a similar view that faked deaths are tough to get away with as the cases involving faked deaths tend to capture the public's interest. Furthermore, Pierce (2017) shares the same sentiment by stating that it is more difficult for fraudsters to stay out of sight after convincing people that they are dead unless they cut all ties as they risk detection by life insurance investigators. Therefore, perpetrators who commit this MO are forced to put some effort into changing their looks, give up all their social media accounts move to a new home and get a new job and they must get a new identity to start over again (Geldenhuys, 2020). However, Greenwood (2016), argues that not everyone can stay out of sight, as the lure of friends and family often proves to be too strong to resist.

Through the years there have been several reported cases of life insurance fraud, where people paid with their lives for insurance money. This life insurance scam is evident in the following reported cases:

In 1989, Dean Plank faked his death, with the help of his friend Gert Swart. The two men murdered a homeless man and set him alight to get their hands on R800 000 which was the amount Dean's life was insured for (Engelbrecht, 2022).

In December 2015, Zak Valentine tried to fake his death. An innocent victim, Jarod Jackson, was murdered and his body set alight so that the R3.4 million life insurance money could be paid out to Cecilia Steyn, who was Zak Valentine's beneficiary (Pijoo, 2019).

More recently, in July 2020, an official of the Durban University of Technology (DUT), Ntombizandile Ndlovu, was sentenced to six years' incarceration for an R850 592 life insurance claim for a non-existent husband. She took advantage of the life and funeral insurance DUT offered to staff and their spouses. Although she was unmarried, she claimed that her husband had died, using the information of an unknown man. The fraudulent claim was paid out, but after DUT had lodged several suspicious claims, the insurance company, Momentum, launched an investigation. Several other staff members were also arrested for submitting fraudulent claims. Following the conviction and sentence of Ntombizandile Ndlovu, the Asset Forfeiture Unit (AFU) obtained a confiscation order for R500 000 against her as this was the amount of money that was in her bank account (Grobler, 2020).

2.11.2 Buying and renting dead bodies.

Reports from life insurers' forensic departments show that the "buying and renting of dead bodies to obtain fraudulent death certificates is becoming a popular scam" (The Citizen, 2019:1). According to the convener of the Forensic Standing Committee of the Association for Savings and Investment South Africa (ASISA) perpetrators disfigure and sell an unidentified body to commit multiple cases of fraud (Evert, 2011). The unidentified body is then called a pauper, commonly known as a John Doe (NCA, 2019). Thus, in the context of this study, the term "John Doe" is used by the researcher to denote an unidentified deceased body. "John Doe" refers to an unidentified or anonymous individual, particularly when the actual name is unknown. In the context of law enforcement in the United States, such names are often used to refer to a corpse whose identity is unknown or cannot be confirmed (Obtaining a John Doe order, n.d). The use of John Doe may be indicative of fraudulent activities where someone attempts to claim on behalf of an individual without revealing their identity. In life insurance fraud, perpetrators use various tactics, and the involvement of a John Doe indicates an attempt to fabricate a claim for a person who may or may not exist. This can include scenarios where someone pretends that an individual has died, potentially using a false identity, or exploiting the lack of proper identification.

In essence, perpetrators take out a life insurance policy on a person who does not exist, then a body is rented or bought from the funeral parlour in which the body is used to obtain a death certificate and a claim is later submitted (NCA, 2019). Furthermore, a dead body can be used on numerous occasions for fraudulent claims and by different individuals (Naidoo, 2020). Mortuary assistants are furthermore known to rent out an unidentified body to as many as five different claimants before clearing it for a pauper's burial. Once a body has been obtained, these fraudsters would then use stolen identities to make fraudulent death claims to cash in on life insurance policies. When a deceased lies unidentified in a mortuary for a specified number of days [30], the onus lies on the government to bury the body (Motala, 2012). Furthermore, unidentified dead bodies may be used by the unscrupulous to commit life insurance fraud by substituting the identity of the deceased for that of a life insured who is still living (Motala, 2012). In addition, Garth de Klerk from the ICB asserts that "renting a corpse is a problem as we have many cadavers moved from one morgue to another" (Naidoo, 2020:1). The most common act of this modus operandi is that it involves death certificates being bought and doctors signing off without seeing a body, for a fee. Another method is where a body is moved

around by different syndicates to various morgues and claims are made to insurers (Naidoo, 2020).

Furthermore, NCA (2017), reported that mortuary workers contact various syndicates who take insurance policies using stolen identity documents (ID) or even fake IDs and inform them about a pauper who is lying and waiting. (Motala, 2012) further states that if the pauper's physical characteristics match any of the IDs, the syndicate will then pick up the body arrange for a cheap funeral or cremation and buy the documentation necessary to register a death with the home affairs. The involvement of John Doe plays a highly intricate role in the commission of life insurance fraud, as perpetrators leverage the anonymity provided by a John Doe to make claims on behalf of individuals who are already deceased and buried.

This is illustrated in the following real-life cases:

“A man took out a life cover with insurance companies for his uncle who was already deceased, to the value of R1.5 million. He paid the monthly premium as usual and waited patiently to claim. The man wanted to claim but a body was needed to represent his dead uncle. He then approached a woman at a funeral parlour in Durban and allegedly promised her R15 000 if she could find him a dead body and forge a death certificate. The woman further approached Zivelele's funeral services to help her find a body. Legally the body needs to be presented to a doctor for certification and then burial later. However, the funeral service did not have a body resembling the ‘deceased uncle’ so they asked the Twin sister's funeral service in Pinetown to help. The approached parlour had a body fitting the description, but it could not be buried because it belonged to another family. Therefore, the Twin sister's funeral services loaned Zivelele funeral services a male body which the claimant presented to the doctor for death, after which he was able to obtain a death certificate. The body was taken back to Twin sister funeral services who were promised R20 000 for their part in the scam. However, Zivelele funeral services still needed a body to bury and Twin sister funeral services helped them again by buying a female body from a mortuary employee at Rk Khan Hospital in Chatsworth for R3000. The body was buried at Shellcross cemetery. The death certificate states that the deceased is a male, but Zivelele funeral services buried a female body dressed in male pyjamas, after the investigation all the involved parties were arrested” (South African Police Service [SAPS] Report, 2023:1).

“In 2012, a funeral parlour owner and a woman were arrested near Umbilo, Durban, for life insurance fraud. The woman created a false identity for a woman named Aphiwe Ntombela.

She then took out life insurance policies, collectively worth R950 000, on this person's life with three different companies. She subsequently paid several monthly premiums. When the waiting period for these policies had passed, she had a dilemma as she had to kill a person who did not exist. To solve this problem, she approached a funeral parlour owner from uMlazi and asked him to lend her a female body from his mortuary, so that the body could be presented to the doctor for certification of death. The funeral parlour owner took a woman's body from his mortuary to the eThekweni mortuary, where he presented it under the name of Aphiwe Ntombela. The doctor saw the body and certified the person as deceased. A death certificate was issued, and the woman used it to lodge fraudulent insurance claims. The funeral parlour owner planned to fetch the woman's body in time so that she could be buried by her real family. Fortunately, the police received a tip-off about the scam and awaited the funeral parlour owner at the eThekweni mortuary where he was arrested" (SAPS, 2012) as cited in Geldenhuys, 2020:4).

In 2018, the ICB was involved in an investigation where a 13-year-old child died under strange circumstances. An official death certificate was issued, and an undertaker confirmed that she had been buried. However, the teenager was later discovered to be alive. An investigation uncovered that she was part of an insurance fraud scheme to receive multiple pay-outs from different insurance companies where the child was covered under various policies. The SAPS is investigating the case to determine the identity of the child who had been buried (IAB, 2020 as cited in Geldenhuys, 2020:4).

More recently in 2021, a man employed as a corpse washer at a funeral parlour in Isipingo and a woman were arrested in Durban after their alleged plot was discovered. Muzi Hlengwa, who owns Bejay Funeral Services, said his company informed the police of the crime after discovering that his mortuary had been used by the suspects to store a body that had allegedly been taken from another mortuary. He further stated that his parlour received a request from another funeral parlour that they have worked with before, that they would like to store a body. According to Hlengwa when the male corpse was brought in his staff noticed that it was sweating, an indication that it was thawing out as it had been taken out of a very cold environment, possibly from another mortuary. This raised a red flag as he had been told that the corpse had been fetched from the deceased's home. He said the following day a woman, who said she was the deceased relative, came in and allegedly filled out paperwork that would allow her to have a death certificate issued to her. Furthermore, Hlengwa said things took a turn when a man, who is employed as a body washer at the Isipingo Funeral parlour came in

and asked to take the body so it can be given to its alleged family. When asked questions such as how the body ended up at Bejay Funeral Services if he was from Isipingo Parlour and if the body was picked up at “home”. The body washer eventually confessed that he had taken the corpse from his workplace Isipingo so that a death certificate could be issued to the female suspect, who was posing as a relative. His cut would have been R3000 (Mthalande, 2021:3).

2.11.3 Murder for insurance money

The practice of concluding life insurance, either on one’s own life or that of another, is nothing new. Life insurance fraud not only comes at a high cost for both life insurers and policyholders, but it is also costing people their lives. Murder for insurance money, “involves the killing (or arranging for the killing) of a person to claim money. It is often the case that the murderer may make the event look like it was an accident or a random killing”, with some perpetrators killing more than once (Geldenhuys, 2020; Muscat, 2013). In addition, Geldenhuys (2019:1), mentions that “death in such cases comes in a variety of ways, such as shooting, drowning, being pushed off a cliff, and electrocution”. The above-mentioned, NCA (2019), states that perpetrators hire hitmen to organise the murders of people who have been covered in the policies. Hence, the use of hitmen in South Africa is commonly average for murders motivated by personal reasons and insurance payouts (Makhaye, 2023). This, therefore, presents a great concern as the rate of hitman killings in South Africa has increased drastically. According to Bahre (2016:150), the high levels of violence in everyday life make it much more probable that someone is killed to cash in on insurance money. The national crime statistics confirms the high levels of violence in KwaZulu-Natal and that the province has become a haven for hitman (Naidoo, 2023).

In a survey conducted by Bahre (2016), it was found that one out of six respondents said that they knew about people being killed to cash in on a life insurance policy. While three out of four respondents said that they saw how someone had registered someone because they knew that the person might die soon. According to the Coalition Against Insurance Fraud (2017), the victims of this crime are typically spouses and lovers. However, it is reasonable to argue that the victims of life insurance fraud are not limited to spouses and lovers, but perpetrators can go as far as killing relatives, children and people they have no relations. Bahre (2016) confirms that victims can be killed for insurance pay-outs by people they might not know personally, or with whom they only have a very distant relationship. Furthermore, in a survey conducted by Bahre (2016), it was found that a vast majority 70 % of the respondents said that they saw how

people took advantage by registering someone who was not a family member. Ndabezitha (n.d) concurs that many people get policies for neighbours or friends of friends. Life insurance policies are taken out on the lives of specially chosen victims. It is clear from the above discussion, that it is almost impossible for an individual to know if a neighbour, colleague, family member or anybody else has a life policy on one's life and might profit from one's death. This, however, emanates from the fact that perpetrators can take up life covers without the consent or knowledge of the person being insured. Furthermore, according to the NCA (2019), it is deemed easy to secure life insurance on someone's life without their consent. To exemplify this point, in a life insurance murder case involving a pastor, his wife, and a hitman, they collectively orchestrated the murders of their victims, all of whom were unaware that life policies had been taken out on them (Githahu, 2021).

To illustrate the above point, (Oellermann, 2016 as cited Geldenhuys (2019:1) quoted a case of *five suspects from Pietermaritzburg who had taken life insurance policies out on the lives of each of the murder victims as well as the attempted murder victim, with three of the accused named as the beneficiaries of the policies. Two of the victims died of their injuries after they were allegedly drugged and deliberately run over by their assailants, using stolen vehicles. The third victim, an allegedly mentally disturbed woman, survived a similar attack as well as a second alleged attempt to kill her by lethal injection while she was recovering in hospital from her injuries. The fourth victim was shot dead after the murderers' plans to get him drunk so that they could run him over allegedly went awry. It was found that claims were submitted to various insurance companies.* From the above quoted case, it can be argued that syndicates are responsible for the recent rise in murder for money cases in KZN. This underscores the urgent need for effective intervention programs to combat the prevalence of this scourge and reduce the high number of individuals who become victims of this phenomenon.

The NCA (2016), reported the severity side of this *MO.* by stating that to some their loved ones are viewed as cheques and obstacles that need to be removed to get to the life insurance money. To illustrate this point, according to Shange, Molyneaux and Muller (2021:1), “Rosemary Ndlovu a convicted killer saw her family as a “living pay cheque”, ready to be harvested at will. Ndlovu was found guilty of the murder of five of her relatives and one of her lovers”. Family, for most, is a concept that represents togetherness, safety, and love despite the occasional conflict. However, perpetrators of life insurance do not think the same about family, friends and loved ones as they are only a pay cheque. High-profile cases involving murders

contributed to R787.6 million in fraudulent and dishonest claims on funeral, life, and disability claims (ASISA, 2021).

Typically, cases that predominantly come to light involve spouses murdering their partners for insurance money. *One such case was that of Odette Barkhuizen who was shot close to her offices in Moffatview in 2015 after her husband, George, had taken out three life policies on her a mere month before the incident. In September 2019, George Barkhuizen was sentenced to life behind bars for his wife's murder. Delivering his judgment, Judge Ramarumo Monama said that not only was George Barkhuizen "arrogant" in his behaviour, but that his crime was motivated by greed. He added that George's plan to defraud numerous insurance companies with his actions should also be regarded in a serious light, as white-collar crimes are "squeezing" South Africa's already ailing economy. Because of these factors, Judge Monama sentenced George Barkhuizen to an additional 15 years' incarceration for fraud, although the sentences would run concurrently (Germany, 2019).*

Additionally, there are also incidents where life insurance policies are taken out on the lives of specially chosen victims. This was the case when two sisters from Barberton in Mpumalanga murdered their mother and staged an accident in January 2020 in which she died to qualify for an R80 000 payment on a death benefit policy they took out on her life. Following the investigation, one of the daughters confessed that her mother did not die from an accident, but that it had been staged (Grobler, 2020).

In a recent case of Rosemary Ndlovu, who was found guilty of orchestrating the murder of her close relatives and the father of her child to benefit from funeral and life insurance pay-outs to the amount of R 1.4 million from Assupol, Clientele Limited, 1 Life insurance and Old Mutual (Maphisa, 2021).

Furthermore, according to Serra (2021), a pastor, his wife and a hitman were handed heavy sentences for Life Insurance murder. This case involves a scam where Monqo (pastor) and his wife took out life insurance policies on behalf of church members, his ex-lover, and the mother of his child and planned their murders with the intent to benefit from the payment of the life insurance policies. Life insurance policies were taken on behalf of 4 people. These unsuspecting victims were insured with Assupol, Liberty Life, Out insurance, 1 Life Insurance, Clientele Life and Discovery and the accused stood to benefit more than R26,9 million.

2.11.4 Exploiting addicts from poor communities

Syndicates prey on drug addicts and alcoholics from poor communities with the promise of a job. In such a way they obtain the personal details, including the bank details of the addicts. With all this information at hand, the syndicate take up a policy for that person. When the waiting period lapses, the syndicates then must find a body and therefore another crime must be committed (Buthelezi, 2021). According to Ndabezitha (n.d), the world of insurance fraud is becoming dark and gritty involving, exploiting addicts from impoverished communities by getting their ID numbers and orchestrating deaths such as hit and run. Similarly, Priyen Moodley, an independent Forensic, Risk and Business Intelligence Consultant, stated that “syndicates apply for cover for people who are homeless, sickly, abusing substances or involved in gang or criminal activities. After a relatively short period the insured person dies unnaturally from gunshot wounds, a stabbing, or a hit-and-run accident to cash in on the insurance money” (du Preez, 2022:1). Further, Carina Thompson, a manager at Xtnd, a forensic and fraud detection company that works with Assupol, expressed that people from all walks of life can fall victim to fraud, but the homeless and the addicted are particularly vulnerable (du Preez, 2022:1).

In one case a syndicate tried to murder the addict on whose life they took out a funeral cover, but the victim managed to escape. In this case, the syndicate had to move to plan B which was to buy a body and then submit a claim. The insurance company’s claims department marked the claim as suspicious and submitted it to the forensic department for further investigation. It was found that the person whose life was insured was still alive. The same syndicate was allegedly also responsible for other fraud cases and suspicious deaths (Business Tech, 2022).

2.11.5 Misrepresentation

According to the Association for Savings and Investment South Africa (2019) misrepresentation occurs when a policyholder deliberately provides misleading information to a life insurer, while material non-disclosure refers to the failure of policyholders to disclose important information about a medical condition or lifestyle. Sheridan (2013) states that life insurance scams work in several ways, but there are continuing variations on certain themes, all involving misrepresentation. According to Kutty (2008) misrepresentation can take place in two forms. Firstly, innocent misrepresentation is related to inaccurate statements made by a policyholder to the underwriter without any fraudulent intention (Kutty,2008). Secondly,

fraudulent misrepresentations refer to false statements that are made with the intent to deceive the insurer or else these are made recklessly without any regard for truth. (Kutty, 2008).

2.11.6 Money laundering

According to an article by Lawrence (2008) criminals convert dirty money into assets which appear legitimate, such as an insurance policy, bank deposit and even real estate. In addition, society does not realise that insurance products, particularly life insurance provide a very attractive and simple means of laundering money. Saving policies are more attributed to money laundering when compared to protection. This is so because the nature of the policies that are available under the savings domain makes them more vulnerable and easier for customers to engage in money laundering activities. Unfortunately, insurance is susceptible to money laundering and life insurance is not an exception. This is true since most insurance business is channelled through intermediaries which consequently makes it vulnerable to money-laundering activities.

There are several ways that launders can use insurance products. Some of the red flags which may indicate money laundering include (Lawrence, 2008:1):

- Paying a large ‘top-up’ into an existing life insurance policy.
- Purchasing a general insurance policy, then making a claim soon after.
- A customer who usually purchases small policies suddenly requests a large lump-sum contract.
- A customer who wishes to fund its policy using payment for a third party.
- Premiums are paid into one policy, from different sources.
- Where the relationship between the policyholder and beneficiary seems unusual
- Making over-payment on a policy, then asking for a refund.
- Where the customer is more interested in learning about cancellation terms than about the benefits of the policy.
- Unusually large payments using cash, money order or traveller’s cheques.
- Redemption of a policy which is unusually early or does not make good economic sense.

2.11.7 Forgery

According to Shoenthal and Shih (2021) most life insurance fraud doesn't involve the policyholder at all but occurs when other parties often a family member or spouse access the policy and change its ownership or named beneficiaries. However, legally only the policy owner is authorized to change the details of a policy, and someone would need to forge documents or misrepresent their identity to alter a policy owned by someone else. Shih and Shoenthal (2021) further added that forgery-based life insurance fraud can also result in denied claims and prosecution.

2.11.8 Identity theft

As more people are committing life insurance fraud, the prevalence (and cost) is increasing, as are the methods used to commit life insurance fraud. New technologies have made committing life insurance fraud easier and more accessible to a broad range of people (Saylor, 2023). According to Faris (2023:1), when identity theft scams involve life insurance, the customer hands over crucial information that can be used to open new accounts using the victim's contact information. Consequently, most people are affected by identity theft, with 30% of people being victims of identity theft (Harrell, 2023). There has been a dramatic increase in fraudulent life insurance policies after criminals receive personnel information (Martin, 2023). Identity theft and life insurance fraud are two types of financial crimes that can have devastating consequences for individuals and families (Hayes, 2023). In addition, Motala (2012) stated that identity theft has become a national problem for the insurance industry, and is most prevalent in the Eastern Cape, KwaZulu–Natal, Mphumalanga and North West. The South African Fraud Prevention Service (SAFPS) has disclosed that an alarming 23% of all reported fraud cases are linked to impersonation (Thura Makelaarsdienste, n.d). To illustrate this point, Majavu (2022) reported that there was recently the case of a Johannesburg couple involved in an insurance fraud scam involving 147 claims and 100 different identities.

While these are some of the most common ways of committing life insurance fraud, it is important to keep in mind that new ways or trends of committing life insurance fraud may emerge daily. As fraudsters become sophisticated and find other ways to try to scam the insurance companies for money. The fight against insurance fraud is complicated by the fact that law enforcers focus mostly on more traditional crimes thus leaving less policed crimes to be more appealing to organised criminal groups and professional criminals. These fraudsters

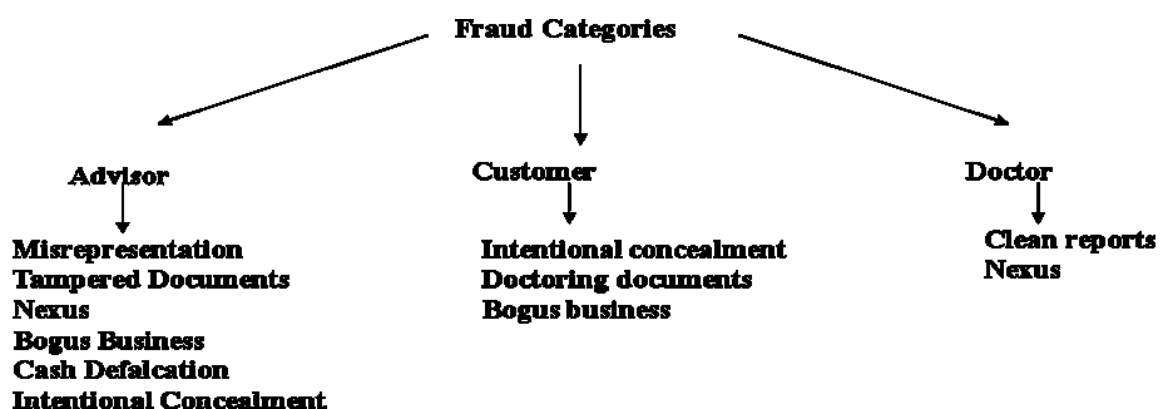
are emboldened by the low-risk, high-reward environment to perpetuate their heinous acts (Njenga & Osiemo, 2013; Kamande, Kiragu & Musumba, 2018; Kiragu, Gikiri & Iminza, 2015).

The subsequent section will focus on the parties involved in life insurance fraud.

2.12. Parties involved in life insurance fraud.

To fully understand life insurance fraud and be able to better detect or mitigate it, it is vital to understand who the key players are and what is their involvement in the crimes. Thus, according to a study conducted by Chudgar (2015), it found that there are three major parties involved in perpetrating life insurance fraud. First are the internal employees or the agents of the company, second is the policyholder/claimant i.e. the customers and third is not direct fraud but indirect fraud i.e. involvement of doctors and mortuaries. Medical professionals today are using different types of unethical schemes to defraud insurance companies (Forte Jr, 2018). To illustrate this point, “KwaZulu-Natal doctor, 84, was arrested for allegedly issuing fraudulent death certificates for R6.5m insurance claim. The Doctor was called out by a funeral parlour owner to certify a dead body. However, upon investigation, it was discovered that the deceased was alive, and the intention was to defraud the insurance company” (Maharaj, 2023:1).

Figure 2.6: depicts perpetrators of life insurance fraud.



Source: Chudgar (2015:10)

According to The Insurance Crime Bureau (ICB) (2023), one area of concern is the increase in professional crimes. Organised syndicates are believed to be behind the growing number of life insurance frauds (ICB, 2023). These syndicates look for every opportunity to exploit and there

has been an upward trend of unnatural deaths in the last few years (du Preez, 2022). Payi (2021) argue that syndicates are familiar with life and funeral policies and procedures in some cases they murder a victim, and in others, they obtain paupers' corpses from mortuaries. However, du Preez, 2022) contends that it is not always syndicates that kill, sometimes family members (opportunists) also kill for life insurance pay-outs.

Furthermore, Chabalala (2021) alluded that the syndicate recruit various persons to join the team, including employees from the Department of Health, and Department of Home Affairs, owners, or employees of funeral parlours and even employees of insurance companies. Payi (2021) emphasised that the goal is to create fraudulent policies and claims. However, Saylor (2023), mentioned that fraud can be committed by a single individual or organised criminal rings (syndicates). In addition, Jung and Kim (2021) stated that insurance fraud is an organised crime with specialised insurance fraud groups involving many people. Lesch and Byars (2008:12), argue that the former—called “single claim” fraud—is more costly than organised rings of fraud. It is therefore important to note that while syndicates do play a significant role in life insurance fraud both in prevalence and cost, life insurance fraud is a complex problem involving many players.

2.13. Measures to prevent and detect insurance fraud.

In the insurance environment, the risk of fraud is extremely high. Therefore, the prevention and deterrence of insurance fraud is essential at the industry and company level because it needs to address the bigger agendas among insurers and the business environment. At the industry level, the ideal initiatives are the attitude change that considers insurance fraud as a significant aspect of the economy without underestimating the amount involved (Abramovsky, 2008). Creek-Tatom (2020) states that proper prevention requires vigilance in staying up to date on fraud trends paired with consistent training.

According to Lees (2012: 9-11), key techniques for detecting and preventing fraud include:

- developing a sound ethical culture;
- periodically assessing fraud risk;
- fraud risk training and awareness;
- reporting mechanisms and whistle-blowing; and
- sound internal control systems

The “fraud management lifecycle is a tool to effectively manage fraud within organisations, irrespective of the nature of business” (Wilhelm, 2004:8-14). Furthermore, Wilhelm (2004:8), contends that the fraud “management cycle consists of eight stages, namely deterrence, prevention, detection, mitigation, analysis, policy, investigation and prosecution”. Wilhelm (2004) additionally states that each stage of the cycle is a critical building block to the entire fraud management lifecycle, and recommends the integration of information technology systems for optimal effectiveness. Lees (2012), shares the same sentiment as Wilhelm (2004) by stating that a combination of detection, prevention, response, and deterrence, supported by technology, is a key element to a good anti-fraud strategy, ensuring that the elements of the fraud triangle are aptly covered. According to research, technology plays a vital role in fraud prevention, but most insurers agree that no single technology is adequate. Thus, a combination of techniques, methods and skills is required to detect both opportunistic and organised fraud. “Automated red flags are the first line of defence employed by most insurers” (Coalition Against Insurance Fraud, 2014:2). However, (Morley, Ball & Ormerod, 2006) argue that research exploring measures employed by insurers to detect and prevent insurance fraud and determining the effectiveness thereof is limited. Further, FRISS (2019) stated that it is of vital importance for insurance companies to increase fraud awareness and training of each employee to be a fraud detector.

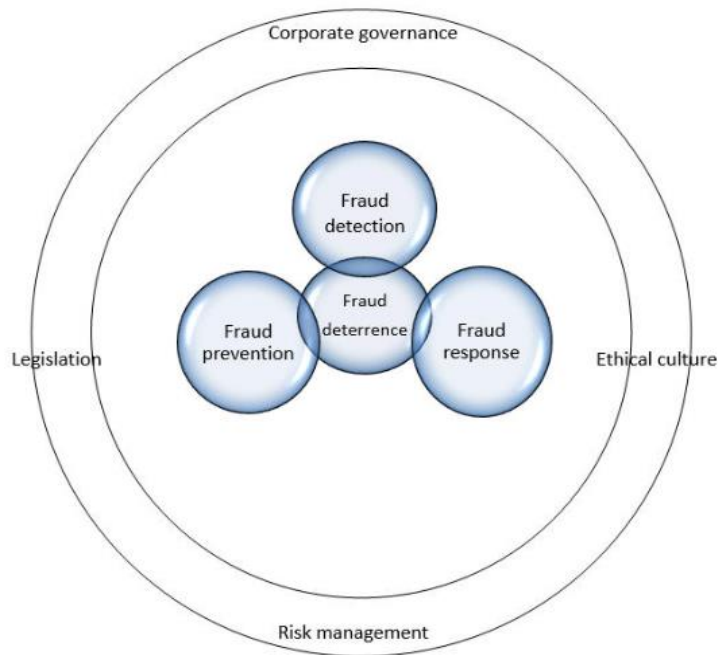
2.13.1 Anti-fraud strategy

Accordingn to Dzomira (2015:1) There are four main components which form an effective anti-fraud strategy namely:

- Prevention
- Detection
- Deterrence
- Response

The following diagram illustrates the essence of these elements and the framework in which anti-fraud strategy operates.

Figure 2.7: Elements and the framework in which anti-fraud strategy operates.



Source: Dzomira (2015:2)

The elements of an effective and sound anti-fraud strategy from the figure above are closely related and each plays its essential role in combating fraud. “Fraud detection can act as a deterrent by spreading a message to potential fraudsters that the company is fighting fraud and that necessary procedures are placed to pick any unlawful activity which could have happened” (Dzomira, 2015:2). Consequently, if there's a chance of getting caught, a potential fraudster would refrain from engaging in criminal activities (Dzomira, 2015). Furthermore, “suspected and detected fraud incidents need a consistent and comprehensive response, this will spread a message across that fraud is a critical issue and that subsequent action would be taken against the perpetrator” (Dzomira, 2015:2). Any fraudulent claims which are detected and investigated should strengthen deterrence and therefore, act as a fraud prevention technique or measure.

The following techniques are commonly used to prevent and detect fraud in the insurance industry (Govender, 2018:12):

Rules and red flags are used to identify specific patterns and highlight activities that look suspicious.

- Data collectively obtained with the support of other database subscribers broaden information in claims investigations.

- Anomalies that exceed the norm and threshold for a particular claim's benchmark are reported.
- Large volumes of adjudicated claims are examined to find discrepancies.
- Predictive modelling – data mining tools are used to build models to produce fraud-propensity scores, rules and red flags.
- Layered voice analysis is used to identify stress levels in claimant interviews.

According to a study conducted by Chudgar (2015:34), it was found that there are various possible ways identified which would help in preventing life insurance fraud. Which include:

- Fraud warnings are a useful tool: these warnings will help the insurer to curtail fraud as people will be afraid of these warnings.
- Management involvement: unless and until the management is involved in curtailing life insurance fraud, it will be indeed very difficult for any insurer to prevent life insurance fraud. If the management is only concerned about its sales growth and is not getting involved in these practices, then it will hinder its own business.
- Stringent action on fraud identified: This is the most effective way of preventing fraud. As the perpetrators will come to know that action such as warning, or termination is given for doing the fraud then they will not get into such practices.
- Awareness and training workshops: This will be a whistle-blower policy wherein it will sensitize the employees regarding the risk factor of life insurance fraud.
- Enabling employees to report and deal with fraud: This will enable the employees to report and deal with fraud which will in turn help in preventing life insurance fraud.
- Verify information on applications: This is the first step of any policy which will be issued. If the first step is taken care of then it will help in preventing life insurance fraud and some more are lower premiums for customers with few/no claims, investigate claims more rigorously, require more documentation, and offer rewards.

According to McAdams and Reindeau (2022:1), fraud prevention must remain a priority and integral to progress. Furthermore, McAdams and Reindeau (2022:1), provided proven steps to detect and prevent life insurance fraud:

- **Implement proper claim controls and processes:** As insurers are constantly accepting copies or waiving death certificates, it is recommended that random post-claim audits be conducted to ensure the legitimacy of the death.
- **Consistently train and educate the claims team to stay current:** It is argued that the perpetrators of life insurance fraud continually adapt and create new avenues to exploit. While the claims officials often receive only initial fraud prevention training without any ongoing follow-up. Therefore, they may not be aware of the latest schemes and are ill-equipped to identify emerging red flags.
- **Ensure everyone in your organization, not just claims and underwriting is aware of fraud schemes and can identify red flags:** It is not unusual for employees across various departments, such as call centre staff, policyholder services professionals, and others, to recognize suspicious activities that could indicate fraud. For instance, an individual in the accounting department might detect inconsistencies in names on checks or identify situations where the payee of a beneficiary check lacks insurable interest in the deceased
- **Collaborate with other business units:** Sharing of policyholder information with other stakeholders can help identify and connect potential fraud red flags.

According to Erickson, Torchiana, Schneider, Newburger, and Hannan (2000:139) insurance companies have been forced to implement anti-fraud measures due to several factors, including the high monetary cost of insurance fraud, the negative impact on profitability and sustainability for insurers, decline in policyholders, government regulations preventing insurers from passing insurance fraud costs to policyholders, and stricter governance of insurers by government legislation. Ng'ang'a (2015), adds that fraud is not self-revealing as the whole transaction is processed like any other normal transaction, therefore means that life insurance fraud must be looked for to be discovered. Unless life insurance fraud is detected promptly it is likely to go unnoticed. Viaene and Dedene (2004:5) concur by stating that the problem in detecting, and ultimately deterring fraudulent claims is the identification of characteristics that distinguish them from valid claims, as a result, most insurers use flags or fraud indicators.

Insurance companies themselves have also implemented various fraud prevention programmes to deter, prevent and investigate cases of life insurance fraud. However, in South Africa, there is a scarcity of research that explores measures used by insurance companies to detect and prevent life insurance fraud. To illustrate this point, research exploring measures employed by insurers to detect and prevent insurance fraud and determining the effectiveness thereof is limited (Morley et al., 2006:164).

There is no one silver-bullet approach to curbing the various types of insurance fraud, and therefore it is important to have a variety of interventions for an effective holistic fraud prevention programme (SAS, 2012:3). Several strategies are used within the insurance industry nationwide to assist in detecting and preventing life insurance fraud. The following strategies that are relevant to this will be discussed below:

2.13.2 Fraud awareness and training

Fraud awareness training is a critical component of a well-rounded program for preventing and detecting fraud (Mauere, 2013). Further, FRISS (2019) concurs that it is of vital importance for insurance companies to increase fraud awareness and training of each employee to be a fraud detector. It can be argued that everyone involved in life insurance fraud (insurers and relevant stakeholders) should be educated on what constitutes life insurance fraud. Creek-Tatom (2020) states that fraud awareness training should include basic information to help employees identify red flags.

He further adds that the basic information refers to the what/ how, the who and the why people commit fraud. Hence, the researcher covered the how, who and why questions in this thesis, with the hopes that the thesis can assist the organisation involved in reviewing and amending the current strategies. To effectively manage the risks of life insurance fraud, it's crucial to implement formal training and educational programs that raise awareness. This will assist insurers to be aware of when major frauds occur, hence preventing people who would be unwittingly close to fraud (underwrites and forensic investigators) from being shocked and dismayed by their lack of awareness (Dzomira, 2015). Such kind of fraud awareness and training would decrease rather than increase the number of fraudulent cases.

2.13.3. Red Flags

According to Padgett (2015:71), red flags, also known as “fraud warning signs,” can be described as “an event or set of circumstances, most often unusual in nature and that should alert an organization to the presence of risk.” A global conducted by the Association of Certified Fraud Examiners in 2014, reported that fraud cases exhibit some warning signals (Mohamed & Jomitin, 2014). According to Mironiuc, Robu and Robu (2012), fraud detection and the recognition of its manifestations imply that the acquisition of flags would help the auditor obtain the best answer regarding the presence or absence of fraud.

Red flags are events and conditions that signal motivation and opportunity for potential or actual fraud occurrences. The SAS (2008), stated that during the early stages of insurance fraud detection and prevention, insurers use red flags to identify suspicious claims. Dionne, Giuliano and Picard (2009:2) showed that “an optimal auditing strategy takes the form of a red-flags approach, which entails referring a claim to the auditing unit once certain fraud signals have been observed”. Furthermore, Dionne et al., (2003) clarify that a red flag process means that if a claim was given certain flags to indicate that it was suspicious, the claim would be further investigated by an insurance claims investigator. Dionne et al., (2003) further highlight that these red flags could be used by criminals to defraud insurance companies, therefore they are not commonly published. According to DeForge and Shorts (2019), when a red flag is triggered, an internet search for local newspaper sites for obituaries of life insurance claims, doctors, and specialists to match the information provided by a claimant is used to double-check a claimant’s story. These red flags and business rules formed the first line of defence for insurers in their fraud prevention programmes (CAIF, 2016b:4).

According to the (Parsons, 2023), the red flag process involves viewing a claim, determining whether the claim contains a red flag or a combination of red flags and subsequently investigating the claim. For example, insurers may raise a red flag if the circumstances surrounding a death claim are unusual or unclear, particularly where the death is a result of unnatural causes. Zalma (2019) states that when assessing a claim and three or more flags are found the need for further investigation should be considered. However, Adinigrat, Marhumi, Masrullah and Fitrianti (2021); Mangala and Kumari (2015) argue that flags do not indicate whether a person is guilty or not, but rather serve as warning signs that fraud is occurring or has occurred. Furthermore, Óskarsdóttir, Ahmed, Antonio, Baesens, Dendievel, Donas and Reynkens (2022) alluded that auditing to detect insurance claims fraud has proven to be problematic as auditors often use sampling during the audit process and hence why several fraudulent claims will always go undetected. A global survey of 1,483 occupational fraud cases, conducted by the Association of Certified Fraud Examiners in 2014, reported that ninety-two per cent of fraud cases exhibit some warning signals (Mohamed & Jomitin, 2014). In essence, red flags in the insurance industry function as a crucial mechanism for early fraud detection.

2.13.4 Forensic Accounting

Forensic is a technique used for the detection of a crime and forensic accounting is a method for detecting and investigating fraud, it is used to detect white-collar crimes such as tax evasion, money laundering, fraud and financial exploitation (Crumberly & Apostolous, 2005). According to Bhasin (2007), forensic accounting refers to a field that includes accounting, auditing, and investigative skills to determine fraud that is suitable for use as evidence in court. Forensic accountant improves auditor's ability to detect fraud and acts as a bridge to the audit expectation gap (Okoye & Okaro, 2011). Bhasin (2007) and Flavin (2020), further assert that insurers use forensic accounting to accurately evaluate a claim and make a recommendation on payment.

Furthermore, Hecht and Redmond (2010) stated that the field of forensic accounting is not a new concept, though it has grown in popularity in recent years as it is founded upon understating the minds of fraudsters and why frauds are committed. Chi-Chi and Ebimobowei (2012) argued that if perpetrator fears being caught by a forensic accountant, then they would never think of committing a crime. In addition, Omondi (2013) conducted a study to find out the impact of forensic accounting services on fraud detection and prevention. He found that the application of forensic accounting services led to increased fraud prevention. Contrary, (Emeh & Obi, 2013), found that the presence of forensic accountants and the number of accountants possessing forensic accounting skills are in negative correlation with the extent of financial fraud. They play an effective role in weak internal control and the improvement of financial reporting (Modugu & Anyaduba, 2013).

2.13.5 Technology in fraud detection and prevention

According to (Morley et al., 2006:166; Viaene & Dedene, 2004:326), the screening of incoming claims against business rules and red flags was formerly a manual process conducted by claims staff or claims adjusters. However, due to the growth in technology and software development insurance companies are now provided with an opportunity to exploit this technology for both detection and prevention of insurance fraud (Insurance Europe, 2013:14).

Insurance fraud is not only limited to claims, but impacts the entire insurance lifecycle, and technology allows insurers to detect and prevent fraud along this lifecycle (CAIF, 2016b:3). In addition to automated red flags and business rules, insurers are using technology to build

predictive modelling tools that score claims on the propensity to be fraudulent, informing insurers on how to deal claims efficiently (CAIF, 2016b:4; Ormerod et al., 2012:371-372).

Other technological solutions being used by insurers include:

- social networking analysis, which is used to identify organised crime patterns through linking relationships;
- text mining, which is used to detect similarities in claims descriptions; and
- voice stress analysis, which is used to detect stress levels.

These technological solutions are being set up with great success in detecting and preventing opportunistic and organised insurance fraud (Chetty, 2020). Insurers using these solutions report an increase in referrals received from these systems, detection of more fraud and reduction in time to investigate claims (CAIF, 2016b:5; Ormerod et al., 2012:372; SAS, 2008:9). A CAIF (2016b:3-4) conducted a study on insurance fraud technology and it was found that 76% of respondents stated that detecting claims fraud was primarily being conducted by anti-fraud technology, while 90% reported having automated red flags and business rules.

2.13.6 Whistleblowing and mechanisms of reporting

One of the significant components of a fraud prevention programme is the establishment of effective reporting mechanisms, which can also positively impact fraud detection (Dzomira, 2015). Whistle-blowers contribute to the detection and prevention of fraudulent practices, protecting the interests of both insurers and the insured (Near & Miceli, 1996). Hence, a whistle-blowing mechanism to facilitate the anonymous reporting of alleged fraudulent claims, and corrupt or unethical behaviour exists within the insurance companies of South Africa. According to (Kenyon, 2018) whistle-blowing policy provides reporting channels and guidance on reporting suspected fraud, misconduct, or irregularity in insurance. A whistle-blower refers to an individual who has reasonable grounds to suspect that the information he/she is reporting indicates that the company or individual (internal or external) to a company has or may have participated in misconduct (Bharti, 2019). Therefore, understanding how and where whistle-blowers turn to blow the whistle and how their information is protected is important for all those concerned (Near & Miceli, 1996). For successful functioning of the whistleblowing program proper channel of communication, protection of a whistle-blower, staff awareness and staff trust are very important (PwC, 2008).

However, Todd et al. (1999) as cited in Kenyon (2018) argue that “whistleblowing is less prevalent in the insurance industry than in other industries, which means that it could be seen as less effective in this context”. Offences reported by the whistle-blowers require further investigation by a fraud investigator to determine or, if fraud has been committed. It is arguable that without the impetus of whistle-blowers, the detailed investigations, the recounts of witnesses and experts, the laying of charges, the judgements of courts and commissions, the findings of innocence and guilt, and the (lamentably infrequent) prosecution of those found guilty would be stymied. In addition, Kenyon (2018) states that if a system that intelligently predicts fraud could supply the investigator with evidence of suspicious activity, it could aid the success of the whistle-blowing process. Whistle-blowers may be external, or internal but external whistle-blowers are less fearful about its consequences (Mangala & Kumari, 2015).

The benefits of an open whistle-blowing culture include the following (Dzomira, 2015:2):

- Depicting potential problems earlier.
- Deterrence of wrongdoing.
- Critical information reaches the right people who can address the issue.
- Demonstration to stakeholders, regulators, and courts that they are accountable and well-managed.
- Reduces compensation and costs from accidents, investigations, litigation, and regulatory inspections.

Most insurance organisations employ whistle-blower fraud hotlines for tip-offs from the public and police as a first line of defence against fraud. These tip-offs are typically investigated by the special investigation unit of the insurance organisation, using internal audit procedures.

2.13.7 The Insurance Crime Bureau

The SAICB was established in September 2008 as a sub-committee of the South African Insurance Association (SAIA). Its primary goal was to support the South African short-term insurance industry in detecting, investigating organised short-term insurance crime and to identify repeat fraudulent offenders that target more than one insurance organisation. After a strategic session in June 2017, the SAICB decided to re-brand and is now known as the Insurance Crime Bureau (ICB) (COVER, 2017). In a concerted effort to combat organised financial crime, in South Africa, the fight against insurance fraud involves collaboration

between insurance companies, law enforcement agencies, and industry organizations. The Insurance Crime Bureau (ICB) is an example of an entity that plays a role in combating insurance fraud. Furthermore, Van Zyl (2022), of the South African Insurance Fraud Bureau stated that specialist investigators, the police and other crime prevention agencies agree that a large proportion of insurance fraud is organised and perpetrated by syndicates. He quotes the Insurance Fraud Bureau in the United Kingdom which found that 40 per cent of the insurance fraud believed to be opportunistic was also organised (Van Zyl, 2022).

2.14. Chapter Summary

This chapter presented relevant information from the literature regarding the topic under investigation. It was evident in this chapter that life insurance fraud is a growing problem that needs more attention. However, there appear to be limited studies on life insurance fraud in South Africa. Life insurance fraud has become one of the greatest challenges in the long-term insurance environment in recent years. It is a heavy financial and moral burden on society. Losses incurred by insurance companies are then absorbed by innocent policyholders through increased monthly premiums, creating a financial impact on millions of lives. Perpetrators of life insurance fraud are intelligent, cunning and very inventive when planning and subsequently committing the crime. Effective use of MO information can assist in identifying criminal activity across the insurance industry. Consequently, collective efforts, skills and knowledge-sharing, in conjunction with the optimal use of available data systems, will aid in proactive insurance fraud detection.

The following chapter will outline the theoretical framework that guided this study. Two key theories that were relevant to this research will be explored, namely the routine activities theory and the fraud triangle theory.

CHAPTER THREE: THEORETICAL FRAMEWORK

3.1 Introduction

The main aim of this chapter is to provide an overview of the theoretical framework in which this study was embedded. This current research employed the fraud triangle theories, which are drawn on to explain the causes and the occurrence of life insurance fraud in KwaZulu-Natl, South Africa. The rationale for employing these theories stemmed from the notion that it's impractical to pinpoint a singular theory that perfectly elucidates the occurrence of a specific phenomenon (such as life insurance fraud). The researcher in this chapter will first provide the background on the selection of the theories underpinning the study, followed by the discussion of the fraud triangle theory and its relevance to this study. Secondly, the researcher will discuss the routine activities theory and its relevance to this study and lastly, the chapter summary is provided.

3.2 Background on the selection of theories

Research on white-collar crimes (financially motivated non-violent crimes such as insurance fraud, corporate fraud, and financial statements fraud) has always been predominantly undertaken from either a macro, social structure, strain theories (Piquero, MacDonald, Dobrin, Daigle & Cullen, 2005) or differential association theory perspective (Donegan & Ganon, 2008; Piquero et al., 2005). Consequently, Skiba (2015:14) argues that theories focussing on examining criminal behaviour regarding insurance fraud have been lacking compared to crimes such as robberies and homicide. Nevertheless, while Skiba (2015:15-18) acknowledges that no attempt has been made to apply the various available theories to insurance fraud, he proposes that it is possible for the “rational choice theory”, “routine-activities theory” and “deterrence theory” to be applied to insurance crime. Similarly, Holtfreter, Reisig and Pratt (2008) aptly noted that although routine activity theory was developed as a model for street crime, it offers a promising conceptual model for financial crimes. Criminological theoretical advancements have yet to be incorporated into research on insurance fraud to enhance our understanding of crime events, prevention, and control. These advancements could offer insightful insights into various critical questions, such as the reasons, locations, timing, and methods behind insurance crimes. Thus, it is against this background that the current study employed the routine activity theory (RAT) to provide insights into the commission of life insurance fraud. Hence, the

present research is among the few studies that have employed the RAT to conceptualize life insurance fraud.

Further, the Fraud triangle theory (FTT) is employed in this study as a holistic approach, suitable for examining the motivations for committing life insurance fraud. In addition, Frank Ztuk, chairman of the Coalition Against Insurance Fraud (CAIF), stated that the fraud triangle theory is a critical framework for helping insurance companies focus on prevention and deterrence efforts (Claims and Litigation Management Alliance, 2013).

Following is a discussion of each theory underpinning the study and their relevance to the study.

3.3 The Fraud Triangle Theory

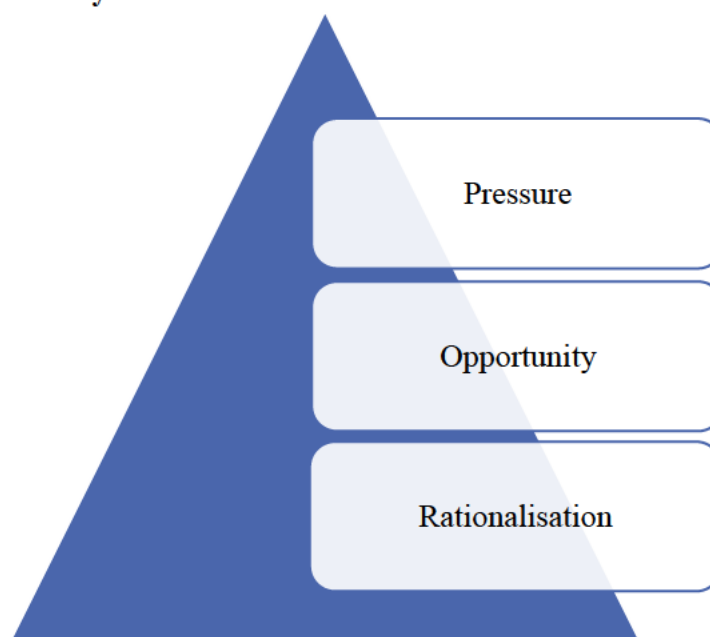
In 1950, Donald Cressey, a criminologist, studied fraud by arguing that there must be a reason behind everything people do. However, only a limited number of criminological studies have used the fraud theory. Questions such as why people commit fraud led him to focus his research on what drives people to violate trust. It can therefore be contended a perpetrators of life insurance fraud (policyholder/beneficiary) could be regarded as “trust violators” (Said, Alam, Ramli, & Rafidi, 2017: 17). According to his study, he found the great majority committed fraud to meet their financial obligations and that circumstances make them violate the trust (Albrecht, 2012). Kennedy (2012) revealed that fraud i.e. life insurance fraud is normally committed by perpetrators for personal benefit. Cressey further states the following: *“Trust violators, when they conceive of themselves as having a financial problem that is non-shareable and have knowledge or awareness that this problem can be secretly resolved by a violation of the position of financial trust. Also, they can apply to their conduct in that situation verbalizations which enable them to adjust their conceptions of themselves as trusted persons with their conceptions of themselves as users of the entrusted funds or property”* (Crassey 1953:742 as cited in Abdullahi & Mansor, 2015). It can therefore be contended that a policyholder/ beneficiary committing life insurance fraud could be regarded as a “trust violator”, as these perpetrators can convince themselves that financial problems can be resolved through illicit means (i.e. murder for money and faking death). Additionally, Cressey defined the fraud problem as a “violation of a position of financial trust” that the person originally took in good faith (van Wyk, 2022). This theory was selected by the researcher because it explicitly

delineates the factors that increase the chances for policyholders/ beneficiaries to commit life insurance fraud accurately.

This theory posits that individuals are motivated to commit fraud when three elements come together, namely a perceived pressure, a perceived opportunity and rationalization that define the behaviour as appropriate in each situation (Vona, 2008). Fraud triangle theory proposed that if all three elements are available, then fraud is likely to occur, and if one of these elements is absent then the chances for fraud to occur are low.

Figure 3.1: shows the relevance of the fraud triangle theory in this study. The figure shows that life insurance fraud occurs when someone with financial need/ greed (*motive/pressure*) with an ability to override the detection systems (*opportunity*) and can justify the act to themselves and or others (*rationalisation*) for committing life insurance fraud.

Figure: 3.1 Fraud Triangle Theory



Source: Researcher's Illustration

Understanding how pressure, opportunity and rationalization contribute to life insurance fraud can assist insurance companies to easily recognise the areas of susceptibility to fraud and strengthen these areas (Albrecht, 2012). All three of these factors will be elaborated on to be able to explain life insurance fraud.

3.3.1 Perceived Pressure/Incentive/Motive

Perceived pressure refers to factors that lead to unethical behaviours, it is a non-observable element (Sujeewa, Yajid, Azam, & Dharmaratne, 2018). These pressures can either be financial or non-financial (Junger, Wang & Schlömer, 2020). According to Cressey (1950:741-742), “the source of the pressure is normally of an urgent financial nature due to a non-shareable problem”. Consequently, every fraud perpetrator faces some pressure to commit unethical behaviour (Mansor & Abdullahi, 2015). Perceived pressure can exist in various ways, especially in non-sharable financial needs. Financial pressure is recognized as the most common factor that leads an individual to engage in a fraudulent action (Sujeewa et al., 2018). Biegelman and Bartow, (2006:33), concur that financial pressure is a common reason for people committing fraud. It is the main reason for the public to turn to crime. Thus, if perpetrators believe that they are pressured by financial pressure, this belief could lead to life insurance fraud. Specifically, about 95% of all fraud cases have been perpetrated due to the fraudster’s financial pressures (Albrecht, Albrecht & Albrecht, 2008). In addition, a survey conducted by the Association of Certified Fraud Examiners (ACFE) in 2013 showed that 42% of fraud activity resulted from personal financial and organisational pressure (KPMG Malaysia, 2013). Examples of perceived pressure include greed, living beyond one’s means, large expenses or personal debt, family financial problems or health, drug addiction and gambling (Vona, 2008). Greed is one of the common examples of nonsharable pressure that promote theft in the first place (Azam, 2018).

Further, Leckey (2009), aptly noted that insurance fraud increases during economic downturns, pressuring people to commit fraud. In a study conducted by Dionne and Wang (2013:83), it was found that “insurance fraud was rife during bad economic times. They argue that, during tough economic times, consumers are more inclined to commit insurance fraud due to financial constraints”. Similarly, Glenn Hickling BrightRock's head of legal, stated that the industry statistics suggest that people are more likely to commit insurance fraud in times of economic hardships (BrightRock, 2021). Consumer surveys conducted by the Coalition Against Insurance Fraud (CAIF) (1997:17; 2008:11) also revealed that consumers reported high insurance fraud tolerance levels due to financial reasons such as seeking a fair return on premiums and non-financial reasons such as insurers making too much money. In addition, Albrecht (2012) also added to this by stating that insurance employees/employers and

policyholders justify their actions to commit insurance fraud because of economic hardships, and unfair benefits received from the insurer.

A study conducted by Skousen and Wright (2006), examined the role of the fraud triangle elements in detecting and predicting fraud cases. The study found that financial stability, external pressure, personal financial needs, and financial targets have each presented pressure as the element that may be involved in the category of fraud risk factors. Pressure is created through problems caused by immoral personal behaviours such as gambling, drugs, extramarital relationships, or the need to live lavishly. Furthermore, Murdock (2008), also adds that the pressure could be related to financial, nonfinancial, political, and social factors. In essence, perceived pressure plays a significant role as a motivating factor for policyholders/beneficiaries to commit life insurance fraud. Lister (2007:63), aptly noted three types of pressure which are personal-related stress, employment-related pressure, and external-related pressure. For the current study, the most relevant type of pressure is personal-related stress.

There is limited existing research on the in-depth analysis of motivations for committing life insurance fraud, particularly in the context of South Africa. In the context of this study, the insurance industry encompasses a group of policyholders/claimants motivated by financial pressures such as greed, extravagant living, substantial expenses or personal debt, and family financial challenges to engage in unethical behaviour, specifically life insurance fraud. Life insurance fraud often begins with financial pressures faced by individuals. Rising debts, medical costs, or other economic difficulties can provide a strong incentive for policyholders/beneficiaries to resort to unscrupulous practices as a means of addressing their financial burdens. The pressure element of the Fraud Triangle becomes apparent when individuals find themselves compelled to manipulate information or create fictitious events to secure a life insurance payout. Desperation and a perceived lack of alternatives contribute significantly to the emergence of this pressure. Researchers have found a significant relationship between pressure and fraud occurrence (Albrecht et al., 2008; Akindele, 2011). Pressure plays a vital role in increasing the likelihood of life insurance fraud occurrence among policyholders and claimants. It can be argued that in South Africa due to the current continuous economic downturns, perpetrators may be motivated by financial pressure to commit life insurance fraud to meet their financial obligation, though this motivation might not apply to every perpetrator of life insurance fraud as some might be motivated by other factors.

3.3.2 Opportunity

Opportunity is created “by ineffective control or governance system that allows an individual to commit organizational fraud, in the field of accounting, this is termed as internal control” (Abdullahi & Mansor, 2015: 40). Opportunity, as defined by Rae & Subramanian (2008), refers to the ability and power of an employee to realize the weaknesses of the organisational system and take advantage of it by making fraud possible. Nonetheless, Wilson (2004), explains “opportunity” as the ability to override fraud controls, inadequate supervision, poor separation of duties, lack of management approval, or weak system control are examples that may provide opportunities that may result in fraud among insurance companies. In essence, opportunity is a weakness in the system that could make life insurance fraud occurrence possible (Wolfe & Hermanson, 2004).

Therefore, the concept of perceived opportunity suggests that people will take advantage of the circumstances available to them to commit fraud (Kelly & Hartley, 2010). Furthermore, Cressey (1953) mentioned that in most cases, the lower the risk of being caught, the more likely it is that fraud will take place. Several factors lead to the existence of an opportunity to commit fraudulent activities in an organization such as negligence of employee’s breach of policies and lack of disciplinary action (Sauser, 2007). Varma and Khan (2012:43) reports that “opportunities are also created by poor ethics, insufficient training, inadequate supervision, no prosecution of transgressors, weak anti-fraud programmes and poor policies and procedures”. Undeniably, opportunity can lead to an intention that influences or causes someone to commit life insurance fraud. Following the abovementioned, KPMG (2013), mentioned that in South Africa, despite the prevalence of insurance fraud, there exists a notably low prosecution rate of fraudsters. Hence, this may emphasise the significance of opportunity in influencing criminal opportunities of life insurance fraud.

According to the survey conducted by KPMG Malaysia Fraud, Bribery, and Corruption, the most influential opportunities within the insurance sector are loopholes in internal control, inadequate competency to detect fraud by the internal audit team, insufficient training to give awareness on fraud, the nature of that industry prone to fraud, and failure to convey organisational code of ethics and values (Said et al,2017). Furthermore, Hooper et, al. (2010) as cited in Abdullahi and Mansor (2015:6), argue that, even when the pressure is extreme, financial fraud i.e. life insurance fraud cannot occur unless an opportunity is present. “An opportunity has two aspects: (i) the inherent susceptibility of the organisation to manipulation,

and (ii) the organisational conditions that may warrant fraud to occur”. In addition, (Dorminey, Fleming, & Kranacher, 2012; Murphy, Free & Branston, 2011; Schuchter & Levi 2013 as cited in Junger, Wang & Schlömer, 2020) are of the opinion that researchers seem to regard this element of the theory as important although not sufficient for the condition of fraud to occur. Nevertheless, the researcher contends that if the opportunity (weak internal control systems) were not present, perpetrators would not have been able to carry out life insurance fraud so extensively.

According to Sujeewa et al (2018), the opportunity provides a chance for fraudsters to commit fraud. Many scholars (Albrecht et al., 2008; Dellaportas, 2013; Manurung & Hadian, 2013), believe that opportunity is a very significant factor that contributes to fraud and other fraudulent activities behaviour in a company, such as embezzlement and loan manipulation, which are mostly caused by lack of internal control within the organization. Significantly, it has become evident that the prospect of committing life insurance fraud emanates from poor controls to manage fraud within the system, which convinces the fraudster (policyholder/ claimant) that the chance of success is high and there is a lower risk of being caught (Abdullahi & Mansor, 2015). An environment that is characterised by poor controls creates an opportunity for fraud to be successfully committed against an organisation.

Opportunities for life insurance fraud arise when there are weaknesses in the insurance company's systems, processes, or oversight. This could include inadequate internal controls, loopholes in claims processing, or insufficient verification procedures that can provide the openings that perpetrators exploit. Hence, the complexity of the insurance industry may create an environment where individuals can manipulate information without immediate detection. Further, the opportunity component of the fraud triangle underscores the importance of robust fraud detection mechanisms and stringent internal controls within insurance companies. Additionally, it can be argued that life insurance fraud arises when potential perpetrators believe they face an unshareable financial problem that cannot be shared, they are aware of an opportunity to solve their problem secretly by violating the trust given to them, and they can rationalize the violation of that trust.

3.3.3 Rationalisation

Rationalisation is the third element of the fraud triangle theory. According to Slezak (2013), rationalisation is defined as a way to legitimize a manner or concept that is incompatible with

one's belief, it refers to the justification and excuses that the immoral conduct different from criminal activity (Kinyanjui: n.d.). According to Lee and Ahn (2014) states that rationalization is an attitude, character, and ethical values that allow certain parties to commit fraudulent acts or people who are in a stressful environment to rationalise fraud. In essence, rationalisation is the mindset of the perpetrator that justifies the execution of life insurance fraud.

Rationalisation happens when the ability of a person causes him or her to reinterpret his or her deprived and wicked actions as morally acceptable to commit the offence (Tsang, 2002). The propensity to commit fraud i.e. life insurance fraud depends on ethical values as well as on the personal attitudes of individuals (Kenyon & Tilton, 2006). This concept indicates that the perpetrator must formulate some morally acceptable idea before engaging in unethical behaviour. According to Abdullahi and Mansor (2015: 40), "if an individual cannot justify dishonest actions, it is unlikely that he or she will engage in fraud". Some examples of rationalisations of fraudulent behaviour include "*I was only borrowing the money*" (Sujeewa et al, 2018).

Rationalisation involves a person reconciling his/her behaviour with the commonly accepted notions of decency and trust. According to (Kinyanjui: n.d:5), "For those individuals who are generally dishonest, it is probably easier to rationalize fraud. For those with higher moral standards, it is probably not so easy. They must convince themselves that fraud is OK with "excuses" for their behaviour". Furthermore, Cressey (1953), believes that an individual, who is a first-time offender with no criminal experience, has his or her justification to support his or her action. Therefore, these offenders are merely people who have found themselves entangled in difficult situations (Cressey, 1953). This finding is supported by the results of a survey conducted by KPMG in 2011 in Singapore. The results showed evidence that most first-time fraudsters rationalise their actions and do not view themselves as criminals (Said et al, 2017).

According to the Association of Certified Examiners (2014), people tend to rationalise a criminal activity before they decide to commit a crime. A study conducted by the ACFE (2014) as cited in Said et al (2017:174) revealed that "fraud in government, employees, or organizations will usually rationalize their conduct of corruption in many ways, which allow them to "innocently" carry out the act". These individuals tend to use excuses, such as "bribery is our country's culture," "we have no idea that the behaviour is considered a bribe," "we are doing this as usual," and "there is no other way to complete this (Said et al, 2017). However,

Abdullahi and Mansor (2015:41) argue that rationalisation is difficult to notice, as it is impossible to read the mind of the fraud perpetrator. Further, Hooper and Pornelli (2010) mentioned that individuals who commit fraud possess a particular mindset that allows them to justify or excuse their fraudulent actions. Kula, Yilmaz, Kaynar and Kaymaz (2011), highlighted that rationalisation is a major factor that contributes to fraud.

A global economic crime survey conducted by PriceWaterhouseCoopers (PWC), in 2011 showed that 12% of the participants believe in people's rationale to provide excuses for their actions as the largest risk of fraud (PWC, 2011). The propensity to commit fraud depends on ethical values as well as on the personal attitudes of individuals (Kenyon & Tilton, 2006). A typical feature of insurance fraud and all white-collar crimes is the lack of feelings or the indifference expressed by offenders stemming from a series of excuses or rationalizations to rid themselves of the guilt arising from deviant behaviour (Anand, Ashforth, & Joshi 2004; Derrig, 2002). In addition, Howe and Malgwi (2006) concluded that a bridge between pressure and opportunity is created when an individual can rationalise fraudulent behaviour. In essence, perpetrators may rationalize their actions by convincing themselves that the insurance company won't suffer much harm or that they deserve the life insurance payout for various reasons.

The need to rationalise wrongdoing can be linked to the rational choice theory, in which the perpetrator makes a rational choice to commit a crime after weighing the potential costs and benefits of an illegal act and are influenced in part by environmental factors (Button, Pakes & Blackburn, 2016). People who commit life insurance fraud may believe that their actions are in the best interest of themselves or their families. The notion of this theory, therefore, requires that all three contributing factors be activated for life insurance fraud to occur in insurance companies. The theory assisted the researcher in explaining why life insurance fraud occurs and the opportunities available to perpetrators to commit this offence. Rationalisation serves as the psychological mechanism that allows individuals to justify their fraudulent actions. In the context of life insurance fraud, policyholders/ beneficiaries may convince themselves that their actions are warranted due to perceived injustices, financial difficulties, or a sense of entitlement. Rationalisations often involve the minimization of the harm caused to the insurance company or the belief that the insurer owes them a payout for various reasons. Addressing the rationalisation aspect of the fraud triangle requires efforts to instil ethical values and emphasise the consequences of life insurance fraud.

In this section, it was postulated that the fraud triangle is a useful theoretical model for understanding the motivating factors behind life insurance fraud. According to the theory three aspects of the theory need to be present for fraud to occur, namely; opportunity, pressure and rationalisation. However, certain conditions must also be present for the continuation of such fraud. For life insurance fraud to transpire, there needs to be a motivated offender, a suitable target, and a lack of guardianship. Notably, the absence of guardianship corresponds to the opportunity aspect of the fraud triangle. Thus, the subsequent section delves into the theory of routine activity theory and its foundational elements.

3.4 Routine Activity Theory

This theory was selected by the researcher because it explicitly delineates the victimisation of the victims of life insurance fraud (*Insurance companies / unsuspecting victims*) accurately. Routine Activity Theory (RAT) is a criminological theory that suggests that crime occurs when three elements converge in space and time: a motivated offender, a suitable target, and the absence of a capable guardian. This theory posits that a motivated offender is somebody capable and eager to take advantage of an opportunity to commit a crime (i.e. *policyholder/ claimant*). A suitable target can be any person or object (i.e. *an insurance company/ insured person*) that is vulnerable to attack, while a capable guardian can be anyone, including neighbours, friends, family, onlookers, security monitors, or any alert system or laser beam that will deter an attack or 'hit' (i.e. *effective detection and prevention strategies*).

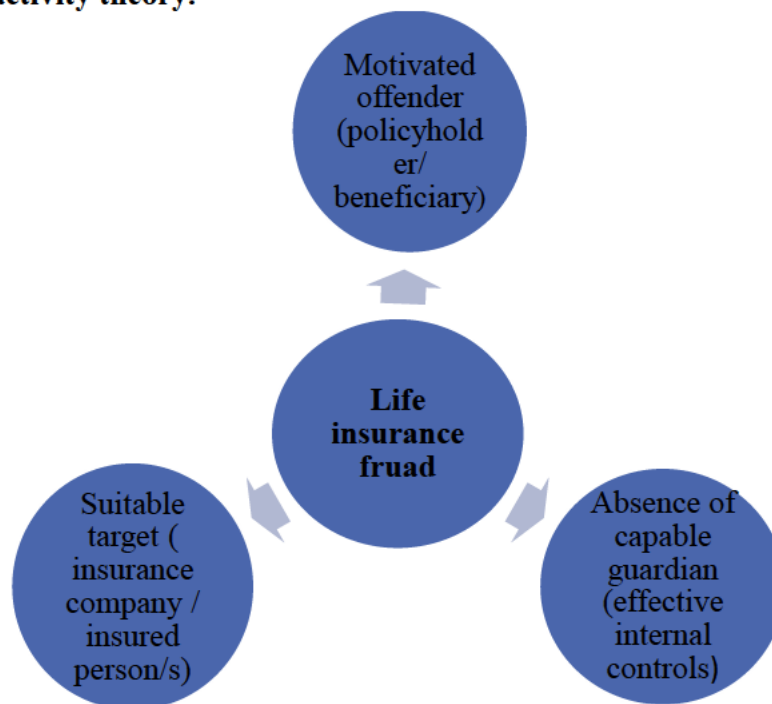
The routine activities theory was developed by criminologists in 1979 and is one of the most influential perspectives for explaining crime patterns (Peacock, 2013). Routine activities refer to “what individuals do during a day in terms of going to work, being at home, and heading out to the shops, and so forth” (Grohe, 2006: 17). Cohen and Felson posit that crime occurs in the presence of three elements which are (1) a motivated offender, (2) a suitable target and (3) lack of guardianship (Argun & Dağlar, 2016). The routine activities theory describes patterns of victimisation by connecting crime with victims' proximity to offenders, exposure to criminal behaviour, and attractiveness levels, either through symbolic or economic value, or a lack of guardianship (Pratt & Turanovic, 2016:22). Routine activity theory proposed that if all three elements are available, then a crime is likely to occur, and if one of these elements is absent then chances for crime to occur is low (Argun & Dağlar, 2016). It emphasises the fact that suitable targets are likely to follow a routine, and most crimes happen daily because of the

routine of people. Criminals observe these routines and then take the tempting opportunity to commit a certain crime (Makhaye, 2016).

Figure 3.2 shows the relevance of the routine activity theory in this study. The figure shows that life insurance fraud often happens when a perpetrator sees an opportunity (a suitable target) to manipulate for financial gain through illicit means (motivated offender), and there might be a lack of effective controls or monitoring in place (absence of a capable guardian). In the context of routine activities theory, life insurance fraud might thrive when these elements come together.

For example, a policyholder might fake a death or hire a dead body (motivated offender) because they know the insurance and investigative process is complicated or lacks thorough verification (absence of a capable guardian). In the insurance world, the routine activities theory can provide insights into how to design better systems and controls to prevent and detect life insurance fraud.

Figure 3.2 Routine activity theory.



Source: Researchers illustration

As part of the routine activity theory conceptualising crime victimisation, Cohen and Felson (1979) stress the importance of how victimisation possibly becomes a function of the social, even ecological, convergence between opportunistic potential offenders and inadequately

guarded potential targets of crime. It is argued that structural changes in routine activity patterns can influence crime rates by affecting the combination of space and time of the three minimal elements of direct-contact crime: (1) motivated offenders; (2) suitable targets; and (3) the absence of a capable guardian (Makhaya, 2016). All three of these factors will be elaborated on to be able to explain life insurance fraud.

This theory traditionally focuses on the social activities and lifestyles of individuals and not on the criminal behaviour of the offender. In addition, the routine activity theory places more emphasis on criminal events and ignores the importance of criminal behaviour (Peacock, 2013). However, Brown, Esbensen and Geis, (2007), oppose the above statement by stating that this theory can be applied to explain the criminal behaviour of offending. Cohen and Felson (1979) argued that criminal activities are not completely biological, psychological, economic, or social in origin and offences are tied to the everyday activities of victims and offenders. In addition, Lugo (2013) argues that routine activities theory can be adapted in such a way that it can be applied to financial crimes. She further asserts that, for financial crime to take place there are three conditions to fulfil: the presence of an offender, victims or organisational setting that prompts contact between the offender and the lack of a guardian (Benson, Madensen & Eck, 2009) as cited (Lugo, 2013:17). To illustrate this point on how RCT can be applied to insurance fraud. Benson et al (2009) mentioned in the case of insurance fraud, the claimant would be the offender, the target is the insurance company, and the guardian insurance fraud is the reviewer of claims.

3.4.1 Motivated offender

According to this theory, crime will only be committed if a likely motivated offender thinks that a target is suitable, and a capable guardian is absent (Murray, 2007). It is the offender's evaluation of a situation that determines whether a crime will take place or not (Makhaye, 2016).

Walklate (2007:39), concurs by stating that this theory posits that offenders are rational human beings and will commit a crime whenever an opportunity presents itself. The motivated offender weighs the costs and benefits of committing a crime. For perpetrators of crime, the costs are less than the benefits, given the fact that they are calculating professionals who will most probably not get caught and will gain something from their criminal act (Makhaye, 2016). According to Makhaye (2016), motivated offenders can be classified as opportunistic criminals

because they always depend on the right opportunity to commit a crime, whether it is in a public or a private location.

Insurance companies as suitable targets include a pool of motivated offenders (*policyholders*) both of which increase the risk of victimization. Concerning this study, a motivated offender refers to an (*applicant, policyholder, beneficiaries, and third-party claimant*) who is motivated to fraudulently submit a claim to an insurance company for a payout. Offenders of life insurance fraud are usually motivated by the incentive of the crime. As previously mentioned, Biegelman and Bartow, (2006) assert that financial pressure is a common reason for people to commit fraud. According to the Insurance Fraud Bureau (2023), fraudsters commit insurance fraud more systematically and deliberately, seeking to make money. Not everyone can commit life insurance fraud, it is those who are motivated, calculative, and deliberate about defrauding the insurance company.

Concerning the current study, a motivated offender is an individual who, under specific circumstances, succumbs to the allure of fraudulent actions within the life insurance industry. Individuals facing significant financial difficulties, debts, or economic hardships may become motivated offenders. The prospect of obtaining a life insurance payout can be tempting for both the potential offender and the person facing financial challenges. Additionally, the Centre for Insurance Policy and Research (2022), pointed out that insurance fraud is committed by an individual who is motivated and intentional about committing a deliberate deception to obtain an illegitimate gain. Thus, the motivation of a fraudster plays a pivotal role because as much as there could be a suitable target and lack of guardianship if the fraudster is not motivated in any way to commit fraud (life insurance fraud) then he/she won't commit the offence. A pertinent illustration is the case of Rosemary Ndlovu, who procured insurance policies for her family members, orchestrated their murders through a hired hitman, and subsequently filed claims with multiple insurance companies. Ndlovu's case vividly exemplifies her role as a motivated offender, being the beneficiary in all active policies she had taken out for her family. Her actions, including the continuous harm to her family members, underscore the persistence of a motivated offender until apprehended. It is crucial to underscore that life insurance fraud may involve more than one motivated offender. By the above statement, Megan Govender stated that in insurance fraud there is a value chain that operates in the industry and along the value chain each person has a role to play. From the people at the Department of Home Affairs to the funeral parlours and mortuaries, they each play a certain role in ensuring the success of the claim (eNCA,2022).

3.4.2 Suitable target

The next element of the routine activities theory is a suitable target. According to Argun and Dağlar (2016), anything can be referred to as a target, such as a person, an object or a place which can be attractive and fruitful for offenders.

Furthermore, Argun and Dağlar (2016) add that a suitable target provides instant profit to the one committing the crime Walklate (2003:39) clarifies that the term target was selected to avoid the moral implications of the word victim and to treat the persons and property the same as objects with a position in time and space. Criminals generally choose to commit a crime upon meeting an opportunity, rather than engaging in serious planning. Thus, it can be stated that the suitability of the target is important for a criminal offence to occur (Argun & Dağlar, 2016).

Within the insurance industry, unfortunately, fraud is prevalent and, on the rise, which indicates that insurance companies are suitable targets for fraudsters. In support of the above statement, Megan Govender, convener of the forensics standing committee at ASISA, stated that there is a continuous increase in insurance fraud because very often the insurance industry is seen as a very soft target and fraud is seen as a victimless crime (eNCA, 2022). Therefore, it can be argued that the industry is seen as a soft target because firstly; the nature of insurance fraud is normally undetectable and it is not a visible crime like robbery or murder (Derrig, 2002, Pao, Tzeng, & Wang 2014). Secondly, the disturbing trend of societal acceptance of insurance fraud, and tolerance by the public perpetuates fraud. The society does not see anything wrong with defrauding life insurance (Considine, 2010). Thirdly, the industry has weak detection and prevention systems which allow a fraudster to continue defrauding without being caught at first (Govender, 2018). Lastly, poor deterrent for the crime employed by the industry, which does not discourage the fraudsters from committing life insurance fraud (Govender, 2018).

3.4.3 Lack of a suitable guardian

The final element of routine activity is the lack of guardianship. Many people become victims of crime not because they attract the offender of crime, but because they are in a place where a criminal act is possible and where no guardianship is present (Makhaya, 2016).

A guardian can be described as “any person who can prevent a crime as a result of his or her presence or direct actions,” or equipment such as closed-circuit television (CCTV) (Davis, 2005:40; Makhaya, 2006:29). The absence of the capable guardian is a significant element to

this theory (Rae Grohe, 2006). Capable guardians can take any form, for this study, the term refers to effective fraud detection and prevention strategies (internal controls). Because, if companies had effective and efficient strategies life insurance would not be on the rise. Hunter and Dantzker (2002) remind us that it is also possible for a guardian to be present, but ineffective. For example, a CCTV camera is not a capable guardian if it is set up incorrectly or in the wrong place or is not monitored (Hunter & Dantzker, 2002). The researcher argues that insurance companies have detection and prevention strategies in place however, these have proven to be ineffective to deter the frequency and severity of life insurance fraud. Within the insurance industry, internal controls are the main guardians of fraud, however weak internal control such as poor detection of fraudulent claims give rise to opportunities for fraud. Following the above-mentioned, researchers such as Simbolon, Ahmad and Elviani (2018) state that fraudsters can commit fraud without being caught because of the internal weakness of controls. Long (2009) argued that strong internal control systems would reduce fraud or make it difficult for a financial crime or fraud.

3.5 Chapter Summary

This chapter presented an explanation focused on two specific theories: the fraud triangle and routine activities theory. It is essential to emphasize that this study represents one of the limited inquiries using routine activities theory to conceptualize life insurance fraud. In saying this, the chapter also looked at the formulation of the theories and how the researcher managed to use the theories underpinning the study to explain life insurance fraud.

The following chapter delves into the research methodology and procedures employed to gather pertinent data, aiming to fulfil the study's objectives and ultimately address the key research questions.

CHAPTER FOUR: METHODOLOGY

4.1 Introduction

The purpose of this chapter is to expound on how the researcher ‘planned’ the research study. The researcher will discuss the methodology that was used to conduct the study and begin by offering the research paradigm, followed by the exposition of the research design and research approach. Furthermore, a clear outline of the selection of participants, the recruitment process for participants and the procedures used when collecting participants’ data to meet the goals and objectives of the study. A highlight of how data was analysed and the trustworthiness of the study is included. The researcher also explained ethical considerations, challenges encountered and possible limitations of the study. The following discussion pertains to the design the researcher used for this research study. The provided diagram depicts the representation of the research methodology employed in this study, elucidating the chapter’s organisational structure.

Table 4.1: Map of the methodology

MAP OF METHODOLOGY

Research Paradigm	Interpretive paradigm
Research Design	Phenomenological study
Research Approach	Qualitative
Selection Of Participants	Purposive sampling
Data Collection Methods	Key informant interviews Semi-structured interviews
Data Analysis	Thematic analysis

Source: Researcher’s illustration

4.2 Research paradigm

A research paradigm is defined as a “model or framework for observation and understanding [that] shape both what we see and how we understand it” (Babbie, 2007:32). Interpretive researchers study how people perceive and make sense of their surroundings because humans contribute meaning to their social reality. This study was located within the interpretive paradigm, which is supportive of the qualitative research approach, which means that the researcher sought to “comprehend social members’ definitions as well as understandings of situations; hence [the study was] not concerned with the search for broadly applicable laws and rules, but rather [sought] to produce descriptive analysis that [elicited] deep, interpretive understanding of the social phenome[non]” under study (Henning, Van Rensburg & Smit, 2004:20). This approach tries to ‘get into the head of the subject being studied’ to understand and interpret what the subject is thinking or the meaning she/ he is making of the context (Kivunja & Kuyini, 2017).

The researcher wanted to get into the heads of fraud and forensic investigators to obtain descriptive interpretations of their understanding of life insurance fraud. Further, Myers (2017); and Nene (2013:36) clarify that research studies that employ an interpretive paradigm seek to emphasise the understanding of the phenomena under investigation through the meanings that people assign to them. Therefore, the interpretive paradigm allowed the researcher to obtain an in-depth understanding of the participants’ perceptions of life insurance fraud in KwaZulu-Natal (KZN). More precisely, the purpose of this research was to gain an understanding of how and why policyholders/beneficiaries commit life insurance fraud from the participants’ standpoint. Different perspectives were sought from the participants who had their interpretation of life insurance fraud. In this context, the researcher took cognisance of Nene’s (2013:36) argument:

“Researchers working in this paradigm assume that people’s subjective experiences are real and should be taken seriously (ontology); that we understand others’ experiences by interacting with them and listening to what they tell us (epistemology); and that qualitative research techniques are best suited to this task (methodology)”.

The table below outlines the characteristics of the interpretive paradigm with specific reference to this study. A paradigm is characterised by the nature of reality (ontology), the nature of

knowledge, the relationship between the inquirer and the inquired-into (epistemology), and the methodology used (Cantrell, 2001).

Table 4.2: Characteristics of interpretivism

Feature	Description
Ontology	<ul style="list-style-type: none"> Realities can be explored and socially constructed through human interactions and meaningful actions. This feature positioned the researcher within the context and realities of the participating SAPS DPCI investigators and Assupol internal forensics investigators by interpreting what they said during the in-depth, semi-structured interviews and key informant interviews.
Epistemology	<ul style="list-style-type: none"> Participants who are active in the research process socially construct knowledge by revealing how they experience real-life situations and a phenomenon in a natural setting. The researcher sought to understand how and why life insurance fraud in KwaZulu-Natal and to identify factors that contributed to this phenomenon as perceived by the research participants.
Methodology	<ul style="list-style-type: none"> Qualitative

	<ul style="list-style-type: none"> • In-depth, semi-structured interviews and key informant interviews.
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Source: Cantrell (2001)

4.3 Research Design

This study adopted a phenomenological research design. A phenomenological study is suitable for “exploring research questions in qualitative research as such a study looks at different ways to construct information” (Lichtman, 2014:112). Furthermore, the phenomenological perspective as a philosophical viewpoint in research is associated with the qualitative paradigm “to translate scientific information into meaningful truths about specific experiences in a social situation” (Matlala, 2012:101). The researcher focused on fraud and forensics investigators' experiences of life insurance fraud in KwaZulu-Natal Province. Considering the basic purpose of phenomenology, the researcher was able to reduce the experiences of these people within the studied phenomenon and to describe its universal essence. This approach was appropriate because it supported the researcher’s quest to understand the participants’ perceptions, perspectives, and understandings of the problem under investigation (Leedy & Ormrod, 2010). In addition, Vishnevsky and Beanlands (2004:236), clarify that phenomenological studies provide “a rich description of the meaning of a lived experience; the researcher [thus] identifies the essence of human experiences concerning a phenomenon as described by [the] participants in a study”. The researcher believed that through the phenomenological perspective participants can best express themselves when asked to do so in their own words during lengthy interviews and by observing the context in which some of their experiences occurred (Henning et al., 2004). Consequently, the main source of the primary data that were obtained for this study was in-depth interviews and key informant interviews between the researcher and the participants.

Phenomenology research requires the researcher to view social life in an unbiased, open-minded way and thus— bracket his or her knowledge of how encounters are socially structured or accomplished (Schwand, Lincoln & Guba, 2007). Thus, the researcher bracketed her knowledge and understanding of life insurance fraud to be able to describe the way South African Police Services Directorate for Priority Crime Investigation (SAPS DPCI) and Assupol forensic investigators accomplish their sense of understanding of life insurance fraud. From a

phenomenological perspective, the researcher collected data from individuals who had first-hand experience and knowledge of the phenomenon, and this allowed the researcher to examine the values, feelings and perceptions of the participants under study. Individuals who had been exposed to the phenomenon of life insurance fraud were selected as they would give the best descriptions regarding the topic under study. This assumed that life insurance fraud cases had become a regular experience for most SAPS DPCI and Assupol investigators in KwaZulu-Natal. One of the principles of phenomenology is the data is often presented in relatively raw form to demonstrate the authenticity of the collected data. Thus, the interview responses are presented verbatim in chapters five, six and seven.

4.4 Research Approach

This study employed a qualitative research approach in which the main aim was to collect in-depth data on investigators' perceptions of life insurance fraud. This approach facilitated an in-depth understanding of the participants' subjective views on and experiences of the phenomenon of life insurance fraud. "Qualitative research is not arrived at through statistical procedures or other means of quantification but deals with research about people's lives, lived experiences, behaviours, emotions as feelings as well as about organisational functioning, social movements, cultural phenomena and interactions between nations" (Strauss & Corbin, 1998:10). Thus, merely gathering numerical data would not have produced such thick and responsive study findings. The emphasis was more on the quality and depth of the information and not on the scope of the information provided. The qualitative research approach uses concepts and clarifications to attempt to interpret human behaviours in a way that reflects not only the analyst 's view but also the views of the people whose behaviour is being described (Crescentini & Mainardi, 2009). Furthermore, according to Creswell (2007:37), "to study the problem, a qualitative research approach is to be used to inquire the natural setting compressing human subjects and places that inform the collection of data". Babbie and Mouton (2010:646), maintain that the objective of qualitative research is defined as "describing and understanding rather than the explanation and prediction of human behaviour".

The qualitative research approach was deemed appropriate for this study, according to Mason (2002:1):

“[it] enables a researcher to explore a wide range of dimensions of the social world that includes the texture and patterns of interconnected elements of everyday life, people’s understanding of their social world, their experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate”.

The researcher explored the phenomenon of life insurance fraud in its natural settings, to make sense of it and provide interpretations in terms of the meanings provided by participants. The outcome of this research study was not the generalisation of study findings, but a deeper understating of the perspectives of the participants selected for this study. In addition, Ritchie and Spencer (1994), revealed that qualitative research is commonly used to bring awareness to social and public issues. Considering the dearth of research relating to life insurance fraud in KwaZulu-Natal, this study sought to bring awareness to society on the severity of life insurance fraud. As this approach enabled the researcher to explore the issue at hand to reach a deeper, more complex, and detailed understanding of life insurance fraud.

This method provides a deeper and richer understanding of social processes that would not be obtainable from methods employed in quantitative research (Punch, 2013). When using the qualitative approach, the researcher seeks to identify the phenomenon from the view of participants (Creswell, 2014). This approach was imminently suitable for this research study as it enabled the researcher to elicit the participants' views and opinions regarding the topic under investigation as it facilitated a setting in which the selected participants could openly and broadly explain and describe their views and experiences. The selected participants were responsible for investigations of the life insurance cases and were also the people who were knowledgeable about the contributing factors of life insurance fraud. While others receive reports of crime incidences and often witness the different scams committed by policyholders and claimants. Eliciting authentic data from these participants was therefore facilitated by the qualitative approach of the study.

4.4.1 Exploratory research

Research methods are categorised according to their unique objectives; for example, a study may be exploratory, descriptive, or explanatory research, depending on whether the principal goal is to explore, describe, or explain a certain phenomenon (Gray, 2013). The researcher used both exploratory and descriptive research approaches since the main goal is the exploration of a phenomenon, (i.e. life insurance fraud) as accurately as possible.

Exploratory research, as the term suggests, aims to address, and explore the research questions and does not provide definitive answers to existing problems. According to Bickman and Rog (2009: 92); and de Vos et al. (2011), “exploratory research is often conducted on newly emerging social issues or recently developed social programs”. Brown (2006) clarifies that exploratory research is conducted when not much is known about a phenomenon. Its theme is to tackle new problems on which little or no previous research has been done thus it explores the research topic with varying levels of depth. Based on the comprehensive literature review conducted by the researcher on life insurance fraud it was found that limited research has been conducted on life insurance fraud research both in South Africa and internationally, consequently not much is known about this phenomenon in South Africa. Thus, the researcher embarked on a study of this nature to fill this gap that was detected in both national and international studies.

In addition, the explorative nature of the current study permitted the researcher to explore, obtain knowledge, and comprehend the views of the selected study participants. The rationale for engaging in an exploratory enquiry was to attempt to identify new knowledge, new insights, new understandings, and new meanings and to explore factors related to the topic from the investigators. This was done by posing exploratory questions to the participants to find answers to the how, what, where, and how questions, among others. The results from this study will not necessarily be generalizable to a larger population but will provide a better understanding of the sample being examined, their experiences and the ordeals they face in investigating life insurance fraud daily. Exploratory studies are utilised to conduct preliminary investigations into relatively unknown areas of research. “They employ an open, flexible, and inductive approach to research as they attempt to look for new insights into phenomena” whereas descriptive studies “aim to describe a specific phenomenon under investigation” (Blanche, Blanche, Durrheim & Painter, 2006:35).

4.4.2 Descriptive research

The goal of descriptive research is to shine a light on current issues or problems through data collection that enables the researcher to describe the situation more completely. In essence, descriptive studies are used to describe various aspects of a phenomenon and its characteristics (Nassaji, 2015). When very little is known about a topic or to explore a research question, a descriptive design is applied. Within the context of this research, the views of life insurance fraud investigators had not been well documented before at the selected organisations (DPCI and Assupol). Thus, the researcher also used descriptive design, which provides an accurate account of the characteristics of a particular phenomenon, event, or group in real-life situations (Nassaji, 2015). Further, Bayens and Roberson (2011:86) state that descriptive research is “the attempt to determine, describe, or identify *what is* rather than to establish *why it is that way* or *how it came to be*”. In essence, in qualitative studies, “descriptions are more likely to refer to a more intensive examination of phenomena and their deeper meanings, thus leading to a more comprehensive description” (Rubin and Babbie, 2005, cited in de Vos et al., 2011:95).

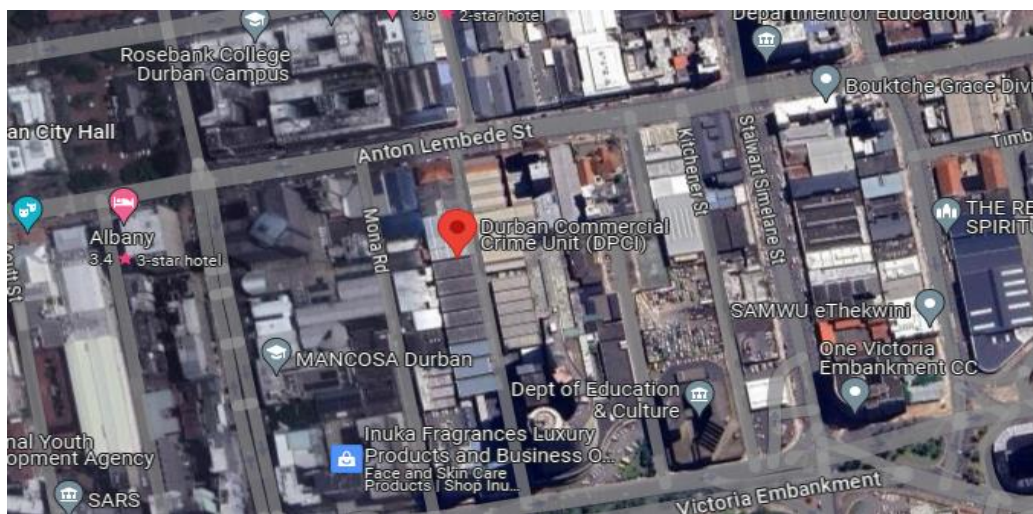
This study included relevant stakeholders who would understand the phenomenon under investigation. Their understandings were probed using pertinent questions that were collected in a comprehensive interview schedule. These questions aimed to discover their viewpoints on the topic under study to provide more detailed information on it. The one-on-one interviews that were conducted thus elicited descriptive rather than quantitative data that are presented in the form of verbatim excerpts that are analysed and discussed in Chapters Five, Six and Seven. Hence, the combination of these research designs provided deep explorative and descriptive information on life insurance fraud in KwaZulu-Natal.

4.5 The Study Site

The study was in Durban, KwaZulu-Natal. Durban (Zulu: eThekwini, from Itheke, meaning bay/the port) is located on the east coast of South Africa in the province of KwaZulu-Natal and the municipality of eThekwini (Cooperative Governance & Traditional Affairs, 2020). According to Pillay (2023), in the KZN province, all major crime categories saw increases, with murder up by 8.3%. Nhlakanipho Ngcobo, chairperson of the Inanda (Local areas in Durban) Community policy forum, stated that the issue of crime is high because there are many people are unemployed and are without an education resulting in them turning to crime (Pillay,

2023). In addition, Independent Online (2023:1), reported that “in 2022, Gauteng experienced the highest percentage of fraud cases at 66%, followed by KwaZulu-Natal at 14% and Western Cape at 7%, making them the three most affected provinces.” In support of the above statement, the Association for Savings, and Investment South Africa (2021), revealed that KwaZulu-Natal accounts for 31% of all fraudulent and dishonest claims when compared to the Eastern Cape, which accounts for 16% and Gauteng with 15%.

Figure 4.1: South African Police Service, Directorate for Priority Crime Investigation



Source: Google Earth (2022 a: n.p.)

Figure 4.2: Location of Durban ASSUPOL insurance company



Source: Google Earth (2022 b: n.p.)

4.6. Gaining access to the research site

Any research involving human participants conducted at the University of KwaZulu-Natal (UKZN) must receive approval from the UKZN Research Ethics Committee before the commencement of the study and the selection of participants. In the following sections, the researcher describes the process of obtaining access to the research site and the criteria used for selecting participants.

Building relationships with gatekeepers, understanding their criteria, and effectively communicating are often important strategies for gaining access or achieving specific objectives within a given context. Organisational gatekeepers are those key individuals in an organization who are both strongly connected to internal audiences, as well as external audiences, and who are capable of translating organizational information across communication boundaries (Tushman & Katz, 1980), “gatekeepers are required to honour the ethical obligations to conduct appropriate stakeholder engagement before and during research, along with respect for the autonomy of institutions and their employees/clients/service recipients” (Singh & Wassenaar, 2016:1). In the context of the research study, gatekeepers are identified as KwaZulu- Natal (KZN) Provincial Commissioner of SAPS and the Forensic Investigations Manager at Assupol.

For the researcher to access the research site, gatekeepers’ permission had to be obtained as required by the University of KwaZulu-Natal Humanities and Social Sciences Research Ethics Committee (HSSREC). Gatekeepers are individuals who have the authority to allow or refuse admission to a particular setting (Hennick, Hutter & Bailey, 2020). Further, Hennick et al. (2020:93) suggest that before commencing the data collection the “researcher will often meet with the gatekeeper to inform them about the study, seek their endorsement, discuss any concerns, and request their assistance with various aspects of the fieldwork”.

The study was authorised by the South African Police Services (SAPS) Division Commissioner: Research (Annexure D) and Assupol (Annexure E), the letters of approval were used to apply for ethical clearance from the UKZN HSSREC (Annexure C). In addition, the researcher had meetings with the SAPS Provincial Commissioner and the manager for forensic investigations from Assupol before conducting the study. During these meetings, the researcher outlined what the research would entail by mentioning the aim and objectives of the study to

indicate the nature of the individuals the researcher desired to interview. Thereafter, the office of the KZN Provincial Commissioner provided the researcher with contact details of SAPS DPCI investigators under the commercial crimes unit who might agree to participate in the study, in addition, the forensics investigations manager from Assupol also provided the researcher with a list of individuals who might be interested to participate in the study. As a gatekeeper, both the KZN Provincial Commissioner and the Forensics Investigations Manager at Assupol played a crucial role in facilitating the researcher's access to appropriate participants for the research. Their support also helped in securing appointments with the participants and ensuring strict compliance with ethical guidelines. An investigator must work collaboratively with the gatekeeper to invite participants into the study (Hennick et al., 2020:93). This was achieved because a gatekeeper was used to elicit the cooperation of participants and to schedule appointments for interviews. This strategy proved beneficial because it also enabled the researcher to build rapport with each key informant facilitated by the assistance of the gatekeeper.

4.7 Study Population

A “population is a group of all individuals, organisations or artefacts that could be involved in a particular study” (Blankenship, 2010:82). Further, Bickman, Rog and Hedrick (2009:77), concur by stating that the study population for a research project can be individuals or other units, such as cities, hospitals, or defined geographical areas such as census tracts, or anything that is investigated as the focus of the research study. It is the specific group that researchers intend to investigate to draw conclusions and make inferences about a particular phenomenon. The contention is that it is important to identify the population first and then select the sample (Ntuli, 2012). The study population is a fundamental aspect of research design and is critical in defining the scope and generalizability of study findings. Hence, for this study, the population consisted of KwaZulu-Natal (KZN) fraud investigators from South African Police Services DPCI (SAPS DPCI) under the commercial crimes unit and forensic investigators from Assupol. The participants above were selected to gain the most accurate responses regarding the research phenomenon at hand. However, it is important to note that the researcher initially proposed that the study population would comprise forensics investigators from (*Old Mutual, Metropolitan Momentum, and Clientele*). Unfortunately, due to unforeseen circumstances, the researcher reached a stumbling block vis-a-vis obtaining gatekeeper letters from the above-

mentioned insurance companies. Therefore, the researcher approached other insurance companies and fortunately was able to secure a gatekeeper’s letter from Assupol.

4.7.1 Sample selection and sample size

Table 4.3: Sample selection and sample size
Study sample

<i>SAPS DPCI investigators (Key informant interviews)</i>	10
<i>Internal forensics investigators (Semi-Structured interviews)</i>	10
<i>Total</i>	20

Source: Researcher’s illustration

“The ideal sample provides a perfect representation of a population with all the relevant features of the population” (Blaickie, 2003:161). The study population (Table 4.3) consisted of members of the SAPS DPCI and Assupol. The study sample that was selected from these groups finally comprised 20 participants in total. Ten (10) South African Police Service DPCI (investigators) from the commercial crimes unit and ten (10) forensic investigators were extracted from Assupol Durban. The total sample included Africans, Indians, and Whites all proficient in either English and/or IsiZulu. In qualitative research, “the goal is to include only those individuals who have extensive knowledge of the phenomenon under investigation in the hope that they may provide useful, thick information that generates new perspectives” (Mbonambi, 2022:112). The sample selected provided rich and thick information that answered the objectives and research questions of this study.

As rightfully purported by Strydom (1998: 195) “There is no rule for sample size in qualitative inquiry. The sample size depends on what needs to be known, the purpose of the inquiry, what is at stake, what is useful, what provides case credibility and what can be done with available time and research”. Further, Hennink and Kaiser (2022) state that saturation is an important indicator that a sample is adequate for the phenomenon studied, reaching saturation has become a critical component of qualitative research that helps make data collection robust and valid (O’Reilly & Parker, 2013:2). The researcher achieved data saturation with the chosen sample

size, indicating that an appropriate sample size had been attained (Hennink & Kaiser, 2022). Given this observation, the researcher believes that even with an expanded sample size, saturation would still have been reached. Thus, opting for a larger sample size was deemed unnecessary, as the selected sample size yielded comprehensive and thick information.

Additionally, Patton and Michel (2002), share the same views as the above author by stating that a qualitative sample size may best be determined by the time allocated, resources available, and study objectives. As mentioned above, the researcher reached a stumbling block vis- a vis obtaining gatekeeper letters from Old Mutual, Metropolitan Momentum and Clientele negatively affecting the sample number from 50 to 20. Nevertheless, despite the obstacles encountered, the researcher successfully acquired a gatekeeper's letter from Assupol. It is crucial to highlight that insurance firms typically have a restricted number of forensic investigators, explaining why the researcher could only sample 10 participants from the entire Assupol Durban office. Regardless of the challenges encountered, the sample selected was able to provide rich and thick information that answered the objectives and research questions of this study and the researcher found that, even with a larger sample, data saturation would have been reached quickly.

To select the actual participants for this study, purposive sampling was used.

4.8 Selection of participants

A qualitative study involves fewer people but acutely examines those individuals, settings and subcultures in anticipation of generating a subjective understanding of a particular phenomenon (Baker & Edward, 2012). Therefore, qualitative research is based on an in-depth understanding of social phenomena rather than on the statistical data imposed by quantitative research. The research aims and objectives of this study required the involvement of a sample of participants who had first-hand experience and knowledge of life insurance fraud. The purpose of sampling in qualitative research is to identify specific groups of individuals who have characteristics or live-in circumstances relevant to the phenomena being researched (Mbewe, 2017). Further, the sample is then examined in detail, and the findings are then applied to understand much larger cases of a similar nature (Neuman, 2011). Sampling varies across every study, the sampling method is determined by the type of research to be conducted, not according to the researcher's preference (Neuman, 2011). Before the researcher determined

the sampling method, the researcher considered the four key factors in sampling, “namely the sample size, the representativeness and parameters of the sample, the access to the sample and the sampling strategy to be used” (Struwig & Stead, 2001 cited in Sibanyoni, 2018:122). While various sampling methods exist, they can be broadly categorized into two groups: probability sampling design and non-probability sampling design. To select the actual participants for this study, purposive sampling methods were used.

“Qualitative research generally is based on non-probability rather than on probability approaches” (Nieuwenhuis, 2013: 79). Hence, the participants were selected using a non-probability purposive sampling technique. Purposive sampling “aims to identify a sample of information-rich participants; meaning that it looks for participants who show characteristics that the researcher is interested in to answer the research questions” (Struwig & Stead, 2013:27). In addition, Huysamen (2001) observe that purposive sampling is a sampling technique that allows a researcher to use cases that have the required information with respect to the objectives of his or her study. Therefore, for this study the subjects were hand-picked because they are informative or they possess the required characteristics. Hence, for this research, participants were hand-picked due to their informative nature. In essence, the researcher chose this technique of sampling because it helped in choosing the most knowledgeable investigators about the topic under study. This selection was thus a process of purposive sampling, allowing the researcher to elicit different points of view from these knowledgeable subjects on the study topic. The interviews with participants took place in a non-intimidating setting.

Furthermore, Creswell (2009:178) advises, that the idea behind qualitative research “is to purposefully select participants or sites (or documents or visual material) that will best help the researcher understand the problem and the research question”. The researcher used purposive sampling to understand the meaning of the phenomena under study (life insurance fraud in KwaZulu-Natal) from the forensic investigators (Assupol) and (SAPS DPCI) investigators from the commercial crimes unit perspective. In contrast to other sampling methods that attempt to create a sample that is statistically representative of a population, purposive sampling enables the researcher to choose people or cases ‘with a purpose’ (Matthews & Ross, 2010). Hence, the researcher selected individuals who are directly involved in the reporting and investigation of life insurance fraud cases. They have first-hand knowledge and experience

in receiving reports of life insurance fraud, investigating fraudulent claims, and understanding the crime in which they work. In essence, the rationale behind the selection of Assupol and SAPS DPCI investigators they allowed the researcher to gain a real-world perspective on the nature of life insurance fraud, specifically in the Durban area and complexities involved in combating life insurance fraud. This first-hand knowledge assisted the researcher to development practical recommendation that are grounded in the realities of the industry.

There are three strategies a researcher can apply for selecting participants when using purposive sampling (Rubin & Rubin, 2005:66), “First, the participants must be knowledgeable about the cultural arena or situation, or experience being studied. The selected Investigators were responsible for the investigation of life insurance fraud and were knowledgeable about the extent of the problem. Secondly, the willingness to talk and lastly, participants must be representative of the range of points of view.” For this research, participants were selected based on their ability to provide rich and relevant information that would be related to the phenomenon under study and their willingness to participate in the study. Purposive sampling was used primarily to select the study participants.

4.8.1 Recruitment strategy

According to the Office of the Human Resource Protection Program (2012), as cited in Mbewe (2017), various recruitment methods or strategies can be undertaken in qualitative research. In this study, one recruitment strategy was employed namely, referrals. Both the Provincial Commissioner and forensic investigator manager knew who in their departments had enough years of experience as a forensic/ fraud investigator and would be able to provide the researcher with rich information on life insurance fraud. At Assupol the manager of forensics provided the researcher with a list of contact details of forensic investigators who had enough years of experience and were willing to participate in the study. In addition, the KwaZulu-Natal–Provincial Office (SAPS) also provided the researcher with a list of contact details for DPCI commercial crimes unit investigators. The researcher then used the inclusion and exclusion criteria to find out if the sampled participants were eligible to be part of the study. Those who were eligible were contacted.

Table 4.3 below presents a diagrammatic representation of the inclusion and exclusion criteria that were followed.

Inclusion criteria	Exclusion criteria
Assupol forensic investigators and SAPS DPCI investigators with 5 years and above work experience	Assupol forensic investigators and SAPS DPCI investigators with less than 5 years of experience
Assupol forensic investigators and SAPS DPCI investigators who is involved in life insurance fraud investigations as part of job responsibility/duties	Assupol forensic investigators and SAPS DPCI investigators who are not involved with life insurance investigations
Willing and able to provide informed consent to participate in the study	Refusal by an individual to participate in the study and unable to provide necessary informed consent
Must be currently working at, Assupol and SAPS DPCI as of the date of initiation of this study	Not working at Assupol and SAPS DPCI during the date of initiation of this study

Source: Researcher’s illustration

The above-outlined criteria aided the researcher in filtering out ineligible participants from the study. Individuals with five or more years of work experience, specifically handling life insurance fraud cases, were recruited. The rationale behind the 5-year experience criterion was to ensure that all participants possessed a substantial level of expertise, enabling them to provide well-informed opinions and presumed greater knowledge of the phenomenon.

4.9 Data Collection Method

Data collection techniques in qualitative research include observations, interviews, documents and audio-visual materials and objects (Creswell, 2007; Leedy & Ormrod, 2005; Patton, 2002). The main methods of gathering data used in the current study were (key informant interviews and in-depth interviews). According to the Centre for Civil Society (2003: 73), an interview “refers to any person-to-person interaction between two or more individuals with a specific purpose in mind.” Interviews are the most employed method to collect information from people. This was confined to the following types of interviewing methods in this study:

4.9.1 Key Informant Interviews (KII)

McMillan and Schumacher (2010:326) explain key informants as follows:

“Researchers search for information-rich key informants, groups, places or events to study; and these samples are chosen because they are likely to be knowledgeable and informative about the phenomena the researcher is investigating.”

Individual face-to-face and in-depth key informant interviews were conducted with ten SAPS DPCI investigators, it is noteworthy that the participants were sampled as key informants due to their wide knowledge and understanding of issues in the study area. An interview schedule with relevant questions was formulated to guide the interview discussions (Annexure A). Before developing the interview guide, the researcher conducted a thorough literature search to identify gaps and give direction to the questions that needed to be asked. In addition, the researcher made prior arrangements with participants who were to be part of the study to determine when they would be available for an interview. The interviews were conducted at locations that were convenient and safe (SAPS DPCI Offices) and they lasted between 30 to 45 minutes each, depending on how much information was provided. However, it is important to highlight that due to COVID-19 regulations 6 of the interviews with forensics investigators were conducted virtually, while 4 were conducted face-to-face. Interviews were recorded on the MS Teams platform for the reference of the researcher to be able to refer to and transcribe the interviews. Data collection took an average of six weeks before saturation had been reached. The researcher is a multilingual African woman who has previous experience in data collection. The questions were asked in English as directed by the interview schedule, but the participants were free to respond in the language in which they felt most comfortable. English and IsiZulu were primarily used.

4.9.2 Semi-structured interviews

Interviews in qualitative research seek to address the research questions. Thus, specific interview questions are compiled in a research schedule and posed to the participants to elicit their responses. The meanings they attach to central themes that are related to their natural settings are then evaluated. Interviews may also be useful as a follow-up to investigate certain participants' responses to the posed questions. According to Burns (2000) and Creswell (2007),

interviewing is as popular as observation in qualitative research. There are three types of qualitative interviews, namely structured interviews, unstructured interviews, and semi-structured interviews (Bogdam & Biklen, 2007). This study adopted a semi-structured interview method through In-depth interviews with the ten Assupol internal forensics investigators to collect relevant and rich data (Annexure B). Semi-structured interviews were deemed suitable for this study because they allowed for a free and open dialogue with the interviewees' Assupol forensic investigators and provided a unique opportunity to acquire in-depth information about their insights on life insurance fraud in KwaZulu-Natal. According to Matthews and Ross (2010), this type of interview can also be used to gather data on a sensitive topic, life insurance fraud is considered a sensitive subject in the insurance industry. Furthermore, this allowed for a great degree of flexibility and enabled probing for more information and clarification of answers to elicit thick data. Gordon (2015:314), indicates that with this method, the researcher usually has a list of questions or specific topics to be covered, often referred to as an 'interview schedule' or an 'interview guide'. Thus, the interviewee has a great deal of leeway in how to reply.

Furthermore, questions may not follow the exact sequence or pattern as outlined in the interview schedule. "Questions that are not included in the guide may be asked as the interviewer may notice that comments by interviewees may require further elucidation" (Gordon, 2015:314). However, it is noteworthy that the interviews were constructed in such a way that less-sensitive questions were asked at the beginning of the interview and more sensitive questions in the middle, once the research participant was comfortable participating in the presence of the researcher. The advantage of a semi-structured interview technique was that it allowed participants the freedom to express their views on their terms and discuss issues beyond the question's limits (May 2001, Struwig & Stead, 2013). This study used this interviewing method in the search for a true understanding of the participants' points of view on the research topic. The researcher had the opportunity to obtain clarification of the participants' responses for a broader understanding of the meanings they attached to their experiences as investigators of life insurance fraud. IDIs open-ended questions were asked because they allowed the interviewee to reply and share information as freely and as extensively as he or she wished (De Vos, et al. 2011:352). These open-ended questions ensured that the selected participants were at ease as they were allowed to express themselves in their own words regarding life insurance fraud in KwaZulu-Natal (Hofstee, 2006:133).

Interviews were held in comfortable venues (an empty office). Before each interview began participants were informed about the purpose of the study, their role in the study and lastly their rights. Participants had to each sign an informed consent indicating their interest in participating in the research. The researcher recorded the useful data thoroughly, accurately, and systematically by taking down notes as the participants were responding. As stated previously, individual interview sessions ranged between 30 - 45 minutes, depending on how much information was given by the participant and ended with each participant being allowed to ask any question he/she might have. The researcher adhered to the interviewing techniques and handy hints suggested by De Vos, et al. (2011:343). The questions were asked clearly and briefly, and one question was asked at a time. The researcher avoided posing leading and sensitive questions and asked the participants to reconstruct their experiences without any interruption on her part. Furthermore, the researcher adhered to the guidelines by Leedy and Ormrod (2014:156-159) for conducting a productive interview by adhering to the following suggestions:

- Ensure that the interview questions pertain to the research questions.
- Make sure that the interviewees are representative of the group (Durban SAPS DPCI investigators and Assupol forensic investigators were interviewed).
- Find a suitable and quiet location to conduct the interviews where the interviewees will be willing to talk and obtain their written consent by explaining to them what the study is about and how the results of the study will be used.
- Establish and maintain a rapport with the participants and do not put words in their mouths during the interview.
- Record the responses of the interviewees verbatim. Accept their answers and keep your reactions to yourself during the interviews.
- Ensure the participants' confidentiality by assigning an individual code or number to each participant

According to Lincoln and Guba, (1985) and Patton (2002), data recording is a process that involves the recording of some information using an interview guide or an interview schedule, which is a list of questions. The researcher may rely on written notes or a tape recorder for recording interview data. In this research, the researcher used a tape recorder to record interview data from the participants. All interviews were recorded using a voice recorder; participants' consent was requested to audio record the interviews. The advantage of using an

electronic recorder is that “it allows the researcher the opportunity to listen to the flow of discussion and the exact vocabulary used by informants” (Activist Guide to Research and Advocacy, 2003:74). The voice recordings of the interviews permitted the researcher to capture all the crucial information that was relevant to this research and be able to listen to these recordings, again and again, to confirm what had been said. Given the sensitive nature of this study, participants were given control over the recorder, for them to pause it if they did not wish to have their views recorded. This was to ensure that participants did not suffer from ongoing stress because of the interview (Matthews & Ross, 2010). After each inter the researcher transcribed the completed interviews to enable data analysis.

4.10 Preparation for the interview

The researcher had met with individual investigators both from SAPS DPCI and Assupol at their respective offices. The purpose of this contact session was to introduce the research topic to them, establish rapport with the life insurance fraud investigators, address any questions, obtain consent for participation and permission to tape record the interviews. The researcher contacted those who were willing to participate in the venue, date and time for the interviews. A writing pad, pen and tape recorder were prepared in advance.

Before each interview, the researcher gave a brief overview of the study topic and objectives. The following procedures were followed:

- a) The study's aim and objectives and the role participants were expected to play were explained to the participants.
- b) The participants were then informed about the voluntary nature of their participation, the need to maintain the confidentiality of their responses, and the fact that the information was needed for research purposes only.
- c) Each participant was given a consent document to read and sign. They were allowed to seek clarification on any points that they did not understand before the interview. The informed consent forms were signed and recollected by the researcher.
- d) The interviews of all participants were conducted in their offices.
- e) The participants were asked in writing whether they wanted to be recorded. They were made aware that they were not being forced to be voice-recorded.

4.11 COVID-19 protocols and safety measures

To maintain the COVID-19 regulations during the collection of data, the researcher ensured that informed consent forms reached the participants through emails beforehand for the participants to sign and scan back to the researcher. In addition, an A4-size plastic bag was used as a holder for the informed consent forms (these were left in the plastic bag for a minimum of three days). During the interviews social distancing was always maintained by not sitting too close and not shaking the hands of the participant, the researcher also ensured sanitising the surfaces (tables, chairs, and voice recorder) before and after each interview and also requested the participants to sanitize their hands. Participants were also encouraged to wear masks throughout the interview, the researcher also ensured that she wore her mask for the duration of each interview and discussion session and brought several masks to change between the interview sessions. For participants who were not available for a face-to-face interview, the use of an audio-visual i.e., Ms Teams was used. As previously stated, 6 of the interviews with Assupol internal forensics investigators were conducted virtually, while 4 were conducted face-to-face. The Ms Team platform adds visual contact between the researcher and the participant.

4.12 Data analysis

Hancock, Ockleford and Windridge (2001: 24), expressed that “data analysis in a research project involves summarising the mass of data collected and presenting the results in a way that communicates the most important features.” For this study, the quantitative data was analysed using thematic data analysis. Thematic analysis is a method that “pays attention to describing both the implicit and explicit data, through a thorough process of identifying, analysing and reporting pattern (themes) within the data” (Braun & Clarke, 2006: 6). Therefore, the collected data was thematically analysed so that a structured, reliable, and valid conclusion could be reached. To analyse data, Braun and Clarke’s (2006) guide to thematic analysis was used, illustrated in Table 4.5

Although the interviews were conducted in English as all the participants were proficient in this language, it is important to state that some participants responded interchangeably in

IsiZulu and English. The data was then translated and noted as per the interview verbatim. Interviews were voice-recorded with the permission of the participants while field notes were also made surreptitiously so as not to disturb the flow of the participants' narratives. After each interview, the voice recordings were listened to very carefully and transcribed into a Word document by the researcher. The responses were transcribed under each participant's name. The table below briefly indicates each step that was followed in the process of data collection with a detailed explanation of each step.

To analyse data, the researcher followed the following steps by Braun and Clarke (2006).

Table 4.5: Steps in thematic analysis, (Braun and Clarke, 2006: 87)

Phase	Description of process
1. Familiarising yourself with your data:	<p>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</p> <p><i>Firstly, the recordings from the interviews were transcribed. Next, the researcher read through the transcribed data several times in conjunction with listening to the interview recordings so that she could make sense of the information provided by the participants and familiarize herself with the data while noting down initial ideas.</i></p>
2. Generating initial codes:	Coding interesting features of the data systematically across the entire data set, collating data relevant to each code.

	<p><i>The researcher then coded interesting features of the data systematically across the entire data set, collating data relevant to each code.</i></p> <p><i>The researcher then coded the transcribed data by systematically writing interesting codes across the entire data set, collating data relevant to each code, and taking note of key points that were emerging from the data.</i></p>
3. Searching for themes	<p>Collating codes into potential themes, gathering all data relevant to each potential theme.</p> <p><i>The researcher collated codes and developed potential themes according to their relevance to the research interest.</i></p>
4. Reviewing themes	<p>Checking if the themes work about the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.</p> <p><i>The themes developed themes were then reviewed to see if they were relevant and the entire data set, thus generating a thematic ‘map’ of the data.</i></p>
5. Defining and naming themes	<p>On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</p> <p><i>The researcher looked at each theme, cleaning it up and refining it to develop clear definitions and appropriate names for each theme.</i></p>
6. Producing the report	<p>The final opportunity for analysis. Selection of vivid, compelling extract examples, the final analysis of selected extracts, relating back</p>

of the analysis of the research question and literature, producing a scholarly report of the analysis.

The final step included reviewing the data to extract key examples that could be used in the final report. This data was then presented, explained, and analysed concerning the research questions and literature.

Source: Braun and Clarke (2006: 87)

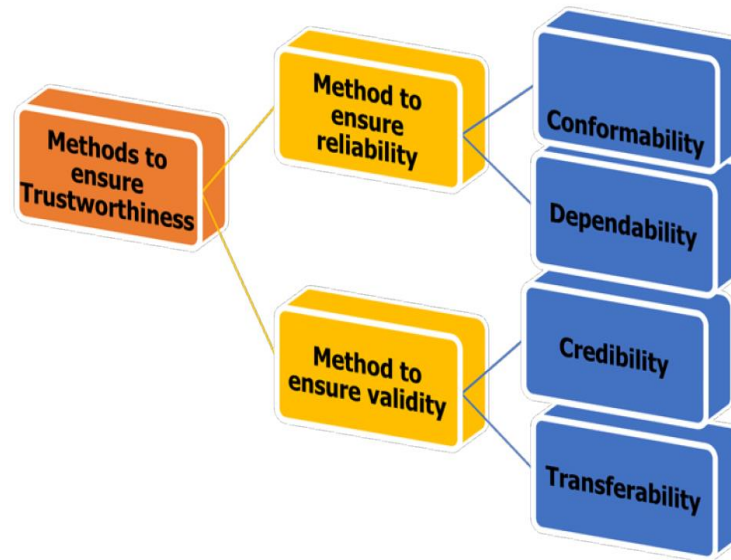
4.13 Rigour in Qualitative Research: Ensuring Trustworthiness

The study utilised semi-structured interviews and key informant interviews with 20 knowledgeable and experienced life insurance fraud investigators as the key data collection methodologies. Raw data were recorded on tape and later transcribed.

The main difference between quantitative and qualitative research is the importance given to the concepts of validity and reliability (Kumar, 2011). Further, (Neuman, 2014) mentions that it is imperative to know whether a study is ‘truthful’, and meaningful and how well an idea ‘fits’ with reality. According to Guba and Lincoln (2005), trustworthiness in a qualitative study is determined by four indicators: credibility, transferability, dependability, and confirmability. Mthiyane (2013:125) suggests that “for qualitative research to be credible (in preference to internal validity) and transferable (in preference to external validity or generalisability), it should be dependable (in preference to reliability)”. If these four indicators are present, they reflect validity and reliability in a qualitative study. Trustworthiness seeks to address issues of accuracy when analysing data to assess the identified proposition taken by the researcher. To fulfil this, the researcher took steps to ensure that the methods of data collection adhered to trustworthiness standards. This was achieved by avoiding dependence on personal assumptions and instead relying on the responses provided by the participants. Further, the researcher maintained extensive records of interviews and thoroughly documented the data that were analysed. During the interviews, the researcher listened intently to the selected participants to ensure the study's reliability and validity. To address the possibility of overlooked details during the transcription process, the researcher revisited the recordings and cross-checked the transcribed information.

The trustworthiness of qualitative research requires assessment through its credibility, transferability, dependability, and confirmability (Babbie and Mouton, 2001; Fossey, Harvey, McDermott and Davidson, 2002), which are the four indicators that were addressed to reflect validity and reliability in the current study.

Figure 4.3: Methods to ensure trustworthiness.



Source: Sibanyoni (2018)

4.13.1 Credibility (as opposed to internal validity)

Credibility is defined as the confidence that can be placed in the truth of the research findings (Macnee & McCabe, 2008). Credibility establishes whether the research findings represent plausible information drawn from the participants’ original data and is a correct interpretation of the participants’ original views (Graneheim & Lundman, 2004). Similarly, Streubert-Speziale and Carpenter (2003:38), stated that “credibility is demonstrated when participants recognise the reported research findings as their own experiences”. According to Lincoln and Guba (1999), credibility can be attained by the following: prolonged engagement in the field, persistent observation, triangulation, peer debriefing, negative case analysis, and member checking. For this study, the researcher interpreted the data received from the participants in a theoretically sound manner. Two theories (discussed in the previous chapter) articulate realities concerning life insurance fraud. The researcher further used two sources of data collection (individual interviews, and document analysis) and even spent long periods with the selected

participants in the natural setting to understand their insights on the subject under investigation. This helped in getting a better understanding of the participants' understandings regarding life insurance fraud.

The following principles of credibility were adhered to, as suggested by Dlamini (2018:101):

- a) All participants were taken through the same main question.
- b) Frequent debriefing sessions involving the researcher and the study supervisor were held. Through our discussions, the researcher's vision widened as the supervisor brought to bear her experiences and perceptions. These collaborative sessions were also used to discuss alternative approaches draw attention to flaws in the study and correct or circumnavigate them.
- c) The researcher interviewed the participants to the point at which there was data saturation (prolonged engagement). No new information was raised.
- d) The interviews were tape-recorded and transcriptions were made of each interview (referral adequacy).
- e) The researcher utilised purposive sampling methods in the selection of participants for this study.
- f) Tactics to help ensure honesty by the informants when contributing data were developed. Each person who was approached was allowed to refuse to participate in the project to ensure that the data collection sessions involved only those who were genuinely willing to take part. They were prepared to offer data freely. The participants were encouraged to be frank from the outset while the researcher established good rapport in the early stages of each session with the participants.
- g) Scrutiny of the research project was encouraged as opportunities for scrutiny of the project by colleagues, peers, and academics were created. Feedback was offered to me at presentations (such as colloquiums, symposia, and conferences) throughout the study period. The different perspectives that these individuals brought often challenged the researcher's assumptions as her closeness to the project frequently inhibited my ability to view it with real detachment.
- h) The researcher went back to some of the participants to ascertain whether the transcribed data was a truthful version of their insight.

4.13.2 Transferability (as opposed to external validity and generalisability)

Transferability is concerned with the extent to which the findings of one study can be applied in other contexts or groups of people. Transferability refers to the degree to which the results

of qualitative research can be transferred to other contexts or settings with other respondents – it is the interpretive equivalent of generalizability (Bitsch, 2005). Guba and Lincoln (2005), argue that, in qualitative research, transferability may be established by thick descriptions and purposive sampling. Transferability was addressed through a thick description of the participants' experiences, regarding their interpretations and feelings of the phenomenon, and was discussed sufficiently to allow comparison of applicability or transferability of the data to another context. The findings of this research can be applied to a similar situation, as the researcher used a purposive sampling method to maximise the range of specific information that could be obtained from the participants about the phenomenon. The researcher is of the view that the research findings of this study can be applied to a similar context, as the data that was obtained from the participants constituted their expert views as they were all trained and qualified investigators who had considerable knowledge and experience about true scope life insurance fraud in KwaZulu-Natal. Future researchers may thus confidently evaluate whether the study findings make sense and are transferable to other settings that face a similar problem.

4.13.3 Dependability (as opposed to reliability)

According to Holloway (2005:143), dependability is related to the consistency of findings. This means that if the study were repeated in a similar context with the same participants, the findings would be consistent. Dependability involves participants' evaluation of the findings, interpretation, and recommendations of the study such that all are supported by the data as received from informants of the study (Cohen, Manion & Morrison, 2011; Tobin & Begley, 2004). Dependability is established using the following strategies: an audit trail, code-recode strategy, stepwise replication, and peer examination (Chilisa & Preece, 2005). The researcher ensured the dependability of the study by providing an audit trail to show how the data was gathered and sufficiently describe the methodology that was used, which will allow future researchers to repeat work in the same context even if they do not necessarily arrive at the same conclusions.

Furthermore, the researcher properly transcribed the responses of the research participants who were interviewed and made sure not to manipulate the data to fit a certain viewpoint. The way In-depth interviews were conducted and recorded thus ensured dependability. The participants were not influenced by the researcher in any way during interviews and their responses were

not altered. For that reason, the researcher is confident that similar results will be obtained if the study is repeated by a different researcher.

4.13.4 Conformability (as opposed to objectivity)

According to Streubert Speziale and Carpenter (2003:38), the purpose of “confirmability is to illustrate that the evidence and thought processes give another researcher the same conclusions as in the research context”.

Tobin and Begley (2004:392) share the same sentiment with the above authors by stating that confirmability is “concerned with establishing that data and interpretations of the findings are not figments of the inquirer’s imagination but are derived from the data”. The role of triangulation in promoting confirmability is essential, as this reduces the effect of investigator bias. To address this requirement, the detailed explanations of how the data were collected and analysed contribute to the confirmability of the study as this information will enable other researchers to scrutinise the research design and methodology that the researcher employed and to determine if the same data collection methods will yield similar conclusions.

In addition, the researcher adhered to the principles of confirmability in this thesis as suggested by Miles and Huberman (1994) in the following manner:

- a) The researcher acknowledged the beliefs underpinning decisions made and methods adopted.
- b) The researcher explained the reasons for favouring one approach over the other and acknowledged the weaknesses in the techniques that were employed.
- c) In terms of the results, preliminary theories that ultimately were not borne out by the data were discussed and discarded. Much of the content about this was derived from an ongoing ‘reflective commentary’.
- d) A detailed methodological description was presented. This will enable the reader to determine if the data and constructs emerging from it may be accepted. Critical to this process is the ‘audit trail’ which allows any observer to trace the course of the research step-by-step by scrutinising the decisions made and procedures described. The researcher selected a data-oriented approach and showed how the data eventually led to the formation of recommendations that were offered because of the processes followed during the study.

4.14 Ethical considerations

Research ethics is referred to as “a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and sociological obligations to the study participants” (Polit & Beck, 2004:717). Ethics are essential in research methodology as they take into consideration the principles of conduct that are known to be correct (Kumar, 2011). Similarly, Strydom (1998) proposes that participants can be harmed in a manner that is not obvious to both the researcher and the participant, yet this can have far-reaching consequences. Hence when dealing with human beings as the objects of study, the researcher must ensure that participants are completely protected against any form of harm. The nature of this study required that the participants be willing to be involved in this research and be open to engaging in conversations about life insurance fraud, types of life insurance fraud committed by policyholders, as well as the contributing factors of life insurance fraud in KwaZulu- Natal. Participants were informed that the study would not contain any derogatory statements about other people and would not involve any object that could harm them, either physically or emotionally. The participants were also under no obligation to participate in this study and, if they did, they were assured that their identities would be kept hidden and that they would be allowed to withdraw at any time.

4.14.1 The University of KwaZulu-Natal Policy on Research Ethics

In this study, ethical consideration was important; ethical clearance was obtained from the University of KwaZulu-Natal’s Humanities and Social Science Research Ethics Committee. The researcher adhered to all the UKZN Policy on Research Ethics requirements. Before submission and approval of the ethical clearance, the researcher was required to present her research proposal before the colloquium of lecturers and colleagues within the discipline of criminology and forensics studies. Thereafter, the researcher refined the research proposal and submitted it for ethical consideration.

4.14.2 Gatekeeper permission

Gatekeepers play a crucial role as mediators in gaining entry to study environments and participants in social research. These individuals, often affiliated with organizations, possess the authority to permit or deny access to individuals or situations during research conducted within those organisations (Andoh-Arthur, 2019).

Essentially, gatekeeper permission refers to access to an institution/organisation. This access can either be physical or informational. Every institution has the right to be informed and to decide whether to permit or deny a researcher the opportunity to conduct research within their jurisdiction. Gatekeepers are solely responsible for granting access permission and do not give consent for the study. Consent is exclusively sought from individual participants, such as caregivers, officials, and guardians. The gatekeeper permission letter should ideally be formally documented and include an official stamp or letterhead from the respective school, company, or clinic. The researcher applied to the South African Police Services Directorate for Priority Crime Investigation and permission was granted in writing. In addition, the researcher also applied at Assupol and the approval was granted.

4.14.3 Informed consent

The consent forms are comprehensive, stating the nature, process, and purpose of the research, what the data collected will be used for and what was expected from the participants. The form also clearly stated that participants were not compelled to be part of the research. If they chose to be part of the study and changed their mind at a later stage during the interview, they were permitted to drop out of the study during the interview without any negative consequences. They were also not compelled to answer any questions that they thought were sensitive or questions that may have caused them sadness. Participants were provided with the necessary information relating to their participation in the research process. “This information included their level of confidentiality, how much of their time was to be used for research purposes, what they could expect from the research, data storage and how the results were to be used” (Kumar, 1999) as cited in (Sakarombe, 2014:83).

Every participant who was involved in this research was also required to sign a consent form which stipulated what the research entailed; the purpose of the study, what it required of the participant, as well as a section stipulating that the participant should in no way feel obliged to answer questions, they were not comfortable with answering was explained before each one–one interview. The consent form also explained that participants can, at any point decide to stop with their involvement in the research and this will in no way have disadvantages. A similar consent form was administered before the interview sessions began, further seeking permission from the participants to be recorded.

4.14.4 Right to self- determination

The right to self – self-self-determination is based on the ethical principle of respect for a person (Burns & Grove, 2001). In essence, this means that participants must be given adequate information about the research study; they must be capable of understanding the information; and they must have the power of free choice, enabling them to voluntarily participate in research or decline participation.

The researcher explained the study to the participants, allowed them to ask questions and their informed consent was obtained. Participants were informed of their rights to withdraw from the study at any time. The researcher discussed and clarified with participants their understanding of the investigation. Furthermore, they were briefed on the objectives and purpose of the study during the pre-interview meeting.

4.14.5 Confidentiality and Anonymity

Confidentiality is “the researcher’s management of private information shared by the participants, which must not be shared with others without the authorisation of the participants” (Burns & Grove, 2001:201). Thus, to protect the confidentiality of participants, each participant was assigned a pseudonym so that their names would not be linked to any of their data. The researcher made it clear that the participants' personal information (names) would not be used for any other purpose, nor would the information be shared that reveals their identity in any way. Given the sensitive nature of this study, the researcher did not share any study-related information with any person other than the study supervisor and participant. To conceal the identity of the participants the researcher assigned pseudonyms. Participants are identified through an alphanumeric method comprising alphabets and a number, an example of this notion is as follows: (FrI1) and (FI:1). The alphabets (FrI) refer to fraud investigator (SAPS DPCI) and (FI) refers to a forensic investigator, the digit (1) is the sequence in which the cited interview was conducted. In addition, although anonymity cannot be completely guaranteed in qualitative research (Strebert & Carpenter, 1999:38), an attempt has been made by the researcher to ensure that there is no unauthorised access to the data. Data is kept safe by locking it in the cupboards inside the supervisor's office. In accordance, with the Protection of Personal Information (POPI) Act, the researcher is ensured to safeguarding the privacy and confidentiality of participants' personal information. To achieve this, all data was securely

stored in the supervisor's office to prevent any unauthorized access or disclosure. This measure ensured that sensitive information remained protected.

4.14.6 Protection from harm and risk

Participants involved in this study had the right to be protected from harm and discomfort (Botma, Greef, Malaudzi & Wright, 2010). The researcher guaranteed that no participants would suffer any harm as a result of their participation in the study, which was completely voluntary. The researcher collected data in a way that did not endanger the participants' lives emotionally, mentally, and physically. Hence, the researcher ensured that there was no harm to the participants in the research and that participation was voluntary. The researcher respected the dignity of all the participants.

4.14.7 Deception

To avoid deception, the researcher did not make up information or give participants information that was false and relevant important information was not omitted to mislead the participants. Furthermore, the researcher informed the participants of the study aims and the interview processes.

4.14.8 Voluntary Participation

It was made clear to the participants that the research was only for academic purposes their participation was voluntary and they were permitted to drop out of the study at any stage. They were further informed that, if the questions are too sensitive, they may choose not to respond to them.

4.15 Delimitations of the study

In qualitative data extraction, i.e. in-depth interviews, participants can lie or fabricate the information given

to the researcher, thus minimising the study's quality of data to be obtained in this study. To overcome this limitation, before data collection, participants were ensured confidentiality and autonomy of participation and were encouraged to answer the questions as honestly as possible. In addition, the researcher used ASSUPOL only and did not use other insurance companies, this fact delimited the study in the sense that a larger representation of the insurance companies may have contributed to the elicitation of more in-depth data. The study focused on the

investigators of life insurance fraud but did not sample the actual perpetrators of the crime that are involved in committing life insurance fraud. The study is only focusing on KwaZulu-Natal and does not involve other provinces, therefore limiting the diversity of information which could be obtained.

4.16 Challenges and Limitations

- a) There is a dearth of literature on the research topic in the South African context and, as a result, it was challenging to compile a comprehensive literature review with adequate information on the South African situation.
- b) One of the major challenges the researcher faced was that, initially she had proposed that the study population would comprise internal forensics investigators from (*Old Mutual, Metropolitan Momentum, and Clientele*). However, due to unforeseen circumstances, the researcher reached a stumbling block vis-a-vis obtaining gatekeeper letters from the above-mentioned insurance companies. Numerous e-mails were sent, and phone calls were made to different insurance companies to invite them to participate in this study, but these efforts were in vain. Thus, to counter the problem, I was persistent and continued to search for willing insurance companies and the researcher was finally granted a gatekeeper's letter by ASSUPOL.
- c) The researcher had proposed to sample 50 participants, however, due to the difficulty of securing gatekeeper letters the current study sampled 20 participants but they provided useful information.
- d) The researcher received the gatekeeper letter from the South African Police Services Directorate for Priority Crime Investigation (SAPS DPCI), however, the South African Police Services National office did not communicate with the provincial head office in Durban timeously, and therefore the provincial office refused for the researcher to conduct her data collection until communication was received. This delayed the researcher as she had to wait another additional 4 weeks or months for the communication to be received by the provincial office.
- e) At SAPS DPCI during the time the researcher had planned to schedule interviews most of the officials were on leave and therefore had to wait.
- f) On the due date of data collection, one of the scheduled participants from SAPS DPCI had an emergency and was not able to do the interview. Therefore, the researcher had to reschedule for another date.

- g) The researcher was not aware that two of the investigators from SAPS DPCI were stationed at Pietermaritzburg, therefore resulting in the researcher travelling from Durban to Pietermaritzburg to conduct interviews.
- h) From data collection the researcher contracted serious flu and only fully recovered after a week. During this time, she had to pause data collection.
- i) Some of the SAPS DPCI officials rescheduled meetings last minute.
- j) At times, technology did not cooperate, which caused severe delays and ample frustration. Due to the current state of load shedding, some of the virtual interviews were disturbed as this affected the network connections.
- k) It was clear from the problems that I encountered during the data collection phase that insurance fraud, particularly life insurance fraud, is difficult to research because of the sensitive nature of the crime. The study did not focus on the life insurance perpetrators, but I found that the insurance industry is a field that is not extensively researched, thus the industry is still hesitant to open its doors to researchers.

4.17 Chapter Summary

In conclusion, this chapter presented the methodology used in the study. The chapter described the research design that was used and the reasons for preferring such an approach. It also described the sampling procedure, the data collection methods used, ethical considerations, and limitations were discussed. Despite the limitation of the small sample size and the fact that that results may not be generalised to the South African context at large and internationally, it is argued that the study holds value as a means for further research into life insurance fraud as the findings can be transferred to other settings where similar research problems are prevalent. The subsequent chapter presents the data and deals with the analyses of the data.

CHAPTER FIVE: PRESENTATION AND DISCUSSION OF FINDINGS

5.1 Introduction

This chapter presents the primary findings that emerged from data collected from (Assupol forensic investigator and South African Police Services Directorate for Priority Crime Investigation investigators (SAPS DPCI)) in KwaZulu-Natal. Their experiences, views, and opinions on the life insurance fraud in KwaZulu-Natal were elicited. To effectively address the key questions and objectives of this study, semi-structured interviews and key informants were conducted. The data was analysed to determine the modus operandi and motivations of life insurance fraud from the perspectives and knowledge of a range of participants and to arrive at an understanding of how this may best be curbed using participant involvement. Apart from information gleaned from relevant literature, the theoretical framework that guided the study was also employed to interpret the data and findings.

The selected study area in South Africa is prone to life insurance fraud and this was the case at the time the study was designed and conducted. Based on the available literature, it was evident that the insurance industry experienced the plight of life insurance fraud. As a result, this study explored the experiences and opinions of life insurance fraud investigators who are relevant in the study area regarding where most cases of life insurance fraud occurred. Given the high rate of life insurance fraud in KwaZulu-Natal, it was envisaged that a study of this nature would elicit insightful knowledge that could assist the insurance industry, the South African police services, and the insurance crime bureau to curb this scourge by employing and/or devising new prevention strategies.

The sample comprised 10 forensic investigators (Assupol) and 10 (SAPS DPCI) investigators, the participants sampled were all involved in life insurance fraud investigations. The questions were posed in English, but the participants were free to respond in the language with which they were most comfortable. English and IsiZulu were the two languages used. The discussions were guided by questions from a pre-planned interview schedule. Each theme commences with an introduction, followed by an explanation of the theme or sub-theme, in addition, the researcher then links any similar comments and highlights any dissimilarities about a specific theme followed by the verbatim narratives of the participants and lastly, a discussion that incorporates the literature and theory is provided. As mentioned in Chapter One, this thesis comprises three presentations and a discussion of findings chapters. Thus, this is chapter one

of the three chapters of presentation and discussion of findings. Furthermore, it is noteworthy, that in this chapter the researcher uses perpetrator and fraudster interchangeably.

In this chapter, the researcher aims to present findings that will address the following research objectives:

5.2.1 To determine the Modus Operandi used by policyholders (Beneficiaries) to commit life insurance fraud in Durban, KwaZulu-Natal.

To conceal the identity of the participants the researcher assigned pseudonyms. Participants are identified through an alphanumeric method comprising alphabets and a number, this is in keeping with the policy of anonymity discussed in the previous chapter. An example of this notion is as follows: (FrI1) and (FI:1). The sequence (FrI) refers to a fraud investigator (SAPS DPCI) and (FI) refers to a forensic investigator, the digit (1) is the sequence in which the cited interview was conducted, digit (1) is the sequence in which the cited interview was conducted. Questions (presented in italics and inverted commas in this section) were posed during the semi-structured and key informant interviews previously stated. The researcher took notes, and a voice recorder was used during the interview sessions. The participants' responses were transcribed in English and are reported verbatim here in the interest of authenticity. The researcher did not alter any participants' responses. Any language inaccuracies therefore remained unedited.

5.1.1 Themes and subthemes

To make sense of the obtained data, the researcher used an iterative process of reflecting, documenting, and tracking thoughts was used to analyse the data. Data analysis, according to the researcher, meant transforming data into discoveries by providing order, structure, and significance to the mass of collected data. As a result, patterns of expressions with similar or divergent themes were detected, and overarching themes that appeared important to the study objectives were highlighted and integrated. Subthemes were also established. Themes and subthemes that arose throughout data collection are presented below:

Table 5.1: Themes and subthemes that emerged during data analysis.

THEME 1	
Modus operandi of committing life insurance fraud	
Sub-theme: 1	Fake death

Sub-theme: 2	Murder for money
Sub-theme: 3	Identity theft
Sub-theme: 4	Unidentified dead body (rent and hire)
Sub-theme: 5	Dead in the rural
Sub-theme: 6	Ghost claims
THEME 2	
Motivations for committing life insurance fraud	
Sub-theme: 1	Greed, quick cash and lavish lifestyle.
Sub-theme: 2	Unemployment
Sub-theme: 3	Loopholes (Poor internal control of the company).
THEME 3	
Strategies used to detect and prevent life insurance fraud and their effectiveness	
Sub-theme:1	Reactive not proactive
Sub-theme: 2	Fraud awareness and training
Sub-theme: 3	Red flagging
Sub-theme: 4	Whistleblowing
Sub-theme: 5	The effectiveness of Assupol strategies to curb life insurance fraud
Sub-theme :6	Challenges

5.2 Understanding of life insurance cover.

The following question was posed: “*What is your understanding of a life insurance cover? [Elaborate on your answer]*”.

This theme refers to the information that there is an incomprehension between life and funeral cover. Learning how investigators comprehend life insurance is essential because, without a clear understanding of what constitutes a life insurance cover, it is difficult to expect SAPS DPCI investigators and forensic investigators to successfully detect and prevent life insurance fraud. Therefore, it was important to unearth the understating of a “life insurance cover” from the perspective of commercial crimes and forensic investigators. To ascertain if the participants understood term life insurance cover.

5.2.1 SAPS DPCI investigators

The data revealed a common understating of life insurance policy. Although participants had their own interpretations of the term, the study found that the SAPS DPCI investigators generally possessed a basic understanding of the concept of life insurance. The findings of this study showed that the participants explained an element of the policy which is the death benefit rather than providing a comprehensive understanding of what life insurance policy typically entails. This is evident in the following excerpts, which reflect verbatim expressions by SAPS DPCI investigators as they disclosed their understanding of the meaning of life insurance policy:

The participant mentioned that a life insurance policy can be obtained to cover the life of another person, to ensure that the beneficiary is financially protected in the event of the death of the insured person. However, an insurable interest needs to be proven that it exists.

“This is how it works you can take a policy for yourself, spouse or relative for the purpose that when the insured dies, he/she can leave something behind for the beneficiary to able to have a comfortable living” (FrI:3).

The participant's response slightly differs from participant (FrI:3), as the participant stated that a life insurance policy is used to protect the asset of the insured, if he/she passes the beneficiary of the policy will be able to continue to pay for the asset, ensuring that even in his or her absent the beneficiary (family) can continue to live comfortably. Additionally, the participant highlighted that the positive intent of life insurance which is now being negatively exploited.

“Life insurance is meant to protect the assets of the deceased. Should it happen that I die you know, I am still paying a bond for my house, I have 3/4 little kids who are still going to school. Life needs to continue even when I am gone. So, I have this 2 million life cover or life insurance so that after my death things must not go bad for my family so they must still have shelter and the kids must still be able to go to school, you, see? It is meant for that purpose, solely for that purpose but now the fraudsters have identified that as an opportunity for them to scam and defraud these insurance companies and to cause the loss of life at the same time. It is meant for a good thing but now they are using it negatively” (FrI:1).

The participant expressed that a life insurance cover financially protects the family in the event of death.

“Life insurance cover financially protects one’s own family when the person dies” (FrI:5).

This participant referred to a life insurance cover as a means to insure a person (relative / spouse) for the benefit from a policy payout upon the death of the insured individual. This highlights that the intentions of individuals to purchase life insurance for other people may not be in good faith, as some purchase covers solely for financial gain, while others may do so to ensure the financial security of their family—particularly if the policyholder is the sole breadwinner.

“People are covered by family or spouse to benefit from a policy payout when a person dies” (FrI:4).

The study found that the participants understood that a life insurance cover is different to a funeral cover. Participants expressed that life insurance cover is a policy taken by an individual to ensure that, in the event of their death, their family can continue to live comfortably in their absence. It is noteworthy that the SAPS DPCI investigators only delved into one aspect of life insurance cover, which is the life cover.

In contrast to SAPS DPCI investigators, Assupol investigators demonstrated a more comprehensive understanding of life insurance cover. This is evident in the verbatim expressions provided by the participants:

5.2.2. Forensic investigators

The responses of the SAPS DPCI and forensic investigators differed slightly in the way in which they explained. The study found that life insurance as an umbrella term encompassing various segments, such as disability, funeral, and life cover. However, the study focused on fraud under the death cover of life insurance. The following narrative reflects what most participants had to say:

The participant refers to life insurance as a long-term policy.

“Life insurance in simple terms is a type of long-term policy that will ensure that at the time of death, your loved one or people that depend on you will continuously... their living style won’t change because of you as the person that depends on you who passed away. Remember that they depended on you and if you passed away, their source of income won’t be the same. So, to take life insurance it’s to balance in terms of the source of income which means depending on the type of insurance that you take it will help the people who are dependent on

you. In which in insurance or law description will be described as insurable interest people who have interest in you. For example, it can be your mother, father, or spouse; so that person when she/ he passes away will continue to live your normal life as if that person is still alive supporting you. Depending on the type of insurance that he takes it might be a funeral or a life policy that you sustain you until perhaps you better your life” (FI:1).

The participant articulated that life insurance is a means to secure oneself and one's family financially, emphasising that it cannot be purchased on someone else's life. However, the researcher holds the perspective that life insurance can be obtained on the lives of other individuals, provided that insurable interest can be substantiated

“Life insurance cover is when someone is insured, and someone benefits from the death of an individual or someone says my family will claim after my death. Nobody can take life insurance cover on anyone’s behalf, the only thing a person can do for them is to take a funeral cover. Now that allows you to cover your family members” (FI:2).

Contrary to the above participant (FI:2), the participant alluded that life insurance has a dual meaning in the sense that it involves a person covering their own life and simultaneously covering the life of another. Additionally, life insurance may be taken to cover significant assets, such as a house, with the aim of repaying debts in the event of the policyholder's death. The participant stated that the primary purpose of life cover, in this context, is to address financial obligations and needs, which can vary based on individual circumstances

“Ummh, so ok. Life insurance is when a client has an intention to cover their life, so it could be for many reasons to make sure that the beneficiaries are taken care of in the event of a death. Or maybe if you are taking up a house as coverage if you die the life cover will be able to repay your debt so that is mainly the reason for a life cover. When an individual wish to cover their life so that they meet their needs which vary. This cover is usually taken to ensure that when a person they family is still financially protected, taken ensure that the family continues to live comfortably and not suffer even when the spouse is no longer around. Also, just to add, the term “insurance “has a double meaning in the sense that they are a person that will cover their own life and also cover the life of another. As you might know, a funeral cover is a type of insurance whereby you will cover your mother or father so that in the event they die you will be able to cover the cost of the funeral” (FI:3).

The participant stated that life insurance is designed to ensure that in the unfortunate event of the life assured's death, those left behind can maintain the same standard of living they enjoyed

while the life assured was alive. This is particularly crucial when the life assured is the sole breadwinner in the household, as life insurance aims to provide financial support for the dependents after the assured individual has passed away.

“Ummh look my understanding of life insurance, is that the life insurance was created to assist the ummh the life insurance in terms of the loved ones where the deceased will pass away, and they will be able to look after the loved ones when they went. The funeral is to assist you immediately after death, with that one it is not a ... to enrich you, it's such to make sure that the family does not get the burden of burying you there is little money with that. Where in terms of the life cover itself where now the life insurance is insured for the life, it's actually to make sure that as deceased those who are left behind are still able to maintain the same life standard that they were able to live while the life assured was still alive in terms of where the life assured is the only breadwinner in the house so it's to look for after those. So, it's the risk between the insurance companies and the life-assured people to say in the term where we are going to exchange premiums for your life as if you die, we will pay your loved ones this much money so that they are still able to maintain the lifestyle and are still able to go to school and all that. ...yes, insurance was meant for that” (FI:6).

The participant referred to life insurance as a broad spectrum that allows a person to set aside funds for the long term, for the benefit of retirement, disability and life cover.

“Ok, life insurance is broken up into several divisions. You can have just the life policy, ummh you can have a life policy with a retirement cover attached to it, you can have a life policy with a disability, with income protection. ummah so it's a broad spectrum that let put money away for long term” (FI:4).

Life insurance includes products covering other adversity, which goes beyond protecting against the risk of death.

“Ok, so you see life insurance is broken into. Ngingathini (what can I say) it's got a different aspect to it. So sometimes we use a border terminology Kathy (that) its life insurance. So, Life insurance has got different segments, you have got your disability cover, so if somebody for example uyasebenza (is working) and if his unable to fulfil his responsibilities, is disabled maybe he was involved in a car accident or whatever that might cause him to be unable his day-to-day duties so that is classified under disability. Then you have your traditional life cover where you take a policy should anything happen to you and then somebody will benefit. For example, your family members. So as a policyholder, you are the applicant. Meaning that you

are the initiator of that policy and then you get funeral policies. Now a funeral policy is where you can insure other individuals, with or without their knowledge. To be able to receive a payout that will cover the funeral should the person die. Life insurance is an umbrella; under this umbrella, you get different segments.” (FI:7).

The study began by unpacking the understanding of life Insurance coverage from the perspectives of fraud and forensics investigators from SAPS DPCI and Assupol. It was important for this to ascertain if the investigators understood the concept of a life insurance cover. According to (Autogen, 2022; Hollard, 2022:1), life insurance cover is a “long-term contract that offers a wider range of protective cover for beneficiaries and insured policyholders in the event of life-changing circumstances, such as a sudden loss of income, the development of a severe disease or disability, or loss of life”. In expressing their understanding of a life insurance cover, participants were clear that a life insurance cover is taken by a policyholder to ensure that in the event of death, their family (beneficiary) is financially protected and is still able to live a comfortable life without them. They went further to indicate that a life insurance cover is divided into three statements, namely, life, funeral and disability. From the above-mentioned explanation, the participants understood what constitutes a life insurance cover. Contrary to Autogen (2022); and Kagura (2017) the participants demonstrated knowledge of a life insurance cover. The study found that the participants understood and were able to differentiate between a life insurance cover was different to a funeral cover as products that are used to support a family after death. However, the study found that forensic investigators possessed a clearer and more in-depth understating of a life insurance cover.

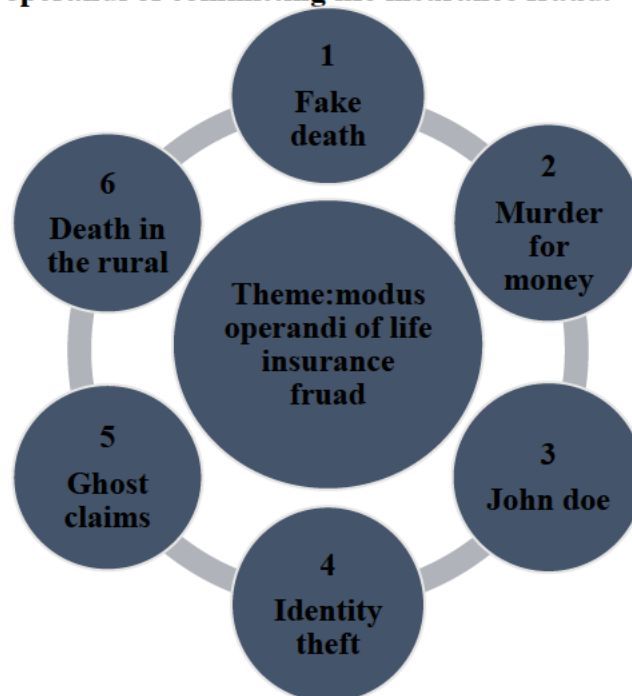
A life insurance cover “ensures that the policyholder and their family are financially protected in the event of a death, disability, severe illness or loss of income, as it guarantees to pay a stated sum to a family on the death of its income earner” (Autogen, 2022:1). This finding demonstrated that forensic and fraud investigators understood that the main aim of a life insurance cover is to provide necessary financial support to families against unexpected financial encounters that result from death. A large proposition of investigators expressed different concerns about the occurrence of life insurance fraud. It is encouraging, therefore, to note that participants comprehend the severity of life insurance fraud, especially for the victims. In exploring the *Modus operandi* (MO) used by perpetrators to commit life insurance fraud, the study found that participants were aware of the different MO used by perpetrators. These included faking death, murder for money, John Doe, identity theft Ghost claims and death in rural areas.

5.3 Modus operandi of Life Insurance Fraud

This theme speaks directly to the first research objective of this study to determine the modus operandi used by perpetrators to commit life insurance fraud. Life insurance fraud comes in all shapes and sizes and there are countless ways in which perpetrators commit this crime. By understanding the complexities of this modus operandi, society can collectively contribute to deterring and preventing life insurance fraud.

It should be noted that findings such as those given below were similar among all the participants. The participants were asked about the MO's used by perpetrators to commit life insurance fraud; they provided different methods. These included fake death, murder for money, John Doe, identity theft, dead in the rural and ghost claims. It is noteworthy that some of the responses include examples of real-world cases to illustrate the seriousness of this crime, that participants have either worked on or were working on during the duration of data collection. Figure 5.1: illustrates to the reader the different modus operandi used to commit life insurance fraud in KwaZulu-Natal which are presented and discussed in this chapter. In the middle of the cycle is the main theme and around the cycle are the sub-themes from one to six.

Figure 5.1: Modus operandi of committing life insurance fraud.



Source: Researcher's illustration

The following discussion pertains to the modus operandi of committing life insurance fraud.

5.3.1 Sub-Theme: Fake Own Death

This sub-theme indicates that as part of the *modus operandi* (MO) of committing life insurance fraud, perpetrators fake their death or the death of other individuals. Hence, they are people who do not know that someone has “killed” them off on paper for financial gain. While some frauds are committed by opportunist, faking death to defraud insurance companies is more elaborate and require well-regulated planning. Participants shared similar responses. They concluded that faking death and life insurance fraud represent intricate schemes that involve deliberate deception for financial gain.

The participant alluded that perpetrators purposely deceive insurance companies into believing that the person is dead when the person is still alive to fraudulently collect life insurance money. Additionally, participants revealed that perpetrators executed this MO by targeting elderly people.

“Fraud is prevalent in both life and funeral. Firstly, in life insurance you find that there are people who fake their death, this refers to people who allegedly state that they are dead meanwhile the person is still alive and kicking or even fake the death of another person” (FI:4).

“In some cases, you find that the person didn’t die, from the insurance we would find that the person has faked either their death or the death of the insured through investigation you discover that the person is alive, now they normally do this to older people because they are home most of the time” (FI:3).

It was expressed that the perpetrators, commonly policyholders who fake death, work in partnership with their spouses to submit the claim on their behalf as this cannot be done directly by the person faking to be dead.

“Faking your death, people lie about being dead to the insurance companies but when in fact you are still alive as a result you submit a fraudulent claim. This is usually teamwork amongst couples because someone needs to submit the claim on behalf of the one faking” (FrI:7).

Contrary to elderly people being targeted for this MO perpetrators also fake the death of people who reside in the rural areas of KwaZulu-Natal. Unlike the people in the cities, the assumption is that people in rural areas are not well informed about insurance specifically life insurance policies. As a result, these people are usually not aware when a false death claim has been submitted under their identity.

“You find that we get a claim, whereby this person says my father passed away only find that upon validation of talking to family members they will be like no, our father is alive and well. His living maybe at Nquthu or something” (FI:10).

When a person pretends to be dead to defraud life insurance money, an actual dead body is needed. The participant expressed that the corpse is usually obtained from a funeral parlour to represent the ‘dead body’ of the alleged deceased. In addition, when looking for a corpse perpetrators consider things such as the height and race of the dead body before choosing it to ensure that it almost resembles that of the alleged deceased. However, it was revealed that in some cases, the perpetrators will cremate the ‘dead body’ to prevent the identification of the body by investigators.

“Ok, so you first need to understand that faking death is one of the complicated MOs used by these fraudsters because, in the process of faking death, you may find a person who fakes his death and a person who fakes the death of another. Usually, a person will have an already existing policy with a certain insurance company, the insured will then fake his death in the sense that he or she will vanish from the surface of the earth pretending to be dead, this means that you lose all relational connections and no longer use any of your documentations. The alleged deceased usually has someone to work with because I mean who is going to submit the claim, in most cases, it is usually the spouse who will work with the funeral parlours to get a dead body that can be used as thou of the deceased, so they will consider things such as the height and race of the corpses before choosing one. Also in some cases, they will go with the cremation route because you must remember that in most funerals especially in African families, the body usually gets a chance to be seen by the people attending the funeral neh. Now to avoid being exposed they cremate the body. Once a dead body has been secured the next player would be the doctor, usually, parlours are connected to doctors so the doctor will come in and complete the BI document verifying that he has indeed seen the corpus of the alleged deceased. So, in the midst of ‘playing’ funeral the claimant is busy this side, so he/ she will submit the required documents to the insurer” (FrI:6).

The following verbatim suggests that several people have faked death and are registered as deceased at home affairs. This is particularly concerning as it may indicate that the South African population rate may be inaccurate.

Individuals engaging in fake death schemes may fabricate death certificates, submit false obituaries, or even stage elaborate events to create the illusion of a person's death.

The participant reported as following:

“You also find that another person is a dead man walking (walking death) at home affairs that person has been registered as a dead person but the person is still alive so you find that his still alive but at home affairs... another thing they do is that you find that they work as a syndicate so they already know that at home affairs they register you as a dead person with the information that comes from the doctor so they register you and even your ID number will reflect as of a dead person. One of the biggest concerns is how these people manage to stay out of sight for so long, apart from the cases in the media can you think how many more people are out there who have faked their very own deaths? So, what I found through one of my cases as I was interviewing one of them to find out how is a person able to live without an identity. What happens is that some go overseas or move to another province, so with a pay-out of 6 million they know that they will be able to survive in another foreign place. You must remember that they will no longer be able to live here without an identity and they still want to live and experience life you cannot survive without things such as a bank account and so forth because all these things will require you to have an ID. So to tell you a bit about this case am referring to, the dead man walking made a mistake because on the system his deceased and he went ahead and killed someone that was the biggest mistake he made because he got arrested and we needed his fingerprints and the system picked up that he was registered as a deceased and fortunately all this happened just before the insurance paid out the policy” (FI:10).

It was also expressed that people can easily fake their deaths, making it significantly more challenging for investigators to trace them once they disappear.

“It is very much easy for them to get away with faking their death because we cannot trace it, it’s like they become ghosts and no longer exist” (FrI:8).

In the early stages of the data collection process, one participant made an important eye-opening contribution. It was revealed that people who fake their death committed more crimes in the process of trying to create their new life i.e. creating fake identity documents or committing murder.

The participant commented that:

“One guy faked his death in Krugersdorp for life insurance money. What he did was they took a homeless person, more or less his height put him in the car and burnt him to death. Also, one thing you need to note is that sometimes these trends are interconnected with each other, for

example with this one case he had faked his death right and so he needed a dead body so he killed someone in the process so that he could be able to fake death and have a body to represent his “dead body”. This is why these people are very precise when looking for targets. There are a lot of people who will go to that extent for insurance money because now you must cover your track and this calls for investigators to conduct clear-cut investigations because here even the smallest detail is very important” (FI:6).

The participants expressed that life insurance payouts are often a goal for people who fake their deaths and the deaths of others. This affirms studies by Nealon (2022); Sheridan (2013) and Muscat (2013) that the insured fakes their death to collect their life insurance death benefit, the money can be claimed by a person who is still alive or never existed. Participants expressed that are not aware that life covers have been taken in their name and are killed on paper for financial gain. The study further found that perpetrators submit false death claims on old people or relatives who reside in rural areas. The assumption is that elderly people and people in rural areas are not well informed about life insurance policies, which makes them easy targets for this crime. Furthermore, this finding suggests that it is difficult for perpetrators to successfully commit this MO without assistance from the funeral parlour and it has been stated that a person who commits this MO often needs a dead body to represent his or her alleged dead body. One participant mentioned that faking their death meant that the person’s identity would no longer exist anywhere including at home affairs as the person would be recorded as deceased and would no longer be able to use any of their documentation i.e. ID. This corroborates findings from Greenwood (2016), who mentioned faking your death is like being in a witness protection programme without the support of law enforcement, a person who has faked their death is on their own and is very much alone as the person there were no longer exists.

In addition, the participant expressed that one of the concerns was understating how perpetrators manage to stay out of sight. Geldenhuys (2020) expressed a similar concern by stating that “the hardest part for people who fake their death is to ‘stay dead’. Pierce (2017) concurs by stating that it is more difficult for perpetrators to stay out of sight after convincing people that they are dead unless they cut all ties as they risk detection by life insurance investigators. This means that perpetrators need to put some effort into changing their looks, lose contact with family and relatives, give up all their social media accounts, move to a new city /or province and get a new identity to start over again. One participant alluded that in some cases fraudsters cremate the alleged dead body. This finding is corroborated by Corvalan (2022) who wrote an article on detecting fraudulent claims associated with falsified death. She

reported that life insurers have seen claims where the dead body is cremated before the death certificate is issued. If the dead body's physical characteristics match any of the identity documents, the syndicates pick up the body, arranging for a cheap burial or cremation (Motala, 2012).

5.3.2 Sub-Theme: Murder for money

Similar views ensued regarding this sub-theme of murder for money. This sub-theme relates to that losing a loved one is a painful experience that shatters the lives of every member of the family, however, the study found that family members are killing other family members/spouses for financial benefit. The study found that innocent people are killed with a single goal of cashing in on the life insurance money. In essence, life insurance fraud costs the lives of innocent people, as people are murdered to obtain a life insurance payout. Drawing from their experiences with life insurance fraud, participants expressed that perpetrators use hitmen to carry out these brutal killings.

Some of the responses are presented below to underscore this finding:

Perpetrators of life insurance fraud kill their victims solely to cash in on the life insurance money.

“One of the famous ones is murder for money, these people go as far as killing others just so that they can get their hands on that policy pay-out” (FrI: 1).

The participants also expressed that murder for money killings involves family members who murder their family members to claim a financial benefit from a life insurer. Furthermore, one participant expressed that the disadvantage of this is that some people are unaware that they have life insurance policies taken on them.

“Secondly, it is the killing of persons that are covered in the policy, usually the spouse or relatives. Anybody for that matter if they are covered. But the downside to this thing is that some of the people do not know that they have life policies taken out on them” (FI:4).

“Killing of relative or spouse for policy payout, those people are usually covered with huge amounts and the person will suddenly die” (FrI:6).

“In insurance, we commonly find cases of people who have been killed to claim insurance money, and victims are usually spouses. In some instances, you find a family member is the killer” (FI: 6).

Participants also revealed that one of how these perpetrators carry out these brutal killings is through the hiring of a hitman. The use of hitmen by perpetrators provides them the advantage of not carrying out the actual killing, making it more difficult for the investigators to connect them with the murderer.

“Also, one way that is deeply troubling is murdering people for life insurance money which can also be arranged using the services of Hitmen, just so that the person can claim” (FI: 1).

Victims of murder in many cases can involve anyone who has been covered in the policy. Perpetrators wait till the policy has reached maturity before arranging hitman to murder the insured.

“Fraudsters identify their target, by identifying the target it could be a relative not necessarily a partner, so basically anyone who has been covered can be a target. So, they will either wait until the policy has matured to kill that person or not wait at all because you must remember that unnatural death means double the money. Fraudsters know very well that a few months down the line once the policy is matured you will disappear (die), either by accident or hire someone to kill you. You know the state of crime in South Africa ... you know those people called izinkabi (hitman), they don't care about the life of a person. They just kill with no care in the world and fraudsters usually use these people because they know that they will do a clean job as in some cases the murderer may make the event look like it was an accident or a random killing. After the plot to kill the target has been completed successfully the person who claims moves to the next step of getting a completed BI from the doctor which is then submitted to home affairs along with other documents for a death certificate. These documents along with ID copies are then submitted to the relevant insurance company for a claim. I remember with this one case in Fryhead a person insured a madman from the area and thereafter killed him. But he made people very suspicious when he contributed with a huge sum of money around R10 000 for the funeral because he knew that he had insured him, mind you these people are not even related” (FrI:10).

“Innocent people are dying for policy pay-outs and there are many cases where people are murdered by hitman so that beneficiaries can get their hands on the life insurance money” (FI:7).

Murder for money killings is commonly perpetrated by the beneficiaries against the insured individual.

“Killing the insured person for policy payout, this is usually done by the beneficiaries of the policy” (FrI:4).

The participants also revealed that perpetrators prey on homeless individuals, for reasons that when a dead body is needed these perpetrators will find a vulnerable homeless person and kill them because they know that the chances of anyone looking for them including family members are zero to none. An example of this view is the following:

“Another thing is innocent people are losing their lives because of this because some take people from the street and kill them their family is unknown, but that person has got a family that loves them somewhere and would not like for the person’s life to be gambled with. So, they take people whom they know that once dead no one will do a follow-up because it is known that he is alive somewhere only to find that the person is dead. We know that in the street people don’t usually carry their IDs, so that makes it even difficult for us to investigate if the body is found. However, you do even find instances where these people go as far as taking out life covers on homeless people” (FrI:2).

The latter participant revealed that perpetrators of life insurance fraud are targeting and making financial gains from the most vulnerable victims of society, due to an impaired level of guardianship.

“And the last one is to cover amaphara (people who live on the street), these people are easy to target because as you know these people live on the street and some do not even know their families. They register those people, kill them if need be and go claim, who is going to follow up on them no one” (FI:6).

According to Muscat (2013:20), murder for insurance money, “involves the killing (or arranging for the killing) of a person to claim money. It is often the case that the murderer may make the event look like it was an accident or a random killing”. Thus, this study found that perpetrators use hitmen to make the killings look natural. Consulted authors explain policies are taken out on people with the sole purpose of cashing in on their deaths (Bahre, 2016; du Preez, 2022; Muscat, 2013). Murdering another individual for the benefits of policy pay-outs is usually committed by the beneficiaries listed in the policy, victims include anyone who has been insured. The study also revealed that perpetrators target homeless people because homeless people usually have no relationships to maintain with family, friends or society, someone will rarely come looking for them. Thus, the study suggests that homeless people/ persons are at risk of being murdered by perpetrators for the sole purpose of having a dead

body and obtaining insurance money. This is particularly a concern because South Africa has a huge homeless population. Similarly, du Preez (2022:1) states that the increase in insurance fraud has led one life insurer to warn South Africans who have family members who abuse alcohol or drugs and/or are homeless, not to let unscrupulous people take advantage of them by getting their identity documents and taking out policies on their lives. This finding is consistent with Ndabezitha (n.d), that insurance fraud is becoming dark and gritty involving people from impoverished communities by getting their ID numbers and orchestrating deaths. Thus, homeless individuals are particularly vulnerable to victimisation of life insurance fraud, sometimes resulting in fatalities. Contrary to Coalition Against Insurance Fraud (2017), the common notion that the victims are typically spouses and lovers, the victims are not always spouses or / family members as one participant mentioned that homeless people are also at risk of being murdered for life insurance money. Bahre (2016) clarifies that victims can be killed for insurance pay-outs by people they might not personally, or with whom you only have a very distant relationship. This study finding revealed that some victims/ targets are usually unaware that they have been covered by a life insurance policy. A DPCI participant also mentioned that family members also kill each other for insurance money. du Preez (2002), indicated that opportunist family members also kill for life insurance pay-outs. In addition, it was apparent from fraud and forensic investigator's responses that life insurance fraud also affects the lives of innocent people, both directly through accidental or purposeful injury or murder.

Life insurance fraud remains a corner for the South African insurance industry, this crime does not only come at a high cost for the insurance industry and policyholders, but it also costs the lives of innocent people. The above data suggest that people are killed for the sole purpose of life policy benefits. This research finding demonstrates the horrific aspect of life insurance fraud. Furthermore, the study found that one of the methods that is used to carry out these killings is to hire a hitman. According to Doyen (2023), hitmen in South Africa commonly average for murders motivated by personal reasons and insurance payouts. Biegelman and Bartow, (2012:33) explain that the fraud triangle theory clarifies that financial pressure is a common reason for people committing fraud, it is the main reason for the public to turn to crime. Thus, most perpetrators murder for money because of the financial benefit that is attached to the crime.

5.3.3 Sub-Theme: John Doe (unidentified dead body)

This sub-theme refers to the common use of the unidentified dead body in mortuaries to claim life insurance money. The findings from this study endorse the notion that the perpetrators have informants in most of the province's mortuaries who alert the perpetrators when an unclaimed or unidentified dead body is available. The study also revealed that perpetrators of this crime perform a visual identification of the unidentified corpus as their relative/ family members and give that corpus an identity of a person who may likely still be alive or never existed. This is further discussed in the following verbatim:

According to the participant, perpetrators rent the dead body of someone they do not know and are not related to file a claim. An unidentified dead body can be rented by multiple people to file a death claim with an insurer.

“The use of John Doe is also a famous scam, which it’s to take the body of a person you do not know and use it to claim and the most common. I once investigated a case of this person who was a John Doe who had been lying at the mortuary for 3 months. So, you can imagine within that period of 3 months how many fraudulent claims were submitted for that John Doe” (FI:10).

Furthermore, perpetrators work with syndicates to claim an unidentified dead body in a mortuary, after which someone identifies the body and files a claim using someone else ID who is still alive.

“Unknown bodies used to come in and together with the syndicate they would give that body an identity and then someone would come and identify that body and claim on insurance policies with someone else ID” (FI:6).

The study found that perpetrators work hand with mortuaries and doctors. The participant expressed that mortuaries alert the perpetrators of the unidentified dead body which they can claim. The doctors are the ones who sign the BI-1663 form, stating that they have seen the body of the alleged ‘deceased’ when in fact it’s the dead body of someone else.

“Then you will have the complex M.O., where someone inside from the mortuary works with the outside people and says do you know what we got somebody here has been laying here for a month or a week unknown. Say a person has a life cover with Assupol and maybe it’s even close to maturity. So, what can happen is that the person can fake his death and use an unclaimed body to process the claim. You find that the corpus had no identity but once a

fraudster who needs a body contact that parlour then that person is now known and has been ID. The people involved will identify the body as if it's their own and collect the deceased body. We once had a case at a funeral parlour in Umbilo Road, a family used that parlour to keep the body with plans to fetch it on Sunday for the funeral so the people in the funeral parlour business know each other and know the fraudsters who claim from the insurance. So, they call each other to say there is a body here of a person this age, do you not know anyone who might need this corpus? This corpus was then moved to another funeral parlour where this fraudster would come in and the Doctor would perform a post-mortem to complete a BI-1663 form and any other relevant documents. so, our members received a tip-off regarding this that a corpus was moved from funeral parlour A to funeral parlour B to commit insurance fraud. The body was supposed to return to funeral parlour A the next day. When we arrived at the scene, we kept the body and prevented it from returning to funeral parlour A, A. The family members arrived to collect the body for the funeral but people from the funeral parlour tried to stall them while communicating with the other parlour to return the body. So, Parlour B told them that the police were there and prevented the body from returning. So, the parlour had to break the news to the family to let them know how the body ended up in Parlour B, which they did that they were attempting to commit fraud. You must also remember that one unidentified body can potentially be used by more than two people to defraud the insurance companies that is why you find a lot of news articles about dead bodies being rented out (FrI:6).

“In the insurance industry, you get what we call an informant, an informant is the one who identifies the body. They confirm the identity of the corpus unidentified corpus as if they know the person who is dead, once they secure the relevant documentation, they go to home affairs for the death certificate and once the death certificate has been received they process the claim from the insurance companies” (FI:1).

Unidentified deceased are claimed by perpetrators as family members' bodies. When, in fact, the perpetrator is not even related to the deceased person. Participants alluded that perpetrators are claiming dead bodies of strangers to file a death claim to life insurers. This can negatively affect society as the corpus can go missing or the family receive the wrong corpus.

“One of the most common scams is claiming a Johndor individual at mortuaries as family members or people there have taken policies out” (FrI:8).

“The scam would be identifying the unknown bodies because of the connections in a funeral home and bury that unknown body claiming it to be that of someone else and also these people can cover that one body in different insurance companies to acquire more money” (FrI:7).

Difficulties in positively identifying the deceased may be used by the corrupt to commit life insurance fraud by substituting the identity of the deceased for that of a life insured who is still living (Evert, 2011). It is noteworthy, that this sub-theme is interconnected with the sub-theme of ‘identity theft’, as in some cases these fraudsters give John Doe’s identities of stolen IDs to obtain fraudulent death certificates. The above narratives demonstrated a strong need for the government to address the issue of unidentified dead bodies in mortuaries. One of the participants mentioned that the same deceased body could be used by ‘10 other different people to claim life insurance pay-outs. In addition, one participant added that perpetrators can cover the same body in different insurance companies. Naidoo (2020) stated that a body can be used on numerous occasions for fraudulent claims and by different individuals. However, it is noteworthy that these responses differed between the fraud investigators and forensic investigators.

Based on all the comments above it can be concluded John Doe is given identities of people who are most likely still alive. The above data attest that life insurance perpetrators work hand in collaboration with mortuaries for the provision of unidentified bodies. In addition, participants revealed perpetrators obtain death certificates using dead bodies that they've rented or bought before submitting a claim. Furthermore, one participant highlighted insurance fraudsters move the dead body along with the ID either on the road or along the roadside to orchestrate a fake hit-and-run. Participants further alluded that a hit-and-run accident involves a stolen corpse placed on the road and then run over by a vehicle to enable them to make the unnatural death claim instead of natural death as this does have a waiting period and the money is slightly more.

5.3.4 Sub-Theme: Identity theft

This Sub-theme revealed that perpetrators (policyholders/beneficiaries) may use stolen identities to purchase life insurance policies and later claim the death benefits when the insured person is still alive. Further, participants explained that perpetrators of life insurance fraud now do away with the paperwork as they can call directly to insurance companies to open policies while impersonating other people. Furthermore, participants stated that taking someone's

identity and impersonating them to commit life insurance fraud is simple; all the perpetrator required was the victims' ID number. One participant highlighted that, in some cases, victims are not killed but instead an unknown body is used to claim as that of the victim of the stolen identification. This finding revealed that the ID documentation/number of an individual is a very important and crucial piece of information in life insurance fraud. Some responses that exemplify this view are the following:

The advancement in technology has allowed the opportunity for perpetrators to be able to call insurance companies and take out policies using the identity of another person.

“It’s to call, they are using cell phones to join, and the cell phone is what they use. Also, they don’t stick to a period of 6 months because that is natural, they pay 3/ 2 premiums after that the person is shot or stabbed which is another scam” (FrI:1).

“The person joins telephonically the policy saying the other people these insurances people need to verify immediately, to ensure that it’s the same person who signed up” (FrI:10).

The participant expressed that; life insurance fraud can result in individuals having their identity stolen. This can have a long-term impact exposing the person to fraudulent scams i.e. life insurance fraud.

“Your ID is lost, right? So, nobody knows about you, they will go take your policy right saying there, are you? and after the waiting period, they will go and say you are dead. So, what they will do that is that because they only have your ID, there will go, and they will work with a mortuary to source an unknown body” (FI:1).

Using technology, perpetrators use stolen identity documents to impersonate themselves as the person in the stolen identity document to take up life insurance policies and nominate themselves as beneficiaries. Once the policy has reached maturity the person will either be killed, or they will work with a mortuary to get an unidentified dead body to rent.

“Also, now people can call these insurance companies and say I’m so and so and would like to take out a life cover on myself. People do a lot of crime there because in the process of pretending to be someone else they end up committing other crimes. This is where the issue of lost IDs comes in. So, say that you have lost your ID, Slindile will pick it up and Slindile will call Assupol and pretend to be Noma and say that she would like to take up a policy cover on herself and nominate Slindile as the beneficiary.

Slindile will then wait for the waiting period and after that Noma will die from an unnatural death Sindile can hire a hitman to kill and murder her and Slindile will have all the required documents and go submit her claim to Assupol. If I can quote one of my cases, there was an individual who called a particular company and covered his neighbour while he was the one pretending to be the neighbour and when the neighbour died from murder, the same person who pretended to be the neighbour called and says the neighbour had a cover and I was nominated as a beneficiary they have been shoot by unknown two men. When we sat down and listened to the recording, we could hear that the person who took out the policy and the alleged beneficiary it the same person and he was the premium payer. When a family member had to identify the body at the mortuary. The recording was played to them, and he bluntly said that was not his brother's voice, he did not speak English because he was uneducated but the in the recording was their neighbour and what was unfortunate was that the person who was involved in all this was a SAPS member” (FrI:9).

The participant expressed that, the lost or stolen ID document places a person at risk of being a victim of life insurance fraud. Furthermore, it may be noted that insurance companies do encourage crime by not informing people when life insurance is taken in their name.

“From what I know one applicant would like to call maybe the call centre, do the application and then pose to be the person who’s taking the insurance of which it is not that person who is insured and then do premium payment and then later on when the waiting period is reached and then the person is killed and then the same person who applied for the insurance he claims now for the life cover to be paid out. And then maybe in the very same company he applied for another person and then the same thing happens and even the insurer discovered it late and at that time we have lost lives already” (FI:10).

Perpetrators take life-influenced policies, using stolen or bought identity documents.

“So umm what they will do is they will buy ID documents or steal them after that take-up life insurance using your identity” (FrI:6).

From the discussion above participants highlighted the seriousness for South Africans to protect themselves against the risks of identity theft by ensuring they always keep their documentation safe to avoid their identity being unlawfully used by another party. Participants reported that victims of identity theft are at risk of even losing their own lives for life insurance payouts. The above data suggest that identity theft is committed by a motivated offender, who is motivated to defraud an insurance company for a pay-out. The routine activities theory posits

that a motivated offender is somebody capable and eager to take advantage of an opportunity to commit a crime. It can therefore be argued that a suitable target is not only the insurance companies but also the public as they stand a risk of becoming victims of identity theft for insurance fraud should the person lose their identity document. This finding concurs with Bernake (2023), who stated that life insurance policies are purchased after criminals receive personnel information of individuals without their knowledge and at times this illegal act leads to criminal activity against the insured.

According to Sproule and Archer (2007) identity theft is a crime in which an impostor obtains key pieces of personal identifying information and uses them for their gain without the victim's permission.

5.3.5 Sub-Theme: Death in the rural

Contrary to the modus operandi found in the literature view of this study, this sub-theme brought new information to light that the death of persons in rural areas can provide opportunities for fraudulent activities. The participant expressed that people have become extremely greedy for money to the extent of gaining financially from the death of a family member or spouse. The study found that death in rural areas, like in any other setting, can be subject to insurance fraud when individuals or beneficiaries attempt to deceitfully claim life insurance benefits. Further, rural areas present unique challenges and considerations for detecting and addressing insurance fraud related to deaths. Most participants revealed that the main perpetrators of this scam are the family member/s of the deceased individual. However, it was also found that people from funeral parlours also role-play in this mundus Operandi. The participants expressed this notion in the following verbatim:

“The family member is involved, somebody passed away in a rural town and never registered the death so they will facilitate this fraudulent death by working with outside parties who will provide all the information, they will even confirm the death as if it happened as per the document. So, it means that they might be getting something from the bigger scheme of things. We don't know because our job is to confirm if the death did happen and if it did happen did it happened as per the date. That's it, we have not been involved where people you know, will apologize if they get caught and they would tell us a lot of stories that they have financial problems if it involved the actual family member, so those are it's the trends we have picked up” (FrI:1).

The participants revealed that in rural areas, the deaths of relatives are usually not reported to home affairs. Therefore, this allows perpetrators who are commonly family members to take life insurance policies for the deceased and submit a claim for a person who has already long been buried.

“They are people you will find that a family member that passed away like in the rural areas. In the rural, people don’t usually register death at home affairs, right? you find that the person died 6 years ago but because that person is not registered which means home affairs won’t be able to see when that person passed away the fraudsters cover that person and go claim. For example, it is January 2022 now and this person died 2 years ago, I will go and say Palesa is dead, have the death registered at home affairs as the death but first take out a policy at Assupol and then when I want to claim. Remember there is a waiting period of 6 months, wait for 6 months and then just after 6 months have passed. Create a death so whereby I will submit an ID of the person who is allegedly deceased and whose death is not registered at home affairs. To register the death and claim the amount from an insurance company. So that is the first type of fraud that we see” (FI:9).

“And also claiming for someone who passed away a long time ago. In the rural areas, most of the deaths are not registered at home affairs so people use that opportunity to cover and claim for people who have long passed away and buried” (FrI:6).

The participant highlighted this MO entails the involvement of Induma or Inkosi (tribal authority), from the community who signs off the death notification which is then submitted at home affairs for the application of a death certificate.

“Another one is when a person emkhaya will pass away and the family may want to cut down on the lengthy logistics of arranging for a funeral and decide to bury the deceased at home say the next day. This means that the burial order and the death will not be registered with the Department of Home Affairs and the identity document of the deceased will be used to open a funeral or life cover of a deceased individual. Also, bear in mind that this person has not been covered, there is no active policy for this person. So, a relative will take that opportunity and use it to cover that dead person. So, then the person takes the ID document of the deceased and goes to take up a cover for them as though the person is still alive. Once the policy reaches the maturity date then they will notify the death of the individual at home affairs, do you understand that this person might have dead like maybe a year or two ago? They will usually need the tribal authority (Induana/ Inkosi) to complete a death notification which is one of the

documents needed at home affairs for a death certificate. Once they have the stamp or death notice it's easy to go register the death at home affairs for the death certificate and they after going to submit the claim, if not detected they get away with it” (FI:10).

Contrary to the above responses, the participant revealed that this M.O. is also used by the people in the funeral parlours.

“Emakhaya khaya (deep rural area), people are people and often do not have money to cover funeral costs. So, because you do not need to book umgodini unlike in the municipal crematoriums, people in the rural end up not even reporting the death to home affairs. For example, when a person dies the corpse is kept in the house and the room is usually divided with a something sheet, so the body is nicely laid on the grass mat on the other side. The problem starts when people go to the funeral parlours and say please help me bury my relative I will pay with a cow or even a goat because they do not have money and the corpse cannot stay long in the house it will start to smell. Now these people use this as an opportunity to make money off someone else's misfortune because they will request the ID of the deceased and the next thing is to cover the person because they have a corpse 'kill them' and later submit a claim. These people so much in undertakers and they lack the right information or procedure on what to do when a person dies at home. The thing is when a person dies at home, the police need to be called and the paramedics to come and certify the person as dead. Then the person can be removed to the funeral parlour, the next thing is to report the death to Inkosi (King) for the BI which is then taken to home affairs.” (FrI:8).

“One of the MOs used by the perpetrators is to insure someone who has already passed. For example, a lady had insured a person for a big amount and that policy was for 6 months, after 6 months she came back to claim 60 thousand. She claimed she was cousins with the deceased who passed due to natural causes. The Doctor and the mortuary were involved because the doctor signed the BI without seeing the body which is one of the red flags and the mortuary said they had the body, but the body was of someone who looked like they passed the day before and even the police said no this was not the right body. So, you will find that the Dr and mortuary is involved and at times you will find that home affairs is also involved because they are the ones who are issuing the death certificate” (FI:10).

“They just go and insure that nobody using those certificates and they know that insurance companies have 6 month waiting period, so after 6 months the person will come to the insurer and say that my child has died and then also by that time they know that the BI system will have

to use a funeral service. so what they will do, they will go to the traditional leader in the rural area and say. even that one is going to be involved because they are going to pay. They need a stamp coz they can't involve the doctor as the doctor may ask to see the body. So, they will have this person dead at home so immediately when somebody dead at home they will go to the traditional leader, they will talk to the person can get a stamp. Once they have the stamp it's easy to register the death at home affairs for the death certificate and they will communicate with a funeral parlour for them to conduct the service even though there is only a procedure so this is another type of insurance fraud they do” (FI:6).

Participants revealed that there is a particular problem of individuals who die in rural areas without the deaths being recorded at home affair; as this allows the ruthless relative or family member to commit life insurance fraud, in some cases without the rest of the family being aware. This finding coincides with the study conducted by Evert (2011), there are many instances in which death may have occurred with no official record of the death being registered with the Department of Home Affairs. In essence, the study unearthed that life insurance fraud is more common in rural locations because people are more likely to die and be buried in rural settings without the death ever being reported at home affairs, giving them a lower chance of getting caught. This finding suggests that verifying the death of a policyholder in a rural area can be more challenging due to limited access to medical facilities and official records. This can create opportunities for individuals to falsely claim that someone has died. The study findings align with the assertions made by Polat, Zeynep, and Reva (2018), who noted that in the realm of life insurance, fraudulent activities may occur with the aim of obtaining indemnity through individuals who have either deceased in the past, gone missing, or are deemed to be of unsound mind.

Rural areas may have different customs and traditions related to death and burial, which can affect the verification process and potentially make it easier for fraudulent claims to be made. This phenomenon is likely prevalent, especially in the rural regions of KwaZulu-Natal. In these areas, financial constraints often lead families to forgo reporting a person's death and decide to bury them in their yard instead. The advantage of this approach is that it typically eliminates the need for the family to incur expenses for a burial plot, as opposed to interment in a municipal cemetery. This finding implies that the accuracy of South Africa's death rate may be compromised by unreported deaths that do not reach the attention of home affairs. Moreover, participants indicated that a crucial factor for carrying out this form of MO is possessing the identification document or number of a deceased individual. This highlights that the ID

documentation of an individual who is deceased or alive carries so much value in life insurance fraud. Hence, this poses a substantial concern as individuals often share or lose their IDs casually with family and friends, and even possibly lose them.

5.3.6 Sub-Theme: Ghost claims/ Paper children

This sub-theme refers to submitting a claim for someone who does not exist. The study found that policy covers are taken out on someone who does not exist, by submitting fraudulent documentation. The participants revealed that perpetrators commit other offences in the process of using this M.O. which includes buying or renting an unclaimed dead body to enable them to claim. It is important to note that, the submission of fraudulent claims for ghosts has not been well recorded in literature and therefore there is minimal literature in Chapter 2 on this M.O. All the participants from the two organisations gave an account of how perpetrators defraud insurance companies by submitting claims/taking covers for people who do not exist.

Responses were repetitive and therefore selected responses are recorded below:

The participant expressed that perpetrators take up life insurance policy for paper children which are later announced as ‘dead’ with the assistance of a mortuary and a medical doctor, thereafter claims are submitted to the insurance company.

“Another scam is that a person who had registered a false child support grant, once the falsified child becomes an adult then they will open a cover that spoke (Ghost). After the cover reaches maturity, they will collude with the funeral parlour and medical doctors and falsify the death of a non-existing person and the claimant will take all those documents to the insurance company to claim for a non-existent person” (FrI:6).

On the issue of ghost claims, the participants revealed that perpetrators create the life of a person who has never existed (*Paper Children*). Furthermore, in the process of submitting claims for paper children perpetrators commit further crimes i.e. buying or renting an unclaimed dead body as a dead body is needed when submitting a dead claim.

“No standard M.O. is used by fraudsters, they use different techniques all the time. For instance, I remember there was a time when Home Affairs was the one paying grants for children and old age people so people were just going to Home Affairs to say I have got this child and they will receive a birth certificate without even validating the birth of the child and SASSA said no a person must come with a child to register for grants so what happened was

those who received the birth certificate without the validation of the childbirth what they did was to use those birth certificate to ensure paper children, um in Xhosa we say IMBOSI (ghost) and later submitted claims (FrI:8).

“One of the M. Os used by the perpetrators is to insure someone that does not even exist. These people work with home affairs because at home affairs you can go pay somebody to create a birth certificate for you to create a life. This is a complex one but after a while has been created the fraudster will take up a cover, wait for the wait period and kill the person on paper. Doctors and mortuaries come into play because a dead body is needed so the Dr working with the mortuary will complete a BI indicating that they have seen the dead body when in fact that body belongs to someone else. Then with the completed BI, the person moves to the next stage of getting a death certificate from home affairs once that is done, she goes and claims. One of the cases that I investigated was a person who created a fraudulent birth certificate and death certificate at the same home affairs when they submitted the claim I think the policy was 3 months in force and the person died in an accident and there was no trace of the person ever living, meaning we went as far as to requesting primary school records like school reports anything to prove that this person was ever alive and there was nothing that came forward and we ended up not paying that claim” (FI:6).

It was revealed that syndicates work with corrupt home affairs officials to create a life (paper children) to claim an insurance payout.

“Number two, these syndicates have connections at home affairs because at home affairs you can go pay somebody to create a birth certificate for you to create a life of a person who has never existed. They create life, ensure the non-existent person, kill them on paper, get a body and submit a claim” (FrI:10).

The Home Affairs Department is a major player in the success of ghost claims, as they are the only ones who can produce fraudulent birth certificates for perpetrators. This finding gives cause for real concern, as it reveals that people can create a life on paper that has never existed, which suggests that our population rate in South Africa is not accurate.

This finding suggests that the fraud and forensics investigators clearly understand that this crime can be committed in several ways, their responses illustrate exactly how fraudsters commit life insurance fraud. The findings suggest that there are various methods used by fraudsters and they continue to improve. This chain of Mundus operandi demonstrates the lengths to which people will go to commit life insurance fraud. The study found that the digital

world is advancing at an unprecedented pace, and life insurance fraud investigators must keep abreast with these developments and MO. These methods used to commit this life insurance fraud continue to expand and evolve. In this context, it is vital that an effective and in-depth understanding of the MO of life insurance fraud perpetrators is imparted through ongoing training and information sessions.

To fully understand life insurance fraud and be able to better detect or mitigate it, it is vital to understand who the key players are and what is their involvement in this crime. Hence, the researcher further asked the participants the following question, “***Who are the major parties involved in perpetrating life insurance fraud in KwaZulu-Natal***” (Elaborate your answer). Responses were repetitive and therefore selected responses are recorded below:

The participants expressed that life insurance fraud is a sophisticated crime that involves the role of a medical doctor who completes fraudulent notice of death (BI) documents.

“Doctors will sign off the BI as if they saw the body, so they work together with these criminals and funeral parlour: They will also validate as if there is a body of the deceased whereas in some cases there is no one. I think doctors and parlours build trust where they say you don’t have to bring in the deceased to me or I don’t have to come and see the deceased at the parlour. You can just bring the documents to me I will sign them and remember the doctor is paid for each body he signs for so that is another contributing factor that I know I am going to get R 400 for each “dead body” I sign for so now if they bring 10 papers I’m going to sign and then I’m going to get R 400 ten times. The doctors are the ones that I can say are involved because we get doctors that don’t see the bodies which is a problem” (FI:2).

The participants revealed that life insurance fraud is often perpetuated by a syndicate as it is unlikely to find a person successfully orchestrating this crime from start to finish, long the process the person will need assistance either from a medical doctor, home affairs or a funeral parlour as these parties play an imperative role in this type of crime.

“These people are operating as a syndicate; you will rarely find a person operating alone from start to finish. For instance, say these people get hold of your ID no one will get your death certificate alone. That person will need to go to a funeral parlour for the registration of the death, there is a BI that needs to be filled in, and then there is a deceased body that needs to be taken fingerprints. Then there is a doctor who needs to certify that I have checked this deceased body, that doctor and the funeral parlour know each other and there are monies that are involved maybe it is 500/600 that is paid. After that there is someone at home affairs who

needs to register the death without digging deep, asking questions when did he die? when is the funeral? where is the body receipt? where is this and where is that? Those body receipts and other documents will come from the funeral parlour person, and you will find that the funeral parlour person is benefiting more after the insurance has paid out” (FI:10).

“I don’t think that you can identify a specific group of people and it's syndicate related because 1 person cannot do it alone. You know you need the body; you need...and sometimes they even get the Doctors involved because the doctor needs to declare the person dead and all that so there is all big syndicate involved. You can’t say it to 1 specific kind of person.

Funeral parlours are also involved at times, for example, in the case we were dealing with the parlour received a body and gave that body a double identity. In the books, the corps was registered as Joseph, but they would also say this guy is Mr Dlamini, giving him a double identity and then the mortuary would forge documents for the syndicate for them to present it to the insurance” (FrI:9).

In contrast to the above verbatim, the participant expressed that life insurance fraud is not only committed by policyholders. Company employees also commit fraudulent acts i.e. approving fraudulent claims.

“ummh, it is the insurance company itself, have you ever heard of what is called an inside job? yes sometimes firstly before life insurance fraud is committed externally is it already committed internally? Sometimes something that is not allowed becomes allowed if you have inside connections. It’s going to be allowed because everyone is going to get their share of the pie at the end. Government Mortuaries will communicate with people that they have unknown bodies and people will go running to claim those bodies. As a result, you sometimes find that 3 families have claimed for one body. If no one at the mortuary suspected or reported anything, they will get away with it. Doctors, to validate the death of which in most cases it is fraudulent” (FrI:8).

In essence, Assupol participants highlighted that policyholders, doctors, company employees and funeral parlours are involved in perpetrating life insurance fraud as this is not an individual crime. Their goal is to create fictitious policies and claims, mainly by forgery and corruption.

“It’s the doctor, funeral parlour, well the funeral parlour means the people that work there know what is going on and the owner might not know what is going on but the people on the ground might know what is going on. umm, the people that also play a role sometimes that are involved in this syndicate is the people that work at home affairs so the consultant who assists

with documentation or processing of the death forms to print out the death certificate because there are sometimes involved” (FrI:9).

“Mmh when I say syndicate, I mean its group of people who have a common intention to defraud, whereby they see ... it can involve the employees that are within the organisation, it can involve doctors because doctors are the ones that sign off the death notices. They will put the stamp that is the one that did the post-mortem and stuff like that and there are funeral parlours that will say we are dealing with the funeral of the deceased only to find out that they were nobody, no funeral. And the family members as well, it’s a lot of ... it’s a chain that the comes to play. It’s a lot of people that are involved in these fraudulent activities” (FrI:6).

Home affairs officials as well they are involved were able to just creating an identity for somebody that did not even exist.

The participant expressed that the perpetrators gathered fraudulent documents with the help of the doctors and the mortuary.

“Initiator (policyholder/ claimant) – being the person who registered for the cover and the Doctor to assist with BI documents, cause of that of all that which can be done legally or illegally mortuary because at the end of the day you going to need a body, you can’t claim without a dead body and that is where the mortuary people come in, mortuaries even hire out corpus. So once the person gathers the documents with the help of the Dr and the mortuary the person can go claim” (FrI:7).

Contrary to the study findings of Chudgar (2015), there are three major parties involved in perpetrating life insurance fraud. Namely, the company employees or the agents of the company, second is the policyholder i.e. the customers and third is not direct fraud but indirect fraud i.e. involvement of doctors and mortuaries. The study findings revealed that the three major parties involved in perpetuating life insurance fraud included policyholders, doctors and mortuaries/ funeral parlours and syndicates were also mentioned as the perpetrators of this crime. This finding vindicates the notion that life insurance fraud is committed by a syndicate, as the participants mentioned that it is unlikely for this type of crime to be carried out by one person from start to finish. Jung and Kim (2021) concur that insurance fraud is an organised crime with specialised insurance fraud groups involving many people.

According to the routine activity theory, crime will occur when a motivated offender encounters a suitable target in the absence of capable guardianship. The findings suggest that

the insurance industry includes a pool of motivated offenders and a lack of effective detection and prevention strategies, both of which place insurance companies at risk of insurance fraud i.e. life insurance fraud. Concerning this study, a motivated offender refers to policyholders/beneficiaries and funeral parlours who are greedy for money (Jung & Kim, 2021).

In essence, the findings of this on the *modus operandi* (MO) of life insurance fraud hold significant implications for understanding and combating life insurance fraud in KwaZulu-Natal. By examining the prevalence MO's of fraud within the life insurance sector in the Durban area, the study sheds light on critical aspects that contribute to the existing knowledge base on this issue. Moreover, the research findings provided insights into the specific types of fraudulent activities occurring within the life insurance industry in Durban. By identifying common MO's, such as falsifying death claims or murdering for money, the study offers a comprehensive understanding of the modus operandi employed by fraudsters in KwaZulu-Natal. This knowledge is invaluable for insurance companies, law enforcement agencies, and regulatory bodies in devising targeted strategies and interventions to detect, prevent, and prosecute fraudulent behaviour effectively. Additionally, it is important to note that the research uncovered fresh insights, revealing that incidents of life insurance fraud can occur in rural areas, much like in other environments. In these cases, individuals or beneficiaries may seek to fraudulently claim life insurance benefits for a deceased person. Moreover, the study revealed that perpetrators (policyholders/beneficiaries) may use stolen identities to purchase life insurance policies and later claim the death benefits when the insured person is still alive. The comprehensive examination of the modus operandi of life insurance fraud within the research directly address to the research question regarding the *modus operandi* used by policyholders (Beneficiaries) to commit life insurance fraud in Durban, KwaZulu-Natal. As a result, the research findings provide a detailed insight into the methods employed by perpetrators, thus answering questions related to the perpetration of fraud in this specific region.

5.4 Chapter Summary

This chapter provided the findings relating to the study objective and research question regarding the *modus operandi* (MO) of life insurance fraud. Some of the questions posed to the participants were presented, analysed, interpreted, and discussed in line with the literature review. From the data obtained through interviews with selected participants, a key insight

emerges: perpetrators of life insurance fraud heavily rely on the collaboration of funeral parlours and doctors to successfully execute their modus operandi. The above discussion evinces that the insurance industry is susceptible to life insurance fraud. In the next chapter, the researcher presents a discussion about the motivations for committing life insurance fraud from the participant's point of view.

CHAPTER SIX: MOTIVATIONS FOR COMMITTING LIFE INSURANCE FRAUD

6.1 Introduction

In this chapter, the findings of the second objective of the study are presented. In this qualitative study, twenty (20) participants who are fraud investigators at the SAPS DPCI and forensic investigators at Assupol, dealing with life insurance fraud investigation and detection in the KwaZulu-Natal Province, were interviewed to understand their views based on their experience in motivating factors that contribute to life insurance fraud. The theme and sub-themes that emerged will be discussed in this chapter. The sub-themes commence with an introduction, followed by the verbatim narratives of the participants and lastly, a discussion that encapsulates the literature and the theoretical assumptions framing the study that is fraud triangle theory and routine activities theory. It is noteworthy, that in this chapter the researcher uses perpetrator and fraudster interchangeably.

This is the second chapter of three chapters devoted to the presentation and discussion of findings. The following sub-themes emerged:

- 6.1.1. Greed, quick cash, and lavish lifestyle.
- 6.1.2 Unemployment.
- 6.1.3 Loopholes (Poor internal control of the company).

6.2 Motivations for Committing Life Insurance Fraud

To address this objective, the following question was posed:

What are the motivating factors that contribute to life insurance fraud in KwaZulu-Natal?

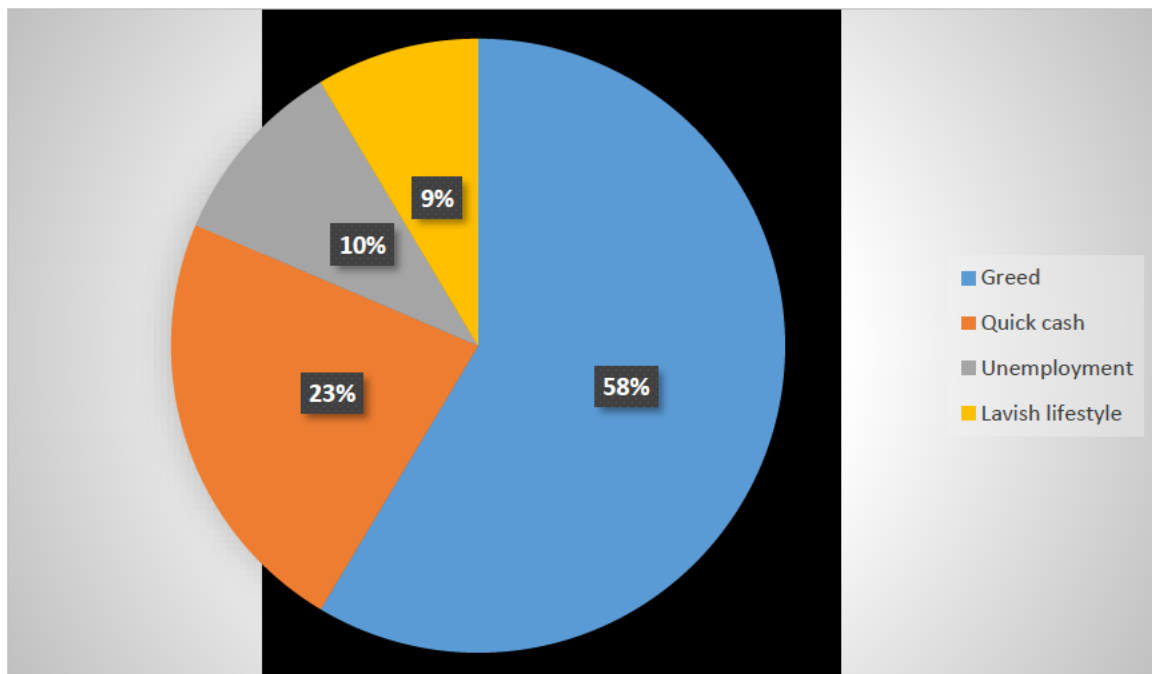
This question was in response to the observed increase in life insurance fraud. This question was adequately addressed. It was quite revealing to note that various factors influenced the commission of this crime, as alluded to by the participants.

This theme refers to the causes that drive people to commit life insurance fraud irrespective of their financial situation. Accordingly, leading motivating factors of life insurance fraud have both practical and social implications. Practical implications within the insurance industry

include poor internal control of the company. Social implications included unemployment, desire for a lavish lifestyle and financial pressure due to greed.

The motivations for life insurance fraud vary on the perpetrator and the specific context in which the crimes occur. The following diagram demonstrates that greed (58%) emerged as the most prevalent motivating reason why people in KwaZulu-Natal commit life insurance fraud. This was followed by quick cash/ easy money (23%), and a lavish lifestyle (9%). Unemployment (10%) was indicated as the least reason why people commit life insurance fraud.

Figure: 6.1 Motivations for Committing Life Insurance Fraud



Source: Researcher's illustration

6.2.1 Sub-Theme: Greed, quick cash and lavish lifestyle

This sub-theme refers to the causes of life insurance fraud across. Most participants stated that perpetrators commit life insurance fraud because of greed for money, the need for quick cash and to live a lavish lifestyle. However, it is noteworthy that the mentioned factors in this sub-theme all show that people defraud the insurance industry because of money (financial pressure). The study also revealed that financial pressure is the root cause for people to commit life insurance fraud. The fraud triangle theory (FTT) states that people are lured by greed and

easy financial gain into committing fraud. In the context of this study, greed refers to the excessive desire for money. This is evident in the following verbatim:

“It has to be greediness, that is a major factor. These fraudsters commit life insurance fraud because they want more money to have a lavish lifestyle. This is a major issue for the industry because how can you prevent someone from being greedy” (FI: 7).

The participant also revealed that because of greed, perpetrators continually commit life insurance fraud until they are arrested. Because of the excessive desire for money and not being satisfied, perpetrators repeatedly commit this crime.

“One of the contributing factors that stand out for me is greediness, people who commit life insurance fraud simply commit it because they are greedy, just to draw an example from a case that might be familiar to you. What do you think made Rosemary commit all those crimes? it was greed. She did not commit life insurance fraud because she was poor or unemployed. She did it because was greedy and kept wanting more money that is why she did not stop committing these crimes till she was arrested by the police” (FI:5).

The participant alluded that though the perpetrators are greedy for money, they are also becoming more sophisticated in making use of different MOs for the primary motive of personal financial gain and further emphasised criminality as being the motive for this crime. The participant further added that perpetrators are motivated by the opportunity factor being represented.

“well, it's greed, well opportunity in the systems being there and lack of education, well not really because these people are sophisticated so it's just greed really because to commit a crime you are greedy for living the lavish life or to get money. I mean it just criminality really because for me to commit a crime I must have something in me that pushes me to crime and for them its greed for money” (FI:9).

In addition, the participant expressed that perpetrators are driven by greed for money and that through their actions they commit life insurance fraud.

“So basically, there are a lot of reasons but the one that stands out is greed, greediness has also made several people commit life insurance fraud because you find that even people who have stable jobs commit this crime” (FrI:6).

As revealed in the following verbatim, the participants' responses illustrate that perpetrators commit life insurance fraud due to the financial situations they face and therefore resort to life insurance fraud to get quick cash. Based on the information obtained from the participants the researcher inferred that the desire for money is the basic motivation for life insurance fraud. This was confirmed in the responses of participants during the interviews, where it emerged that the main motivating factor for life insurance fraud is financial gain.

"It is financial situations that people are faced with. You find that a person is frustrated and wants a quick and easy way to make money," (FI:2).

"Though some commit it because of greediness, you find that the person has money, but they still want easy money or fast money, and other thing innocent people are losing their lives because of this. So yeah, it quick cash but at the expense of someone's life" (FrI:1).

While some of the participants expressed quick cash, and easy money as the motivating factor for life insurance fraud, some mentioned that perpetrators of life insurance fraud are motivated by the desire to live a soft life (lavish lifestyle) into defrauding life insurers. Perpetrators get motivated to commit life insurance fraud to maintain a social standing in front of others or to please others.

"It's greediness, people want to live a soft life. Life is expensive sisi (sister), we want to live a soft life. for example, the money that I earn is not enough for me to cover all my expenses and as you know their people in jail now for crimes some of whom committed crimes to be able to provide. Even my colleagues end up doing crimes themselves because the money is not enough. So, I would say that it is greediness and the desire to live better than others. and wanting respect, people believe with money you attain respect" (FrI:4).

Participants alluded that, the lure to display a lavish lifestyle and earn quick money are the prime factors that lead fraudsters to commit life insurance fraud.

"People want to live a lavish lifestyle that they cannot afford if they go to work every day and they think of quick ways of making money" (FrI:)

"Some commit this crime because they want extra money to live a lavish lifestyle and stand out... want to be the talk of the town so how that person makes extra money by committing crime while also working" (FrI:)

Life insurance fraud exists in our society. Thus, it is indispensable to learn the various contributing factors for committing life insurance fraud, as this crime has eaten so deep into the structure of the insurance industry. This sub-theme is in harmony with the findings of other studies such as those that were conducted by Coalition Against Insurance (2020) and Sujeewa, Yajid, Azam and Dharmaratne (2018). These authors claim that perpetrators commit life insurance fraud due to financial pressure which is centred on greed. Greed is one of the common examples of nonsharable pressure that promote fraud in the first place (Azam, 2018). The study finding concurs with Coalition Against Insurance (2020) who stated that the causes of insurance fraud vary but are usually centred on greed and holes in the protection against fraud.

In any society crime is an extraordinarily complex socioeconomic issue; this is particularly accurate to South Africa than for many other countries due to the rise in cost of living as the country is still recovering from the aftermath of lockdown. Similarly, Smith (2015) stated that the worsening social and economic circumstances in South Africa may attract more individuals to crime. These findings confirm the widely acknowledged notion within the insurance industry that financial pressure is recognized as the most common factor that leads some individuals to engage in fraudulent crimes i.e. life insurance fraud (Biegelman & Bartow, 2006:33; Sujeewa et al, 2018). Furthermore, a study conducted by Murdock (2008:81) explained that financial pressure is created through problems caused by immoral personal behaviours such as gambling, drugs, extramarital relationships, or the need to live lavishly. This study also found similar results which suggest that the financial pressure to commit life insurance fraud is often created by the need to live a lavish lifestyle. Furthermore, this study corroborates findings from Omar, Nawawi and Puteh Salin (2016:1539) who found that some of the causes of fraud include social factors like lifestyle and financial pressure due to a low income as well as unplanned financial needs.

In a study conducted by Chudgar (2015), it was found that one of the major reasons which would compel one to commit life insurance fraud is that fraudsters think they can get away with life insurance fraud. However, the current study found that fraudsters committed life insurance fraud due to greediness for money. Regardless of the impact of crime on others, the primary goal of criminals is financial gain (Ishak, Baker and Zakaria, 2020). The study findings revealed that participants are aware that fraudsters of life insurance fraud are individuals who fall under the working class and have some source of income but commit this type of crime because of the desire to have money to finance a lavish lifestyle, commonly known as a “soft life” this is recognizable by the fact that once these individuals start defrauding the insurance

money they never stop till they are caught and this can be seen in the recent case of Rosemary. This corroborates findings by Schich (2010) that insurance policyholders defraud funds from insurers to maintain or return their previous standard of living. Furthermore, one participant revealed that perpetrators are also motivated by the opportunity to make money from weaknesses in claims processes. Fraud triangle theory (FTT) postulates that opportunity is linked to weaknesses and control breakdowns in an insurance company's processes, which makes it easy for insurance fraud to take place. Thus, the study concurs that opportunity has a direct link to an insurance company's structure and processes. This finding highlights a great need for the insurance industry to review its current prevention and detection strategies.

In addition, reviewing the respondents' comments reason for this is associated with the high cost of living in South Africa and the financial burden experienced by the public seems to be in part what motivates claimants to commit life insurance fraud. This leads again to financial pressures and couples with life covers' desire to get money easily as a motivating factor to commit insurance fraud – thus, claimants seek financial benefit. Chetty (2020a), conducted a study on fraud tolerance as a predictor of insurance behaviour, although the content of her study was different to the current study because the study explored the role that policyholder tolerance has on predicting claims behaviour in the South African insurance market. However, the findings of both studies are similar in that life insurance fraud is perpetrated due to the financial pressure encountered by the fraudster and that this theme has an impact on one of the elements of the fraud triangle theory (FTT), namely pressure. The FTT proposes that motive/ financial pressure is an enabling factor for fraud. Examples of perceived pressure include greed, living beyond one's means, large expenses or personal debt, family financial problems or health, drug addiction and gambling (Abdullah & Mansor, 2015). The findings from this study endorse the notion that the greed of money and the desire to live beyond one's means motivate fraudsters to commit life insurance fraud. The study also confirms the study findings, conducted by Ishak, et al. (2020) that greed, lifestyle, and personal financial pressures are the leading motivations for fraud and deception.

6.3 Sub- Theme: Unemployment

This sub-theme is in contrast with the above sub-theme, it implies that perpetrators of life insurance fraud may also be motivated by unemployment to commit this crime. The study found that some participants argued that unemployment also motivated people to defraud insurance companies for life insurance money. However, the researcher argues that

unemployment plays a minimal role in motivating people to commit a crime of this nature as it has been previously mentioned that perpetrators commit this crime not because of poverty or unemployment but because they are simply greedy for money and want to display a lavish lifestyle. Below is an excerpt that exemplifies this viewpoint:

The participant mentioned that perpetrators commit life insurance fraud because of unemployment. This verbatim is also consistent with the Fraud Triangle Theory (FTT) in that, people are pressured to commit fraud for different reasons which includes pressure by negative influences such as unemployment.

“Unemployment, with unemployed people they resort to crime because people are not earning anything. As I said it's a syndicate so people can get recruited and become runners and they will be paid. This is like a full-time job to some, they plan, they have HR, they have working hours, they do research just like you...” (Fri: 6).

The participant emphasised that the lack of employment opportunities in KwaZulu-Natal due to the aftermath of the COVID-19 pandemic is an issue faced by many. This left individuals desperate for money and thus people resort to crime i.e. life insurance fraud because of unemployment.

“There is a high rate of unemployment in KwaZulu-Natal, so people use the opportunities they get to resort to life insurance fraud, It is general knowledge that when a person is desperate for money and does not have any sort of income. He/ she is more likely to commit a crime and we know that a lot of people recently lost their jobs due to Covid-19” (FI:1).

The participant indicated unemployment is contributing to the high rate of life insurance fraud.

“The unemployment rate is contributing a lot. Because people need money, they look for any kind of cash that can come quickly or easily. Unemployment is the one that is currently hitting the insurance industry” (FI:6)

Contrary to all the above responses, some participants debated that unemployment is not the reason for people to commit life insurance fraud, they emphasised that perpetrators of this crime simply commit life insurance fraud due to financial pressure as some of the people who commit life insurance fraud have stable jobs. This is evident in the following verbatim:

“I don’t believe that unemployment or poverty should be a reason for people to commit this type of crime. The love of money is the root of evil, I mean with the current cases that we have all the suspects have good professions, but you also get people who do this for a living” (FrI:8).

Contrary to the above participants, the participant recounted that unemployment does not propel people into committing life insurance fraud.

“I cannot use an excuse that there is a high unemployment rate. Crime is a crime; you commit it intending to benefit from that crime. People want to live a lavish life that they cannot afford by simply just going to work every day, so they think of quick ways of making money” (FrI:10).

The participant alluded that unemployment is not the reason for life insurance fraud as this crime is commonly committed by people who are well-placed in financially rewarding careers.

“One thing for sure it is not unemployment because most of these people have good paying jobs. So, I would say that is greediness, they people simply want more money and nothing else” (FrI:9).

In addition, the latter participant also argued that unemployment or poverty does not motivate people to commit life insurance fraud. The participant mentions that this is because the crime is committed by people who are already financially stable.

“One thing you must understand is that people who commit this crime some of them already have money so I cannot say it is unemployment or poverty. Anyone can commit life insurance fraud” (FrI:6).

According to Shabangu (2006), unemployment breeds poverty, which consequently breeds criminality. Similarly, the study found that with the current job scarcity in South Africa due to the aftermath of COVID-19, out of desperation people will do anything for money including committing life insurance fraud. Furthermore, Colquitt and Hoytt (1997), mentioned that insurance frauds were higher in the states where unemployment was high. Thus, it may be surmised that the desperation due to unemployment may potentially be a driver for people to resort to life insurance fraud. The ASAI stated that due to the COVID-19 pandemic, the desperation due to job losses is driving more people to resort to crime. (IOL,2021), concurs that the industry statistics suggest that people are more likely to commit insurance fraud in times of economic hardship. This finding suggests that the economic circumstances in South Africa may attract more individuals to this crime.

In a study conducted by Jawadi, Malick, Cheffou and Augustine (2021), it was found that a higher unemployment rate increases non-violent crime. The study found that unemployment limits the access of unemployed persons to the goal of living a good life and can push them to commit crimes if this enables them to get monetary benefits. This finding suggests that with unemployment being a great cause for concern in South Africa, life insurance fraud will continue to increase. According to the routine activity theory, the occurrence of crime requires three conditions (motivated offender, suitable target, and lack of suitable guardianship) However, the research postulates that if employment opportunities could reduce suitable target (*insurance companies*) and increase effective guardianship (*prevention and detection strategies*), it would result in a decrease of life insurance fraud.

6.4 Sub-theme: Loopholes (Poor internal control of the company)

This sub-theme indicates that the cause of life insurance fraud is Ineffectual in the internal ineffectual control of the companies. In this study, participants SAPS DPCI revealed that the insurance industry is duly responsible for their work environment to ensure that detection and prevention strategies are in place and effective. However, participants stated that people commit life insurance fraud because of loopholes within the insurance companies.

The participants revealed an environment that is characterised by poor internal controls creates an opportunity for life insurance fraud to be successfully committed against an insurance company. However, it is noteworthy that these responses differed between the fraud investigators and forensic investigators. Below are the fraud investigators' responses that highlight this sub-theme:

The loopholes within the insurance companies motivate perpetrators to commit life insurance fraud. The participant further revealed that insurance companies do not have enough manpower to detect and prevent some of the fraudulent claims from slipping through their hands. Perpetrators take advantage of the fact that insurers must review hundreds of thousands of claims which need to be processed within the statutory term of 30 days.

“People always finding ways to take advantage of big business and insurance companies are deemed to be big business as well there are so many loopholes in insurance companies and people end up committing fraud because of the loopholes. There don't have enough manpower to verify every single claim so it's on a selective basis, so if your syndicate is targeting an

insurance company with 10- 20k claims a year the chances of anyone looking into them are very small, so they have that thing that I can get away with it without being caught” (FrI:1).

The participant expressed that weak detection measures (loopholes) in insurance companies make it possible for perpetrators to fraudulently claim the benefits of life insurance policies.

“The insurance companies also have loopholes and that also contributes to people committing this crime, because weak s detection measures in the companies open an opportunity for these people to fraud. So, if you know the loopholes what would make you not do this crime, that is why we continue to see this crime increasing because these people know the weakness of the internal control” (FrI:6).

The study found that fraudsters find ways to leverage the loopholes within the insurance control systems and make use of them to commit life insurance fraud. Kenyon and Tilton (2006) state that weak internal controls, lack of supervision, and inadequate segregation of duties may create an opportunity to commit fraud. This theme corroborates findings by Shah and Asthana (2013), that poor internal controls are responsible for driving life insurance fraud. Abdullahi and Mansor (2015) explain that the fraud triangle theory clarifies that opportunity is created by ineffective control or governance system (internal control weakness) that allows an individual to commit insurance fraud. These authors further state that this theory posits that opportunity can lead to an intention that influences or causes someone to commit fraud. KPMG Malaysia Fraud, Bribery, and Corruption concur that the most influential opportunities are loopholes in internal control, inadequate competency to detect fraud by the internal audit team, and insufficient training to give awareness on fraud (Said, Alam, Ramli & Rafidi, 2017).

Thus, despite insurance companies implementing strategies to detect and prevent fraud, fraudsters continue to successfully defraud life insurers indicating that there are loopholes in the fraud detection techniques. Chudgar (2015) states that loopholes in the fraud detection technique of life insurance indicate a lack of internal control system of the insurance companies. Therefore, it is imperative for insurance companies to properly scrutinize their current strategies to detect the loopholes in the internal control and amply address them to curb life insurance fraud in KwaZulu-Natal. The study findings suggest that the prospect of committing fraud emanates from poor internal controls to manage and detect fraudulent claims. In essence, a great majority of life insurance claims are based on simple methods which exploit procedural imperfections and the inefficiency of the internal control systems. They argue that efficient prevention of life insurance fraud will only be possible if the industry identifies the

loopholes. Guardianship refers to people or objects that prevent crime by their presence or through direct or indirect action (Peacock, 2013:95). The researcher thus argues that the insurance industry does have prevention and detection strategies, however, they are ineffective in proactively deterring this crime (Hunter & Dantzker, 2002).

It is noteworthy, that the study did not find any reasons for committing life insurance fraud that were related to the rationalisation factor of the FTT.

Essentially, the findings regarding the motivations behind life insurance fraud offered valuable insights into the dynamics of fraudulent behaviour within Durban, KwaZulu-Natal. Understanding these motivations was crucial for delving into the root causes of life insurance fraud in the Durban area. These motivating factors encompassed various causes, including financial pressures such as economic hardships or indebtedness, alongside personal motives like greed, desperation, or the pursuit of material gain. As a result, these findings directly addressed the research inquiry regarding the motivations behind committing life insurance fraud by providing a deeper understanding of why individuals decide to engage in such fraudulent activities in Durban. By identifying the underlying factors propelling fraudulent behavior, the research contributed to a nuanced comprehension of the intricate interplay between individual and socio-economic influences on fraud within Durban, KwaZulu-Natal and consequently adding to the existing knowledge base on life insurance fraud in KwaZulu-Natal by offering a more refined understanding of the driving forces behind fraudulent behavior within the life insurance sector. It is noteworthy that the study further found that unemployment may increase the likelihood of individuals engaging in fraudulent behavior due to the perceived opportunity for financial gain. As those who are unemployed may view life insurance fraud as a way to generate income or obtain financial support during times of economic hardship, especially if they perceive the risk of detection to be low.

6.5 Chapter Summary

The chapter presented the findings of the study. The chapter revealed that the participants had experienced different motivation factors concerning life insurance fraud. The findings revealed that greed for money, quick cash and desire for a lavish lifestyle were the leading sources of life insurance fraud, however, other factors such as unemployment and loopholes of insurance companies also contributed to the commission of life insurance fraud as stated by the participants. In essence, it can be argued that irrespective of the person's financial situation,

perpetrators are motivated to commit life insurance fraud because of greed. Chapter 7 will provide the third and last data presentation chapter.

CHAPTER SEVEN: STRATEGIES USED TO DETECT AND PREVENT LIFE INSURANCE FRAUD AND THEIR EFFECTIVENESS

7.1 Introduction

This chapter presents primary findings and discussion of data obtained from semi-structured and key informant interviews conducted with participants (SAPS DPCI) commercial crimes investigators and (Assupol) forensics investigators. The study set out to explore the perceptions of investigators on life insurance fraud in KwaZulu-Natal. As mentioned in chapter one of this thesis there are three finding chapters. Chapters five and six discussed the modus operandi of committing life insurance fraud and the motivating factors. In this final chapter, the researcher will discuss sub-themes relevant to the latter objective of this which is to explore the strategies that companies use to detect and prevent life insurance fraud and their effectiveness. Thematic analysis was performed through the process of coding in six phases to create established, meaningful themes. The findings are presented as verbatim quotations from participants. Individuals are not identified by name, and this is in keeping with the policy of anonymity discussed earlier and for reasons associated with ethical considerations already outlined in the previous chapter. The following sub-themes emerged:

7.1.1 Reactive not proactive

7.1.2 Fraud awareness and training

7.1.3 Red flagging

7.1.4 Whistle-blowing

7.1.5 The effectiveness of Assupol strategies to curb life insurance fraud

7.1.6 Challenges

7.2 Strategies used to detect and prevent life insurance fraud.

This theme refers to the strategies used to detect and prevent life insurance fraud and their effectiveness within the different organisations. The study highlighted that SAPS DPCI did not have any prevention and detection strategies. The participants alluded that the organisation responded to life insurance fraud crime after it had occurred, as a result, they predominantly focused on the element of investigation. Assupol participants stated that the insurer employed various strategies, such as fraud awareness and training, red flagging, and whistleblowing.

7.2.1 Sub-theme: Reactive not proactive

This sub-theme outlines that SAPS DPCI lacks employed strategies for the prevention and detection of life insurance fraud, as a result, the organisation predominantly focuses on the element of investigation. The study highlighted that law enforcement (SAPS DPCI) responds to life insurance fraud after a crime has been committed. Furthermore, participants from SAPS DPCI indicated that there are no strategies in place in their organisation to curb life insurance fraud. The participants emphasised that fraud detection and prevention remain an insurance industry priority, this information is printed in bold in the responses for emphasis. In essence, the study findings show that at SAPS DPCI there remains a lack of tangible and effective strategies to detect and prevent life insurance fraud.

The responses of the SAPS DPCI participants were very similar. Some responses are presented below:

The findings indicate that the participant was not open to responding to the question. The assumption could be that this hesitancy might stem from the participant's commitment to maintaining confidentiality within the department.

“Unfortunately, I cannot answer because something that is only communicated to the public by the right channels of communications” (FrI:1).

The participants alluded that the SAPS DPCI as a law enforcement department often reactively responds to cases of life insurance fraud. In essence, SAPS DPCI does not have implemented strategies to prevent and detect life insurance fraud. The participants stated that the department responds to life insurance fraud after the crime has been committed.

*“We don't have any to be honest as we are reactive when it comes to insurance frauds, we are not proactive within the DPCI, so we **get it after it happened so on our investigations**” (FrI:8).*

The organisation might not have any implemented strategies. However, the participant alluded that they normally advise the insurance industry to improve their internal control systems. For the organisation to give such advice, clearly indicates that there is something wrong with the internal control systems of insurance companies that is causing them as external stakeholders to be concerned.

“We have nothing because we are reactive, we act after the crime has been committed. There is nothing much we can do but we normally advise the insurance people, like guys you see this

*it is escalating so I think you must improve your internal security because honestly, **it's not our baby***" (FrI:5).

The participant alluded that the organisation is at the end of the investigative chain of life insurance fraud. However, as fraud investigators, they do fulfil their duties to effectively investigate reported cases of life insurance fraud.

*"Mmmh, we don't have any because we are at the end of the chain. We are involved when the crime has already been committed. So, our role is to investigate the crime by checking the person of interest, and possible suspects, profile that person, and what the person has and had before the crime was committed that is section 205 in terms of profiling. Then the insurance companies have their investigators so you collude with them, should we need anything. In most cases **they are the ones who smelt the rat first**"* (FrI:10).

The participant expressed that prevention and detection of life insurance fraud falls outside the scope of SAPS DPCI.

*"We are reactive so we only act once we are informed of the crime so the **proactive of the insurance fraud part falls outside of DPCI** we know that intelligence is a driven organisation so we are reactive once the case has been reported its investigated"* (FrI:6).

The participant bluntly stated that the organisation has not implemented any prevention and detection strategies as they predominantly focus on the element of investigation. Considering that the case (docket) reaches the right hands, some of the investigators do not take cases of life insurance fraud seriously.

*"I doubt we do any detection or prevention strategies; thina (we) investigate the cases. The insurance company brings us the case we pursue the case and if the case reaches the right hands of the right investigator **because some of the investigators are not taking such cases seriously**. When investigating a lot of things come into play because those cases must go until considered murder if you look at the circumstances of the person they claimed for, how the person passed away they amount to murder and those are very serious cases that require serious attention"* (FrI:9).

Crime awareness is an essential component is crime prevention. However, the participant highlighted that SAPS DPCI did not have any crime awareness campaigns regarding life insurance fraud. The participant stated that the organisation does not have any strategies that

seek to reduce life insurance fraud including workshops to bring about awareness about this crime.

I would be lying if I said we have any, we don't even have any workshops to bring about awareness about life insurance fraud (FrI:4).

The participants expressed that SAPS DPCI has no strategies or clear guidance about how they intend to tackle life insurance fraud. Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) (2019) stated that the police have an important role in investigating offences and pursuing suspects, however, the responsibility for protecting the public from life insurance fraud is less clear. This finding is in harmony with Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) (2019), that the SAPS DPCI unit focuses on the investigation and prosecution of life insurance fraud. The participants alluded that there are resources or strategies available to disrupt or prevent fraud from being committed in the first place. Thus, the study findings revealed that at SAPS DPCI remains in lack of tangible and effective strategies aimed at addressing insurance fraud and specifically life insurance fraud. However, the study did find that the organisation does have strategies to investigate life insurance fraud, as the organisation predominantly focus on the element of investigation of life insurance fraud. Unfortunately, when the participants were asked about the investigative strategies, they stated that they were not at liberty to answer the question, as they were restricted by the policy not to share the information with the researcher as it may favour fraudsters in the future. One participant mentioned that the department does not provide any workshops to bring about awareness of life insurance fraud. Considering the scale of life insurance fraud in KwaZulu-Natal, it can therefore be argued that not enough is being done by the SAPS DPCI to prevent this crime from being committed. Similarly, Budhram, and Geldenhuys (2017:1) stated that the South African Police Service (SAPS) struggles to protect victims from commercial crime that threatens the economy.

The study further found that the SAPS DPCI believe that life insurance fraud detection and prevention remain an insurance industry priority. The study findings concur with Jung and Kim (2021), who stated that the government believes that insurance fraud needs to be dealt with primarily by insurance companies and that these companies have a direct responsibility for managing insurance fraud. While combatting life insurance fraud remains an industry priority, it is vital that SAPS DPCI also play a central role in the fight against life insurance fraud and

create the right proactive strategies to ensure that wherever possible life insurance fraud is minimised.

7.2.2 Sub-Theme: Implementing fraud awareness and training

This sub-theme outlines that Assupol has implemented fraud awareness and training as part of its strategies to detect and prevent life insurance fraud. The rate of life insurance fraud is escalating as perpetrators continually adapt and innovate to find new avenues to exploit insurance companies. Consequently, there is a dire need for effective strategies to curb this scourge. The study highlighted that to effectively detect and prevent life insurance fraud, employees in the insurance sector need to be trained on the latest scams and be ill-equipped to identify emerging red flags. The participants stated that Assupol had implemented strategies including fraud awareness, training, and reflagging. This view is supported by the following narratives:

Fraud awareness and training for all employees in an organisation is one of the most important components of any effective anti-fraud strategy. The participants alluded that the company implemented fraud awareness and training as one method to detect and prevent life insurance fraud.

“So first, as forensic investigators, we conduct training on fraud awareness” (FI:9).

Fraud awareness and training assist Assupol in raising awareness of fraudulent acts and assist company employees in preventing, detecting, and reporting life insurance fraud.

“You see we do a lot of fraud awareness we ... internal awareness, so we train people on what to look for in terms of documentation and that is basically what we do and we do an ongoing fraud awareness and that fraud awareness do have a contributing factor because we see then that we can detect some of those fraudulent claims before those claims are paid in many instances. So, insurance companies have embarked on fraud awareness where they provide information to the employees so that they can detect any suspicious fraudulent claims” (FI:1).

Furthermore, participants highlighted that fraud awareness was focused more on the claims department. The study found that these strategies had shortcomings in which no awareness was directed to the public. The researcher is of the view that public awareness is equally important to mitigate fraud as internal fraud awareness and training. The public needs to be conscious about the things that affect them.

“We have fraud awareness so that employees especially the claims department can recognise irregularities” (FI:6).

“ummh, firstly there is fraud awareness training for the claims department and other relevant departments. This helps us to mitigate fraud risk and ensures that internal controls are effective” (FI:7).

Participants reported that employees are trained on how to detect and prevent opportunities for fraudulent activity within the organisation. In addition, one participant expressed that fraud awareness training assists the organisation in mitigating fraud risk and ensures that the anti-fraud controls are effective. Creek-Tatom (2020:1), stated that a comprehensive fraud awareness should include basic information to help employees identify when something is not right. The basic information is the what/how, the who, and the why people commit fraud. FRISS (2019) concurs that it is of vital importance for insurance companies to increase fraud awareness and training of each employee to be a fraud detector. This finding suggests that it is vital to give employees the knowledge they need to reduce the risk of life insurance fraud. Creek-Tatom (2020) states that proper prevention requires vigilance in staying up to date on fraud trends paired with consistent training.

7.2.3 Sub-Theme: Utilising Red flagging

The participants mentioned that red flagging had been implemented as a strategy to detect fraud. Furthermore, participants alluded that they could not go into detail regarding the exact red flags as this could be of an advantage to the fraudsters in the future. The following verbatim captures the participant responses:

Participants expressed that red flagging as an early warning system has been used by Assupol to determine the possibility of life insurance fraud. Reflag is used to pick up things that are out of the ordinary and may need to be investigated further but does not necessarily indicate guilt or innocence.

“We have got a list of red-flagged we use for suspicious doctors, funeral parlours and anybody that has got to do with like ..., also suspicious insurance policyholders and the home affairs. To explain further death certificates have site codes which means it has been printed at the home affairs in DBN umngeni the code is meant for certain branches of home affairs so have got a system in place that traces for instance if I receive a death certificate from Umngeni branch and it would prove to be fraudulent we reflag it on the system so for instance if we receive

documents from that branch again, it's not to say there are fraudulent because some deaths do happen but we do look deeper into it to try do further checks ins and quantize to certain level. Beyond that we have assessors that check claims that also run on another system whether it is a spreadsheet that we have done, they check everything on a spreadsheet and they do extra checks by contacting the relevant parties that are on the document that we have received funeral parlours, informant etc. So, there are systems and checks that we have got in place, and sometimes those systems and checks do need a human intervention which is where the investigators come in, where they need to go and investigate physically in the region or area or speak to police officers just to make sure that all the ducks are in a row just before we pay” (FI:6).

In support of the above participant, the latter participant indicated that Assupol has individuals/institutions whom they have reflagged.

“We use red-flagging, we have got doctors that we reflag that we know are involved, we have got funeral parlours we reflagged claimant and death people we red-flagged” (FI:8).

According to Dionne et al., (2009), the red flag process means that if a claim was given certain flags to indicate that it was suspicious, the claim would be further investigated by an insurance claims investigator. Participants alluded they watch for common (and not-so-common) signs of fraud, and to have tools at their disposal to help them further investigate any concerns. According to DeForge and Shorts (2019), when a red flag is triggered, an internet search for local newspaper sites for obituaries of life insurance claims, doctors, and specialists to match the information provided by a claimant is used to double-check a claimant's story. Therefore, the effectiveness and efficiency of fraud prevention and the success rate of fraud detection may be increased by using automated means of checking claims against lists of red flags (Dionne et al., 2003). The finding concurs with SAS (2008), that during the early stages of insurance fraud detection and prevention, insurers use red flags to identify suspicious claims.

7.2.4 Sub-Theme: whistle-blower reporting

This sub-theme indicates that whistleblowing serves as a vital mechanism for insurance companies in detecting and addressing life insurance fraud. This finding suggests that whistleblowing is a mechanism that is used by insurance companies to alert forensic investigators of issues related to fraud.

Participants expressed varying perspectives on whistleblowing, considering it both as being a trigger for fraud investigation and a valuable tool in the detection of fraudulent activities.

“There is a whistle-blower tool which we use to trigger a fraud investigation” (FI:3).

“We have also whistle-blower hotlines that assist us in detecting fraud” (FI:2).

“Also people can use whistle-blowing to report fraud” (FI:9).

The study found that the organisation has adopted the basic provisions that govern whistleblowing instructions on hotlines. The study findings suggest that whistle-blowing accounts for the uncovering of life insurance fraud. Furthermore, the study finding suggest that insurance organisations utilize whistle-blower reports as a primary defence against life insurance fraud. These tips are typically subject to investigation by the forensic investigation department. However, the study did not determine whether this method is also applicable to the public or the procedure that must be followed by the public while applying this strategy. The data in this research reiterate that the whistle-blowing policy provides reporting channels and guidance on reporting suspected fraud, misconduct, or irregularity in insurance that might otherwise go unnoticed. (Kenyon, 2020). Additionally, this finding concurs with (Near & Miceli,1996) that whistle-blowers contribute to the detection and prevention of fraudulent practices, protecting the interests of both insurers and the insured.

7.2.5 Sub-Theme: The effectiveness of current strategies in responding to life insurance fraud

Despite all the methods implemented at Assupol to detect and prevent life insurance fraud, this crime continues to be a problem. Consequently, this begged the question of whether these strategies were adequate with a view to addressing this problem more effectively in the future. It is noteworthy, that the SAPS DPCI investigators were asked this concerning the current investigative strategies.

The following question was thus posed to the participants:

Are the current strategies that are used...effective in responding to life insurance fraud? Why do you think so?

This question was posed to assess the perceived effectiveness of current strategies to address the problem of life insurance fraud. The participants acknowledged that the current strategies

were effective, however mentioned that improvements would make them more effective. They had the following to say:

Despite the effectiveness of the strategies, the participant highlighted perpetrators are always a step ahead of the implemented strategies. In essence, perpetrators' modus operandi and motives change. Therefore, for the insurance fraud prevention methods to be fully effective, the industry needs to be aware of and adjust to those changes.

They are effective, look the fraudsters are always one step ahead but from where I am they are effective, and they are working. so, it's not something that ... you know there will go to the soft targets. So, these guys don't go to insurance companies that they know they will get caught (FI:1).

Implemented strategies have successfully assisted Assupol investigators in detecting and investigating cases.

"They are effective, why am saying effectively?"

It is because we have been able to use them to detect and efficiently investigate fraud cases" (FI:2).

In support of the above participant, this participant highlighted the importance of reviewing the implemented strategies. The participant made a valid point by stating that, strategies need to be reviewed and evaluated to ensure their effectiveness in fraud prevention and detection.

The participant highlighted that reviewing current strategies will assist the organisation in recognising when strategies are no longer fully operative in serving the desired goal of minimising risk.

"Yes, they are effective, but strategies need to be reviewed to ensure that there still in line with the trends of fraud. What is the point of having strategies that are not accommodative of the crime that needs to be addressed? I always say to my colleagues that these syndicates hold conferences on how to defraud or what loopholes can be found within our systems. Meaning that these people 90 percent of the time are ahead of us. So, these strategies must be reviewed at least yearly to ensure that are in line with the changes of fraud trends" (FI:6).

Methods of committing life insurance fraud are constantly fluctuating, the latter participant added that strategies need to be improved to accommodate the change and thus ensure.

“Mmh yeah, I believe that they are effective because they get the job done whether there sufficient. Ummh you know there is always room for improvement because you know fraud changes which means even the strategies need to be improved to accommodate those changes” (FI:3).

In general, the participants thought the current strategies were effective. They believed, however, that it could be reviewed at least yearly as fraudsters are always looking for loopholes within the industry. Perpetrators are always one step ahead and most companies can only follow their trends. Therefore, it is important to ensure that insurance companies implement effective and efficient fraud prevention and detection strategies.

7.3. Challenges

This theme intends to highlight any obstacles that might exist in preventing Assupol and DPCI from effectively detecting, preventing, and investigating life insurance fraud. The participants shared various challenges that hinder them from effectively detecting, preventing, and investigating life insurance fraud. The most pertinent responses are the following:

7.3.1 Sub-Theme: informant, person’s identity, logistics issues and stakeholders

The participants vented different challenges that hindered them in responding effectively to this crime. The participants highlighted the refusal of an informant to corporation in a criminal investigation. Considering the nature of life insurance fraud, the researcher is of the view that investigators need to try to establish rapport before interviewing investigators who encounter this problem. Some key responses are presented below:

“In most cases, the challenge is the people we interview. They refuse with the information; some think we are also going to defraud them and fingerprints getting lost” (FI:1).

“As part of investigations we need to talk to people and ask them questions, but the problem is that those people don’t want to talk to us so yeah it’s a problem for us (FrI:7)

“Mostly when we want to talk to the informant, the informant runs away or refuses to speak to us and in most cases that informant was also involved” (FI:7).

In addition to the above-mentioned challenge, participants also mentioned that the faked identity of perpetrators was a challenge. This finding highlights the problem of gathering evidence by investigators. Furthermore, the use of technology by perpetrators is a problem.

“ummh, I think what is the biggest challenge with some of the cases is the identity of the people are completely fake. You get people who do fraud for a living and so all the details the person uses are fraudulent, and so is the information at the bank, the cell phone number, and RICA information is all fraudulent. And the biggest obstacle is that those institutions that are supposed to work with us in identifying the suspect fail so we can't move forward because we need to prove who did it. And another challenge is that everything is electronic now, people don't even need to go into the offices now to claim, which is making it tricky to investigate these cases” (FrI:10).

“It's profiling, so say am investigating a claim submitted by Palesa right? Sizwe is dead so right now the only information I have is palesas and Sizwe's information only and no one's else information besides the funeral parlour and stuff like that so it becomes a problem at times if Palesa is the person responsible for the funeral parlour cause now it means the funeral parlour would have the same information that has so now it's going to be hard for me because the person that I can call is palesa and palesa is the claimant so I need to call somebody. maybe a neighbour or Sizwe's brother just to ask and verify things such as did Sizwe die? when did he die, where did he die those questions help you get to the truth because if Palese says Sizwe died at Nquthu and the brother says he died at Ndwedwe that's a red flag you see?” (FI:8).

Crimes such as life insurance fraud commonly involve the use of cell phones for communication between the individuals involved and bank transactions because often someone needs to get paid. Thus, this is important information and failure to access such information would potentially jeopardise the investigation as stated by the participant.

“Mmh its delays to receive section 205 which deals with banks' transaction details and section 70 (cell phone records) is the biggest challenge. When investigating a case of this nature you need it because the syndicates will communicate via cell phones. So, these sections are very effective in such cases but the magistrate does not want to authorize investigators to do that” (FrI:8).

This finding shows that investigators face the challenge of people involved in the investigation not honouring appointments and thus wasting the time and resources of the investigators.

“Ummh challenges, I mean it's a lot hey. I mean sometimes you travel to a place you don't even know and you set up an appointment with the investigating officer and when you get there, they are out on another important case, meaning you have just driven there for nothing.

Meaning you either must sleep there and come back the following day after speaking to him” (FI:9).

Considering the provided responses, the obstacles/challenges hampering the effectiveness and efficiency of investigating life insurance fraud were varied. The challenges ranged from interviewed people refusing to share information, insurance companies not cooperating fully, the fake identity of perpetrators, delays in receiving section 205, and travelling logistics of investigators. However, the most predominant problem seemed to be the refusal of information from the people who were interviewed as this affected the outcome of the investigation.

7.3.2 Sub-theme: The South African Police Services (SAPS)

This sub-theme outlines that the South African Police Services’ (SAPS) lack of collaboration with other stakeholders becomes a serious concern. The study found that the sharing of data between the public and private sectors is necessary to help prevent, detect and successfully investigate life insurance fraud. Thus, a relationship between the key stakeholders is of vital importance, particularly in terms of communication and cooperation. The insurance industry cannot effectively fight life insurance fraud alone. Some participants expressed that there is a lack of cooperation from SAPS officials. The participants emphasised that SAPS officials at the station level (charge office) are not cooperative and lack a basic understanding of what compasses life insurance fraud. It is noteworthy that the participants were referring to SAPS at the station level and not particularly DPCI, however, this is a serious concern as all fraud cases are commonly reported at the police station and thereafter referred to one of the specialised units, depending on the merits that require further investigation as screened by the general detective. Pertinent comments in this regard are the following.

The participant expressed that another factor inevitably undermining the investigation is the lack of cooperation from the SAPS, furthermore, the participant added that the reason could be the involvement of SAPS members in this crime.

“SAPS that is our first obstacle They don’t prosecute our cases, they don’t investigate them. We give them all the facts, we have the ID number of the claimant, right? we have a number for the funeral parlour, we have an address. We have all the information because for you to claim you must give us your information, so we give that information to SAPS but ...because some of the SAPS members are involved, we have SAPS that submits fraudulent claims.

They do not work well with us as they don't take these cases seriously, I don't know what they do because we open the cases, but they don't arrest the people" (FI: 10).

The participant mentioned that SAPS members are not well informed or educated about insurance fraud, specifically life insurance fraud. Hence, they do not understand insurance terminology.

"You know I had a person that was killed in Kwamashu, the person was killed for life insurance. The person who was claiming did not even know the name of the child of the deceased, but they were supposedly staying together as spouses, I did not have to tell SAPS that. They should have picked it up if they had done a proper investigation. SAPS waste our time; those people are not well informed about insurance fraud. They are not fully cooperative and give us a hard time when we go open cases" (FI: 7).

"And also the resistance from the SAPS, because they don't understand life insurance fraud, they don't understand insurance terms. For example, insurable interest, they don't understand insurance fraud as a whole let's start there. You have to explain to them what fraud and you have to take them down how this fraud was committed, who committed this fraud, how they committed this fraud, and what they used to commit this fraud for them to now open a docket to say ok am opening a docket of fraud because of 123. I feel like they need to be educated on what insurance fraud is and a special unit needs to be opened for all the insurance fraud cases, that understand what insurance is because our usual saps that are at the charge office know to stamp an affidavit that's it" (FI:5).

Despite the above findings, a participant from SAPS DPCI also expressed that insurance companies are not cooperative during investigation processes.

The complainant (insurance company) is a challenge because we are sitting with dockets, and we don't know our complainant. Whenever you say am coming to your office the person will tell you that they are busy. Even then they are a stumbling block, they give us a hard time when we need to conduct our investigations (FrI:7)

Considering these responses, it became evident that unaddressed challenges exist that hinder ASSUPOL from effectively and efficiently investigating life insurance fraud. These challenges include the resistance to cooperation from SAPS. This is a matter of concern because life insurance fraud is a huge problem and is endemic in society. So much so, that no single organisation can effectively curb life insurance fraud in isolation. Participants alluded that one

of the challenges with SAPS members is that they lack a basic understanding of what is life insurance fraud, in some cases forensic investigators need to explain to them what happened for the member/s to be able to open a docket. This finding suggests that there is an ineffective relationship between the SAPS DPCI and the insurance industry. One of the participants expressed that members do not take these cases seriously. This may be due to the lack of understanding, as people often perceive fraud as a victimless crime. Overall, the finding suggests that in response to life insurance fraud, there must be full cooperation between SAPS specifically the DPCI and the insurance industry. Furthermore, one participant emphasised that SAPS members (charge office) needed to be educated on life insurance fraud for them to be able to do their jobs efficiently. This finding implies that all the cases are registered at the police station and if the case is under the mandate of DPCI, only then it gets transferred to them for further investigation. Furthermore, this finding coincides with (Zenani, 2023:8), who stated that “most of the general detectives at the station level lack the intellectual capacity and competency to handle and utilise forensic techniques to investigate fraud matters”. Thus, this could potentially affect the whole chain of investigation if these cases are not adequately dealt with at the station level.

7.4 Responses to general probing questions

7.4.1 Sub-Theme: Social / Human impact

This sub-theme implies that life insurance fraud negatively affects victims, their families, and communities with real and irrevocable consequences. The current research revealed that emphasis on financial impact may be overstated in literature when the impact of life insurance fraud goes well beyond this. In this study, participants shared their concerns and a sense of seriousness as they expressed that the social impact of this crime is often overlooked. The study found that life insurance fraud can also cause emotional impairment for individuals. This is illustrated by the following narratives:

While the direct financial loss is borne by the consumers, behind every case of life insurance fraud there are real individuals, families, and communities whose lives have been impacted or even destroyed by this crime. The damage to these individuals can be financial, emotional, or even physical.

“It is so sad to think that most people do not understand that life insurance fraud also has a social impact. Say you had kids and I killed you, how will they survive without you? The worst

part they will not benefit from your death; it will be difficult for them. Relatives suffer, say that person was playing a big role, he was the breadwinner paying for food, school fees or whatever playing a role in a family. When he is dead who will play that role even that money that is being defrauded is not going to the ones that need it the most, it's going to benefit 1 or 2 people. It breaks family ties due to a lack of trust, family members or the society at large no longer trust anyone with their IDs. Like especially in the African culture, have you seen how uncomfortable a person becomes the moment you ask them for their ID? They immediately think that you going to cover them even if you know that is not what you need it for. So, you can see that there is an impact here” (FI:1).

A participant expressed that the social impact of life insurance fraud is often overlooked, the participant highlighted that the biggest problem is that the insurance industry has turned a blind eye to the social impact of this crime.

“Yoh that's a hard one, I have never really looked at it from that point of view. I think we always look at it from the economic point of view. ay these companies are so big, that it's hard to say. which does not make sense because this crime like any other crime has economic, social, and emotional effects on the victims or society. But maybe what I can say is that the first problem is that we turn a blind eye to the social effect of this crime” (FI:4).

Life insurance fraud can have far-reaching impacts beyond the individual, as people affected can suffer psychologically and emotionally. Because life insurance can put people's lives at risk, people are now scared to causally share their ID numbers or documents with family members for fear of being covered and later killed. Thus, it damages relationships with family and friends and breaks the trust in families.

“(salient) I would say in families' trust has become a problem because people are now scared that someone has covered them and when someone has covered you it's very easy to just kill you. And it breaks families because people would kill family members which becomes a problem when the family finds out, that something can never be fixed. As the same person who is killed through life insurance fraud might have kids, now imagine kids growing up without parents and maybe suffering in the process. The victims of this crime suffer the most emotionally, physically and psychologically some people never recover from that pain, and some end up being depressed and taking their own life in the process. In love relationships, spouses would be scared that their partner might kill them over policy pay-outs” (FI:5)

In addition to monetary loss, the participant mentioned that life insurance fraud can result in emotional impairment as it affects and delays the burial processes of families. Thus, whenever a new fraud scam comes to light the processing of claims becomes slower due to additional verification processes which can affect genuine claims. Furthermore, during the interviews that are conducted by the forensic investigator victims relive the trauma that they experienced.

“We see it affects communities is that you have genuine death. Look at for example that is certified by traditional leaders where the person genuinely passed away. There Is now a delay in terms of processing that claims the cause of the fraud. This means that yes, the death did happen but because of all the other complications it now takes us longer in terms of validating the claim. Which means it delays the grieving family the validation of their claims. The social impact is that would have been a normal claim paid within 24 hours sometimes it can be delayed to 36 hours which might result in what we now see and have termed the old mutual scenario. where they brought the deceased person into the insurance company which is inhuman basically. that is a direct impact of the conduct of fraudsters which now affected the social side of things. where the families with genuine death have now to go through these interviews you know confirming the death, people are grieving then we need to ask them you know did the person passed away as per the date recorded. and sometimes you find unrelated people, you know taking advantage of those people who are struggling to ensure their relatives, yet they are not even related to them. Now they must answer questions, how is this person related to you? it becomes uncomfortable. so that is the social impact that we see from our side. You know sometimes we must go to their homes while still in the mourning period because want to fast track the finalization of the claim” (FrI:2)

In this study, it has been revealed that life insurance fraud can affect the victim's well-being. These comments confirm that life insurance fraud like other serious crimes has a societal impact. Participants revealed that the consequences of life insurance can negatively impact the victims and their families. Furthermore, the participants mentioned that life insurance fraud affects relations as it breaks family ties and creates a lack of trust within families or romantic relationships. One participant mentioned that the victims of this crime suffer the most emotionally, physically, and psychologically as some people never recover from that pain and betrayal. This finding is supported by SEMutual Insurance (2018) which maintains that t insurance fraud can result in death or physical injury, as well as emotional and psychological impairment to the members of the public. Furthermore, one participant expressed that the impact of life insurance fraud is often viewed from an economic stance. However, life

insurance fraud is like any other crime which affects society economically, socially, and emotionally.

This response suggests that life insurance fraud is less recognizable for causing harm to society, as more attention is directed to the financial implications of this crime. Choudhary (2014) concurs by stating that insurance fraud is not only a financial offence costing individuals, businesses, and government. It is also an aggressive crime that can involve murder, personal damage and serious property harm, life insurance fraud forces other personal hazards such as disrupted lives and families, lost jobs, and financial failure. Considering the societal impact of life insurance fraud will assist the insurance industry in approaching fraud in a way that is most meaningful to the public. This finding implies that the social impact of life insurance fraud is quite elusive yet the extent of it looms large in society.

7.4.2 Sub-Theme: Lack of public awareness around life insurance fraud

This sub-theme outlines the organisation's lack of public awareness of life insurance fraud. It is reported that the public is unaware of the harsh reality of life insurance fraud. The participants alluded that the public is not aware that life insurance fraud exists until a case has been published in the media. They explained that most of the public does not know about this scourge of crime and explained that they believe it is because the insurance companies do not share such information with the public to protect their business image. The participants shared the following views:

There has been a lack of public awareness on life insurance fraud, the participant mentioned that the public was not aware of life insurance fraud and what constitutes this type of crime.

“Not really, they don't know it's not a lot of people who know about this because only now we receive these docket and then we like let us go to the hospital where this person was stabbed and talk to ... and then when you get there and you like ok am investigating a case of life insurance fraud, the people would ask a lot of question to show that they have no idea of what we are talking about. I remember when I was taking section 205 to the magistrate, he was so shocked in such a way that he was like wait let me drink some water because I had 2 cases of life insurance fraud. So, you see people are not aware those who know about it are like me and you who work with such cases. Hence, I advised the complainant to share his case with the media. We still need to make some kind of awareness and I foresee that it is also our

responsibility as DPCI because, at the end of the day, these cases come to us for investigation” (FrI:2).

The participant expressed that society is unaware of life insurance fraud unless a case has been published on social media. Importantly the participant highlighted that the media broadcast cases, however, the public forgets about this crime.

The researcher concurs that it is easy for the public to easily forget about this crime because unlike cases of murder or rape that are on TV and newspaper almost every week, cases of life insurance fraud are not always published in the media.

“(laughs) Society is not aware of most crimes that happening around them, society still wants to believe the good in people, so I don’t think they are fully aware until it comes to newspapers and the media and stuff.

Society is not aware of these things. Yes, they get warnings and look after their documents, but I don’t think society knows and realises what can happen if someone gets hold of their identity document. How they can be implicated or used in these types of crimes. I don’t think society knows that I think society still wants to believe that everybody is good and there is no evil. I don’t think they are aware unless it’s come on in the news, I think there was that lady who was a policeman and then she insured all those people, so until something like that comes on TV people are not aware and then they forget about it again” (FrI:4)

The participant mentioned that the lack of public awareness is a result of a lack of self-education. The public does not educate themselves on the things that affect them.

“Not when it comes to insurance and anything else that is related to it. People only know that when it comes to insurance you only open a policy, pay premiums, and claim that it. Doubt they even care about anything else; you would expect them to be aware of at least the financial implications of this crime because it affects them but I don’t think they know. This thing of us not wanting to educate ourselves is a problem, insurance companies need to try to make consumers aware of such and stop thinking about themselves” (FrI:10).

The participant revealed that the insurance industry fails to public awareness because insurance companies want to obtain a competitive advantage over others, thus will rather adverse the good over the bad to maintain their public status.

“So, in terms of public awareness, in terms of publicity which means the company need to do an advert that will reach out to the people, telling them about fraud in the insurance industry. Now have you ever seen on SABC 3 where you see Desmond Dube talking about Clientele, talking about insurance fraud? Why? because now they are afraid that the people will start to change ships and move to another insurance company, companies are trying to protect their image. You don’t tell people what could happen... fraud blah blah. They will not trust you; you understand? rather you tell them how good the policies are and when they are in, then you need to guard the policies against fraud” (FI:2)

The mass media has a very big power in modern society, it plays an important role in informing and educating the public about crime. However, the participant highlighted that with life insurance fraud very little is published about the crime.

“Because the mainstream media will only put it out there if someone was murdered for insurance money but there is very little that is said about this crime. Say we are looking at R20 000 no media house will report on that because nobody got injured. The awareness or education is not out there, for example before this recent case of Rosemary do you think the public was aware or alert of life insurance fraud, No. We still need to do a lot of education on this topic with several role players because it something that should concern everyone, and I just wish that the people could take it seriously” (FI:6)

The society is not well educated on life insurance fraud, the participant alluded that the public, specifically people in the rural areas are not aware or educated about life insurance fraud. Thus, more public awareness needs to be generated around this crime.

“There is no awareness, let’s be honest ummh. In fact, ..., a few years ago I wanted to start a talk show or a radio show, I wanted to have an insert in a show educating the people about insurance, insurance fraud, funeral cover, and life cover the differences and how fraud can be committed and the different aspect of insurance fraud and the different dynamics that I have just touched on now. Because I don’t think there is enough awareness for an everyday person in the public, for instance, a person that comes from emakhaya (rural area) or comes from the villages or even the city doesn’t know much about insurance for that matter. More particularly life insurance fraud, people are not aware, and you would be surprised Noma that even people who are learning and working who are doctors, teachers, and nurses you know middle-class South Africans do not understand how insurance works or what life insurance fraud is. So, I wanted to tackle that because I felt like our people sometimes get robbed due to a lack of

knowledge. I do believe there is not enough awareness even from the sale of the policy whether it is funeral, life or disability whatever insurance that is being sold I don't think there is enough awareness also with regards to the insurance ..., where the fraud is concerned and how fraud is committed there is no awareness, to be honest with you. unless you are interested in reading such or cases like Rosemary that lady that killed her family then that ..., it was only blown because it was a court case, so with that I feel like now we are starting to open our eyes as a country with that case to say ok, there is such a thing were family members kill each other but I can tell you now she's just a drop in the ocean of what is happening in this country in terms killing for insurance money” (FI:8).

However, in contrast to the above quoted verbatim the latter participant expressed that feeding the public with too much information could yield immoral consequences.

“Yes, but if a person wants to do it they will do it, whether society knows or doesn't know. Because they know that it's a crime. Also, remember that too much information could be bad, so you find that at times when you trying to create awareness you may also be shooting yourself in the foot. That is why most companies will use 1 line that zero tolerance for fraud” (FI:10).

Life insurance fraud is a perennial threat to both the insurance industry and society, thus it will remain a threat in the future if not properly addressed. According to (BryteEdition, 2022), insurance companies need to be on the front foot of life insurance fraud by proactively equipping people with knowledge. Insurance fraud prevention (2023) authority concurs by stating that making the public aware of the serious issues of insurance fraud is crucial to fraud-fighting efforts.

The findings suggest that the public does not comprehend the plight of life insurance fraud faced by the industry and society due to the lack of public awareness around this issue. This corroborates findings by the Centre for Opinion Research (2009), that most insurance consumers do not know exactly what insurance fraud is. One of the major points that arose from one of the participants is that the insurance companies do not share with the public the scope, severity, and impact of life insurance fraud due to companies trying to protect their image and escape competition in the industry. However, Considine (2010:1), emphasised that consumers should be made aware that in addition to insurance fraud being widespread- it also affects everyone. Furthermore, (Deloitte, 2023) concurs by stating that insurance companies need to increase awareness of the many different areas and types of fraud.

Thus, life insurers must be able to share knowledge, perspectives, and fraud-prevention ideas. This finding suggests that the insurance industry in collaboration with SAPS DPCI and other relevant stakeholders needs to remind and educate the public about the scope and impact of life insurance fraud.

The research findings on the strategies employed to detect and prevent life insurance fraud, as well as their effectiveness, directly address the research question regarding the approaches implemented by SAPS DPCI and Assupol in KwaZulu-Natal to mitigate the occurrences of life insurance fraud. Consequently, these findings provide detailed insights into critical aspects of how these organizations are tackling the challenges posed by fraudulent activities within the study area. As noted earlier, the study revealed that SAPS DPCI has not implemented any proactive measures, instead responding to life insurance fraud only after it has occurred. This discovery enhances our understanding of the preventative and detection interventions aimed at mitigating fraud risks within the Durban area, particularly in understanding the specific actions taken by law enforcement and insurance companies to address this serious crime. Moreover, this insight offers a comprehensive view of the obstacles encountered by SAPS DPCI and Assupol in effectively identifying, preventing, and investigating instances of life insurance fraud.

Furthermore, the research findings shed light on a previously overlooked aspect—the social impact of this crime. Despite being often overlooked, every instance of life insurance fraud affects real individuals, families, and communities, sometimes causing significant harm or devastation. Additionally, the findings indicate that the public generally remains unaware of the existence of life insurance fraud until cases are publicised in the media.

7.5. Chapter Summary

The analysis of the data and findings were presented in this chapter concerning the three objectives for the exploration of life insurance fraud. The study's findings were interpreted based on the categories that each theme encompassed. The findings were presented, analysed, interpreted and discussed in line with the literature review and theoretical frameworks that underpin this study. Themes were used to present the findings about each objective of the study. In addition, contributing factors to life insurance fraud were also examined and the findings indicated that perpetrators are commonly driven by financial pressure into committing this

crime. The next chapter presents a conclusion that can be derived from the foregoing discussion, followed by the overall recommendations, and proposed future research paths.

CHAPTER EIGHT: INTEGRATIVE DISCUSSION

8.1 Introduction

This study was based on the premises of the research problem which was described in Chapter One of this thesis. According to various authors, KwaZulu-Natal has a high rate of life insurance fraud in South Africa. To articulate this problem, a research study was designed that would explore the MO and causes of life insurance fraud. The research was sparked by a dearth of empirical research that explored life insurance fraud in South Africa, which was a gap the researcher wished to fill.

A comprehensive review of related literature was presented in Chapter Two. This review provided the background to this study and enlightened to reader regarding life insurance fraud and thus located the study in the existing body of knowledge regarding this topic of investigation. The third chapter provided information regarding the theoretical framework and the thesis focused on two theories, namely the routine activities theory, and the fraud triangle theory. To achieve the research objectives, a suitable methodology was chosen, and a discussion of this methodology was presented in the fourth chapter of this thesis. The qualitative research method that was located within the interpretive research paradigm using the phenomenology strategy of inquiry was also explained. The findings that were derived from in-depth semi-structured interviews and key informant interviews with research participants were presented in chapter five. These findings were discussed and integrated with other related scholarly literature and the theoretical framework. This final chapter presents the main conclusions based on these findings and offers pertinent recommendations.

General conclusions that were reached will be discussed in terms of the objectives of this study, which were to:

- To determine the Mundus Operandi used by policyholders to commit life insurance fraud in Durban, KwaZulu-Natal
- To determine the key contributing factors of the policyholder in perpetrating life insurance fraud in KwaZulu-Natal.
- To explore the strategies that companies use to detect and prevent life insurance fraud and their effectiveness.

8.2 Conclusions relating to the achievement of the objectives of the study.

Table 8.1: Findings in sequence

Objective	Research question	Theme
1. To determine the Mundus Operandi used by policyholder to commit life insurance fraud in Durban, KwaZulu- Natal.	1. Based on your experience, What is the M.O of committing life insurance fraud in Durban?	1. MO's of life insurance frauds: <ul style="list-style-type: none"> • Fake death • Murder for money • Identity theft • Rural death • unidentified dead body • Ghost claims
2. To determine the key contributing factors of the policyholder in perpetrating life insurance fraud in KwaZulu- Natal.	2. What are the contributing factors of policyholder in perpetrating life insurance fraud in KwaZulu- Natal?	2.Reasons for committing life insurance fraud: <ul style="list-style-type: none"> • Greed, quick cash and lavish lifestyle • Loopholes (Poor internal control of the company)
3.To explore the strategies that companies use to detect and prevent life insurance fraud and their effectiveness.	3. What are the strategies that companies use to detect and prevent life insurance fraud and their effectiveness?	3. Strategies used to detect and prevent life insurance fraud and their effectiveness <ul style="list-style-type: none"> • Reactive not proactive • Fraud awareness and training • Red flagging • Whistle blowing • The effectiveness of Assupol strategies to curb life insurance fraud

8.3 Common types of life insurance frauds committed by policyholders in KwaZulu-Natal

The sampled participants of this study alluded that the most common types of MOs used by claimants to commit life insurance frauds included fake death, murder for money, identity theft, rural death, use of unidentified dead body and ghost claims. The study revealed due to financial pressure, compelled some of the claimants to adopt criminal behaviours to get quick cash /or easy money and unfortunately one of those ways is to submit fraudulent claims to insurance companies. The above-mentioned *M. O's* indicate that life insurance fraud is a sophisticated crime that requires elaborate planning. The study participants indicated that perpetrators may fake their deaths or arrange for someone else to fake their deaths to collect the life insurance payout. They may go to great lengths to create the appearance of a genuine death, such as staging accidents, using fake identities or hiring unidentified dead bodies to represent the dead body of the alleged person. These alleged faked deaths can include the “death” of a relative who stays in the rural areas, particularly old people, for example, grandparents. It is unlikely for old people to be aware of such as some of them are illiterate and know nothing about life insurance policies. To accomplish this MO, perpetrator usually work with funeral parlours and doctors. Essentially, the concept of faking death involves the intentional misrepresentation of an individual's demise. Whether motivated by a desire to escape legal consequences or to secure insurance pay-outs, perpetrators engage in a range of deceptive practices. These may include the creation of counterfeit death certificates, submission of false obituaries, or the orchestration of elaborate events to simulate a person's death. It was discovered that the different MOs can be interlinked to each other. A person who fakes death is likely to murder in the process to be able to have the dead body of the alleged deceased to claim.

Moreover, participants in the study highlighted that killings for financial gain often involve the hiring of hitmen, commonly known as contract killers. These hired individuals are tasked with orchestrating the murders of those individuals covered by insurance policies. The study found that an individual might acquire a life insurance policy for another person, often without their knowledge or consent, and subsequently deliberately cause that person's demise. This is done to deceive the insurance company by making the death appear accidental or natural, all to illegitimately obtain the insurance payout. Essentially, this illicit practice entails deliberately causing someone's death to collect life insurance or other financial benefits. Disturbingly,

perpetrators view their family members and loved ones as mere financial assets, considering the obstacles that need to be eliminated to access life insurance money. A critical concern is the ability of perpetrators to take out life insurance policies without the knowledge or consent of the person being insured, thereby encouraging these murders. In essence, life insurance purchased to insure the life of another can have the unintended effect of tempting a murderous beneficiary to kill the insured to obtain the insurance payout.

The research participants also disclosed that individuals involved in life insurance fraud adopt the strategy of claiming unidentified deceased individuals (referred to as John Doe) as their relatives or family members. The practice of using / hiring dead bodies for insurance fraud takes various forms. Individuals may resort to creating elaborate scenarios, including staged accidents/ death. In some cases, syndicates may be involved, taking advantage of vulnerable populations to carry out these dreadful acts. In this scheme, the perpetrators procure a life insurance policy for a fabricated person, then acquire a body, either through rental or purchase from a funeral parlour. This body is used to obtain a death certificate, and subsequently, a claim is submitted. It was observed that mortuary workers play a significant role in promoting this modus operandi, often notifying syndicates about available John Doe's. A crucial aspect of this fraudulent activity is ensuring that the physical characteristics of John Doe closely match those of the person whose identity is being used. This practice is particularly prevalent in South African mortuaries, where the occurrence of unidentified deceased individuals (John Does) is relatively high. Beyond the financial toll on insurance companies, the human cost of using John Doe for insurance fraud is perhaps the most distressing aspect. As innocent lives are not only manipulated on paper but, in some cases, are tragically cut short. Murders orchestrated for the sole purpose of obtaining a life insurance payout reveal the depths of moral decay within those willing to engage in such terrible acts.

Participants also highlighted another method employed in life insurance fraud, which involves the theft of identity documents (ID). Perpetrators steal identification documents and use them to take out life insurance policies, assuming the identity of the person on the stolen ID. They designate themselves as the beneficiaries of the policy. The owner of the stolen ID may either be harmed, leading to their demise, or the perpetrator may use a John Doe to obtain a death certificate. This finding suggests that the rise of identity theft and life insurance fraud poses a significant threat to individuals and the financial sector. These illicit activities not only cause devastation on the lives of unsuspecting victims but also undermine the integrity of essential financial systems.

Ghost claims in the context of life insurance fraud refer to fraudulent claims made for policies covering individuals who are either fictitious or deceased. This deceptive practice involves creating a false identity or using the details of someone who has passed away to file a claim and obtain the associated benefits. The study found that ghost claims often involve the fabrication of non-existent individuals. Perpetrators may create entirely false identities, complete with false personal information, to establish life insurance policies to later make claims. This finding reveals a complex web of deceit, where perpetrators exploit insurance policies for financial gain through a series of orchestrated steps.

The study participants alluded that perpetrators exploit the details of deceased individuals to make fraudulent claims. This could involve using stolen personal information or often collaborating with corrupt officials from home affairs to generate a birth certificate (paper children) or other documentation to support the false claims. Thus, fabricating the existence of a person who has never actually lived. This finding suggests that this form of MO involves creating a paper trail, including fabricated documents such as birth certificates and identification, to support the existence of individuals who have never been born or do not exist. Perpetrators may make regular premium payments for these paper children, impersonating the financial activities associated with legitimate insurance policies. This helps maintain the illusion of genuine policyholders. Hence, when it comes time to capitalise on the life insurance policy, the perpetrator files a claim using the fabricated details. This could involve staged events or circumstances, leading to a pay-out based on the insured paper child's supposed condition or demise. Consequently, the researcher argues that perpetrators often employ sophisticated methods to mimic legitimate policyholders, making it difficult for insurance companies to identify red flags and prevent fraudulent claims. This finding indicates inaccuracies in South Africa's birth rate data, leading to an unreliable population rate. In essence, the association between ghost claims and life insurance fraud highlights the need for constant vigilance and enhanced preventive measures within the insurance industry

A noteworthy finding is that some deaths in rural areas, referred to as “emakhaya,” go unreported to the Home Affairs department. Rural areas, characterized by their picturesque landscapes and tight-knit communities, are not immune to the challenges associated with life insurance fraud. While rural living has its unique charms and traditions, it also presents distinctive challenges when it comes to verifying deaths and preventing insurance fraud. Essentially, this finding revealed that in this environment, the occurrence of deaths may not always reach the wider public or regulatory authorities (home affairs) promptly, creating an

opportunity for deceitful individuals to exploit the situation. Further, the participants expressed that in rural areas, the occurrence of deaths and subsequent life insurance claims may unfold without immediate scrutiny.

This is often due to financial constraints or a desire by the family to cut down on the lengthy logistics associated with arranging a funeral. In such cases, the deceased is promptly buried at home, typically the following day. This expedited burial process enables individuals to take out life insurance policies. When these policies mature, the death is then reported, and a fabricated identity is used for a deceased body. Subsequently, a death certificate is obtained, and a claim is submitted. The study further found that contrary to the common perception that life insurance fraud in rural areas is confined to familial circles, an intriguing twist emerges. This illicit act is not solely orchestrated by family members seeking financial gain but also involves individuals associated with funeral parlours. The researcher argues that the involvement of funeral parlour personnel introduces a new dimension of complexity to life insurance fraud in rural settings. These personnel, equipped with knowledge of the deceased and access to crucial documentation, become strategic players in executing this MO.

Furthermore, it is evident that the perpetrators heavily rely on the collaboration of funeral parlours and doctors to execute this modus operandi successfully. This sequence of operations illustrates the extent to which people are willing to go for the sake of securing life insurance payouts. Thus, the Insurance companies face financial losses due to fraudulent pay-outs for policies covering non-existent individuals. This can lead to increased premiums for honest policyholders and undermines the overall integrity of the insurance industry.

8.4 Motivations for committing life insurance fraud

Following the literature review, the study aimed to understand the reasons for committing life insurance fraud in South Africa as perceived by policyholders (beneficiaries). Several factors contributing to the occurrence of life insurance fraud have surfaced, including greed, the pursuit of quick cash, a desire for a lavish lifestyle, and the exploitation of loopholes. A clear perception by the participants was that beneficiaries commit life insurance fraud because they are greedy for money to maintain a lavish lifestyle. The study further found that the desire for a lavish lifestyle can be a motivating factor for some individuals to engage in life insurance fraud. When individuals aspire to maintain or attain an extravagant way of living, they may succumb to the temptation of manipulating insurance companies for financial gain. Further,

greed, often driven by the desire for quick cash, is identified as a motivating factor for policyholders or beneficiaries to engage in life insurance fraud. Greed is one of the strongest motivators of life insurance fraud. In cases where perpetrators are driven by an insatiable desire for financial gain, they may engage in fraudulent activities within the life insurance system. This can manifest in various forms, such as murder for money, faking death, and identity theft.

In pursuit of easy financial gains, perpetrators may be tempted to commit fraudulent acts to seek financial benefit. Essentially, one primary driver behind life insurance fraud is financial desperation. Faced with economic hardships, individuals may see fraudulent insurance claims as a quick and seemingly easy way to alleviate their financial burdens. This motivation is often rooted in a sense of urgency and the belief that the potential financial gain outweighs the risks involved. However, the study found that the inherent human tendency towards greed can lead some individuals to orchestrate fraudulent activities for financial gain. The prospect of a significant insurance payout may be too enticing for those driven by avarice, prompting them to manipulate circumstances to secure financial benefits. In essence, individuals facing financial difficulties may resort to fraudulent activities to alleviate economic strain. This aligns with the first element of the Fraud Triangle Theory (FTT), which suggests that individuals are motivated to commit fraud by perceived financial pressures or incentives.

Perpetrators of life insurance fraud view their victims as cheques waiting to be cashed. Additionally, it was also found that the desire to secure financial advantages for oneself or specific family members may drive individuals, not only spouses but also other family members, to engage in deceptive schemes of life insurance fraud. The results also revealed that exploiting loopholes can be a contributing factor to life insurance fraud. This is because perpetrators identify weaknesses in the internal systems and thereafter manipulate these gaps for personal gain. This finding highlighted that opportunities to commit this crime may arise due to weaknesses in the insurance company's internal controls, lax verification procedures, or gaps in oversight. For example, inadequate scrutiny of policy applications or insufficient monitoring of claims processing may create opportunities for individuals to submit false information or fabricate claims. Consequently, this finding corresponds to the second element of the FTT, which posits that fraud occurs when individuals perceive opportunities to exploit weaknesses in systems or processes. Similarly, applying routine activities theory (RAT) to life insurance fraud provided valuable insights into the criminological dynamics underlying fraudulent activities in this context. Weaknesses in the insurer's internal controls or verification procedures may render them vulnerable to exploitation. RAT emphasizes that the presence of

suitable targets, such as vulnerable insurance policies or lax verification procedures, facilitates fraudulent activities.

Moreover, individuals facing financial strain due to job loss may commit life insurance fraud to secure insurance payouts. The pressure of unemployment, coupled with financial difficulties, leads some individuals to make false claims, to obtain monetary benefits from life insurance policies. Life insurance fraud is a multifaceted issue rooted in diverse motivations. Insurance companies in the study area lack guardianship such as the effective and efficient prevention and detection measure, which means that such companies are particularly enticing to motivated perpetrators. Hence, understanding these underlying reasons is crucial for the insurance industry to develop strategies to prevent and combat fraudulent activities effectively. Therefore, addressing the economic, psychological, and ethical factors that drive individuals to commit life insurance fraud can help ensure that life insurance remains a reliable and ethical means of financial protection.

In essence, perpetrators of life insurance fraud are weeded by greed, prepared to spill blood for money. The death benefit of a life insurance policy is only disbursed upon the death of the policyholder/ the insured person. This explains instances where individuals resort to murdering for fraudulent financial gain. As long as the policyholder/ insured person remains alive, the designated beneficiary cannot access the funds. The findings of this study are therefore consistent with some of the previous studies conducted.

8.5 Strategies used to detect and prevent life insurance fraud and their effectiveness

The SAPS DPCI lacks tangible and effective strategies to detect and prevent life insurance fraud, however, according to the participants, this is because the organisation only reacts in response to the crime after it has occurred as opposed to preventing it in advance. Some fraud investigators openly stated that fraud detection and prevention remain an industry priority and that life insurance fraud needs to be dealt with primarily by insurance companies as they have direct responsibility for managing insurance fraud.

The fact that the participants felt that the detection and prevention of life insurance fraud was the responsibility of insurance companies thus testifies to the inefficiency in curbing life insurance fraud by the SAPS (DPCI). Hence, the SAPS DPCI must change its strategy in carrying out its prevention function before life insurance fraud occurs, because if life insurance fraud occurs, it will have even greater socio-economic implications, especially for public trust

in life insurance companies, causing a public interest to decline. Nevertheless, Assupol has adopted the following strategies to aid in the reduction of life insurance fraud. These strategies include fraud awareness and training, whistleblowing and reflagging. Routine Activities Theory underscores that the absence of capable guardians increases the likelihood of successful fraudulent activities. The researcher argues that the guardianship measures implemented by Assupol are ineffective. As a result, fraudsters continue to exploit opportunities with reduced risk of detection or apprehension. The study emphasises the need for insurance companies to strengthen guardianship measures to deter fraudulent behaviour.

The study found that insurance companies prioritize educating their staff on the nuances of life insurance fraud through comprehensive awareness and training programs. These initiatives aim to equip employees with the knowledge and skills needed to identify suspicious activities and patterns indicative of fraudulent behaviour. Further, establishing red flag indicators and conducting thorough risk assessments are crucial components of fraud prevention strategies for insurance companies. This finding suggests that by identifying patterns associated with past fraudulent claims and assessing the risk associated with specific policies or claims, insurers can proactively intervene and investigate suspicious cases. Additionally, whistleblowing serves as a beacon of integrity within the insurance industry, offering a mechanism to expose and eradicate fraudulent practices. In the ongoing battle against insurance fraud, whistle-blowers stand as guardians of ethical conduct, ensuring that the industry upholds its commitment to fairness and justice. However, despite these strategies, the high rate of life insurance fraud remains a problem in KwaZulu-Natal as none of the devised strategies are effective in addressing this problem. In essence, the industry needs to emphasise detection and prevention strategies so that financial losses and losses will not occur in the future, especially for victims due to life insurance fraud. fraudulent activities.

8.6 Recommendations: Insurance Companies, DPCI, and Community Members

Careful consideration of the findings that emerged from the data prompted the following recommendations:

Recommendation One: Insurance companies should consider biometrics identification of the covered individual at the inception of the policy to ensure that the person is still alive. This will help prevent people from submitting claims for people who have fake deaths and claims of people who have long passed.

Recommendation Two: Insurance companies must proactively inform the public about the negative impact of insurance crimes, specifically life insurance fraud and its domino effect of higher premiums to policyholders. This could assist the public to be more vigilant and they may take extra precautions to avoid being victims of this crime. Furthermore, members of the community should be educated on ways people can protect themselves from being victims of this crime such as being careful with IDs and ID numbers.

Recommendation Three: The SAPS (DPCI) and the insurance industry should work collaboratively to curb life insurance fraud as life insurance fraud is a societal crime.

Recommendation Four: Insurance companies should maintain a national database of insurance fraudsters that can be accessed by the various insurers. To assist in profiling of fraudsters.

Recommendation Five: The insurance industry should partner with academic institutions to encourage more academic research on life insurance fraud.

Recommendation Six: Regulators should encourage insurers to provide adequate warnings for policyholders to better understand the consequences of committing life insurance fraud.

Recommendation Seven: The insurance regulators should make it a law for the insurance industry to notify people when a life insurance policy is taken for them. This will prevent perpetrators from taking out policies on people without them being aware.

Recommendation Eight: Insurance companies should limit the number of people that the policyholder can cover. Policyholders should not be able to cover the same people more than once and in different insurance companies.

Recommendation Nine: With the increasing rate of people taking life insurance covers telephonically. insures need to implement a verification solution to ensure that the person taking the cover is the correct person including verifying the identities of claimants.

Recommendation Eleven: The insurance industry needs to run public awareness campaigns in rural communities to educate residents about the consequences of insurance fraud and the importance of honesty in insurance dealings.

Recommendation Twelve: The industry needs to develop remote verification processes that make use of technology to confirm deaths in rural areas, possibly by working closely with local authorities or medical professionals.

Recommendations for Future Research: Taking into consideration the understudied nature of life insurance fraud in South Africa, more research is required to explore this phenomenon. Such studies should elicit both quantitative and qualitative data for comparative purposes and to make accurate projections of crime trends over a longitudinal period. In addition, explore the experiences and perspectives of victims of life insurance fraud to understand the emotional, financial, and social impacts of fraudulent activities on individuals, families, and communities. Such studies and the recommendations they offer will be highly beneficial in the Criminology and forensics studies field.

8.7 Limitations of the study

- Several insurance companies declined to take part in the study even though the researcher fully explained that she would not ask sensitive questions. The researcher had to identify and approach an alternative insurance company, which was time-consuming.
- This study, like any other study, had certain limitations that must be acknowledged. One of the shortcomings was that the study was confined to forensic investigators in only one insurance company in KwaZulu-Natal (KZN). The scope was thus relatively limited, and the findings may not be generalised to the entire insurance population in KZN or South Africa.
- The academic literature on life insurance fraud in South Africa is limited. While some research may have been conducted on insurance fraud in South Africa, the findings of such research were not available in academic sources.
- There were limited published statistics on both the rate and costs of life insurance fraud in SA; most of the statistics provided were contained in media reports.
- Taking into consideration the understudied nature of life insurance fraud in South Africa, more research is required to explore this phenomenon. Such studies should elicit both quantitative and qualitative data for comparative purposes. Such studies and the recommendations they offer will be highly beneficial in the Criminology and forensics studies field.

8.8 Chapter Summary

The study provided sufficient evidence to corroborate earlier findings that life insurance fraud is a concern for the insurance industry in South Africa. Although statistical data were not provided to support this statement, the rich, authentic views of fraud and forensics investigators

in KwaZulu-Natal (KZN) attested to the fact that the financial pressure had often escalated to intolerable levels of life insurance fraud. Underpinning the data and findings using the fraud triangle theory has proven to be quite useful in better understanding the contributing factors of life insurance fraud. Greed and the desire to get quick cash are also key factors that instigate and exacerbate life insurance fraud within the insurance industry. One pivotal finding is that when a person dies in a rural area, the death is not reported to home affairs, as a result, some family members utilize that as an opportunity to take up a life cover on the deceased. Based on the findings, various stakeholders must work together to curb life insurance fraud. The research questions and objectives were adequately addressed as the findings succeeded in identifying the types and causes of life insurance fraud in KZN. Conclusions were then drawn based on the results of the study. Thereafter, some limitations of the study were noted. Lastly, imperatives for future research were stated.

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**ANNEXURE A: INTERVIEW SCHEDULE GUIDE (SAPS DPCI): A
CRIMINOLOGICAL INQUIRY INTO LIFE INSURANCE FRAUD IN KWAZULU-
NATAL: AN EXPLORATORY STUDY**



Section A: This section consists of questions pertaining to the modus operandi of committing life insurance fraud

1. What is your understanding of life insurance?
2. Generally, what do you think of life insurance fraud? (Elaborate on your answer)
3. In your experience, what is the *Modus Operandi* (M.O) used to commit life insurance fraud? (Elaborate on your response).
4. Who are the major parties involved in perpetuating life insurance fraud?

Section B: Consists of questions regarding motivations for committing life insurance fraud

1. In your opinion, what are the motivating factors to the current spate of life insurance fraud? (Elaborate on your answer).

Section C: Consists of questions regarding strategies used to respond to life insurance fraud

1. Are there any current strategies you are aware of that your institution has implemented against life insurance fraud? (Elaborate on your answer).
2. Do you consider the current strategies used in your institution to respond to life insurance fraud adequate or ineffective? Why do you think so?
3. In your experience, what are the obstacles/challenges that hamper the effectiveness and efficiency of investigating life insurance fraud? (Elaborate on your answer).

General questions

1. In your opinion, do you think that the public find it easy to commit life insurance fraud? (Motivate your answer).
2. In your view, what is the social impact of this crime? (Elaborate on your answer).

3. In your view, is the community aware of life insurance fraud? (Elaborate on your answer).
4. Any other comments or recommendations you would like to make, regarding responding to life insurance fraud?

Thank you for your time and participation

ANNEXURE B: INTERVIEW SCHEDULE GUIDE (ASSUPOL FORENSIC INVESTIGATORS): A CRIMINOLOGICAL INQUIRY INTO LIFE INSURANCE FRAUD IN KWAZULU-NATAL: AN EXPLORATORY STUDY



Section A: This section consists of questions pertaining to the modus operandi of committing life insurance fraud

5. What is your understanding of life insurance?
6. Generally, what do you think of life insurance fraud? (Elaborate on your answer)
7. In your experience, what is the *Modus Operandi* (M.O) used to commit life insurance fraud? (Elaborate on your response).
8. Who are the major parties involved in perpetuating life insurance fraud?

Section B: Consists of questions regarding motivations for committing life insurance fraud

2. In your opinion, what are the motivating factors to the current spate of life insurance fraud? (Elaborate on your answer).

Section C: Consists of questions regarding strategies used to respond to life insurance fraud

1. Are there any current strategies you are aware of that your institution has implemented against life insurance fraud? (Elaborate on your answer).
2. Do you consider the current strategies used in your institution to respond to life insurance fraud adequate or ineffective? Why do you think so?
3. In your experience, what are the obstacles/challenges that hamper the effectiveness and efficiency of investigating life insurance fraud? (Elaborate on your answer).

General questions

5. In your opinion, do you think that the public find it easy to commit life insurance fraud? (Motivate your answer).
6. In your view, what is the social impact of this crime? (Elaborate on your answer).

7. In your view, is the community aware of life insurance fraud? (Elaborate on your answer).
8. Any other comments or recommendations you would like to make, regarding responding to life insurance fraud?

Thank you for your time and participation

ANNEXURE C: UNIVERSITY OF KWAZULU-NATAL FULL APPROVAL LETTER



30 November 2023

Nomathamsanqa Mthethwa (211535116)
School Of Applied Human Sc
Howard College Campus

Dear N Mthethwa,

Protocol reference number: HSSREC/00002368/2021

Project title: A criminological inquiry into life insurance fraud: A case study of 4 KwaZulu-Natal insurance companies in Durban, South Africa.

Amended title: A criminological inquiry into life insurance fraud in KwaZulu-Natal: An exploratory study.

Degree: PhD

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 07 November 2023 has now been approved as follows:

- Change in title
- Change in data collection method

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

HSSREC is registered with the South African National Health Research Ethics Council (REC-040414-040).

Best wishes for the successful completion of your research protocol.

Yours faithfully



.....
Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: <http://research.ukzn.ac.za/Research-Ethics/>
Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

ANNEXURE D: SOUTH AFRICAN POLICE SERVICES FULL APPROVAL LETTER

<i>South African Police Service</i>			<i>Just Afrikaanse Polisie</i>	
Private Bag 394	Pretoria 0001	Faks No. / Fax No.	(012) 393 2129	
Your reference/ U verwysing:		THE HEAD- RESEARCH SOUTH AFRICAN POLICE SERVICE PRETORIA 0001		
My referensie/ my verwysing: 3042				
Enquiries/ Vrae:	Lt Col Joubert AC Thenga (012) 393 3118			
Fax:	JoubertG@saps.gov.za			
Email:				

APPROVED

**N Mthethwa
UNIVERSITY OF KWAZULU-NATAL**

RE: PERMISSION TO CONDUCT RESEARCH IN SAPS: A CRIMINOLOGICAL INQUIRY INTO LIFE INSURANCE FRAUD: A CASE STUDY OF FOUR KWAZULU-NATAL INSURANCE COMPANIES IN DURBAN, SOUTH AFRICA: UNIVERSITY OF KWAZULU-NATAL: DOCTORATE DEGREE: RESEARCHER: N MTHETHWA

The above subject matter refers.

You are hereby granted approval for your research study on the above mentioned topic in terms of National Instruction 1 of 2006.

Further arrangements regarding the research study may be made with the following office:

The National Head: Directorate for Priority Crime Investigation:

- Contact Person: Brigadier M Mohajane
- Contact Details: 084 9522 230
- Email Address : MohajaneM@saps.gov.za

The Provincial Commissioner: KwaZulu-Natal:

- Contact Person: Lt Colonel DN Govender
- Contact Details: (031) 325 5808/4934
- Email Address: GovenderDN@saps.gov.za

The National Head: Directorate for Priority Crime Investigation has stressed that the researcher must provide a copy of the research report to the Directorate for Priority Crime Investigation.

The Provincial Commissioner: KwaZulu-Natal has stressed that participation in interviews will be on a voluntary basis and respondents may refuse to answer questions implying sensitive information.

RE: PERMISSION TO CONDUCT RESEARCH IN SAPS: A CRIMINOLOGICAL INQUIRY INTO LIFE INSURANCE FRAUD: A CASE STUDY OF FOUR KWAZULU-NATAL INSURANCE COMPANIES IN DURBAN, SOUTH AFRICA: UNIVERSITY OF KWAZULU-NATAL: DOCTORATE DEGREE: RESEARCHER: N MTHETHWA

Kindly adhere to paragraph 6 of our attached letter signed on the 2021-02-26 with the same above reference number.

[Redacted Signature]

GENERAL

DATE: 2021-10-21

ANNEXURE E: ASSUPOL APPROVAL LETTER



Dear Ms Mthethwa,

PERMISSION TO CONDUCT RESEARCH STUDY WITHIN ASSUPOL LIFE- NATAL INSURANCE COMPANIES, SOUTH AFRICA

In response to your letter dated 2 March 2021, I hereby confirm that you are allowed to conduct your interviews with the Assupol Life members working in Forensic Department in KZN.

I also would like to confirm that this permission is subject to non-disclosure of any propriety or confidential information of Assupol Life.

Two members of Forensic Department whom you can consult with are copied in this Email for ease of reference.

1. Mr Sithembiso Sibiya
2. Mr Amos Ncgobo

Kind Regards,



PJ PHELANE (Rev)
MANAGER: FORENSIC DEPARTMENT



t 0861 235 664 PO Box 35900 Summit Place Office Park, Building 6
f (012) 366 3500 Menlo Park 221 Garfontein road, Menlyn
w assupol.co.za Pretoria, 0102 Pretoria, 0181

Assupol Life Limited Reg No. 2010/025083/06. Authorised financial services provider. Directors: AS Birell (Chairperson), EDJ Ashior, ILM Bamett, D de Klerk, ID Greenstreet, NE Gubb, R Kisten, MB Mokuwena-Halala, T Muranda, SL Nkwatza, CJ van Dyk. Company secretary: SJ De Beer.

ANNEXURE F: INFORMED CONSENT LETTER



INFORMED CONSENT FORM FOR VOLUNTEER PARTICIPANTS

RESEARCH TOPIC: A criminological inquiry into life insurance fraud in KwaZulu-Natal: An exploratory study.

Dear Sir/Madam,

My name is Nomathamsanqa Mthethwa, I am a PhD student enrolled with the University of Kwa-Zulu Natal in the discipline of criminology and forensic studies. Under the supervision of Dr Sazelo Mkhize, I am conducting a research study based on “*A criminological inquiry into life insurance fraud in KwaZulu-Natal: An exploratory study.*”

You are being invited to participate in a research study that seeks to understand and explore the nature of life insurance fraud. The aim of this study is to investigate the nature of life insurance fraud and provide a criminological perspective on this phenomenon.

YOUR PARTICIPATION IN THE STUDY IS VOLUNTARY

Your participation in this study is strictly voluntary and you should not hesitate to ask any questions if you are unclear about anything stated in this form. If you agree to be part of this study, you will be asked to sign this consent form. When you join the study, I hope that you answer the questions honestly and to the best of your ability. I want to reassure you that none of the information you will provide will be shared with anyone outside the study.

PROCEDURE

Data will be collected using semi-structured interviews and key informant interviews which will be scheduled according to your availability. It is further requested that these interviews proceedings be audio recorded for the purpose of this research, provided you agree to this. The duration of the interviews will be an hour long. The data obtained through interviews will be kept securely for a period five years for purposes of verification by the supervisor, Dr Sazelo

Mkhize, at the University of KwaZulu-Natal. Should the participants' request it, an electronic copy of the final thesis will be sent to them on completion.

RIGHT TO REFUSE STUDY PARTICIPATION

Your participation in this study will not disrupt or affect your duties at work in any way. If you choose to be part of the study and change your mind at a later stage, you may withdraw from the research without any negative consequences.

THREATS OF PARTICIPATING IN THIS STUDY

There are no threats that are foreseen for participating in this study.

CONFIDENTIALITY

In order to maintain confidentiality, you will be assigned with a pseudo name so that your name will not be linked to any of your personal data and any data gathered will be treated with the strictest confidentiality. There is a great value in the information that you will be providing hence, the researcher will not share any study related information to any person other than the study supervisor.

Your willingness to participate in this study will greatly be appreciated.

Details of the researcher and institution of research:

	Address	Phone Number	Email address
Researcher	Miss Nomathamsanqa Mthethwa	064 117 0552	211535116@ukzn.ac.za
Supervisor	Dr Sazelo Mkhize	078 653 9437	Mkhizes1@ukzn.ac.za
Human Social Science Ethics	Research Office	031 260 4557/4609	<u>HssrecHumanities@ukzn.ac.za</u> <u>Hssrec@ukzn.ac.za</u>
<i>Please do not hesitate to contact any of the above persons, should you want further information on this research, or should you want to discuss any aspect of the interview process.</i>			
Signed consent			

<ul style="list-style-type: none"> • I understand that the purpose of this interview is for solely academic purpose. The findings will be published as a thesis, and may be published in academic journals. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I was provided with enough details and information with regards to the research, and I was given an opportunity to ask questions with regards to the research study 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I swear that I voluntarily chose to be part of this research and I know I can withdraw at any stage. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I consent to give truthful information. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I was informed about the procedure and threats. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand that I reserve the right to discontinue and withdraw my participation any time. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand that an audio recorder will be used during the research proceedings. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand I will not be coerced into commenting on issues against my will, and that I may decline to answer specific questions. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<ul style="list-style-type: none"> • I understand I reserve the right to schedule the <i>time</i> and <i>location</i> of the interview. 	Yes <input type="checkbox"/>	No <input type="checkbox"/>
* By signing this form, I consent that I have duly read and understood its content.		
_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

ANNEXURE G: TURNITIN DIGITAL RECEIPT AND REPORT



Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author: Nomathamsanqa Mthethwa
 Assignment title: Mthethwa N Dissertation
 Submission title: A criminological inquiry into life insurance fraud in KwaZulu...
 File name: o_life_insurance_fraud_in_KwaZulu_Natal_An_exploratory_st...
 File size: 448.32K
 Page count: 275
 Word count: 70,854
 Character count: 383,703
 Submission date: 29-Dec-2023 04:30PM (UTC+0200)
 Submission ID: 2265500182

CHAPTER ONE: GENERAL ORIENTATION
 1.1 Introduction
 Life insurance is a vital financial instrument that provides individuals with peace of

Turnitin Originality Report

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1% match (student papers from 01-Feb-2016) Submitted to Barry University on 2016-02-01					