October 2025

Insurance Regulatory and Development Authority of India issues Fraud Monitoring Framework

The Insurance Regulatory and Development Authority of India ("**IRDAI**") has issued the IRDAI (Insurance Fraud Monitoring Framework) Guidelines, 2025 ("**Guidelines**") which will be in effect from April 1, 2026. The Guidelines repeal the IRDAI circular on Fraud Monitoring Framework, dated January 21, 2013 ("**Erstwhile 2013 Circular**").

The Guidelines provide a robust governance and operational framework to foster resilience against fraud within the insurance ecosystem and introduces a comprehensive, risk-based, and proactive framework focused on prevention, detection, and governance. The Guidelines also recognise growing threat of digital and technology-enabled fraud.

Key aspects of the Guidelines

Applicability and scope of the Guidelines

The Guidelines apply to all insurers, reinsurers and distribution channels (including insurance intermediaries). The Erstwhile 2013 Circular's application was limited to insurers and reinsurers. The Guidelines extend the scope to distribution channels as well. Foreign reinsurance branches are also required to adopt either the host jurisdiction's framework or the Guidelines depending on whichever framework is more comprehensive.

The Guidelines define insurance fraud, categorisation of different types of fraud, and a governance framework for the regulated entities to prevent and manage incidents of fraud.

Definition of fraud and classification of fraud

The definition of fraud as defined in the Guidelines is inclusive in nature and not exclusive. Fraud is defined to mean an act or omission intended to gain advantage through dishonest or unlawful means, for a party committing the fraud or for a related party and fraud includes and is not limited to misappropriating funds; misrepresenting or concealing or not disclosing one or more material facts relevant to any decision or transaction; misuse of position of responsibility or a position of trust or a fiduciary relationship.

Fraud is further categorised as follows:

1. **Internal Fraud**: Fraud involving the insurer's employees and/or senior management.
2. **Distribution Channel Fraud**: Fraud involving intermediaries or other distribution partners.
3. **Policyholder and/or claims fraud**: Fraud committed by any person during the purchase, servicing, or claiming of an insurance *policy* to obtain undue coverage or payment.

4. **External fraud**: Fraud involving third parties such as service providers, vendors, or other external entities.
5. **Affinity or complex fraud**: Fraud involving collusion among 1 (one) or more perpetrators across any of the aforementioned categories.

Fraud Risk Management Framework

A central feature of the Guidelines is the requirement for every insurer and distribution channel to adopt a Fraud Risk Management Framework ("**FRM Framework**") based on a principle of zero tolerance for fraud.

A board approved anti-fraud policy ("**Policy**") forms the core of the FRM Framework which will be reviewed by the board annually. The Policy should include, *inter alia,* red flag indicators, procedures to detect and report fraud, defined responsibilities and delegation of authority, timelines for investigation, whistleblower protection mechanisms, due diligence for recruitment and vendor engagement, and provisions for dealing with non-compliance.

Fraud Monitoring Governance

The Risk Management Committee ("**RMC**") of each insurer will be responsible for the effective implementation and oversight of the FRM Framework across all operations and distributions channels.

Each insurer must constitute:

1. a Fraud Monitoring Committee ("**FMC**") headed by a key managerial person including senior representatives from relevant departments such as underwriting, claims, legal or any other department as deemed necessary; and
2. fraud monitoring unit that functions independently from the internal audit, to support FMC in effective discharge of functions.

The FMC will be responsible for operationalising the FRM Framework, overseeing prompt investigation and response, maintaining records of fraud incidents, and facilitating collaboration with law enforcement and industry peers. The FMC is also required to conduct an annual Comprehensive Fraud Risk Assessment ("**Risk Assessment(s)**") to identify vulnerabilities and emerging trends. The FMC will ensure a multilayered oversight structure by submitting reports on:

1. a quarterly basis to the RMC on all its activities, findings, recommendations in relation to, *inter alia,* the financial impact of fraud on the insurer;
2. on Risk Assessments to the board of directors through RMC; and
3. internal frauds to the audit committee, in addition to the RMC.

Training

The Guidelines emphasise upon the importance of continuous training and awareness. Insurers, intermediaries, and distribution channels must conduct periodic programmes to educate employees, management, and policyholders about fraud risks and prevention methods. Regular training for board members and distribution partners is also mandated to ensure accountability and vigilance across all levels of the insurance value chain.

Role of the Insurance Information Bureau

To strengthen industry-wide coordination, insurers are mandated to participate in the fraud monitoring technology framework developed by the Insurance Information Bureau ("**IIB**").

Additionally, the IIB will maintain a Caution Repository ("**Repository**") containing information on blacklisted distribution channels, vendors, hospitals, and known fraud perpetrators. This Repository will serve as a preventive tool to help insurers avoid engagement with entities/persons having a history of fraudulent conduct. The IIB, in consultation with the life and general insurance councils, will also adopt a unique identifier mechanism to enhance traceability and consistency in fraud reporting.

Reporting obligations

Insurers are required to report fraud incidents to law enforcement agencies or other relevant authorities in accordance with the applicable law. Annual returns in Form FMR-1 must be filed with the IRDAI within 30 (thirty) days of the close of the financial year. Any fraud involving distribution channels registered with the IRDAI must be reported to the IRDAI without delay.

Conclusion

In the era of growing digital technology and evolving and growing insurance ecosystem, through the Guidelines, IRDAI has equipped regulated entities to establish a principle-based governance framework and identified accountability of each participant in the insurance ecosystem to prevent, detect and rectify fraud.

Insurance Practice

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