Benefits Fraud

Employee Benefits Fraud occurs when a plan member, provider, or both, intentionally deceive the insurance carrier to obtain reimbursement for a claim that was not incurred, or may not have otherwise been eligible for reimbursement.

The impact of Employee Benefits Fraud extends beyond the financial implications to your organization and your employees, it can also have a negative impact on employee morale and culture.

Our Commitment

We believe in a proactive approach to mitigate the risks to our clients associated with Employee Benefits Fraud. When implementing a new program or becoming your new Agent of Record, we complete a thorough review of your program to identify potential areas of vulnerability. When possible, we will complete reviews of your claims history to identify any suspicious or irregular claim patterns or activity. We can provide tools or training for your team, to educate employees and management on the types of benefits fraud, the potential consequences, and the importance of reporting any suspicious activity.

Plan Sponsor Best Practices

* Implement clear fraud prevention policies that include and define the consequences of engaging in Benefits Fraud.
* Foster a culture of integrity within your organization that focuses on honest and transparent behaviour.
* Establish clear and confidential channels for employees to report fraudulent activities.

Plan Member Responsibilities

* Regularly review their claims history, to ensure the information is accurate and reflective of their actual usage.
* Avoid signing blank claim forms, or giving their policy/certificate number to providers unless services have been incurred, or an estimate is being submitted on their behalf.
* Report suspicious or fraudulent activities or unrecognized claims to their employer and/or insurance carrier.

Please Note:

Every insurance carrier maintains an internal "delist" of practitioners or clinics for which no claims are eligible for reimbursement, regardless of the payee or program type. Plan Members and dependents are encouraged to review the 'delist' prior to incurring services or claims from a new provider, to avoid incurring ineligible out-of-pocket costs.

These lists are updated as required, when an insurance carrier confirms a specific provider has been submitting fraudulent or abusive claims. Providers are always given details of the insurance carrier's investigation and are notified that any services provided are deemed ineligible for reimbursement, before being 'delisted' by the insurance carrier.

** This is not a legal document, and is intended solely for informational purposes.*