



The impact of insurance fraud

About Insurance Europe

Insurance Europe is the European insurance and reinsurance federation. Through its 34 member bodies — the national insurance associations — Insurance Europe represents all types of insurance and reinsurance undertakings, eg pan-European companies, monoliners, mutuals and SMEs. Insurance Europe, which is based in Brussels, represents undertakings that account for around 95% of total European premium income. Insurance makes a major contribution to Europe's economic growth and development. European insurers generate premium income of almost €1 100bn, employ nearly one million people and invest around €7 700bn in the economy.

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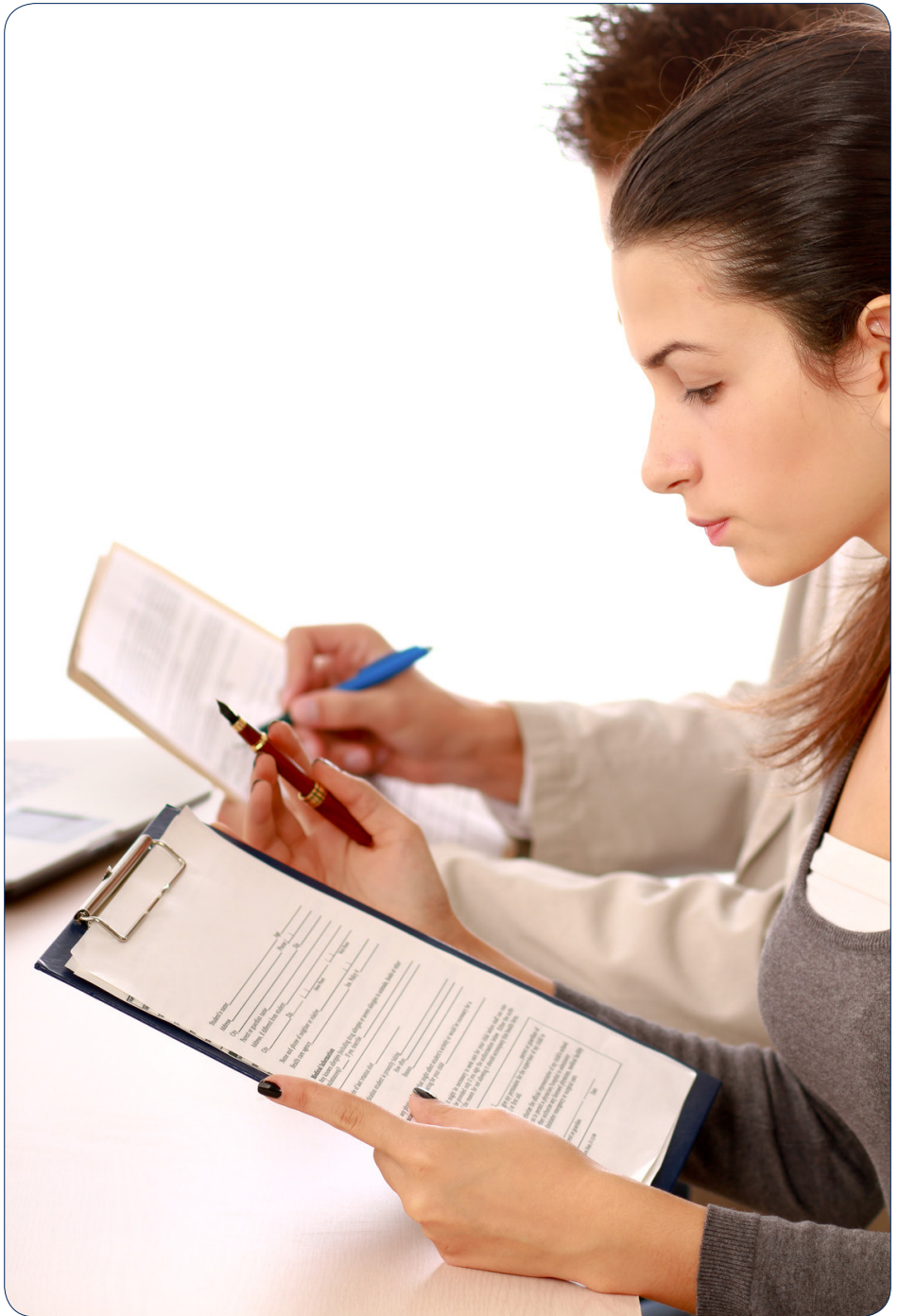


Introduction

This booklet provides an overview of the type, scale and impact of insurance fraud throughout Europe. It also describes the insurance industry's actions to reduce fraud. Reducing and deterring insurance fraud is a priority for insurers throughout Europe.

Insurance is based on the principle of mutual benefit and is designed to protect against significant, but uncertain, losses. Insurance fraud undermines this system, as fraudulent applications and claims deplete the funds paid in by the many honest customers to cover genuine losses. Fraud has an impact not only on insurers but also on their customers. It also has an impact on society in general because insurance fraud can be used to fund criminal activity.

Insurance fraud is not a victimless or insignificant crime. The vast majority of honest customers end up paying for the dishonesty of the few through higher insurance premiums. This is why the industry is determined to do all it can to reduce the problem.



What is insurance fraud?

Fraud affects every type of insurance, whether it is non-life insurance, life and protection cover or health insurance. It includes:

- providing untruthful or incomplete information in applications for insurance or answers on an insurance proposal form;
- submitting a claim for a loss based on misleading or untruthful circumstances, including exaggerating a genuine claim; and
- otherwise being misleading or untruthful in dealings with an insurer with the intention of gaining a benefit under the insurance contract.

Insurance fraud may be committed by the policyholder or by a third party claiming against an insurance policy. It can range from opportunistic claims, through claims for phantom passengers and fictitious injuries in road accidents, to highly organised crime rings.

Here are some examples:

- In the UK, a man faked his own death by drowning. He was traced to Panama, where he was living with his wife off the proceeds of his life insurance policy. Both were convicted and served several years in prison.
- In Slovenia, three individuals took out several life and injury insurance policies each before travelling to Canada on holiday. While there, they allegedly sustained personal injuries in a car accident and claimed for their injuries under their policies. It was later discovered that all three had made insurance claims for other accidents during the period of injury. Criminal and civil charges were brought and the individuals were made to pay all the costs of investigating the fraud and to repay the sums already paid out under the insurance policies.
- In France, a well-known surgeon faked the circumstances of how he sustained injuries that he had suffered in an off-piste skiing accident; an activity not covered by his travel insurance. He first alleged the injuries had been caused by another skier. When this was investigated and rejected, he made an exaggerated fake claim, alleging the injuries had been sustained in a car accident with a third party. Again, the claim was investigated and disproved. The man received no payment for his genuine injuries.

Whatever its form, the outcome of fraud is the same: an unfair cost for the honest policyholder.



What is the scale and impact of fraud?

The extent of insurance fraud varies between countries. Detected and undetected fraud is estimated to represent up to 10% of all claims expenditure in Europe. This figure varies between countries and classes of insurance due to a number of factors, such as how the market functions or the local prevalence of one type of insurance.

The approach to identifying insurance fraud also differs between European countries. In some countries, importance is placed on establishing an accurate estimate of detected and undetected fraud, while other countries place little emphasis on this distinction, choosing instead to focus on reducing the amount of known fraud.

Nevertheless, the aim remains the same: to establish the extent to which current counter-fraud initiatives are successful and whether further initiatives are required.

Several markets collect precise data on the prevalence of fraud. For example:

UK

Figures from the Association of British Insurers (ABI) show that:

- Despite insurers detecting more fraud, it is estimated that around £1.9bn (€2.2bn) of fraud goes undetected each year.
- Insurers are detecting more fraud — the value of detected fraud in 2011 rose 7% to £983m (€1 148m) from £919m in 2010.
- In 2011 insurers uncovered 138 814 fraudulent insurance claims — equivalent to 2 670 claims every week — up 5% on 2010.
- The value of savings for honest customers from detected frauds represented 5.7% of all claims, compared to 5% in 2010.

Germany

A study conducted by the insurance association (GDV) concluded that more than half of all claims arising from loss or damage to smartphones or tablet PCs could not have arisen and therefore must have been fraudulent to some extent.

Sweden

Figures from Insurance Sweden (Larmtjänst) reveal that:

- Insurance fraud investigators, established by insurance companies, conducted 6 200 investigations into suspected fraud in 2011 and detected a total of €40m of fraud.
- A study found that 10–20% of all fraudulent claims are claims for losses arising from events that never occurred (ie untruthful claims) and 80–90% of all fraudulent claims are exaggerated claims.

Also in Sweden, a serious problem was identified with vehicle arson. In the autumn of 2012 there was at least one car fire per day in the south of the country, with most of the cars over 10 years old and many only owned for less than three months. The cars were being purchased cheaply at online auctions and then registered to and insured with fictitious owners. The damage claims were for compensation significantly higher than the purchase value of the vehicle.

France

Figures from the insurance association (FFSA) reveal that 35 042 fraudulent insurance claims were recorded in 2011, leading to €168m not being paid out to dishonest individuals.

Finland

A study of 1 000 adults conducted by the insurance association (FFI) in 2012 found that 27% said they knew a person “who has deceived his/her insurance company”. This figure is up from 25% in a similar study in 2010.

What are the consequences of fraud?

Fraudulent claims and the cost of investigating suspected frauds lead to higher premiums for honest customers. Investigating fraud also has an impact on insurers' ability to deal with genuine claims quickly. In addition, evidence from recent studies carried out by insurers suggests that insurance fraud funds and facilitates other serious crime.

- According to the Danish insurance association (F&P), insurers in Denmark withhold approximately DKK 500m (€67m) from claims payments due to documented fraud.
- In Germany, the GDV estimates that the cost of fraud exceeds €4bn per year.
- In the UK, the ABI estimates that fraud adds, on average, an extra £50 (€58) a year to the annual insurance bill for every policyholder.
- Sweden identified a criminal network that arranged at least 214 staged traffic accidents. Every major non-life insurance company in the Swedish market was affected by its activities.

Insurers remain committed to paying all genuine claims as quickly as possible, and strive to achieve a balance between investigating potential frauds and ensuring that genuine claimants do not face delays as a result. While insurers must investigate all potential frauds, they do all they can to ensure that genuine claimants get their claims paid quickly and efficiently.

Insurers take action against those that commit fraud. The consequences can include:

- non-payment of claims
- cancellation of the insurance policy
- the insurer seeking costs incurred (for example for experts in assessing the claim)
- subsequently being unable to obtain insurance and other financial services
- reporting of the case to the police for further investigation
- prosecution and a custodial sentence
- a criminal record

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What is the industry doing to combat fraud?

The insurance industry's responses to fraud vary between countries and the initiatives are wide-ranging. For instance:

- In several countries, insurers **exchange relevant information** to help them identify potential frauds. Insurers are transparent about this and operate in compliance with data protection and privacy requirements. Such exchanges of information among insurers (in varying forms) exist in Croatia, Estonia, Finland, Germany, Ireland, Malta, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and the UK, and are currently being considered in Cyprus.
- **Cross-border cooperation** also exists. For example, the Nordic countries meet regularly to discuss trends, issues and common challenges, since trends in one country have been seen to spread to neighbouring countries.
- In several countries, including France, Sweden and the UK, insurance companies have set up (more or less) **formalised groups to investigate insurance fraud**.
 - In France, insurers set up a national body (Agence pour la lutte contre la fraude à l'assurance, ALFA) in 1989 to investigate suspicious claims. ALFA aims to promote counter-fraud activities, drawing up suitable tools to assist the industry in combating fraud. These include: training and certification of fraud investigators, advice on how to handle fraudulent cases that target several insurers at a time, and advice on managing relationships with law enforcement agencies.
 - In Sweden, insurance undertakings have created special investigation units that are charged with detecting insurance fraud. Insurance Sweden encourages these units to make police reports of detected or suspected frauds.
 - In the UK, the Insurance Fraud Bureau (IFB) focusses on detecting and preventing organised and cross-industry insurance fraud. The IFB leads or co-ordinates the industry response to the identification of criminal fraud networks and works closely with the police and other law enforcement agencies. It encourages and helps people to report suspected or known frauds anonymously through an insurance cheat-line. The impact of the IFB has been hugely positive since its launch in July 2006, with numerous arrests and tens of millions of pounds of savings for insurers and ultimately their customers.

- Insurers have also increased their **co-operation with law enforcement** agencies in several countries. This is the case, for example, in Croatia, Denmark, Estonia, Germany, Ireland, the Netherlands, Portugal, Spain, Sweden and the UK.
 - Evidence from several law enforcement agencies shows that many are unaware of the simple visual checks that can be made to identify possible stolen private or commercial vehicles. International efforts to train law enforcement staff have been initiated by Europol, Interpol and national insurance associations.
 - In Denmark, insurers are urged to report every documented fraud to the police. F&P organises exercises at the Danish Police Academy on how to combat insurance fraud. Former police officers are often employed in the insurance industry to assist with detection and evidence-gathering.
 - In Croatia, the insurance association initiated a Protocol on Cooperation to Combat Insurance Fraud in 2002. The Protocol formalises co-operation both between insurers and between insurers and third parties such as the police, the judiciary and other agencies. The Protocol has an international reach and is signed by several other national insurance associations in the region, including Austria, the Czech Republic, Slovenia and Hungary.
 - In the UK, the Insurance Fraud Enforcement Department (IFED) is funded by insurers. Set up in January 2012, it forms part of the City of London Police, the UK's lead police force for economic crime and insurance fraud. It investigates potential frauds referred by insurers in all types of insurance. In its first nine months of operation, IFED made over 200 arrests with £12m (€14m) of suspected insurance fraud under investigation.
 - In Spain, almost all insurance undertakings have appointed fraud representatives. These representatives have access to a confidential extranet containing data from the police about current investigations.
- Insurers increasingly use **technology** to uncover fraud. Methods include electronic devices to detect the authenticity of documents submitted in support of claims and the use of publicly available information on various social media and other websites.
 - In Sweden, insurance undertakings use advanced key-readers to confirm that car keys submitted in support of a claim for a stolen vehicle are those belonging to the car alleged to have been stolen.

- In the UK, a claim for alleged back injuries was rejected when Facebook images showed the claimant performing gymnastics and training for a charity run.
- **Training** of insurance staff and police is widely used to raise awareness of fraud, to show how to detect it and to highlight the new and ever-changing methods used by fraudsters.
 - In Denmark, F&P organises seminars on insurance fraud for its members. Seminars are aimed at general insurance fraud, but can also be tailored to specific areas, such as car immobilisers and car keys, luggage handling at airports, fraud via internet freight exchange, codes of ethics for investigators, fraud in household content insurance and so on. Training is provided to those working in fraud detection, including insurance investigators, chief claim handlers and specialist claim handlers.
 - In Germany, annual training is given to claims adjusters to teach them how to detect and combat fraud. The training is conducted by practitioners from the insurance industry, legal advisors, technical specialists, police experts and medical scientists. Participants can take an exam to acquire a certificate of expertise in detection.
 - In the UK, bodies like the IFB and IFED run specialist workshops for counter-fraud staff, and many insurance companies additionally run training schemes at induction and throughout employees' careers and appoint "fraud champions" who emphasise and remind colleagues of the possibility of fraud in all areas of the business.
 - In Finland, the insurance federation has been organising seminars and training with the police, other authorities and the media for 30 years.
- The use of "**cheat-lines**" is successful in several countries, including Ireland, Sweden and the UK. Members of the public can call a helpline to report suspected or known insurance fraud. The caller will generally retain anonymity to encourage such reporting.
 - In Ireland, a man obtained motor insurance with an insurance company. On the proposal form he completed to obtain the insurance, he stated that he had no previous motor convictions. However, the insurance company received an anonymous tip-off via the insurance federation's Insurance Confidential hotline that the man had several motor convictions. The insurer's internal investigation team carried out further investigations, which resulted in the matter being passed to the police. The individual was subsequently convicted for obtaining insurance by making a false declaration and driving without insurance. He received a four-month suspended sentence.



Conclusion

Detecting and reducing insurance fraud is a key priority for insurers. Insurance fraud is not a victimless crime. This is reflected in the serious consequences for those found guilty of fraud, which can include custodial sentences.

Honest customers should not have to pay the price for fraudsters through higher premiums.

The insurance industry continues to strengthen its systems and controls to ensure that all types of fraud are detected and prevented — whether committed at the application or the claims stage — to minimise the cost of fraud to insurers and therefore the impact on honest customers. Insurers' methods are constantly evolving to combat changes in fraudster behaviour.

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