ANTI-FRAUD POLICY MANUAL

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This Manual is a property of KGI-MBA Inc.

"*Pamilya ay Nakaseguro, Benepisyo ay Sigurado***"**

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PART I

I. Brief History of the Organization

KGI started in Kalookan, Zambales and Malate by lending only to families wishing to improve their lives by building their business to source their daily needs. While multiplying the members, one of the problems facing the institution is the death of the member while it still has a loan. The management then started to seek on how to provide risk protection to its members and their dependents. Thus, the KGI implemented MMF or the Members Mutual Fund. The MMF became the response to cover the remaining loan balance of the members and no need to pay more by his family.

Over the years, KGI continually enhanced and increased the benefits of the members in MMF. Until not only the debt left by members of the MMF were answered but also a small amount were given to his family members to bury him/her properly. Further, a portion of their hospitalization were also covered by their contribution to MMF.

In 2008, KGI began to study about Mutual Benefit Association, a more stable institution that can provide the members and their legal dependents a benefit in case an unforeseen event come to their lives. An institution that is guided by the Insurance Commission (IC) and the Securities and Exchange Commission (SEC) and ensures that the institution meets the benefits promised to its members.

Due to Joint IC-CDA-SEC Memorandum Circular No. 01-2011 of the Insurance Commission, the management and Board of Trustees of KGI decided to establish its own MBA through the help of RIMANSI, a Non—Government Organization who helps microfinance institutions to have their own MBA, in preparing the documents and doing assessment for KGI to be able to register KGI's MBA to SEC and have the license to operate to the Insurance Commission. In 2010, RIMANSI and KGI had the Memorandum of Agreement and completed the required documents to become a full MBA.

In September 23, 2011, KAZAMA Grameen (KGI) Mutual Benefit Association (KGI-MBA), Inc. was registered to the Securities and Exchange Commission with certification number CN201117039, and also received its license from the Insurance Commission dated 14th of February, 2012 with license number 2012-2-0.

With the help of a thorough study of the actuary for providing proper benefits for members and staff, the management is searching for other benefits to increase service and to meet their other insurance needs that will match in times of crisis.

At this time, KGI and KGI MBA is committed to its mission and its true concern for the poor family. The program continues to grow and continuing serving the poor people through micro-financing and micro-insurance program.

II. Vision, Mission, Goals, Core Values

Association's Vision:

By year 2028, KGI-MBA is one of the 5 leading Mi-MBA's in Luzon.

Association's Mission:

Protect low-income Filipino households from life-cycle risks.

Goals & Objectives:

That the purpose for which such association is formed is to advance the interests and promote the welfare of the poor in particular and the interest and welfare of the Philippines in general. Specifically the association shall seek:

1. To extend financial assistance to its members, spouse, children and parents in the form of death benefits, sickness benefits, provident savings and loan redemption assistance;

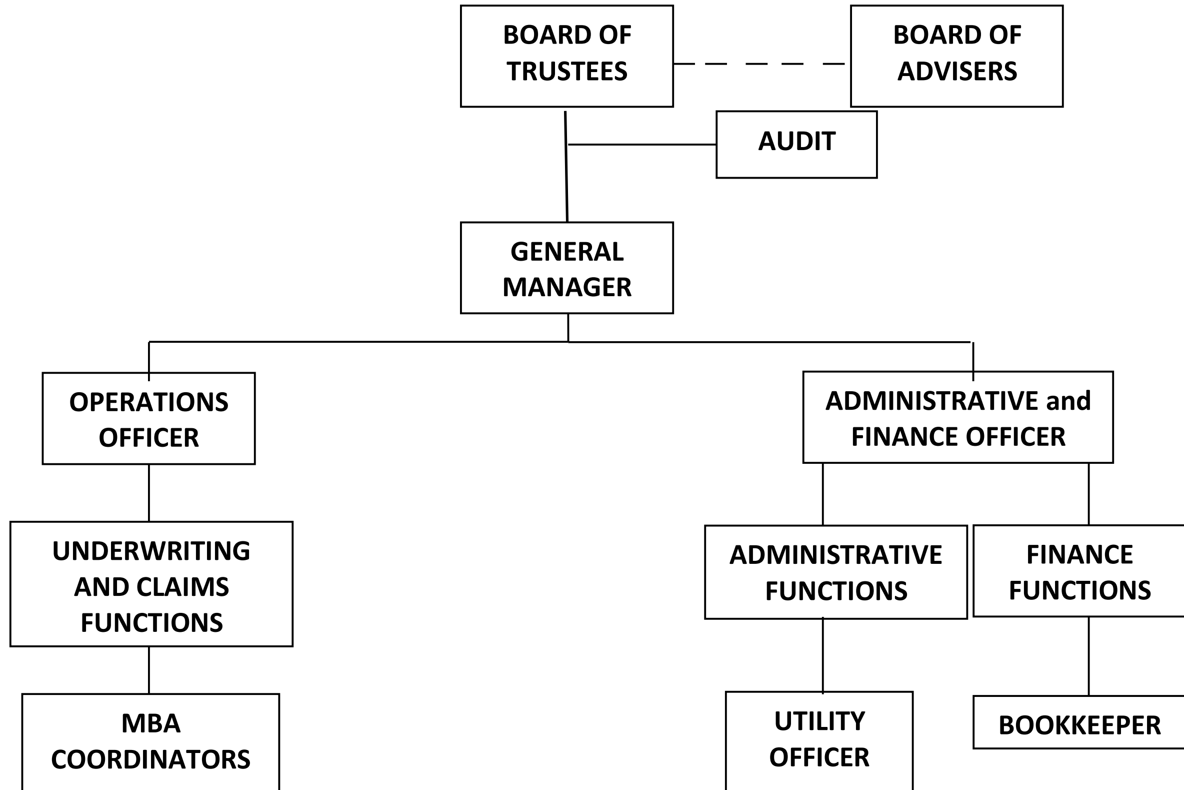
2. To ensure continued access to benefits/ resources by actively involving the members in the management of the association that will include implementation of policies and procedures geared towards sustainability and improved services

Core Values

Love
Teamwork
Respect
Integrity
Service
Excellence

III. Organizational Structure

Organizational Structure



IV. Overview of Programs

KAZAMA Grameen (KGI) Mutual Benefit Association (KGI-MBA) Inc. is a duly licensed provider of microinsurance coverage for various risks involving life, accident, sickness and other contingencies. KGI MBA was established on September 23, 2011. KGI MBA operates in Region III (Pampanga, Bataan, Zambales, Pangasinan, Tarlac), NCR (Quezon City, Caloocan City, Manila), Region I (San Fernando, LaUnion) and CAR (Baguio City), covering members of KAZAMA Grameen Inc., it's Microfinance partner.

The KGI-MBA provides a micro-insurance program for the poor. It has the following products:

1. Life insurance program with disability and health benefits
2. Refund of member's Savings or Equity Value and
3. Credit Life Insurance Plan.

PART II

I. Introduction

This Anti-Fraud Manual is established to facilitate the development of controls that will aid in the detection and prevention of fraud against KGI MBA. It is the intent of KGI MBA to promote consistent organizational behavior by providing guidelines and assigning responsibility for the development of controls and conduct of investigations.

II. Definition of Fraud

In general, fraud is defined as the intentional distortion of truth in order to induce another party to part with something of value or to surrender a legal right (Merriam-Webster Dictionary).

Fraud, as defined by the International Association of Insurance Supervisors, is a deceptive act or omission intended to gain advantage for a party committing the fraud (the fraudster) or for other parties.

III. Statement of Anti-Fraud Policy

KGI MBA does not tolerate fraud, whether carried out by the Association's members or by outsiders/non-members, its trustees, management or staff, or by its microfinance partners, consultants or suppliers. As appropriate, KGI MBA will investigate any suspected or actual fraud including but not limited to insurance claims, benefits, premiums, contributions, or misappropriation of assets. If there is probable cause, KGI MBA will take action based on the gravity of the offense or even take legal action including reporting the fraud to the proper authorities in order to get conviction, recover assets or obtain compensation for loss.

Any investigative activity required will be conducted without regard to the suspected wrongdoer's length of service, position/title, or relationship to the Association.

IV. Purpose of this Anti-Fraud Plan

This Anti-Fraud Plan aims to do the following:

a. Define the procedures involved in preventing, detecting, reporting, and investigating suspected or actual cases of fraud involving members, intermediaries and internal staff, in the areas of membership enrollment, collection of contributions, claims, and handling of assets.
b. Confirm the Management's *overall responsibility* for the Association's anti-fraud efforts.
c. Identify the Anti-Fraud Coordinator *directly responsible* for, and the procedures involved in, the following anti-fraud efforts:
    i. Development, implementation, review, and maintenance of the Anti-Fraud Plan;
    ii. Functioning of the Special Investigation Unit (SIU).
d. Identify the member of the Board of Trustees tasked with *oversight responsibility* over the Anti-Fraud Plan.
e. Confirm the Association's commitment to develop a program to provide continuing anti-fraud education and training for members and staff.

V. Oversight and Operational Responsibilities

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

b. The Board of Trustees, acting through the Treasurer, has *oversight responsibility* over the Association's anti-fraud efforts.

c. The Management has the *overall responsibility* for the development, implementation and regular review of the Anti-Fraud Plan.

d. The Compliance Officer is designated by the Management as the Anti-Fraud Officer responsible for the continued maintenance of the Anti-Fraud Plan. He/she is also designated as the Head of the Special Investigation Unit (SIU), in charge of coordinating any investigation of actual or suspected fraud, with assistance provided by Internal Audit. He/she is also in charge of contacting the police and law enforcement authorities whenever appropriate.

VI. Categories of Fraud

1. Member/Policyholder Fraud and/or Claims Fraud

This involves fraud in the application by, and enrollment of, members and dependents, and in the purchase and/or execution of an insurance product, including claims and benefits.

2. Intermediary Fraud

This includes fraud committed by the Association's microfinance partners, collection agents, insurance/MBA coordinators and other intermediaries.

3. Internal Fraud

This group of fraud includes misappropriation of cash/assets by any of the Association's trustees, managers or staff. This also includes fraud at governance level, e.g., creation of a loan facility for the Trustees/Management that have terms and conditions highly disadvantageous to the members or to the Association.

VII. Prevention and Detection of Fraud

1. Membership Enrollment

a.The business model of microinsurance MBAs involves partnership with microfinance institutions which are the source of members for KGI MBA and which provide various services such as collection of MBA contributions, facilitating the reporting and validation of claims and disbursement of insurance benefits. Thus, for administrative and cost reasons, KGI MBA principally relies on the microfinance partner to do the verification of member's personal circumstances such as identity, age, source of income, home/business address and names(s) and age (s) of legal spouse/dependents.

b. As co-owners of the Association, all members recognize that they play an important role in fraud prevention. Before an applicant is allowed to join a local group/center, existing members of the group/center screen the applicant's background and determine if he/she will be an asset or a liability to the group.

c. Apart from the assessment made by existing members, the Association also requires prospective members to fill up a membership application form in fulfillment of the know-your-customer (KYC) requirement. This is done through the microfinance partner as part of the support services provided to the Association.

d. The MFI Staff, having been trained to watch out for fraudulent applications, will examine the application form by checking the completeness of answers and the consistency of application information (such as name, date of birth, etc.) with information stated in civil documents (e.g., birth certificate, marriage contract), or alternative / substitute documents (e.g., Indigenous Persons Certification) or, if available, government-issued identification documents (e.g., Driver's license).

e. The MFI staff have been given examples of fraudulent acts that they should watch out for. The examples listed below are not intended to be exhaustive but are rather meant to be instructive and serve as a guide for the detection of member- and intermediary-related fraudulent activity.

	Membership
Member	• Falsification of application documents of applicant, dependent or beneficiaries • Falsification of applicant's age in order to qualify for membership and insurance coverage • Inclusion of over-age or otherwise ineligible dependents • Misrepresentation of relationship (by blood or by law) to overcome the lack of insurable interest
Intermediary	• Intentional acceptance of false member information • Manipulation of enrollment date to avail of continuous benefit • Adjustment of dates to make a member qualified • Submission by MFI of fictitious data on non-existent members and/or spouse and dependents which data will eventually be used to claim insurance benefits; • Submission by MFI of request for credit life insurance covering a fictitious loan.
Internal	• Intentional acceptance of fabricated documents

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

"Section 251 of the Insurance Code, as amended, imposes a fine not exceeding twice the amount claimed and/or imprisonment of two (2) years, or both, at the discretion of the court, to any person who presents or causes to be presented any fraudulent claim for the payment of a loss under a contract of insurance, and who fraudulently prepares, makes or subscribes any writing with intent to present or use the same, or to allow it to be presented in support of any claim."

2. Collections

a. MBA contributions are collected together with the member's payment of their loans and savings by the Center Manager and premiums at the release of the member's loan at the branch of KGI. MBA collections stayed in the branch and are remitted every first week of the next month. Claims, expenses incurred in collection, and Coordinator's expenses are deducted prior to remittance of collection to the MBA office. A copy of validated deposit slip of the branch is then submitted to the MBA head office for verification of deposits.

b. KGI MBA Finance is in charge of receiving collections of MBA contributions remitted by the MFI partner and will issue receipt. Collection reports sent by the MFI partner are regularly reconciled against bank deposits made by the MFI partner to determine if there was any misappropriation of collections.

c. KGI MBA Finance regularly reconciles the members' subsidiary ledgers against the general ledger. Member subsidiary ledgers include: basic life premiums, equity values, credit life premiums, etc.

d. KGI MBA Finance coordinates the regular reporting to the Management/Board of Trustees by the membership Enrollment, MIS and Claims departments on new members gained or lost, status of membership, claims submitted/in-process/denied/paid, etc.

e. KGI Finance is in charge of posting members' payments to the members' corresponding subsidiary ledgers. Control totals of subsidiary ledgers are generated, both before and after making the ledger postings. The change in control totals should correspond to the total payments made. Similarly, withdrawals from members' ledgers due to death, resignation or retirement are reconciled. This ensures that all movements in ledger balances are fully accounted for, with audit trails as reference.

	Collection
Member	• Insists of payments not made • Intentionally unrecorded collection from other group members • Purposeful unremittance of collection to branch ("hold-up me")
Intermediary	• Deliberate *non-remittance or partial remittance* of collection to branch • Deliberate non-issuance of provisional receipt/passbook/collection sheet/center logbook • Misappropriation of funds (e.g. contribution intended for payment of MBA insurance applied to loan/savings of MFI, advanced MBA contribution of a member used to pay other member's unpaid contribution) • Tampering of original payment made in the original receipt

	• Imitating bank deposit formats and layout to prove that payments are made • Intentional double recording of collections
Internal	• Manipulation of collection posting

3. MIS

a. Management Information System (MIS) is a series of processes and actions which capture raw data and then process the data into a usable information, so that this information can be disseminated to users in the form needed. The MIS should be able to maintain databases of member and dependents, products, payment or transactions, and claims, at the minimum.

b. The purpose of the MIS is to support effective and efficient management as well as facilitate good governance on the part of the Board of Trustees.

c. MIS is in charge of safekeeping member records. MIS staff are not allowed to do postings, withdrawals or any changes to member records in order to ensure segregation of duties/responsibilities between Finance (account updates) and MIS (safekeeping).

d. There are audit trails on any changes in the members' database and a defined hierarchy of positions who are authorized to make changes or to view records.

	MIS
Intermediary	• Deliberately encoded false entry of member details, payments, and claims • Forced balancing on records/remittances
Internal	• Manipulation of client's account/records which may include equity value and premiums (e.g. encoding of payments which is not made) • Creation of fictitious clients' records • Unauthorized deletion and addition of information • Connivance of management and claimants

4. Claims

a. Once an insurance claim is filed by a beneficiary, the MBA Coordinator / MFI field staff will conduct on-site validation. Claims staff relies on the submitted validation report and other necessary documents such as the following (as applicable):

- Death certificate;
- Birth or baptismal certificate;
- Marriage contract;
- Police report;
- Hospital records;

b. Claims staff also validates insurable interest issues. If there is no insurable interest, Claims Department denies the claim and notifies the claimant accordingly.

c. The Claims Department will also coordinate with Membership Enrollment /MIS or Finance in order to confirm if the coverage is in force / within the grace period / lapsed.

d. The one-year contestability period provides some measure of protection from uninsurable applicants especially if death occurs within a relatively short period after acceptance of membership. If death is due to a pre-existing health condition, the Association pays a lower amount of benefit according to a pre-defined benefit schedule.

e. If the Claims staff suspects fraud was committed (especially in case of death due to accident), a *cost-effective investigation* is initiated to gather evidence including police report, hospital/medical clinic record, and interview of witnesses.

f. If the initial investigation points to a need for a deeper investigation by the Special Investigation Unit, the Claims Department will report it to the Anti-Fraud Coordinator who will, together with Internal Audit, (as the head and member, respectively, of the Special Investigation Unit) conduct a full investigation. The investigation will include the cause of death, place of death, financial and medical circumstances of the insured, and his/her relationship to the beneficiary.

g. If the insurance coverage or policy is already incontestable, the Claims Department verifies only the needed information (in-force or within the grace period) before approving payment of the claim.

h. In case of a claim filed by a microfinance partner for Credit Life benefits, the Claims Department requires the submission of a statement of account showing the amount of original loan, repayments made and outstanding (unpaid) principal balance. The Association settles the outstanding principal balance and pays the remaining amount (if any) to the borrower’s beneficiary.

i. To aid the Claims Department in validating the claim, following are some examples of “red flags” that may trigger further investigation (these “red flags” are also included in the claims procedure manual).

- Death happened outside of the country;
- Cause of death is “undetermined”;
- Dates on submitted documents are conflicting;
- Death certificate looks irregular;
- MBA is notified of the death claim only after burial.

j. Examples of fraudulent acts:

- Submission of fake death claim documents by beneficiary;
- Submission of fake resignation / retirement documents;
- Submission by a non-member / outsider of fake membership documents.

k. To raise anti-fraud awareness and to help deter claims fraud, the Association has released appropriate Advisories addressed to members, intermediaries and internal staff, respectively, regarding the anti-fraud warning stated under the aforementioned Circular Letter No. 2016-50. The

anti-fraud warning will, henceforth, also be included in all claims notices/forms. *(Please refer to the exact wordings shown in the Membership Enrollment section of this Plan).*

	CLAIMS
Member	• Submission of fake death/disability/hospitalization claims' documents (e.g. fake police report, death certificate, medical certificate, incident report, and blotter report from the barangay) • Tampering of death/disability/hospitalization documents • Manipulated cause of death (whether or not pre-existing, natural death or accidental death)
Intermediary	• Payment of unqualified claims due to sympathy without notification to MBA office • Intentional tampering of documents to qualify as beneficiary • Account officer aid in the processing of fictitious claims to benefit from the claims proceeds • Account officer forge the signature of inactive member to withdraw members' equity value • Payment of understated equity value to the members • Payment of understated benefit to the beneficiary
Internal	• Process a fictitious claim in order to benefit from the claims proceed • MBA coordinator asks for "processing fee" to hasten the claims benefit acquisition

5. Internal Audit

a. Internal Audit performs audit and operational reviews of the Association's functional areas based on the amount of risk exposure of the area and also based on available resources. These audits aim to identify weakness in internal controls, pinpoint responsibility for non-compliance to procedures and make recommendations for operations improvement. At the end of the review, Internal Audit holds an exit meeting with the Management to discuss findings and agree on corrective steps or improvements in processes and procedures. To ensure independence with respect to its own audit function, Internal Audit directly reports to the Audit Committee of the Board. Findings that needs board approval, actions and resolutions must be elevated to the board.

b. As Internal Audit is not involved in the line operation of the Association's insurance business, Internal Audit is in a distinct position to do audit reviews covering all of the three (3) above mentioned categories of fraud. In particular, Internal Audit pays special attention to Membership Enrollment, MIS, Finance and Claims and other processes that likewise have significant risk exposures for the association i.e. backlogs, under time, etc., as these areas normally have significant risk exposures to fraudulent activity. Among other audit steps, the auditor reviews transactions on audit sampling basis, reviews membership enrollments for completeness of required information, traces contributions, and reviews changes in members' records and claims payments if properly authorized.

c. It is important for Internal Audit to distinguish between errors or omissions in insurance operations due to incompetence, lack of training, lack of supervision, etc., and those that are due to fraudulent activity. Such as claims payment on fictitious records, inclusion of non-existent members and

erroneous posting of wrong contributions; on the other hand, the payment may have been made as a result of fraud/collusion among staff in charge of membership records and claims by creating fictitious records on non-existent members and proceeding to process fake insurance claims. In the former case, Internal Audit proceeds with its usual review, while in the latter, the auditor will discuss it with the Anti-Fraud Coordinator to determine if there is a need for a deeper investigation by the Special Investigation Unit.

6. Compliance Officer/Anti-Fraud Officer

a. The Compliance Officer works with the individual departments to ensure compliance with rules and regulations issued by the Insurance Commission, and other regulatory bodies such as the Anti-Money Laundering Council, Securities & Exchange Commission, Bureau of Internal Revenue, etc. Compliance Unit also provides advice to management on conduct of insurance business and other compliance issues.

b. While the Management has overall responsibility over the Association's anti-fraud efforts, the Compliance Officer, as the Anti-Fraud Coordinator, has the direct responsibility for the development, implementation, review, and maintenance of the Anti-Fraud Plan and the functioning of the Special Investigation Unit (SIU).

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

7. Internal Control and Financial Management

a. The MBA should practice sound financial management to include the following:

1. Projected Financial Statement and Performance Objectives
2. Investment Plan
3. Monthly Financial Statements
4. Annual External Audit
5. Recording of Financial Transactions
6. Annual Budget

b. It is of utmost importance that KGI MBA maintains at all times the trust of its members. Thus, the goal of the Association is to prevent and detect at the earliest possible time any theft of cash, investment collections, padding of expenses and other forms of misappropriation of assets. Any actual or suspected internal fraud committed by staff, management or trustees, calls for immediate investigation by the Anti-Fraud Coordinator and/or Internal Audit.

c. These are the common fraudulent acts related to internal control and financial management:

1. Window dressing/false reporting
2. Receiving gifts, favors or benefits in cash or in kind from suppliers (optional) that may affect decisions
3. Conflict of interest such as acquisition of assets, services that constitute conflict of interest for decision makers

4. Theft and misappropriation of funds and other assets (e.g. cash advance use for other purposes)

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

e. Following are some of the internal controls implemented by KGI MBA:

- Staff cannot approve his/her own expenses.
- Managers, depending on job function, are authorized to approve only those expenses within their area of responsibility.
- Maximum amount of expense allowed to be paid from the petty cash fund is One Thousand Pesos (Php1,000.00.)
- All requests for payment either through the petty cash fund or in check must be properly supported by invoice, receipts, statement of account, etc.
- Expenses for travel, accommodation, entertainment, representation must be reviewed for compliance with the Association's guidelines before payment.
- Checks up to Php 100,000.00 should be signed by General Manager and Finance Officer.
- Checks higher than the foregoing amount should be signed by General Manager and Treasurer or President.
- Bank reconciliations are regularly prepared to detect any forged/fraudulent checks paid, collections not deposited, unauthorized debits to bank account, etc.
- Cash advance limits and liquidation period.
- Purchasing policy
- Budgeting and approval process
- Periodic review and analysis of financial reports
- Policy manuals are made available to all employees
- Development of code of conduct

f. If any employee notices a fraudulent activity, he/she must first report it to the his/her immediate supervisor or the next higher authority, who will then report it to the Anti-Fraud Coordinator who shall take the necessary action in accordance with his/her role as head of the SIU.

8. Education and Training

a. Applicants for membership in KGI MBA are required to attend the KAZAMA Basic Course (KBC). Among the topics included in the seminar are anti-fraud policies and procedures, duties and responsibilities, anti-fraud awareness, claims fraud prevention and the negative effects of fraud on the institution's solvency. Through this seminar, the Association widens its anti-fraud prevention network by involving members in screening applicants and providing community-based (informal) claims validation. More so, regular updating of anti-fraud policies should be included in the re-orientations.

b. In order to keep the Membership Enrollment, Claims, Internal Audit and Compliance staff up-to-date on insurance claims handling and fraud investigation, the Association requires the aforesaid staff to attend

regular training, conferences / seminars on the subject. Training also covers fraud "red flags" as well as high profile current events and topics related to insurance fraud.

c. The Association requires all new/existing staff including managers to read and follow this Anti-Fraud Plan. Management emphasizes the importance of strictly following the policies, procedures and internal controls laid out in the Plan in order to discourage fraud and to increase the staff's awareness of suspicious acts.

d. From time to time and as necessary, the Association shall revise procedure manuals and internal controls in order to incorporate improvements to policies and procedures.

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

f. KGI MBA in coordination with the intermediary should conduct fraud awareness orientation to all its staff and concerned stakeholder. Further, anti-fraud advisories or memos should be made available/visible in the respective offices. Regular skills training on fraud identification handling and reporting should also be conducted to update and refresh knowledge of the staff.

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

VIII. Reporting Fraudulent Activity / Suspected Fraud

a. In case any member sees or suspects a fraudulent activity involving any co-member, management or staff, he/she should report it immediately to the proper authority (Branch Manager or CPS) through personal appearance and using incident report form including his/her email address, or mobile number.

b. In case any staff of MFI or MBA sees or suspects a fraudulent activity is happening, he/she must report it to his/her manager, or directly to the Compliance Officer/Anti-Fraud Coordinator, in case his/her manager is involved, using Incident Report Form. In turn, any manager who receives such report must immediately notify and forward the Incident Report Form to Compliance Officer/Anti-Fraud Coordinator.

c. The Compliance Officer/Anti-Fraud Coordinator will make a preliminary evaluation as to whether the matter appears to be fraudulent. If fraud is detected, he/she will initiate a full internal investigation. (*Refer to the section on Special Investigation Unit*) and notify the following, as applicable: MBA President/General Manager, Internal Audit, HR / Legal. The report should be treated with utmost confidentiality.

IX. Special Investigation Unit (SIU)

a. The SIU is headed by the Compliance Officer/Anti-Fraud Coordinator who will report directly to the Board of Trustees through the Board Treasurer. He/she is assisted by the Internal Audit in the functioning of the SIU and in undertaking fraud investigations.

b. The SIU shall determine if an internal investigation is sufficient or if an external resource is needed to conduct the investigation. Each reported case of fraud or suspected fraud will be handled in a way suitable to its size and nature.

c. The SIU expects full cooperation from specific staff or departments who have responsibility over the matter being investigated. The investigative team will interview, as necessary, those individuals with knowledge or information related to the suspected fraud and will review pertinent documents. Each staff or member of management is required to cooperate fully with the investigation process and shall not in any way hinder the investigation. Pertinent records will be made easily available to the SIU. The investigative team should observe procedural fairness and due process.

d. As earlier stated, all claims submitted within the Basic Life's contestable period are initially investigated by the Claims Department. If fraud is suspected, the investigation is placed under the guidance of the Anti-Fraud Coordinator. The investigating team will call upon the departments and specific individuals whose responsibilities are important to the investigation and may also request help from an outside investigator, if necessary, for external investigations

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

X. Reporting and Monitoring Results of Investigation

a. The SIU will issue an initial briefing report to be distributed to the following: MBA General Manager, Treasurer, and the Audit Committee of the Board of Trustees. This report will provide a summary of the issue, an outline of procedures for the investigation, liaison with or notification to the proper authorities, other areas of the business for which the fraud might be relevant, the reporting timetable of the investigation and any other relevant information.

b. Upon completion of the investigation, the SIU will issue a final report to the Manager, Treasurer and Audit Committee which will further report to the Board covering all aspects of the case. This will serve as formal record of the case including action taken. Contents of this report will include the following:

- Facts and circumstances of the fraud and its discovery;
- Procedures and findings;
- Damage inflicted whether financial or non-financial in nature;
- Amount involved;
- Recommended sanctions (based on Staff/Employment Manual) for erring staff or member of management;
- Recommended corrective action to improve procedures;
- Recommendation, if any, to pursue legal action.

c. The Anti-Fraud Coordinator given a specific timeframe shall ensure that the recommended sanctions, corrective actions, and the pursuit of legal action once deemed necessary, is enforced.

d. If an investigation results in a recommendation to terminate an individual, the recommendation will be reviewed for approval by the designated representatives from Human Resources and the Legal Department and, if necessary, by outside counsel, before any such action is taken. The Unit does not have the authority to terminate an employee. The decision to terminate an employee is made by the employee's management. Should the Unit believe the management decision inappropriate for the facts presented, the facts will be presented to executive-level management for a decision.

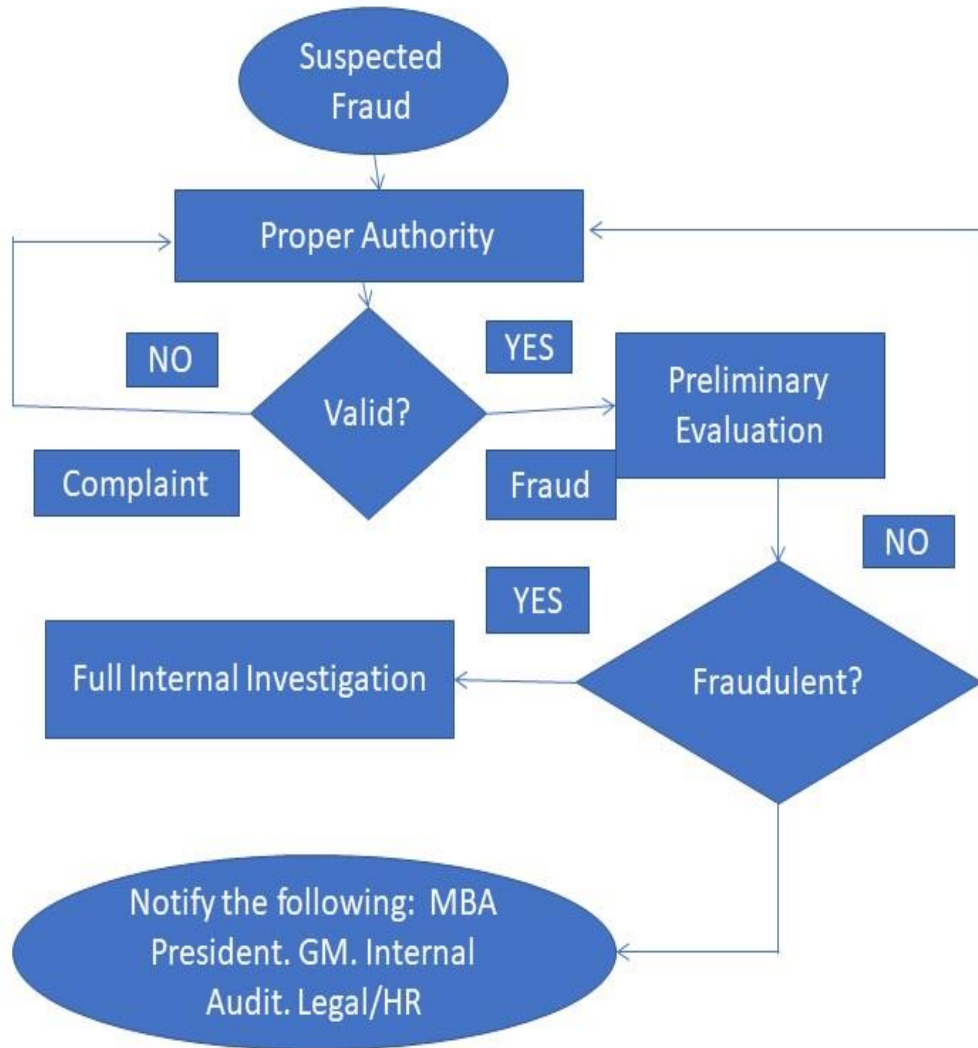
XI. Referral for Legal Action

a. The Board of Trustees will make the final decision regarding the cost-effectiveness and practicality of pursuing legal action against prosecuting the ones who committed the fraud.

- The decision to institute legal action / prosecute depends not only on the amount of loss/fraud involved but also in instances wherein the Association's interest will benefit from showing the case as an example of the Association's non-tolerance of fraud, especially if staff or management are involved.
- If the case involves members, the decision shall take into account possible negative effects against the Association's reputation including loss of members' trust.
- If the case involves the microfinance partner, the decision shall take into consideration all factors involved including ramifications of any action.

ANNEXES

Annex 1
Process Flow of Reporting Fraudulent Activity



Annex 2
Incident Report Form

KGI MUTUAL BENEFIT ASSOCIATION INC.

Block 12 Lot 25 Sta. Monica Subdivision, Subic, Zambales
Telefax No. (047) 232-1871 Email: kgi_mba@yahoo.com

INCIDENT REPORT FORM

Date : ________________________

Branch: _________________

Full Name of Person Reporting: _______________________________________

Contact # of Person Reporting: __________________________

Persons Involve: ____

Act/s Committed:

When: _______________________

What: ________________________

Others: _______________________________

Details of the incident:

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Received by: __________________________________

Date: ______________________________________

------------------------------------ **For Anti-Fraud Coordinator's Use** ------------------------------

Date Received: ___________________________

Type: ____ Complaint ______ Fraud

Tracking No. ______________________

Annex 3
Anti-Fraud Coordinator Terms of Reference

Terms of Reference
Anti-Fraud Coordinator

1. Accept and record reports and complaints related to fraudulent acts.
2. Make preliminary investigation and report to establish probable cause.
3. Form an ad hoc team to investigate the suspected fraudulent act.
4. Prepare and submit investigation report with recommendations to the Board.
5. Perform or monitor actions directed by the Board.
6. Safekeep records of investigations and actions related to fraud with utmost confidentiality.
7. In-charge in the maintenance and monitoring of implementation of the anti-fraud plan.
8. Conduct or participate in institutional education and training related to fraud management.