EFFECT OF FRAUDULENT COMPENSATION CLAIMS ON PERFORMANCE OF INSURANCE FIRMS IN KENYA

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A DISSERTATION SUBMITTED TO FACULTY OF BUSINESS AND COMMUNICATION STUDIES IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF A MASTER OF BUSINESS ADMINISTRATION (STRATEGIC LEADERSHIP AND MANAGEMENT) OF ST. PAUL'S UNIVERSITY

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SEPTEMBER, 2017

DECLARATION

This dissertation is a product of my own work and is not the result of anything done in collaboration. It has not been previously presented to any other institution for any academic award. I agree that this dissertation may be available for reference and photocopying at the discretion of the University.

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Word Count: 18,194

We confirm that the work reported in this dissertation has been done by the student under our supervision.

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Mary Kibuine

Signature ……..…… Date……..

Dr. Hellen Mugambi

DEDICATION

I dedicate this work to my lovely wife, Babyface Gasheri, my daughter, Abigail Mwende and my two sons Asa and Cayleb Japheth for their love, support, encouragement and patience throughout the time I was doing this work.

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ABSTRACT

The aim of this study was to investigate the effect of fraudulent compensation claims on performance of insurance firms in Kenya. The specific objectives were: to examine the influence of ethical practices on performance of insurance firms in Kenya; assessing the influence of online social networking on performance of insurance firms in Kenya; examining the influence of regulatory framework on performance of insurance firms in Kenya; and to establish the relationship between fraudulent compensation claims and performance of insurance firms in K enya. The research employed a cross sectional descriptive research survey design. The study targeted 44 insurance companies and 968 employees in finance department. The sample size constituted two finance managers from each insurance company giving a total sample size of 88 managers. The study used primary data which was collected through self-administered questionnaires. Collected data was analyzed by use of descriptive and inferential statistics. The findings were categorized in order to analyze and determine the attributes of the data. The fitness of the model was determined in order to assess its stability in establishing the relationship between the independent and dependent variable. Coefficient of correlation (r) was used to determine the magnitude of the relationship between the dependent variable (performance) and the independent variables (Ethical practices, online social networking and regulatory framework). The study found out that: customers fail to disclose all material information; insurance companies do not disclose full information, online transaction processing had increased cases of money laundering, regulations, implementation of risk based supervision model and separation of ownership and management had reduced incidences of frauds. The study concludes that adherence to ethical practices provided had a positive impact on fraud prevention and detection which could be committed by the employees, there is growing amount of information that is posted to social media networking sites, underwriters have discovered that social media can be a useful investigative tool for conducting research and uncovering relevant information on underwriting and in order to ensure a high performance level in the insurance industry in the long run, it is essential to constantly adapt the insurance regulatory framework. The study recommends that insurance companies should observe ethical practices and supports its implementation including setting up policies and guidelines, invest in technology to prevent claims fraud and fully comply with guidelines, rules and regulations on good corporate governance.

TABLE OF CONTENTS

DECLARATION ..... **ii**
DEDICATION ..... **iii**
ACKNOWLEDGEMENT ..... **iv**
ABSTRACT ..... **v**
TABLE OF CONTENTS ..... **vi**
LIST OF TABLES ..... **viii**
LIST OF FIGURES ..... **ix**
ABBREVIATIONS AND ACRONYMS ..... **x**

CHAPTER ONE: INTRODUCTION **1**
1.1 Background of the Study 1
1.2 Statement of the Problem 6
1.3 Research Objectives 8
1.4 Significance of the Study 9
1.5 Scope of the Study 9
1.6 Limitations of the Study 10

CHAPTER TWO: LITERATURE REVIEW **11**
2.1 Introduction 11
2.2 Concepts Review 11
2.3 Theoretical Framework 18
2.4 Empirical Review 21
2.5 Conceptual Framework 22
2.6 Research Gaps 23

CHAPTER THREE: RESEARCH METHODOLOGY **24**
3.1 Introduction 24
3.2 Research Design 24
3.3 Target Population 24
3.4 Sampling and Sampling Size 25
3.5 Data Collection instruments 25

3.6 Data Analysis 26
3.7 Analytical Model 26
3.8 Tests of Significance and Interpretation 27

CHAPTER FOUR: DATA ANALYSIS AND INTERPRETATION 28
4.1 Introduction 28
4.2 General Information 29
4.3 Ethical Practices 33
4.4 Online Networking 36
4.5 Regulatory Framework 38
4.6 Claims Performance 41
4.7 Regression Analysis 42
4.8 Bivariate Correlations Analysis 44
4.9 Discussion of the Findings 45

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMEDATIONS ... 46
5.1 Introduction 46
5.2 Summary of the Findings 46
5.3 Conclusion 48
5.3.1 Ethical Practices 48
5.3.2 Online Social Networking 48
5.3.3 Regulatory Framework 49
5.4 Recommendation 49
5.5 Recommendation for Further Studies 50

REFERENCES 51
APPENDIX I: QUESTIONNAIRE 57
APPENDIX II: LIST OF INSURANCE COMPANIES IN KENYA 62
APPENDIX III: RESEARCH CLEARANCE PERMIT 64
APPENDIX IV: CLEARANCE FROM FINANCE 65
APPENDIX V: LETTER FROM THE UNIVERSITY 66

LIST OF TABLES

Table 3.1: Population Distribution..... 25

Table 4.1: Ethical Practices..... 34

Table 4.2: Online Networking 37

Table 4.3: Regulatory Framework 39

Table 4.4: Claims Performance..... 41

Table 4.5: Model Summary 42

Table 4.6: ANOVA..... 43

Table 4.7: Coefficients..... 43

Table 4. 8: Correlations..... 44

LIST OF FIGURES

Figure 2.1: Conceptual Framework 23

Figure 4.1: Response Rate 28

Figure 4.2: Age Distribution 30

Figure 4.3: Marital Status 31

Figure 4.4: Period Working in the Insurance Sector 31

Figure 4.5: Highest Level of Education 32

Figure 4.6: Kind of Business the Insurance Company Underwrite 33

ABBREVIATIONS AND ACRONYMS

ABI	-	Association of British Insurers
ACB	-	Aberrant Consumer Behaviors
AKI	-	Association of Kenya Insurers
CAIF	-	Coalition Against Insurance Fraud
CEA	-	Comité Européan des Assurances (Association of European Insurance Companies)
IAIS	-	International Association of Insurance Supervisors
IRA	-	Insurance Regulatory Authority
IRC	-	Insurance Regulatory Commission
ISO	-	International Standard Organization
P&C	-	Property and Casualty
U.S.	-	United States
UNCTAD	-	United Nations Conference on Trade and Development

CHAPTER ONE
INTRODUCTION

1.1 Background of the Study

The proliferation of insurance fraudulent claims is attributed to factors such as the difficulty in detecting some forms of fraud, lack of concerted efforts to combat the vice, and unwillingness of the insurance companies to fight the fraud (Derrig, 2012). Insurance fraud is causing huge losses to the insurance companies hence affecting the profitability. Derrig expounded on two types of insurance fraud; the hard fraud which occurs when the insured invests an incident with an aim of defrauding an insurance company. The claim is normally not genuine, but it is staged to appear as if it is real. It is very difficult for the insurance companies to determine the authenticity of such claims when they occur, yet they run into millions of dollars in compensation. The 'soft' insurance fraud is the most common (Coalition against Insurance Fraud, 2013). Unlike the hard fraud, the soft fraud occurs out of genuine incidents. The insured takes the advantage of the incidents to gain from the company. They do this by exaggerating the losses or providing misleading information. Therefore, insurance fraud has been defined as obtaining value from an insurer through false information. Derrig asserts that insurance fraud should be treated as a crime, since the value or money is obtained through fraudulent means and leads to huge financial losses to the insurance companies.

The perceptions, beliefs, and attitudes towards the insurance company has an impact on the insurance fraud. A significant number of the insured have negative feelings towards the insurance companies. According to Crocker and Tennyson (2012), the contract design and the claims settlement strategies are some of the major issues that might create negative feelings towards insurance companies. Sometimes there is a discrepancy between what one gets from the insured sum and what one was expecting. When the benefits are below the expectations, it is common for the insured to be skeptical about the insurers. This explains why Tennyson (2012) indicated that more than 73.8% of respondents in a study to determine the perception on soft fraud said that it is an acceptable behavior. Since the perception of the insured is that the insurers engage in unethical practices, they also feel justified to give misleading information.

The changes in morality, previous experiences, and poverty are other major incentives that contribute to the rise in fraudulent compensation claims. Morality has become relative and not universally agreed upon. The definition of what morality differs from one individual to another, explaining why people have varied perception on insurance fraudulent claims. Beliefs and perceptions are strong determinants of behavior. The illegitimate claims are also attributed by the increased poverty in the families. According to Miyazaki (2009) economic status will determine the rise in incidences of both the hard and soft fraudulent claims. However, it is still controversial as to who between the economically stable and low economic status is likely to engage in fraudulent claims. The previous experiences will also have an effect on fraudulent claims. The decision to defraud an insurance company might be determined by what one has heard others say about an insurance company.

While the insurers know the negative effects of insurance fraud to the insurance companies, they have done little to control the vice. The insurers think that fighting fraudulent claims is a costly affair (Tennyson, 2012). They also claim that they do not have the effective mechanism to deal with fraudulent cases. The fatalistic position taken by the insurers is to blame for the increased incidences of fraud. There have also been little efforts to liaise with other stakeholders to manage and control fraudulent claims. With the increased complexity in both the hard and soft fraudulent claims, insurers are expected to have more effective strategies to prevent insurance fraud. One of the recommendations is that the insurers should take fraudulent compensation claims seriously. While it might be costly to combat it, the long-term effects are vital in enhancing financial growth and development.

1.1.1 Fraudulent Compensation Claims

Insurance fraud has become a common challenge for the insurance companies. It has been attributed to the inefficiencies at the insurance companies and the attitudes of the policyholders. Weak internal controls at the insurance companies make it difficult to detect and prevent increased incidences of insurance fraud. Insurance fraud comes in different forms. They include exaggerated claims, underwriting claims, and the failure by the policyholders to disclose the relevant information. One of the main challenges in

addressing insurance fraud is the fact that most of the fraudsters do not think that they are acting unethically. According to Tennyson (2012), there is a need to address the attitudes, perceptions, and beliefs of the policyholders in regards to insurance fraud issues. Changing their perceptions and attitudes should be the first step in finding an amicable solution to the problem of insurance fraud. The attitude towards insurance companies will also have an impact on insurance fraud. If people believe that insurance companies engage in unethical practices, then they are also likely to exaggerate claims or provide misleading information (Tennyson, 2012). Therefore, insurance companies have to create a good impression about their businesses.

According to Saqib, Dutta, Plusquellic, Ortiz and Pattichis (2015, the perceptions and feelings of the insured towards the insurance companies play a huge role in promoting or reducing insurance fraud. The rise in what is commonly known as the soft fraud. This type of insurance fraud occurs when one exaggerates an incident to profit from the insurance company. However, unlike in the hard fraud where the incidents are invented, in soft fraud, the incidences are genuine. It is imperative that insurance companies work closely and educate the insured and the community in general about the roles and responsibilities of insurance. One of the major setbacks is the information gap about insurance companies among the insured. They might not understand why they will gain from some insured sums, while they do not in another. The lack of adequate information prompts the policyholders to believe in skewed and biased information. The resultant effect is a negative attitude towards the insurance institutions, which again leads to a rise in insurance fraud.

A study conducted from 1994 to 1995 attributed the increase in insurance fraud to the lack of effective means to combat the vice (Kirlidog & Asuk, 2012). The CEA lamented that the cowardly approach in the fight against insurance fraud has been the major reason why the challenge continues to exist. Most of the insurance companies argue that they do not have the resources to combat insurance fraud. They claim that the cost of fighting the vice is too costly for the insurance companies. However, little efforts have been put towards liaising with other agencies including the government apparatus in combating the

insurance crimes. That shows that the insurance companies are largely to blame for the ongoing fraudulent practices.

1.1.2 Organization Performance

The actual results and the intended goals are imperative in determining the organizational performance. To assess the organizational performance, it is equally important to focus on whether the initial goals and objectives have been achieved. The organizational behavior and appropriate infrastructure are imperative in fostering organizational performance. Competent workforce, effective technology, teamwork, and visionary leadership are vital in determining if an organization will achieve its goal. The management or Board of Directors in any organization play a vital role in enhancing organizational performance. Their goal is to design, manage, and implement programs that foster organizational performance. If the organizational performance falls, the management or Board of Directors modifies the organizational behavior and provides the relevant infrastructure. There are also various tools that will be used by the management to enhance change. The 'HR scorecard' is one of the most important tools in determining organizational performance. According to Becker and Huselid (2003), the 'HR Scorecard' provides a platform for measuring performance and the achievement of the goals and objectives

The most commonly used performance management tool was developed by Kaplan and Norton (2007) which is the balance scorecard (BSC). The Balance Scorecard looks at both the financial and non-financial aspects as Key Performance Indicators (KPI's). Under these KPI's there are four perspectives, which are, Financial, Customer, Internal Business Processes and Learning and Growth. The financial perspective ensures that there are low costs to increase profitability and revenue and that data available is accurate and on time. The customer perspective explains out the significant awareness on customer focus and satisfaction. Therefore, the organization must be able to meet customers' needs and wants for them to maintain and improve customer base and attain more potential market share in the market and as well lower the waiting time. Internal business processes perspective explains out the day to day operations of the firm and how they are carried out to achieve and support the firm's goals and objectives through

increase on process efficiency and lower cycle time. Learning and Growth perspective includes the corporate and employee cultural attitudes associated to both individual staff and the company self-improvements and innovations. Thus, this allows the managers and their employees to use the performance tool to identify where to refocus and concentrate funds on areas that will be most effective. This can be done by improving knowledge and skills, tools and technology used in the organization. Ensuring organizational performance sustainability using the balance scorecard is essential for a favorable output and as well as advancing performance in the organization as a whole.

In a general view, the balance scorecard can be widely used by most firms in an industry depending on what key performance indicators they use to measure performance. Most organizations mainly use the financial indicators to measure performance. Recently, firms have adopted both financial and non-financial indicators to look at the firm performance as a whole. In the insurance industry, the key performance indicator that is frequently used is the financial indicator. Some of the financial indicators regularly used are the profitability of the firm, return on assets and return on investment. Other indicators are market share and customer satisfaction. Different stakeholders require different performance metrics because of the diversity of their information needs to enable them make informed choices amongst alternatives.

1.1.3 Insurance Industry in Kenya

The insurance industry in Kenya is growing gradually as more people continue to take policies. The Insurance Regulatory Authority (IRA) is the body that is currently mandated by the law to regulate the insurance industry in Kenya. All the insurance companies are expected to operate under Association of Kenya Insurers (AKI). AKI is a legal body, established under Societies Act CAP 108. It is an insurance body that was established in 1987. While AKI is a body that represents the interest of the insurance industry, becoming a member is not mandatory. AKI plays a number of roles in the sector. One of the main roles of AKI is to enhance good relationship and to enhance the trust between the industry and the consumers. At the business level, the goal is to ensure that the insurance industry does not engage in any unethical practices. AKI establishes policies that guide the behavior of all the players in the industry. At the community level,

AKI plays a vital role in the dissemination of information about the insurance companies. This is done with an aim of ensuring that consumers can make informed choices when deciding to take a policy.

The Insurance Regulatory Authority has the mandate of protecting the interest of the policyholders. The IRA establishes guidelines that are aimed at ensuring that policyholders get fair treatment and compensation. IRA has the power to take action against the insurers when they engage in unethical business activities. For instance, directors or managers who engage in mismanagement of the company's assets or embezzlement will be punished under the IRA laws. Therefore, IRA fosters the trust in the industry, hence promoting growth and development. IRA also acts in public interest by managing the assets when the need arises. It also ensures that insurers are able to cover the risks underwritten. It does this through the implementation of the Risk Based Capital Supervision. This assures the clients that they will be compensated when the need to do so arises. There has also been a need to promote professionalism in the insurance industry in Kenya. As a result, the Insurance Institute of Kenya was established. Its aim is to offer training to management and employees to enhance their skill levels and competence.

There is a brighter future for insurance industry in Kenya. This is attributed to the increased dissemination of information on insurance and the development of new products. The growth and development in ICT and the realization of the Vision 2030 are also important factors that will contribute to the growth of insurance industry in Kenya.

1.2 Statement of the Problem

Despite the uptake of insurance products having registered reasonable growth over the years, the penetration levels as represented by the ratio of Gross Direct Premiums to Gross Domestic Product (GDP) stood at 3.16% as at end of 2012 (Insurance Industry Annual Report, 2012). This may look comparatively reasonable viewed against similar numbers for Sub-Saharan economies which stand at rates below 1%. However, bench-marked against peer states in the Southern African Region, Kenya is way below. The low penetration rate was attributable directly to a number of factors including; unhealthy competition, apathy by consumers due to poor image, pervasive fraud and low levels of

consumer awareness. All the reasons given above may be attributable to undesirable behavior by intermediaries. This in turn translated to inadequate profit levels for the insurance sector in Kenya. The resultant effect is high ratio loss ratios in the Kenyan insurance industry. According to one study by PwC (2013), the loss between 2010-2013 stood at about 60%. This has negative effects owing to the fact that a majority of the insurers rely on the investment income to compensate the insured in case of any losses.

Studies have demonstrated the need by the insurance companies to provide new products that are client-centered. Developing more products and packaging them appropriately will increase the number of the insured (Okeeno (2014). According to Okeeno (2014), weak internal controls, for instance, make it difficult to detect fraudulent activities, including the embezzlement of funds. One of the negative effects of insurance fraud is that it makes the insurance policies to become more expensive. The policyholders are also required to pay higher premiums to cover for the losses. The rise in fraudulent claims leads to the inclusion of unnecessary charges (Jans, Van, Lybaert & Vanhoof, 2011). Such charges are secretly added, which makes it difficult for the policyholders to detect them. As a result, insurance companies are able to secretly cover for the losses they incur. However, this is being done at the expense of other insured persons, who are forced to take expensive policies. The increased dishonesty among the insurance agents is one of the other factors that shape the attitude of the insured towards the soft fraudulent claims. According to Forbes (2010) the insurance fraudulent claims affects everyone in the industry, even those that do not engage in unethical behavior. Therefore, there is a need to ensure that the vice is controlled before it causes more damage and cripples the growth of the industry in Kenya.

The magnitude and impact of insurance fraud has made the industry regulator (IRA) to operationalise an Insurance Fraud Investigations Unit (IFIU) which is a department fully dedicated to the pursuit of fraud mitigation strategies. The study aims at determining the effects of fraudulent compensation claims to performance of insurance firms in Kenya.

1.3 Research Objectives

1.3.1 General Objective

The general objective of the study was to determine the effects of fraudulent compensation claims on performance of insurance firms in Kenya.

1.3.2 Specific Objectives

i. To examine the influence of ethical practices on performance of insurance firms in Kenya.
ii. To assess the influence of online social networking on performance of insurance firms in Kenya
iii. To examine the influence of regulatory framework on performance of insurance firms in Kenya
iv. To establish the relationship between fraudulent compensation claims and performance of insurance industry.

1.4 Research Questions

The research was guided by the following research questions.

1. What is the influence of ethical practices on performance of insurance firms in Kenya?
2. What is the influence of online social networking on performance of insurance firms in Kenya?
3. What is the influence of regulatory framework on performance of insurance firms in Kenya?
4. What is the relationship between fraudulent compensation claims and the performance of insurance companies in Kenya?

1.4 Significance of the Study

The study would enable the practitioners in the insurance industry to have a better understanding on the selected variables on fraudulent compensation claims in the insurance firms in Kenya. Therefore, it would enable the insurance firms build up better solutions to handle the variables on fraudulent compensation claims. This would make them have an influence in curbing fraudulent compensation claims and hence improve performance of the insurance firms in Kenya.

The study would enable the Government under the body of Insurance Regulatory Authority (IRA) to formulate policies that would enable govern the insurance industry and inform future policy studies in light of escalating fraudulent claims by clients in the sector. It would help them understand the rules and regulations that they have to implement for the industry to be relevant and contribute to the growth of the economy. Thorough comprehension of these rules and regulations would enhance efficiency and effectiveness in general regulation of the insurance sector.

The study would enable the researcher and academicians to have a well-versed knowledge on the effects of fraud compensation claims on performance of insurance firms. The study would also contribute to the frontiers of knowledge in the continuing advocacy against fraud in the insurance sector. Researchers and academicians would rely on limitations, gaps and findings of the current study in establishing areas for further researcher. This would increase the level of information to the current one.

1.5 Scope of the Study

The study targeted senior claims and finance managers in insurance companies who are located in Nairobi County in a three month period (March – May, 2016) as respondents. Besides being the capital city, Nairobi County hosts the headquarters of all the insurance companies listed as appendix two. Furthermore, the study restricted itself to the influence of the three variables namely; Ethical practices, Online social networking and regulatory framework on fraudulent compensation claims and performance of insurance companies. The study was conducted

1.6 Limitations of the Study

The researcher experienced fear of giving information from the respondents. To delimit this limitation the researcher assured the respondents of confidentiality and also inform them that the information gathered was used for academic purposes only. Another limitation was lack of cooperation from the respondents to fill correctly the questionnaire as they overlooked the significance of the study. However, attempt of lack of commitment from the participants was used by the researcher to take time to meet with all potential respondents and clarify to them the scope of the study and its significance to the organization.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter provides a review of literature that is relevant to the study from various scholarly authors. It also covered concepts on fraudulent compensation claim, online social networking, ethical practices and regulatory framework, empirical literature indicating the research gap filled, and the conceptual framework designed. The conceptual framework indicates the relationship between the variables of the study. All the subsections are in line with the objectives of the study.

2.2 Concepts Review

2.2.1 Fraud Compensation Claims

One of the most common forms of financial fraud is referred to as insurance fraud. In this case, individuals who engage in this criminal behavior intentionally seek to obtain financial benefits which they do not deserve. Alternatively, one may commit this crime by intentionally denying another person financial benefits that they may be entitled to. According to reports by the Federal Bureau of investigations, insurance fraud may take place through fee churning usually conducted by brokers so as to acquire higher commissions, premium diversion also conducted by insurance agents where the funds are paid under the guise that they are paying for an insurance policy, asset diversion where the assets of the company are improperly diverted that could lead to the bankruptcy of the organization, and fraudulent schemes in worker compensation (Crocker & Tennyson, 2012).

As presented in the above cases, it is evident that individuals associated with such crimes are mainly workers or high-end executives of the company. However, there are numerous cases where the claimants may seek to defraud the organizations affected. The fraudulent claims in the modern society account for a significant portion of the operations associated with the companies and can reach up to numerous billions of shillings in a year. The fraudulent schemes taking place are in a diverse form and in different areas of the industry. In this regard, the claimants may slightly exaggerate the claims to deliberately

cause accidents so as to collect from the insurance company (Picard, 2016). The occurrence of these crimes usually affects the lives of innocent individual in the society through physical damage of property or injuries sustained. They may also be affected indirectly through the significant increase in premium costs for the different accidents. These financial crimes are a major problem to the society prompting the national government among other related organizations to take significant measures to prevent members of the society from engaging in them.

2.2.1.1 Ethical Practices

The term ethics is recognized as the code of conduct used to direct individuals to what is right from what is wrong (Barnett and Valentine, 2004). In this regard, ethics plays a major role in the organizations as the ability of the staff members to adhere to these guidelines will determine the significant performance that will be realized by the corporation in question (Adnan et a., 2013). Nevertheless, professionals in this industry demonstrate the penetration of immoral behaviors particularly at the workplace (Schwepker and Schultz, 2013). The continued rise of such practices is due to the shift in focus from good business practice to seeking maximum benefit in the transactions taking place. Corporations like Enron, WorldCom, JP Morgan and Madoff Pyramid have called attention to the need to enforce ethical practices in the financial industry (Adnan et a;., 2013).

It is evident that the guidelines of moral conduct identify numerous customer relationship issues. According to Akinbola and Ejide (2010), ethical practice ensures a good business performance. Therefore, the continued increase in abuse for the profession has brought about the urgent need to address the causes for such negative behavior (Sommers, Gunja, Finegold & Musco, 2015). Low et al., (2000) reviews ethical decision making in the businesses has significantly grown over the previous decades due to the multiple cases presented in media and various news outlets. The financial industry, insurance being one of them, has always established a sense of trust such that clients and the organization can rely on one another to uphold the ethical standards of the industry. As the products sold by insurance companies are intangible services, consumers expect the organization to uphold their end of ethical responsibility. Despite this need, the major concern is why

these organizations engage in unethical conduct and the impact on the affected corporations.

Any business, in this case, insurance companies, cannot survive in the modern economic environment without enforcing ethical standards. In this regard, every transaction that the firm engages in will be based on the practice of good conduct. According to a report by Henry (2004) when one organization demonstrates appropriate ethical conduct, its associates are required to uphold ethical behavior in the same way. The awards of integrity, honesty, productivity and quality are earned through its ability to meeting the needs of employees, consumers and suppliers with care. The employees who are treated as per the requirements of the guidelines of ethics by their employers will also extend the same when interacting with consumers (Henry, 2003). In this way, the profits earned by an organization are mere by-products and not the sole goal of the company.

The report by Henry and Lee (2004) provides a definition of ethics as the standards of conduct that are upheld by the business professionals and not always the entire organization. In this regard, when the business itself does not establish an ethical foundation for its practices it is more likely than not to fail. The organization may do this by creating a code of conduct that all of its employees must adhere to as a means of building a reputation that one is reliable and dependable in the business. The clients will not seek the services or products of an organization that has a reputation of disregarding the regulations of the government resulting in fraudulent schemes (Green, 2004). Despite increased attentions on the issue of moral practices, there are minimal theoretical and empirical evidence on ethical decision-making process (Jones 1991). Various researchers have pursued this in an effort to develop techniques of minimizing the occurrence of fraudulent cases.

2.2.1.2 Online Social Networking

The insurance industry is developing significant measures of coping with the fraudulent claims through investment in research and development departments. As the technology in the modern society becomes more innovative, it is the responsibility of insurance adjusters to recognize numerous ways that fraudsters may seek to cheat the business

(Derrig, 2012). In the previous decade and a half, social media has become nearly an omnipresent commodity used in the daily activities of the members. As a result, insurance investigators have incorporated the use of this commodity in identifying significant evidence of fraudulent claims. The use of social media started off as a leisure tool for engaging in distant interactions between friends, acquaintances and family members making the global society appear as a small village. However, in a very short period, social media has become one of the most important tool for undertaking numerous activities including marketing, politics, and source of data. In some cases, the data is publicly available for all its members.

The aspect of socialization has been surpassed as platforms like Facebook, Twitter and Instagram have become an institution of business for each of the organizations. It is evident that corporation in the modern economic environment have established a social media presence through the use of available platforms to market their various brands and products. The insurance companies have not been left behind as they identify the importance of social media beyond just marketing their products where the company investigators may incorporate the use of the same platform to investigate claim for numerous hours in a day (Millner & Duhl, 2011). This practice could be the most important aspect of ensuring the company can save up millions by identifying fraudulent claims. The organizations in this industry have called attention to the importance of social media as an effective platform that could save up the company from multiple losses of unidentifiable fraudulent claims.

The use of social media in the modern society has become a common practice among ordinary citizens such that individuals do not control the information they relay to the rest of the world (Andergassen, 2008). This practice becomes an unintended benefit to insurance companies who take note of the large source of public information relayed through the various platforms. According to reports dated April 2016, there are more than 1.59 billion users on Facebook, 400 million on Instagram, and 320 million on Twitter every month. In this regard, these users account for majority of the population providing data that is beneficial to the insurance companies. According to the default settings that an individual may establish on these platforms, all information posted to the public is

considered public unless otherwise indicated. As a result, the insurance companies have free access to the information that may help in combating cases of fraud (Persons, 2012).

There have been multiple cases where the insurance companies have succeeded in acquiring information by investigations carried out on social media. There is a case where a woman had reported to her insurance company that she had lost her wedding ring hence sought compensation for the lost item. However, intense monitoring of the individual's social media led to identification of uploaded pictures where she was wearing the alleged "lost" ring. In this regard, the numerous platforms available in this modern age is a significant source of improving operational processes (Kenealy, 2013). One major obstacle that the insurance companies encounter is application of social networking data as underwriting for the insurance claimants (Ha, 2011). In this regard, regulators and the companies have not established clear guidelines for the use of data on social media. Additionally, scientific research has not made it clear which data from social media is appropriate for use in the studies (Ha, 2011). All in all, insurance companies need to turn to the qualitative approach of social media investigation since it presents an appropriate source for evidence that can be used to minimize fraudulent practices.

2.2.1.3 Regulatory Framework

The insurance industry is one of the most important industries and indispensable for the functioning of today's economy and society. Because of its vital importance, insurance markets have always been among the most regulated markets. The regulatory framework of the insurance industry is currently subject to fundamental changes. The ongoing reforms affect prudential supervision and many other areas, e.g. insurance distribution, data processing or product policies. Therefore, they will inevitably have profound implications for the insurance industry and insurance markets (Pasiouras & Gaganis, 2013).

The design of these reforms will not only affect how well the insurance industry can cover the risks of private households and companies. It will also influence to what extent the society can benefit from the specific potential of insurers as long-term investors, e.g. in the financing of property, businesses, banks or the public sector. Insurance regulation

often requires striking a fair balance between the interests of individual policyholders and the collective interests of the community of the insured. In order to ensure appropriate regulatory decisions despite this high level of complexity and competing objectives and interests, it is vital to set high standards regarding legislation and regulatory governance (Anja, 2015).

Every country has an insurance regulatory authority responsible for supervising insurance business. The work of the regulator being to harmonize policies, legal, technical, financial and organizational structures in the sector. With the discovery of oil and gas in the region, it is imperative for the authorities to create regional capacity to deal with risks. The problem of availability of data and lack of research can be dealt with more appropriately from the regional front. Working together as a region will help member states regulators to articulate their issues better at the International Association of Insurance Supervisors (IAIS) forums (AKI, 2012).

Governments the world over are faced with challenges relating to the regulatory environment, emerging global trends in the insurance sector, technological innovations and liberalization of the insurance sector. The impact of these trends is perhaps more pronounced in the case of developing countries, who stand to benefit from liberalization of the insurance sector provided due consideration is paid to putting in place an efficient and well-functioning institutional and regulatory framework, tailored national policies and well-planned sequential commitments on insurance liberalization. One of the principle areas is the security and stability of the insurance sector, which in turn is linked to setting up and ensuring a well-functioning insurance supervisory and regulatory authority. Other concerns include the possibility of anti-competitive practices, selective marketing to high value client's, possible loss of employment in the case of privatization, selective sectors of operation, protection of nascent insurance operations and perhaps the most important of all the need to set in place strong and adaptable regulatory systems within the insurance sector (UNCTAD, 2007).

The importance of setting in place efficient regulatory structures as a prerequisite to the efficient operation of the insurance sector and particularly in the context of insurance liberalization and an evolving global insurance sector is essential. Emerging trends in the

global insurance market particularly those relating to technology, newer financial products and corporate failures have under scored the value of regulation in the insurance sector. There exist differences, sometimes large ones in the regulatory and supervisory structures of developed and developing countries. In respect of regulation most Governments are faced with a number of challenges which include setting up efficient regulatory structures, and harmonization of prudential and regulatory structures across countries (Ma and Pope, 2003).

Ericson and Doyle (2006) report the results of interviews of sales and management personnel in the life insurance industry in Canada and the United States, concluding that deceptive practices in that segment are prevalent and institutionalized, and that regulatory efforts fall short of needed consumer protections. Berardinelli (2008) has outlined recently- revised claim settlement practices at one large property-casualty insurer in the United States (Allstate) which he asserts places profits above policy-holders, resulting in "…consistent underpayment of claims…" (p. 43). Allstate has argued otherwise of course, although it has recently (2010) agreed to the terms of a multi-state settlement with implications in all locales in which it does business, addressing its use of software, claimant communication and other matters associated with claims management and regulatory oversight (Hunter, 2007; Multi-State Market Conduct Regulatory Agreement, 2010).

2.2.1.4 Performance of Insurance Firms

Insurance firms have undergone difficult point in time and have incurred lump sum claim payouts that are fraudulent. Therefore this has forced insurance firms to get to the drawing board and re-evaluate ways in which they handle compensation claims (Karau, 2008). Most of the fraudulent compensation claims are committed by a lobby of criminal offenders through exaggerated claims or claims of non- existence nature. According to Wahome (2010), fraud is one of the leading causes of insurance firms collapsing and hence the insurance firms record poor performance for those that survive. When the genuine clients need to be compensated on time, the insurance firm has to know how to separate them from the fraudulent ones by carrying out investigations. The investigation process requires resources hence increasing the company are operating costs.

Furthermore, these investigations are time consuming thereby leading to dissatisfied customers who will end up leaving the insurance firm and in turn the insurance firm records poor performance.

Once fraudulent compensation claims are paid off the insurance firm loses company funds to the fraudsters leading to poor financial performance. With this kind of trend in the industry, the genuine and the fraudster clients will be affected because the insurance firm may be forced to increase their premiums. Therefore, if the fraudsters are successful with this kind of malpractice then in future they will be tempted to continue with the malpractice (Roff, 2004).

2.3 Theoretical Framework

This study was anchored on the White Collar Crime theory, Fraud Scale Theory and General Crime Theory. Each of these theories is expounded in subsequent sections below. The discussion of each of the theory structured based on the proponents of the theory, the key contributions of the theory and the relevance of the theory to the study. The researcher strived to establish a link between each of these theories and the current study.

2.3.1 White Collar Crime Theory

Sutherland (1924) in his leading text, Principles of Criminology, first stated the principle of differential association whereby individuals are believed to learn the various skills, techniques, motives and attitudes associated with criminal behavior. This learning process clearly shows that criminality is through association with individuals who have engaged in similar behavior. Adding on to the theory, it proposes that social disorganization and conflict within the community are just some of the factors that lead to the development of such behavior of deviance. Sutherland was certain that the presence of social classes in the society is a major factor towards increased criminality, coining the phrase white-collar criminal and went ahead to define it as a criminal action undertaken by an individual who is respectable and of a high social class. In this regard, the crime may take place in his occupation. Usually crimes of corporations, such as financial fraud

may be classified as a white-collar crime. Through the theory of differential association, such criminal acts are not innate, but are learnt usually from intimate personal groups. Notably majority of fraudulent claims are often committed by individuals who acquire the criminal behavior as result of association with criminals. Therefore, this theory is relevant to the study as it helps in understanding why even honest individuals and employees would engage in fraudulent activities when then associate with criminals.

2.3.2 Fraud Scale theory

Albrecht (1986) established nine significant factors that motivate an individual to commit a fraudulent crime. These factors may also be considered to be the personal characteristics of the individual. They include: A spend thrift behavior where one lives a life beyond what they can afford; Usually having a desire to ensure personal gain at all costs; Having multitudes of personal debts; Usually has a close association with clients; Demonstrates a feeling that the salary is not equal to the amount of work done; Portrays a wheeler-dealer attitude; Usually believes he has the challenge to beat the system and change financial situation; The individual may engage in excessive gambling; and usually feels that there a lot of pressure from family and peers to become successful creating a belief that he is not recognized for his job.

Through the development of the fraud scale three significant factors were identified as relevant for the occurrence of fraud: High level of situational pressures, Low Personal Integrity, and significantly high levels of perceived opportunity. The situational pressures include high amount of debt and losses incurred. The low personal integrity identifies the lack of personal codes of ethics. The perceived opportunity is evident where the individual believes he can benefit more from taking the risk to alleviate the problems currently experienced. Fraud scale premise is relevant to this research as it gives an illumination to the financial and ethical factors that would lead to employees and other third parties into engaging in fraudulent activities

2.3.3 General Crime Theory

According to Gottfredson and Hirschi's (1990) theory of crime is also identified as the general theory of crime where individuals lack the self-control to successfully avoid criminal behavior. In this case, the behavior begins during childhood where parents are actively required to monitor the actions of their children and effectively correct bad behavior. An individual will be able to demonstrate control through similar efforts made during childhood to prevent bad behavior. The term self-control can be defined as the extent that shows an individual is not susceptible to the temptations one may experience at the moment. Once an individual is able to uphold such a practice, he or she will demonstrate acceptable social behavior. The people who may not acquire such behavioral actions could lead to a liking of delinquency where they engage in multiple acts of deviance against the law and authority in place. The research by Gottfredson and Hirschi (1990) indicates that self-control is the precursor for any influential aspect towards crime and the best to identify the same behavior. In this regard, lack of self-control intersects with numerous opportunities that demonstrate possibility for personal gain.

According to the research, every individual is well aware of the benefits associated with criminal behavior. However, the individuals who cannot empathize with the suffering of the victims of crime have a different cost calculus. This occurrence prompts these individuals to lack awareness or complete disregard for the consequences either social or legal that may occur. In the presence of lacking self-control, there are numerous intertwined traits that are presented. They include determination to receive quick satisfaction for action, inability to perform accurate calculation of the consequences of one's behavior, and require little planning or competence for the actions that should be performed. The effects of these actions usually show inadequate gains on a long-term basis and commitments. The presence of the risk of being caught during the criminal activity provides the perpetrators with significant thrill of going through with their plans. These elements show that there are numerous vulnerabilities an individual could encounter temptations and opportunities. This theory emphasizes the need to have regulations and controls to behavior as certain individuals are poised to commit fraud due to their lack of self-control and inclination to short term gain.

2.4 Empirical Review

There is a general feeling that the insurance industries are doing little to combat the insurance fraud. A study by the Insurance Times (2014) claimed that a significant number of insurance professionals felt that insurers were not winning the battle on fraudulent compensation claims. In the study, only 6% of the respondents indicated that they believed that the existing strategies and resources will effectively help in combating the fraudulent claims. Close to 70% of the respondents said that they did not believe in the effectiveness of existing strategies in combating fraudulent incidences. This is supported by the fact that fraudulent claims have continued to rise despite the insurers' efforts to fight the vice.

Honeycutt, Glassman, Zugelder and Karande (2011) conducted a study on determinants of ethical behavior. The results did not find any correlation between age, education and ethical behavior. From the study, it was also clear that economic factors might determine ethical behavior. Poverty might prompt people to engage in unethical behavior for economic gain. However, the opportunity to commit a criminal behavior and the rewards thereafter was also strong determinants. In the insurance industries, weaker controls mean that most people can commit the crimes without being caught. That in itself is an incentive that her led to the perpetuation of the vice.

Relating to ethical practices, at the global scene in UK, a study by Diacon and Ennew (1996) on ethical issues in insurance marketing in the UK concluded that ethical problems in marketing were many in the industry. Besides the views of marketing staff regarding ethical issues differ significantly from those of non-marketing staff with marketing staff inclined far more to un ethical practices. In Nigeria, a study by Isimoya (2014) on business ethics in insurance industry in Nigeria asserted that there was a correlation between the unethical behavior and growth of the insurance industry. The increased fraudulent behavior also leads to loss of confidence about the industry. The stunted growth of the insurance industry in the sub-Saharan Africa and most parts of the world is largely attributed to the negative feelings about the industry. According to Rand (2014), both Kenya and Greece needed to allocate more resources towards improving

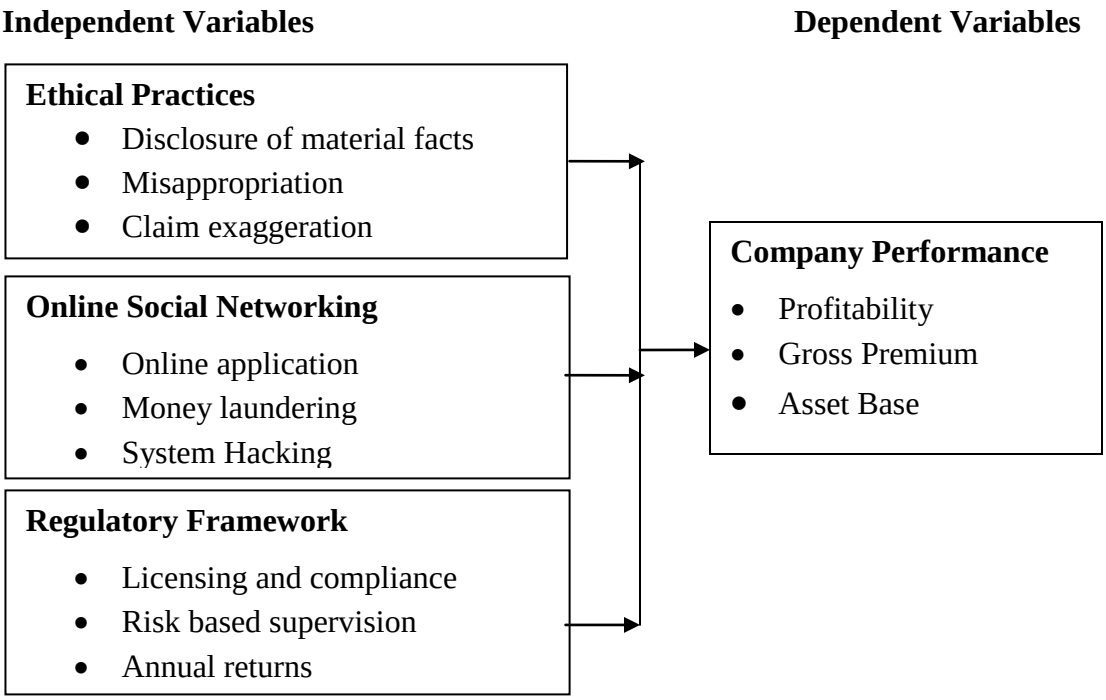
quality delivery of services and overcoming the vice of insurance fraud to attract a larger customer base.

Ndumia (2015) did an investigation on influence of regulatory framework on performance of building construction projects in Nairobi County, Kenya. The study found out that Architects and Quantity Surveyors trained and licensed in the planning and designing of buildings, their work is to advise his clients and study their needs, Nairobi County had formulated a statutory and regulatory framework to embrace digital system for management of developments applications which involves the public and stakeholders in policy formulation, NEMA effectively implements environmental policies, proposes effective mitigation measures for significant negative impacts of building construction projects and NCA registers and certifies constructors, regularly publishes the code of conduct for the building construction industry. The study concludes that a regulatory framework in which regulators challenge firms to improve based on constructive and active engagement can be effective in ensuring compliance before a serious problem emerges and regulatory framework governing the construction industry could seek legal capacity to prosecute errant developers.

2.5 Conceptual Framework

A conceptual framework helps the reader to quickly see the proposed relationships between the variables in the study and shows the same graphically or diagrammatically (Mugenda & Mugenda, 2003). The conceptual framework of this study was based on the three independent variables namely; ethical practices, online social networking and regulatory framework. The dependent variable was company performance both in the financial and non-financial metrics in the insurance sector in Kenya. Figure 2.6 shows how the various independent variables influence the dependent variable under study.

Figure 2.1: Conceptual Framework



Source: Researcher (2017)

2.6 Research Gaps

A vast majority of empirical research on fraudulent compensation claims show that the payment of these claims decrease insurance firms growth and performance (Munyua, 2013). Despite these findings most insurance fraud studies have been characterized by lack of solid theoretical foundation explaining the factors causing the observed levels of poor performance. The available literature also indicates serious lack of empirical studies designed to investigate exactly how ethical practices, online social marketing and regulatory framework with regard to fraud affect the performance of insurance companies (Soltani, 2014). On this background therefore, this particular study is conducted to investigate the influence of ethical practices, online social networking and regulatory framework and the relationship between fraudulent compensation claims and performance of insurance companies in Nairobi Kenya and to provide a better understanding of the relationship between these variables.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The chapter will focus on the framework for used in conducting the scientific research. This will include the target population, research design, data collection, analysis, and the population of study. The area will also focus on the rate sampling techniques that help in selecting a representative sample.

3.2 Research Design

The study used descriptive research design. According to Mugenda and Mugenda (2003) a descriptive research is a process of collecting data in order to answer questions concerning the current status of the subjects in the study. A descriptive research design seeks to demonstrate the relationship between the variables. The relationship in this sense is that of fraudulent compensation and performance of insurance firms. The descriptive research provides the rationale behind the relationship between the independent and the dependent variables. According to Wyk (2016), the main aim of descriptive research is to provide an accurate and valid representation of the factors or variables that pertain or are relevant to the research question as well as possible relationship among variables.

The rationale for the use of descriptive research design was the fact that it gives the characteristic of a social phenomenon under examination. However, the major weakness is that the descriptive research design might not provide an explanation on why the relationship exists.

3.3 Target Population

According to the IRA (2015), there were 44 insurance companies in Kenya. The insurance companies are classified in terms of their core business as: General insurance companies, Life insurance companies and Composite insurance companies. The target population in this study was 968 employees working in finance department in all the three categories of insurance companies as indicated in the Table 3.1.

Table 3.1: Target Population

Department	No. of Insurance Companies	Target Population
Life Insurance	23	506
General Insurance	8	176
General and Life Insurance	13	286
Total	44	968

Source: AKI (2014)

3.4 Sampling and Sampling Size

The sample size constituted two managers from the Finance department in each of the three categories of insurance companies. The sample size was 88 managers as shown in the Table 3.2:

Table 3.2: Population Distribution

Category of Insurance	No. of Insurance Companies	No. of Respondents	Total No. of Respondents
Life Insurance	23	2	46
General Insurance	8	2	16
General and Life Insurance	13	2	26
Total	44		88

Source: AKI (2014)

3.5 Data Collection instruments

A questionnaire was the main data collection instrument that was used in the study. It was composed of a number of questions based on the research questions and objectives. The questionnaire contained both the open-ended and closed question designs. The importance of a questionnaire is that it ensures that the responses are specific. In the closed questions, the response is either 'Yes' or 'No.' However, such a data collection instrument might limit the responses and interfere with the validity and reliability of the study. That explains why open-ended questions were also included. The goal was to give the respondent an opportunity to give rationale to their claims. That was important in enhancing data processing and analysis. Unlike the interviewing techniques, questionnaires are less expensive and easier to administer.

3.5.1 Piloting

Piloting was important for this study. The purpose was to test for the validity of the research instrument. Piloting was done using a population of 20 respondents across the three insurance companies in Nairobi. Another goal was to enable the researcher to modify the research questions and the research instruments to foster reliability and validity of the study. The time taken for the piloting process was a week.

3.5.2 Reliability and Validity

Kaliapen and Hilman (2013) explain that validity is the extent to which a research instrument is able to measure what it is supposed to measure. Reliability on the other hand is explained by Mugenda and Mugenda (2008) as a measure of the degree to which research instruments yield consistent results. The validity of the data was ensured by undertaking a pilot test for pre-testing the questionnaires to a sample of respondents. Reliability was ensured through Cronbach Alpha Coefficient to assess the internal consistency of the instruments.

3.6 Data Analysis

Data was tested for normality by use of scatter diagram and frequency tables. Inferential statistics of Regression and correlation analysis was used to determine the relationship between fraudulent compensation claims and performance. All the findings were categorized into the respective perspective for all the attributes and model of goodness of fit calculated to establish the relationship and the percentage contribution of the variables (attributes) to the performance of insurance companies.

3.7 Analytical Model

The relationship between fraudulent compensation claims and performance was tested through a regression model as:

$$\text{Performance} = f(\text{fraudulent compensation claims}) \quad \text{.....3.1}$$

$$\text{Performance} = \alpha + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \varepsilon \quad \text{.....3.2}$$

Where:

Performance; Insurance Company Performance

X_1; Ethical practices

X_2; online networking

X_3; Regulatory framework

α,; Intercept or constant

β_1, β_2, β_3, Coefficients that explain variation of the independent variable on the dependent variable

e; The uncontrollable error distributed around the mean

3.8 Tests of Significance and Interpretation

ANOVA was used to test for the variance in order to determine homogeneity of the data. Coefficient of correlation (r) was used to determine the magnitude of the relationship between the dependent variable (performance) and the independent variables (Ethical practices, online social networking and regulatory framework). Coefficient of determination (r^2) was also be used to show the percentage for which each independent variable and all independent variables combined explain the change in the dependent variable.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

The chapter presents the analysis and interpretation of the findings as set out in the research methodology. The study outcomes were presented to determine the effects of fraudulent compensation claims to performance of insurance firms in Kenya. Data was collected using questionnaires as the research instrument which was in line with the objectives of the study. The findings were presented using frequencies, percentages, means and standard deviations in form of graphs and frequency tables.

4.1.1 Response Rate

A total of 88 questionnaires were distributed to the claims and finance managers of the insurance companies out of which 65 questionnaires were fully filled and returned giving a response rate of 74%. This response was considerable and representative of the population and conforms to Mugenda and Mugenda (2003) stipulation that a response rate of 70% and above is an excellent representation of the population. These finding is presented in the Figure 4.1.

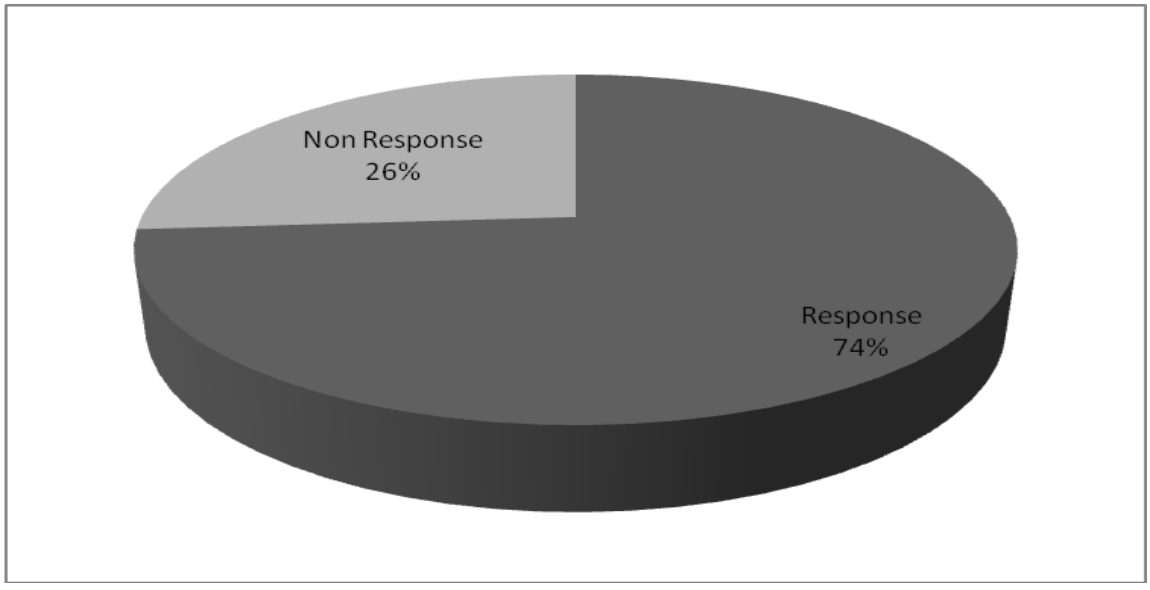


Figure 4.1: Response Rate

4.1.2 Data Validity and Reliability

Kaliapen and Hilman (2013) explain that validity is the extent to which a research instrument is able to measure what it is supposed to measure. The researcher conducted a pilot study to determine the validity and reliability of the research instrument. The findings are indicated in Table 4.1.

Table 4.1: Data Validity and Reliability

Variable	Number of Items	Cronbach Alpha
Ethical Practice	9	0.711
Online Networking	7	0.721
Regulatory Framework	10	0.710
Claims Performance	4	0.713

From the findings, Ethical Practices had Cronbach Alpha coefficient of 0.711, Online networking had 0.721, regulatory framework had 0.710 and claims performance had 0.713. Since all the Cronbach Alpha coefficients were above 0.7, this implies that scales used were reliable.

4.2 General Information

The study sought to determine the general information of the respondents so as to assess their suitability in undertaking the study. The findings are presented in the subsequent sections.

4.2.1 Age Distribution

The respondents were asked to indicate their age. The findings are shown in Figure 4.2.

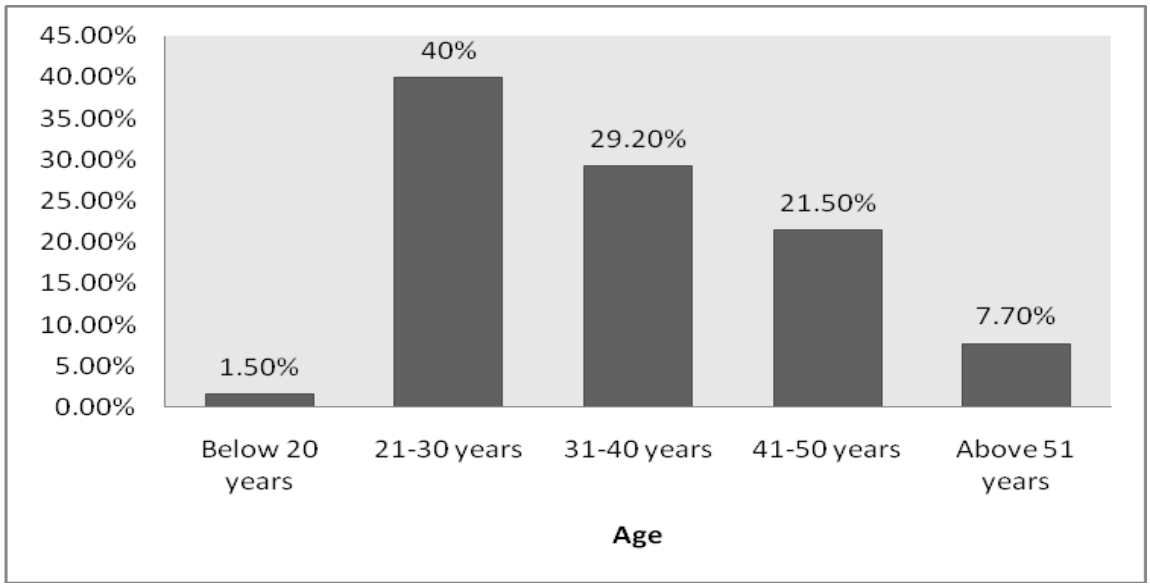


Figure 4.2: Age Distribution

The finding shows that 1 (1.5%) were below 20 years, 26 (40%) were between 21-30 years, 19 (29.2%) were between 31-40 years, 14 (21.5%) were between 41-50 years and 5 (7.7%) were over 51 years. This indicates that all age group was included in the study thus provided relevant and reliable information for the study.

4.2.2 Marital Status

The respondents were required to indicate their marital status. The finding is shown in Figure 4.3.

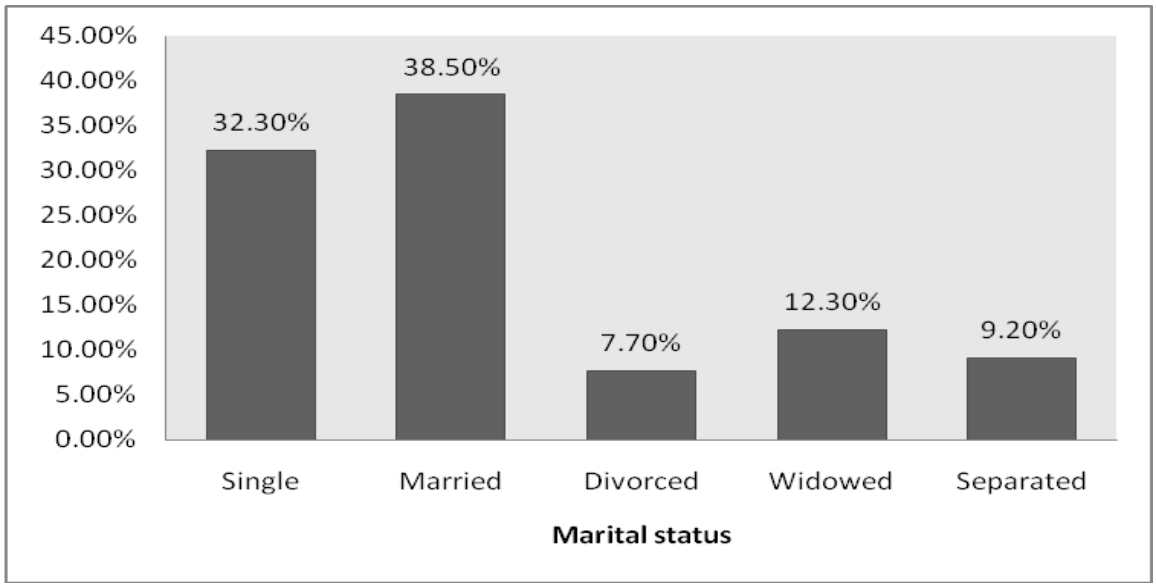


Figure 4.3: Marital Status

From the responses, 21 (32.3%) of the respondents were single, 25 (38.5%) were married, 5 (7.7%) were divorced, 8 (12.3%) were widowed and 6 (9.2%) were separated. This indicates that the researcher enhanced diversity in the study hence findings are more representative.

4.2.3 Period Working in the Insurance Sector

The respondents were required to indicate the period they have been working in the insurance sector. The finding is shown in Figure 4.4.

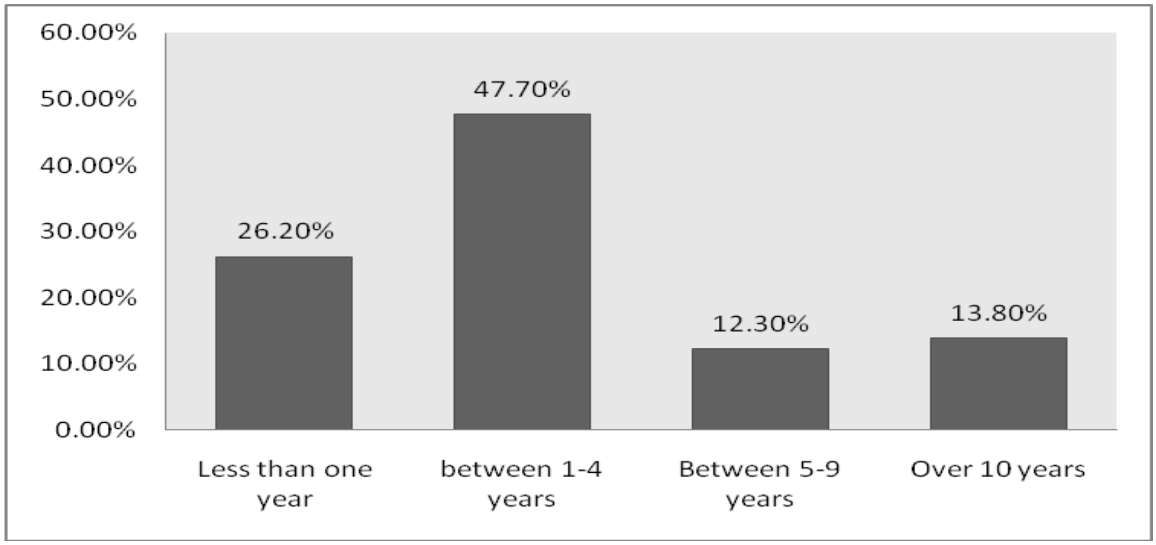


Figure 4.4: Period Working in the Insurance Sector

From the finding, 26.2% of the respondents had worked for less than 1 year, 47.7% for between 1-4 years, 12.3% for between 5-9 years and 13% for over 10 year. This shows that the respondents had worked long enough in the insurance sector thus they provided reliable information for the study.

4.2.4 Highest Level of Education

The respondents were required to indicate their highest level of education attained. The finding is shown in Figure 4.5.

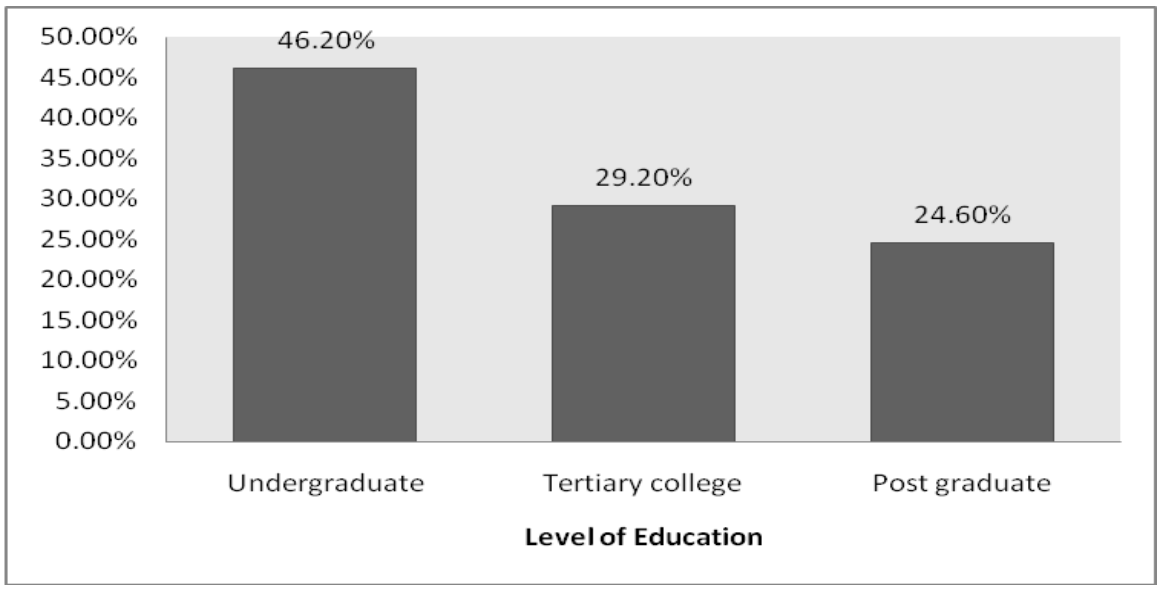


Figure 4.5: Highest Level of Education

From the findings, 30 (46.2%) of the respondents were undergraduates, 19 (29.2%) had tertiary/ college education and 16 (24.6%) were postgraduates. This implied that majority of the respondents had relevant knowledge thus they had no in addressing the question and provided the correct responses.

4.2.5 Kind of Business the Insurance Company Underwrite

The respondents were required to indicate the kind of business their insurance companies underwrite. The finding is shown in Figure 4.6.

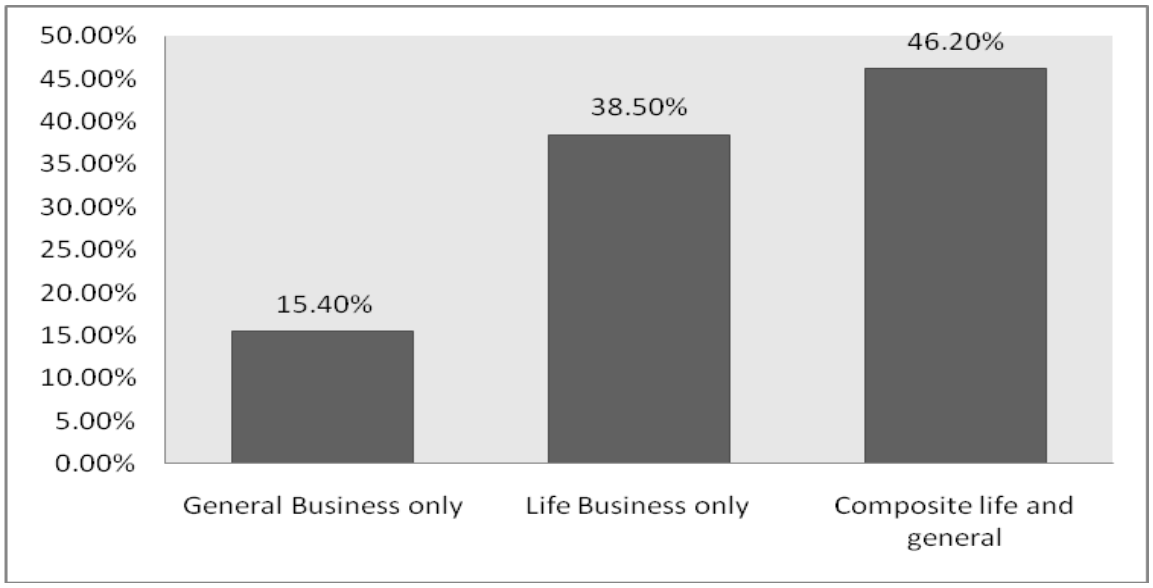


Figure 4.6: Kind of Business the Insurance Company Underwrite

From the findings, 10 (15.4%) indicated that they underwrite general business only, 25 (38.5%) underwrite life business only and 30 (46.2%) underwrite composite life and general. This shows that the insurance companies underwrite different kinds of insurance thus the information provided by the respondents was reliable for the study.

4.3 Ethical Practices

Several statements on ethical practices were identified and the respondents were required to indicate their extent of agreement. A scale of 1-5 where strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5) was used. Mean and standard deviation were calculated for ease of comparison and generalization of finding. The analysis therefore was based on 1-1.4 strongly disagree; 1.4-2.4 disagree; 2.5-3.4 Neutral; 3.5-4.4 agree and 4.5-5.0 strongly agree. The finding is shown in Table 4.2.

Table 4.2: Ethical Practices

	Minimum	Maximum	Mean	Std. Dev
Customers fail to disclose all material information on the risk when taking up insurance cover	1.00	5.00	2.72	1.305
Insurance sales people do not continuously observe the code of conduct when making a sale	1.00	5.00	2.13	1.116
Customers do not pay keen attention to terms and conditions of a policy when signing for it	1.00	5.00	1.80	1.048
Insurance companies do not disclose full information to policy holders for their decision making	1.00	5.00	2.55	1.601
The sales team misappropriate premiums collected from clients	1.00	5.00	4.43	.900
Some clients take up insurance in bad faith as they have more information concerning the risk compared to the insurers	1.00	5.00	4.36	1.097
Customers exaggerate claims values	1.00	5.00	3.49	1.532
The insurance industry loses huge amounts through misrepresentation by sales intermediaries	1.00	5.00	2.53	1.250
Insurance Companies lose huge sums through delays in claim settlements	1.00	5.00	2.69	1.210
Insurance companies lose huge sums of money through collusions between clients and sales representatives	1.00	5.00	2.43	1.262
Mean	**1.00**	**5.00**	**2.91**	**1.23**

The respondents agreed to a great extent that customers fail to disclose all material information on the risk when taking up insurance cover which had a mean of 2.72 and a standard deviation of 1.305. According to Low et al., 2000's review, the nature of insurance business has to do with trust between insurers and the insured clients. This is because insurance products are intangible products; they are not edible items that you can hold with your hand. Insurers are trusted by those who ask them to carry their risk and they have a duty to carry the risk responsibly. Therefore there is need for ethics in the conduct of insurance business. The study established that insurance companies do not disclose full information to policy holders for their decision making had a mean of 2.55 and a standard deviation of 1.601. According to Adnan et al. (2013), ethics play a very

important role in its performance as it influences the decision making abilities of individuals within the organization and this enhances the performance of the organization.

The study further established that the insurance industry loses huge amounts through misrepresentation by sales intermediaries had a mean of 2.53 and a standard deviation of 1.250. This implies that respondents were neutral on the statement. The finding concurs with a study by Diacon and Ennew (1996) on ethical issues in insurance marketing in the UK concluded that ethical problems in marketing were many in the industry. Besides the views of marketing staff regarding ethical issues differ significantly from those of non-marketing staff with marketing staff inclined far more to unethical practices.

Moreover, insurance Companies lose huge sums through delays in claim settlements had a mean of 2.69 and a standard deviation of 1.210. According to a study by Okeeno (2014), it was necessary for insurance companies to change claims settlement and management strategies. The study established that insurance companies lose huge sums of money through collusions between clients and sales representatives had a mean of 2.43 and a standard deviation of 1.262. The findings above indicate that there are numerous inefficiencies within systems of insurance companies and these affect performance. In line with this finding, Akaah (1997) posits that increasing awareness of potential and actual business abuses has resulted to increased attention on investigating causes of unethical business behaviors.

The respondents agreed to a great extent that the sales team misappropriate premiums collected from clients who had a mean of 4.43 and a standard deviation of 0.900. In line with this finding, Okeeno (2014), the current marketing management strategies of the insurance products and services need to be changed. The study established that some clients take up insurance in bad faith as they have more information concerning the risk compared to the insurers had a mean of 4.36 and a standard deviation of 1.097 and customers exaggerate claims values had a mean of 3.49 and a standard deviation of 1.532. From the findings, it is evident that ethical behavior can be established on different

grounds. According to Rupal (2010), ethics is an attitude that touches every aspect of the customer relationship. It is a known fact that good ethics makes a good business

The respondents disagreed that insurance sales people do not continuously observe the code of conduct when making a sale which had a mean of 2.13 and a standard deviation of 1.116. The finding concurs with Ndumia (2015) who investigated influence of regulatory framework on performance of building construction projects in Nairobi County, Kenya and established that NEMA regularly publishes the code of conduct for the building construction industry. The study further established that customers do not pay keen attention to terms and conditions of a policy when signing for it had a mean of 1.80 and a standard deviation of 1.048.

From the findings, the overall mean was 2.91 and this indicates that respondents were neutral on whether ethical practices affect performance of insurance companies in Kenya. This seems to signify the important role played by ethics in enhancing performance of insurance companies. In view of these, Adnan et al., (2013), established that considering the organizations, ethics play a very important role in its performance. All the decisions made in the organizations are by the individuals or the group of individuals and how they pay attention to the moral judgments will certainly reflect in the organizational decision making process. The finding further concurs with Isimoya (2014) who established that unethical practices holds sway in the industry, resulting in loss of confidence, poor insurance patronage and stunted growth for insurance industry.

4.4 Online Networking

Several statements on online networking platform and their effect on compensations and general performance of insurance companies in Kenya were identified and the respondents were required to indicate their agreement or disagreement using a scale of 1-5 where Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5) was used. Mean and standard deviation were calculated for ease of comparison and generalization of finding. The interpretation of the means was based on 1-1.4 strongly disagree; 1.4-2.4 disagree; 2.5-3.4 neutral; 3.5-4.4 agree and 4.5-5.0 strongly agree. The finding is presented in Table 4.3.

Table 4.3: Online Networking

	Minimum	Maximum	Mean	Std. Dev
Adoption of online insurance cover application has increased incidences of insuring assets that do not exist	1.00	5.00	2.07	1.314
Online networking platforms have increased the severity of organizational reputation in case of negative publicity	1.00	5.00	2.49	1.572
Online business transaction has increased cases of document forgery	1.00	5.00	3.81	1.519
Online reporting of claims has increased incidences of falsified claims	1.00	5.00	4.38	1.155
Online communication with clients has led to huge losses in cases of media hacking	1.00	5.00	3.83	1.329
Online transaction processing has increased cases of money laundering among clients	1.00	5.00	3.01	1.546
Online networking platforms have increased incidences of customer impersonations on payouts	1.00	5.00	2.61	1.283
Mean	**1.00**	**5.00**	**3.17**	**1.38**

The respondents disagreed that adoption of online insurance cover application has increased incidences of insuring assets that do not exist which had a mean of 2.07 with a standard deviation of 1.314. There are several other platforms of online tools for example face book, twitter among others. In line with this finding, Millner and Duhl (2011) established that insurance industry is one of the industries taking its use of social media beyond marketing. Claims investigators for insurance companies might be found spending hours of their day on Facebook, Twitter, and various other social media platforms.

The study established that and online networking platforms had not increased the severity of organizational reputation in case of negative publicity had a mean of a mean of 2.49 with a standard deviation of 1.572. According to Kenealy (2013), social media networks therefore provide a rich source of data that insurers can use to improve a variety of operational processes

The respondents agreed that online transaction processing has increased cases of money laundering among clients which had a mean of a mean of 3.01 with a standard deviation of 1.546 and online networking platforms have increased incidences of customer impersonations on payouts had a mean of a mean of 2.61 with a standard deviation of 1.283. The above findings however contradicts with Persons (2012) who established that insurance industry thrives off of data for business purposes such as underwriting, and now, this social media "data" may help insurance companies succeed in combating insurance fraud.

The respondents strongly agreed that online business transaction has increased cases of document forgery which had a mean of a mean of 3.81 with a standard deviation of 1.519, online communication with clients has led to huge losses in cases of media hacking had a mean of a mean of 3.83 with a standard deviation of 1.329. However, according to Persons (2012) insurance industry thrives off of data for business purposes such as underwriting, and now, this social media "data" may help insurance companies succeed in combating insurance fraud. Online reporting of claims has increased incidences of falsified claims had a mean of a mean of 4.38 with a standard deviation of 1.155. In line with these findings, Andergassen (2008) orates that with the immensely high rate of social media usage, some insurance companies are turning to this large source of public information to help combat insurance fraud.

On overall, the Likert mean was 3.17 and this indicates respondents were neutral on the statement. In view of this finding, Chiang (2014) conducted a study in Taiwan, a and concluded that neither regulators nor insurers have developed guidelines for the overall use of social data, and scientific studies have not determined what types of social medial data can be used reliably.

4.5 Regulatory Framework

Several statements of regulatory framework and how it affects claims performance of insurance companies were identified and the respondents were asked to indicate the extent to which you agree with each of them in as far as your company is concerned. A scale of 1-5 where: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly

Agree (5). Means were analyzed based on 1-1.4 strongly disagree; 1.4-2.4 disagree; 2.5-3.4 Neutral; 3.5-4.4 agree and 4.5-5.0 strongly agree. The finding is shown in Table 4.4.

Table 4.4: Regulatory Framework

	Minimum	Maximum	Mean	Std. Dev
The regulations enforced by IRA have reduces incidences of fraudulent claims	1.00	5.00	2.26	1.202
Rules and policies governing insurance industry operations have reduced incidences of fraudulent claims	1.00	4.00	1.67	.867
Continued regulation on sales personnel qualifications have improved claims settlements	1.00	5.00	1.81	.998
Annual renewal of practicing certificate for insurance professionals have reduced incidences of claims fraud	1.00	5.00	4.50	.831
Annual filing of returns on performance of new and repackaged products has reduced incidences of fraud in claims	3.00	5.00	4.61	.677
Implementation of risk based supervision model products has reduced incidences of fraud in claims	1.00	5.00	2.26	1.202
Separation of ownership and management products has reduced incidences of fraud in claims	1.00	5.00	2.24	1.173
Separation of life and general business has reduced incidences of fraudulent claims through cooperation	1.00	4.00	1.69	.917
Compulsory membership to industry associations (AKI) has improved management of fraudulent claims in the industry	1.00	4.00	1.86	.982
Regulations on financial soundness of insurance companies has improved management of claims	1.00	5.00	4.38	1.056
Mean	**1.00**	**5.00**	**2.37**	**1.06**

The respondents disagreed that rules and policies governing insurance industry operations have reduced incidences of fraudulent claims which had a mean of 1.67 with a standard deviation of 0.867. The finding concurs with Insurance Times research (2014) which established that 70% of industry professionals reported an increase in fraud over the past year, while 64% believe many policyholders think it is acceptable to make a fraudulent claim.

The study established that continued regulation on sales personnel qualifications had not improved claims settlements had a mean of 1.81 with a standard deviation of 0.998, separation of life and general business has reduced incidences of fraudulent claims through cooperation had a mean of 1.69 with a standard deviation of 0.917. According to Ndumia (2015) a regulatory framework in which regulators challenge firms to improve based on constructive and active engagement can be effective in ensuring compliance before a serious problem emerges and regulatory framework governing the construction industry could seek legal capacity to prosecute errant developers.

Compulsory membership to industry associations (AKI) had not improved management of fraudulent claims in the industry had a mean of 1.86 with a standard deviation of 0.982. The respondents disagreed that the regulations enforced by IRA have reduces incidences of fraudulent claims which had a mean of 2.26 with a standard deviation of 1.202. According to Anja (2015), in order to ensure appropriate regulatory decisions despite this high level of complexity and competing objectives and interests, it is vital to set high standards regarding legislation and regulatory governance.

The study further established that implementation of risk based supervision model products had reduced incidences of fraud in claims had a mean of 2.28 with a standard deviation of 1.904 and separation of ownership and management products had not reduced incidences of fraud in claims had a mean of 2.24 with a standard deviation of 1.173. According to UNCTAD (2007), one of the principle areas is the security and stability of the insurance sector, which in turn is linked to setting up and ensuring a well-functioning insurance supervisory and regulatory authority.

The respondents strongly agreed that annual renewal of practicing certificate for insurance professionals have reduced incidences of claims fraud which had a mean of 4.50 with a standard deviation of 0.831. The essence of certificate is to regulate the conduct of the insurance industry. According to UNCTAD (2007), this will reduce the possibility of anti-competitive practices, selective marketing to high value client's, possible loss of employment in the case of privatization, selective sectors of operation, protection of nascent insurance operations and perhaps the most important of all the need to set in place strong and adaptable regulatory systems within the insurance sector.

Annual filing of returns on performance of new and repackaged products has reduced incidences of fraud in claims had a mean of 4.61 with a standard deviation of 0.667 and regulations on financial soundness of insurance companies has improved management of claims had a mean of 4.38 with a standard deviation of 1.056. Ma and Pope (2003) established that the importance of setting in place efficient regulatory structures as a prerequisite to the efficient operation of the insurance sector and particularly in the context of insurance liberalization and an evolving global insurance sector is essential.

On overall, the mean was 2.73 and this implies that respondents were generally neutral on the statement. In view of this finding, Ndumia (2015) established that a regulatory framework in which regulators challenge firms to improve based on constructive and active engagement can be effective in ensuring compliance before a serious problem emerges and regulatory framework governing the construction industry could seek legal capacity to prosecute errant developers.

4.6 Claims Performance

The respondents were required to indicate their level of agreement with the identified aspects of performance which accrued as a result of fraudulent compensation claims in their organization. The researcher analyzed the means based on 1-1.4 strongly disagree; 1.4-2.4 disagree; 2.5-3.4 Neutral; 3.5-4.4 agree and 4.5-5.0 strongly agree. The finding is shown in Table 4.5.

Table 4.5: Claims Performance

	Minimum	Maximum	Mean	Std. Dev
Claims experience for the Company has improved over the last five years	1.00	5.00	2.38	1.54
Premiums of the Company have increased over the last five years	1.00	5.00	3.47	1.63
Fraudulent claims have reduced over the last five years	1.00	5.00	4.01	1.36
Profitability of the Company has improved over the last five years	1.00	5.00	3.67	1.37
Mean	**1.00**	**5.00**	**3.38**	**1.47**

The respondents were neutral on the statement that claims experience for the Company has improved over the last five years. The respondents also agreed that premiums of the Company have increased over the last five years which had a mean of 3.47 with a standard deviation of 1.630. According to Roff (2004) with fraudulent compensation claims, the genuine and the fraudster clients will be affected because the insurance firm may be forced to increase their premiums.

Fraudulent claims had reduced over the last five years had a mean of 4.01 with a standard deviation of 1.363. In view of this finding, Wahome (2010) established that fraud is one of the leading causes of insurance firms collapsing and hence the insurance firms record poor performance for those that survive. When the genuine clients need to be compensated on time, the insurance firm has to know how to separate them from the fraudulent ones by carrying out investigations.

Profitability of the company had improved over the last five years had a mean of 3.67 with a standard deviation of 1.370. Roff (2004) held that once fraudulent compensation claims are paid off the insurance firm loses company funds to the fraudsters leading to poor financial performance. The overall mean of the on claim performance was 3.38 and this implies that respondents were neutral on the statement. According to Karau (2008), insurance firms have undergone difficult point in time and have incurred lump sum claim payouts that are fraudulent. Therefore this has forced insurance firms to get to the drawing board and re-evaluate ways in which they handle compensation claims.

4.7 Regression Analysis

The study conducted regression analysis to determine the effects of fraudulent compensation claims to performance of insurance firms in Kenya. The study results are shown in the subsequent sections.

Table 4.6: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.479[a]	.229	.192	2.27857

Table 4.6 shows that the coefficient of determination R^2 is 0.229. This means that the combined influence of the predictor variables (ethical practices, online networking and regulatory framework) explains 22.9% of the claims performance.

Table 4.7: ANOVA

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	94.311	3	31.437	6.055	.001[b]
Residual	316.705	61	5.192		
Total	**411.015**	**64**			

The F critical at 5% level of significance was 2.75. F calculated is 6.055 which is greater than the F critical (value = 2.75), this shows that the overall model was significant. The significance is less than 0.05, thus indicating that the predictor variables (ethical practices, online networking and regulatory framework) were significant in explaining the variation in the dependent variable.

Table 4.8: Coefficients

	Unstandardized Coefficients		Standardized Coefficients		
Model	**B**	**Std. Error**	**Beta**	**t**	**Sig.**
(Constant)	8.387	1.717		4.883	.000
Ethical Practices	.357	.102	.413	3.492	.001
Online Networking	.305	.092	.403	3.327	.001
Regulatory Framework	.028	.117	.028	.239	.012

From the regression findings, the regression equation becomes:

$$\mathbf{Y= 8.387+ 0.357\ X_1+ 0.305X_2+0.028X_2+ \varepsilon}$$

Where: Y= Claim Performance, X_1= Ethical practices, X_2= Online networking, X_3= Regulatory Framework and ε = Error Term.

From the findings in the regression analysis, if the factors (ethical practices, online networking and regulatory framework) were held constant, claims performance would be at 8.387. A unit increase in ethical practices would lead to an increase in claims performance by 0.357. This means that ethical practices contribute 35.7% to fraudulent claims. A unit increase in online networking would lead to an increase in claims performance by 0.305. This implies that online networking as a variable contributes 30.5% to fraudulent claims payment. A unit increase in regulatory framework would lead to an increase in claims performance by 0.028, meaning that regulatory framework contributes to 2.8% of the fraudulent claims payment.

4.8 Multivariate Correlations Analysis

In order to determine the effects of fraudulent compensation claims to performance of insurance firms in Kenya, correlation analysis was used. Pearson's correlations analysis was conducted at 95% confidence interval. Table 4.9 indicates the correlation matrix between the factors (ethical practices, online networking and regulatory framework).

Table 4. 9: **Multivariate Correlations**

		Claims Performance	**Ethical Practices**	**Online Networking**	**Regulatory Framework**
Claims Performance	Pearson Correlation	1			
	Sig. (2-tailed)				
	N	65			
Ethical Practices	Pearson Correlation	.293	1		
	Sig. (2-tailed)	.018			
	N	65	65		
Online Networking	Pearson Correlation	.270	.305	1	
	Sig. (2-tailed)	.029	.013		
	N	65	65	65	
Regulatory Framework	Pearson Correlation	.022	.130	.257	1
	Sig. (2-tailed)	.040	.303	.039	
	N	65	65	65	65

From the correlation matrix, there is a positive and significant relationship between ethical practices, online networking and regulatory framework and claim performance with magnitudes of 0.293, 0.270 and 0.022 respectively. There is a positive and significant relationship between dependent and independent variables with P-value of 0.018, 0.029 and 0.040 respectively at 95% level of confidence.

4.9 Discussion of the Findings

The findings of regression analysis indicated that ethical practices significantly contributed towards performance of insurance companies $p=0.001<0.05$. The finding is consistent with Low et al., (2000) who established that ethical decision making in the businesses has significantly grown over the previous decades due to the multiple cases presented in media and various news outlets. According to Henry (2004), when one organization demonstrates appropriate ethical conduct; its associates are required to uphold ethical behavior in the same way. Ethics therefore plays an important role towards performance of any organization.

The study documents that online networking had a significant effect on performance of insurance companies $p=0.001<0.05$. According to Millner and Duhl (2011), insurance companies have identified the importance of social media beyond just marketing their products where the company investigators may incorporate the use of the same platform to investigate claim for numerous hours in a day. This practice could be the most important aspect of ensuring the company can save up millions by identifying fraudulent claims.

The study established that regulatory framework was significant in affecting performance of insurance companies $p=0.012<0.05$. According to Pasiouras and Gaganis (2013), the regulatory framework of the insurance industry is currently subject to fundamental changes. The ongoing reforms affect prudential supervision and many other areas, e.g. insurance distribution, data processing or product policies. Therefore, they will inevitably have profound implications for the insurance industry and insurance markets.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMEDATIONS

5.1 Introduction

This chapter presents the summary of the key data findings, conclusions and recommendations made from the findings based on the objectives of the study

5.2 Summary of the Findings

This section presents the summary of the findings as per the research objectives and the research questions.

5.2.1 Ethical Practices

The study found out that customers failed to disclose all material information on the risk when taking up insurance covers as supported by a mean of 2.72. The insurance companies did not disclose full information to policy holders for their decision making as indicated by a mean of 2.55 as the respondents were not very sure. Findings further indicated that the sales team misappropriates premiums collected from clients as supported by a mean of 4.43. The study established that some clients took up insurance in bad faith as they had more information concerning the risk compared to the insurers as supported by a mean of 4.36. The findings further indicated that customers exaggerated claims values as supported by a mean of 3.49.

The respondents disagreed that insurance sales people do not continuously observe the code of conduct when making a sale which had a mean of 2.13. The overall mean was 2.91 and this indicates that respondents were neutral on whether ethical practices affect performance of insurance companies in Kenya. This seems to signify the important role played by ethics in enhancing performance of insurance companies. All the decisions made in the organizations are by the individuals or the group of individuals and how they pay attention to the moral judgments will certainly reflect in the organizational decision making process. The contribution of this variable to the overall fraudulent claims payment was 35.7%.

5.2.2 Online Networking

On online networking, the respondents disagreed that adoption of online insurance cover application has increased incidences of insuring assets that do not exist which had a mean of a mean of 2.07. Further findings indicated that online networking platforms had not increased the severity of organizational reputation in case of negative publicity had a mean of a mean of 2.49. The respondents were not sure as to whether online transaction processing had increased cases of money laundering among clients as supported by a mean of a mean of 3.01 which suggests neutrality.

The study established that online transaction processing had increased cases of money laundering among clients, increased incidences of customer impersonations on payouts, increased cases of document forgery and online communication with clients has led to huge losses in cases of media hacking and incidences of falsified claims. The respondents strongly agreed that online business transaction has increased cases of document forgery as supported by a mean of 3.81. Findings further indicated that online communication with clients had led to huge losses in cases of media hacking as supported by a mean of 3.83. Online reporting of claims had increased incidences of falsified claims as supported by a mean of a mean of 4.38. On overall, the mean was 3.17 and this indicates respondents were neutral on the statement. The contribution of this variable to the overall fraudulent claims payment was 30.5%.

5.2.3 Regulatory Framework

On regulatory framework, respondents disagreed that rules and policies governing insurance industry operations have reduced incidences of fraudulent claims as supported by a mean of 1.67. On continued regulation on sales personnel qualifications had improved claims settlements as supported a mean of 1.81. The respondents disagreed on the separation of life and general business as to whether it had reduced incidences of fraudulent claims through cooperation as supported by a mean of 1.69. Compulsory membership to industry associations (AKI) had not improved management of fraudulent claims in the industry as supported by a mean of 1.86 which indicates that the respondents disagreed. The respondents disagreed that regulations enforced by IRA had not reduced incidences of fraudulent claims which had a mean of 2.26. The study further

established that implementation of risk based supervision model had not reduced incidences of fraud in claims had a mean of 2.28. Separation of ownership and management products had not reduced incidences of fraud in claims as supported by a mean of 2.24.

The respondents strongly agreed that annual renewal of practicing certificate for insurance professionals have reduced incidences of claims fraud which had a mean of 4.50. Annual filing of returns on performance of new and repackaged products has reduced incidences of fraud in claims had a mean of 4.61. Regulations on financial soundness of insurance companies had improved management of claims had a mean of 4.38. On overall, the mean was 2.73 and this implies that respondents were generally neutral on the statement. The contribution of this variables to the overall fraudulent claims payment was 2.8%.

5.3 Conclusion

5.3.1 Ethical Practices

The study concludes that just as insurance companies use other means of reducing the occurrence of frauds, adherence to ethical practices provided had a positive impact on fraud prevention and detection which could be committed by the employees and therefore should also be used in its efforts to reduce frauds. Among the ethical practices utilized in the companies, personal responsibility emerged as one of the most preferred strategies of curbing frauds.

5.3.2 Online Social Networking

The study concludes that the growing amount of information that is posted to social media networking sites, underwriters have discovered that social media can be a useful investigative tool for conducting research and uncovering relevant information on underwriting. Data derived online can serve to provide further confirmation of the information filled in an insurance application form, thereby assisting underwriters to develop a proper social media underwriting guideline. The impact and influence of social media on underwriting handling, fraud preventing, and adverse selection avoiding cannot be ignored.

5.3.3 Regulatory Framework

The study also concludes that in order to ensure a high performance level in the insurance industry in the long run, it is not only desirable, but essential to constantly adapt the insurance regulatory framework to the changing requirements of economy and society so as to reduce the incidences of fraud in claims.

5.4 Recommendation

The study recommends that insurance companies should observe ethical practices and support its implementation including setting up policies and guidelines as this would greatly deter fraud. Risk management activities and control over efficiency of operation should be undertaken to ensure fraud detection.

The study recommends that insurance companies should invest in technology to prevent claims fraud. Technology-based tools to fight insurance fraud can be used individually or in combination to help companies to detect and prevent criminal claim activities. Some fraud-detection techniques screen claims during processing and help prevent improper payments. Others involve analysis of adjudicated claims and help uncover the activities of fraud rings, internal fraud and leakage. These techniques are powerful deterrents for fraudsters who seek to profit at the expense of insurance companies and their good policyholders.

The study recommends that insurance companies should adhere to set policies and guidelines as this has shown to greatly deter fraud and should also endeavor to fully comply with guidelines, rules and regulations on good corporate governance in order to take control of the situation.

5.5 Recommendation for Further Studies

This study concentrated on the effects of fraudulent compensation claims to performance of insurance firms. This study therefore recommends that in the future a study should be conducted in other organization. This will enable comparison and generalization of the findings.

Further studies should concentrate on insurance firms across the East African market to enlarge the scope and application of the findings. This will enable generalization of findings to a wide scope.

From regression analysis, the value of R square was 22.9%. This means that the contribution of the factors under study that is ethical practices, online social networking and regulatory framework contributes to 22.9% of fraudulent compensation claims on performance of insurance firms in Kenya. This indicates that there are other factors other than fraudulent compensation claims that affect performance of insurance firms in Kenya. Future studies should be carried out to uncover these other factors that contribute towards 77.1% of performance for example management factors.

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APPENDIX I: QUESTIONNAIRE

Serial No……..

Kindly answer the questions by writing a brief statement or ticking in the boxes provided as will be applicable. The information provided will be treated as strictly confidential and at no instance will your name be mentioned in this research. This research is intended for an academic purpose only.

SECTION ONE: GENERAL INFORMATION

1. Name of insurance firm (optional)…….
2. Kindly indicate your age:

   Below 20 years [ ] 21-30 years [ ] 31-40 years [ ]

   41-50 years [ ] Above 51 years [ ]
3. Kindly indicate your marital status?

   Single [ ] Married [ ] Divorced [ ]

   Widowed [ ] Separated [ ]
4. Kindly indicate the period you have worked in the insurance sector?

   Less than one year [ ] between 1-4 years [ ]

   Between 5-9 years [ ] Over 10 years [ ]
5. What is your highest level of education? (Please tick one)

   Secondary school [ ] Undergraduate [ ]

   Tertiary college [ ] Post graduate [ ]

   Other (specify) ……..
6. What kind of business does the insurance company underwrite? (Please tick one)

   a. General Business only [ ]
   b. Life Business only [ ]
   c. Composite life and general [ ]

SECTION TWO: ETHICAL PRACTICES

7. Below are several aspects of ethical practices and how they affect performance of insurance companies. Kindly indicate the extent to which you agree with each of them in as far as your company is concerned. Use a scale of 1-5 where: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

No	Description	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)
i.	Customers fail to disclose all material information on the risk when taking up insurance cover					
ii.	Insurance sales people do not continuously observe the code of conduct when making a sale					
iii.	Customers do not pay keen attention to terms and conditions of a policy when signing for it					
iv.	Insurance companies do not disclose full information to policy holders for their decision making					
v.	The sales team misappropriate premiums collected from clients					
vi.	Some clients take up insurance in bad faith as they have more information concerning the risk compared to the insurers					
vii.	Customers exaggerate claims values					
viii.	The insurance industry loses huge amounts through misrepresentation by sales intermediaries					
ix.	Insurance Companies lose huge sums through delays in claim settlements					
x.	Insurance companies lose huge sums of money through collusions between clients and sales representatives					

SECTION THREE: ONLINE NETWORKING

8. Below are several online networking platform and their effect on compensations and general performance of insurance companies in Kenya. Kindly indicate the extent to which you agree with each of them in as far as your company is concerned. Use a scale of 1-5 where: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5).

No	Description	Strongly disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)
i.	Adoption of online insurance cover application has increased incidences of insuring assets that do not exist					
ii.	Online networking platforms have increased the severity of organizational reputation in case of negative publicity					
iii.	Online business transaction has increased cases of document forgery					
iv.	Online reporting of claims has increased incidences of falsified claims					
v.	Online communication with clients has led to huge losses in cases of media hacking					
vi.	Online transaction processing has increased cases of money laundering among clients					
vii.	Online networking platforms have increased incidences of customer impersonations on payouts					

SECTION FOUR: REGULATORY FRAMEWORK

9. Below are several statements of regulatory framework and how it affects claims performance of insurance companies. Kindly indicate the extent to which you agree with each of them in as far as your company is concerned. Use a scale of 1-5 where: Strongly Disagree (1), Disagree (2), Neutral (3), Agree (4), Strongly Agree (5)

		Strongly disagree(1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly agree (5)
i.	The regulations enforced by IRA have reduces incidences of fraudulent claims					
ii.	Rules and policies governing insurance industry operations have reduced incidences of fraudulent claims					
iii.	Continued regulation on sales personnel qualifications have improved claims settlements					
iv.	Annual renewal of practicing certificate for insurance professionals have reduced incidences of claims fraud					
v.	Annual filing of returns on performance of new and repackaged products has reduced incidences of fraud in claims					
vi.	Implementation of risk based supervision model products has reduced incidences of fraud in claims					
vii.	Separation of ownership and management products has reduced incidences of fraud in claims					
viii.	Separation of life and general business has reduced incidences of fraudulent claims through cooperation					
ix.	Compulsory membership to industry associations (AKI) has improved management of fraudulent claims in the industry					
x.	Regulations on financial soundness of insurance companies has improved management of claims					

SECTION FIVE: PERFORMANCE OF INSURANCE FIRMS

Please indicate your level of agreement with the following aspects of performance which are accrued as a result of fraudulent compensation claims in your organization. Using the Likert scale of 1 to 5 point scale as (1 = Not At All, 2 = Less Extent, 3 = Moderate Extent, 4 = Great Extent and 5 = Very Great Extent)

No	Description	Not at All (1)	Less Extent (2)	Moderate Extent (3)	Great Extent (4)	Very Great Extent (5)
	Claims experience for the Company has improved over the last five years					
	Premiums of the Company have increased over the last five years					
	Fraudulent claims have reduced over the last five years					
	Profitability of the Company has improved over the last five years					

THANKS FOR YOUR RESPONSE

APPENDIX II: LIST OF INSURANCE COMPANIES IN KENYA

No.	Insurance Company Name
1.	AAR Insurance Kenya Limited
2.	A P A Insurance Limited
3	Africa Merchant Assurance Company Limited
4.	Apollo Life Assurance Limited
5.	AIG Kenya Insurance Company Limited
6.	British-American Insurance Company (Kenya) Limited
7.	Cannon Assurance Limited
8.	Capex Life Assurance Company Limited
9.	CFC Life Assurance Limited
10.	CIC General Insurance Limited
11.	CIC Life Assurance Limited
12.	Corporate Insurance Company Limited
13.	Directline Assurance Company Limited
14.	Fidelity Shield Insurance Company Limited
15.	First Assurance Company Limited
16.	G A Insurance Limited,
17.	Gateway Insurance Company Limited
18.	Geminia Insurance Company Limited
19.	ICEA LION General Insurance Company Limited
20.	ICEA LION Life Assurance Company Limited
21.	Intra Africa Assurance Company Limited
22.	Invesco Assurance Company Limited
23.	Kenindia Assurance Company Limited
24.	Kenya Orient Insurance Limited
25.	Madison Insurance Company Kenya Limited
26.	Mayfair Insurance Company Limited
27.	Mercantile Insurance Company Limited
28.	Metropolitan Life Insurance Kenya Limited
29.	Occidental Insurance Company Limited

30. Old Mutual Life Assurance Company Limited
31. Pacis Insurance Company Limited
32. Pan Africa Life Assurance Limited
33. Phoenix of East Africa Assurance Company Limited
34. Pioneer Assurance Company Limited
35. Real Insurance Company Limited
36. Shield Assurance Company Limited
37. Takaful Insurance of Africa Limited
38. Tausi Assurance Company Limited
39. The Heritage Insurance Company Limited
40. The Jubilee Insurance Company of Kenya Limited
41. The Monarch Insurance Company Limited
42. Trident Insurance Company Limited
43. UAP Insurance Company Limited
44. UAP Life Assurance Limited

Source: Insurance Regulatory Authority (IRA) website: www.ira.go.ke

APPENDIX III: RESEARCH CLEARANCE PERMIT

CONDITIONS

1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.
2. Government Officer will not be interviewed without prior appointment.
3. No questionnaire will be used unless it has been approved.
4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.
5. You are required to submit at least two(2) hard copies and one (1) soft copy of your final report.
6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice

REPUBLIC OF KENYA

NACOSTI

National Commission for Science, Technology and Innovation

RESEACH CLEARANCE PERMIT

Serial No.A 14210

CONDITIONS: see back page

THIS IS TO CERTIFY THAT:
MR. GABRIEL MUTIIRIA KANAKE
of ST PAULS UNIVERSITY, 46143-100 NAIROBI,has been permitted to conduct research in *Nairobi County*

on the topic: *EFFECTS OF FRAUDULENT COMPENSATION CLAIMS ON PERFORMANCE OF INSURANCE FIRMS IN KENYA*

for the period ending:
30th May,2018

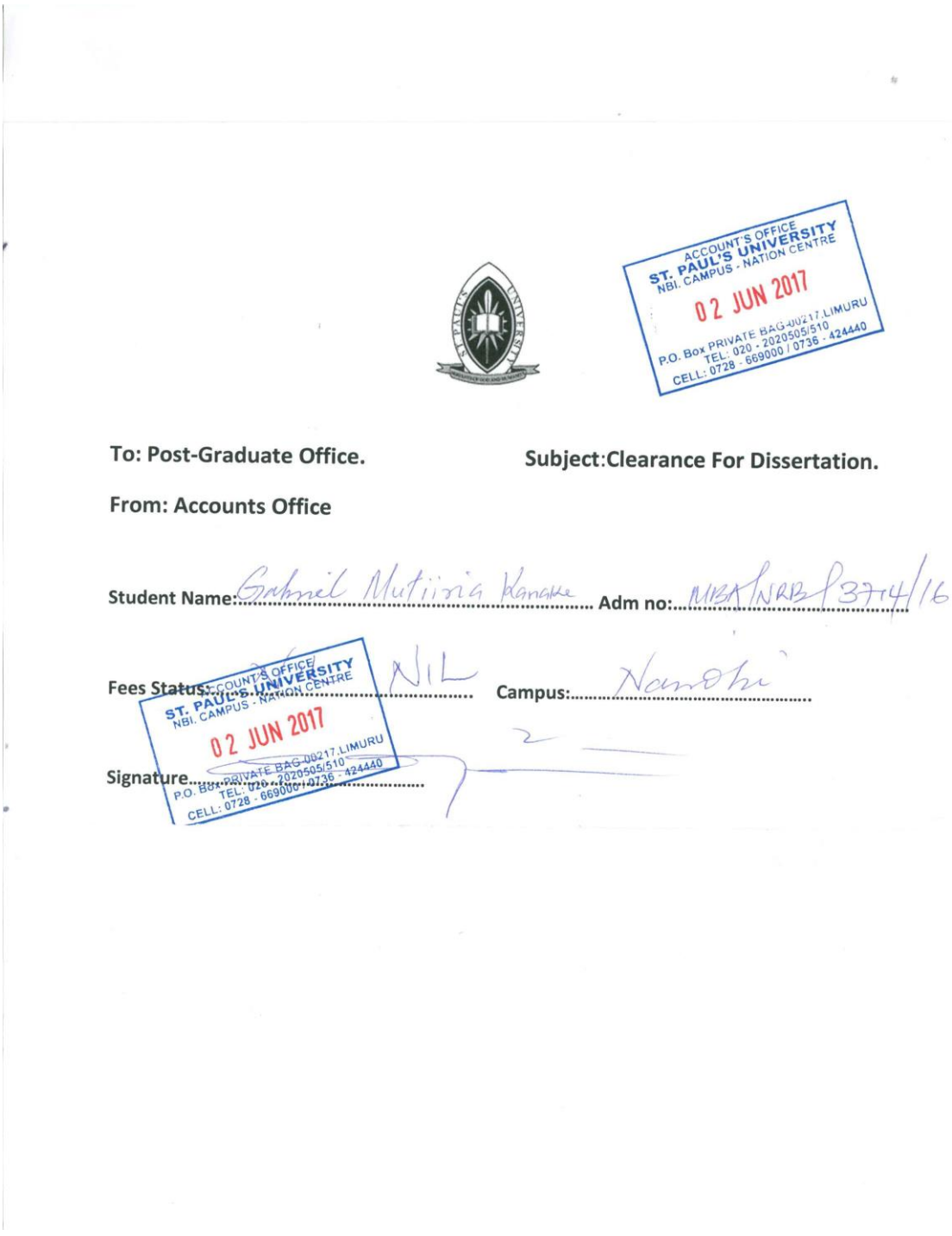
Permit No : NACOSTI/P/17/39801/17433
Date Of Issue : 30th May,2017
Fee Recieved :Ksh 1000



.....
Applicant's Signature

.....
Director General
National Commission for Science, Technology & Innovation

APPENDIX IV: CLEARANCE FROM FINANCE



ACCOUNT'S OFFICE
ST. PAUL'S UNIVERSITY
NBI. CAMPUS - NATION CENTRE
02 JUN 2017
P.O. Box PRIVATE BAG-00217,LIMURU
TEL: 020 - 2020505/510
CELL: 0728 - 669000 / 0736 - 424440

To: Post-Graduate Office. **Subject:Clearance For Dissertation.**

From: Accounts Office

Student Name: Gabriel Mutiiria Kanaiwa **Adm no:** MBA/NRB/3714/16

Fees Status: NIL **Campus:** Nairobi

Signature

ACCOUNT'S OFFICE
ST. PAUL'S UNIVERSITY
NBI. CAMPUS - NATION CENTRE
02 JUN 2017
P.O. Box PRIVATE BAG-00217,LIMURU
TEL: 020 - 2020505/510
CELL: 0728 - 669000 / 0736 - 424440

APPENDIX V: LETTER FROM THE UNIVERSITY

ST. PAUL'S UNIVERSITY

Private Bag 00217 LIMURU, KENYA
Email: bps@spu.ac.ke
Website: www.spu.ac.ke

Tel Office: +254(0) 20-2020505/10
Mobile: +254(0) 728- 669000
(0) 728- 062420
(0) 736- 424440

BOARD OF POSTGRADUATE STUDIES

8th March 2017

National Commission for Science and Technology,
P.O. BOX 30623-00100,
Nairobi.

Dear Sir/Madam,

Re: Recommendation for Gabriel Mutiira Kanake to conduct a Masters of Business Administration (MBA) research.

This letter confirms the above named person is a second (final) year student of the MBA Programme at St. Paul's University.

The final year consists of a major research work leading to a dissertation comprising 20,000 words. The student's selected topic is '*Effects of fraudulent compensation claims on performance of insurance firms in Kenya*'.

The research will take place in Nairobi County from March 2017 to May 2017.

Kindly grant this student the required permit.

Yours Faithfully,

Dr. Sammy Githuku
Director, Postgraduate Studies