

***DETECTING & HANDLING FRAUD IN  
INSURANCE CLAIMS***

**Being Text of the Paper Delivered**

**At The**

**WORKSHOP ON ADVANCED CLAIMS MANAGEMENT**

**Organised by**

**FAS CONSULTANTS**

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## **INTRODUCTION**

Marketing of insurance products over the years has always been an Herculean task. Not much for lack of understanding of the concept but more importantly because of the fact that the products themselves are intangible. Unlike manufactured goods, you can not feel, smell or see the benefits derivable from the insurance products being sold to you.

Practically speaking, what an insurance policy offers is a promise to make good a loss whenever the event insured against occurs. The reliability of such a promise is therefore put to test when a claim for loss arises. At this stage, the relevant principles governing the conduct of insurance business such as utmost good faith, insurable interest, proximate cause, indemnity and subrogation come to play.

These guiding principles impose a moral duty on the underwriter to the extent that only claims satisfying the conditions of the relevant principles would qualify for consideration. A common catch phrase by most insurance companies is the willingness to pay all *genuine* claims with dispatch. The emphasis on genuineness of certain claims presupposes the existence of some claims that may be categorised as *not genuine*.

In technical terms, any claim that fails to satisfy the authenticity test is adjudged as a fraud. The common dictionary definition of fraud is 'a deliberate deception for unfair or unlawful gain.'

In law, however, fraud is viewed as a general term for any instance in which one party deceives or takes unfair advantage of another. Any means used by one person to deceive another may be defined as fraud. In equity, fraud includes any act, omission, or concealment, involving a breach of legal or equitable duty or trust, which results in disadvantage or injury to another.

Fraud can also be constructive, that is, deemed fraud by interpretation. The sole difference in the case of constructive fraud is that no dishonest intent need be adduced. It arises from a breach of duty, such as the breach of a fiduciary relationship in which a trust or confidence has been betrayed.

From the various definitions of fraud that has been provided, it can be seen that the act extends to criminal deception and concealment of facts. It is also embarked upon with a deliberate intention to pervert the truth and falsely obtain something of value from another person.

Most insurance companies recognise the cankerworm that this act of fraud constitutes to the well-being of their organisations hence measures are usually employed to safeguard the underwriting activities of each company against susceptibility to the act. The systems of checks and balances often manifest in underwriting guidelines designed to detect any unfavourable pointer to moral hazards inherent in any risk being proposed for cover. In spite of all such measures, the sophistication and ingenuity often displayed by some unscrupulous elements that are out to defraud insurance companies can circumvent perceived fool-proof measures put in place by any vigilant underwriter. A survey conducted in the Britain about six years ago ie. 1994 revealed that the British insurance industry lost about US\$600 million as a result of fraudulent insurance claims. Available statistics show that out of the Gross Premium Income of N9.4 billion recorded by the insurance industry in Nigeria in 1997, a total claim of N1.8 billion was made and it is not unlikely that a significant amount would be related to fraud within that figure but which underwriters might have found difficult in proving hence the eventual payout.

In leading discussion on the subject of this paper which is aptly described as “Detecting and Handling Fraud in Insurance Claims,” I would like to examine the various facets of fraud that are perpetrated in insurance before looking at ways of handling such cases. It would also be imperative to explore the industry approach to the problem with a view to gaining a broader insight into the range of solutions that could prove useful in the long term and consequently guarantee the survival and profitability of insurance business in our environment.

### **PERPETRATION OF FRAUD**

Fraud, in insurance, comes in different guises. It is usually initiated solely by an unscrupulous element in the society or with active connivance of either an insurance intermediary, staff of insurance company or a loss investigator/adjuster. The areas in which the act is practically common in insurance could be listed as follows:

- ◆ Property Insurance
- ◆ Motor Insurance
- ◆ Personal Accident Insurance
- ◆ Marine Insurance
- ◆ Money Insurance
- ◆ Fidelity Guarantee Insurance

#### Property Insurance

Claim for losses resulting from fire and theft have been found to be characterised by fraud in certain instances. A building could be touched deliberately by an element in order to cover evidence of some criminal acts. This is technically referred to as arson which is not covered by insurance. Other reasons why fire could be started deliberately with a view to making false claims under an insurance policy include:

- Poor sales involving large stock of goods
- Obsolete machinery and plants
- General decline in fortunes of the business

The corollary of such a move in terms of fraud on insurance will include:

- ◆ Inflated estimate of repairs or reinstatement of building
- ◆ Claim for replacement of obsolete equipment and plant
- ◆ Inflated claim for indemnity for loss of stock

In the case of theft, the motive is similar as claim could be made for genuine burglary incident as well as organised event. The nature of fraud often experienced in this regard include:

- ◆ Inflated estimate for loss sustained through the incident
- ◆ Claim for obsolete stock
- ◆ Claim for non-existent stock

### Motor Insurance

In the Nigerian market, motor account for virtually half of most insurance companies portfolio. The high volume of activities in this area of insurance has been capitalised upon by unscrupulous elements of the society to commit fraud on the pool of policyholders' funds. The nature of fraud often committed in this regard include:

- ◆ Insurance of non-existent vehicle
- ◆ Arrangement of multiple cover on same vehicle with different insurance companies
- ◆ Contrived accident
- ◆ Fire loss on overinsured vehicle
- ◆ Third Party Liability

### Personal Accident Insurance

Given the fact that claims under this heading involve great reliance on the advice of respectable authorities like the medical profession and government authorities, it is amazing to note that cases of fraud also do

occur in this regard. The type of fraud often perpetrated in this area include:

- ◆ Insurance on life of a fictitious person
- ◆ Inflation of compensation for permanent disability
- ◆ Excessive leave of absence from work after injury
- ◆ Inflation of medical expenses

### Marine Insurance

Marine insurance is a big time business. It is international in nature and brings together parties operating from different parts of the world with varying cultural background. Maritime fraud has once been described as a “multi-million dollars venture” and the main area where fraud is of significance has to do with cargo insurance.

Participants in maritime fraud may spread across two or three continents and operate as a syndicate to swindle insurance companies. The most popular types of fraud often perpetrated in this case include:

- ◆ Arrangement of cover based on fake documents
- ◆ Manipulation of charterparty arrangement
- ◆ Arrangement of dual cover ie. foreign/local

### Money Insurance

The incidence of fraud under this type of insurance is restricted because of the fact that the majority of policyholders are corporate bodies. Nonetheless insurance companies do witness attempts at perpetrating fraud in the following guises:

- ◆ Stage-managing of robbery operation
- ◆ Exaggeration of loss amount in transit
- ◆ Exaggeration of loss amount in safe/hold-up

### Fidelity Guarantee Insurance

This is another type of insurance policy the purchase of which is restricted to corporate bodies. Issues bordering on fraud in this instance would include:

- ◆ Framing of trading loss as embezzlement
- ◆ Concealment of recovered portion of embezzled fund
- ◆ Non-disclosure of right entitlements of defaulting member of staff

## **MANAGING THE RISK OF FRAUD**

Even though, fraud cannot be regarded as an insurable peril in the parlance of risk management and its corollary of risk transfer mechanism, it still constitutes the greatest threat to the stability and survival of any insurance company in this market. In order to devise means of tackling the problem, a clearer understanding of the issues involved is called for.

We can briefly summarise the noticeable trends in all the instances cited earlier as follows:

- **Forgery** of documents to induce settlement of false claim
- **Collusion** of two or more parties to defraud insurers
- **Exaggeration** of value of loss

Getting to the root of a fraudulent claim and providing evidence to prove such an act is usually an uphill task for any underwriter. In most instances, perpetrators of the act would have cleverly plotted the scheme in such a way that their tracks are covered. There are, however, viable options open to the discerning underwriter in confronting the problems often encountered. Each of the issues listed above should be tackled as follows:

### **Forgery**

The underwriter should cultivate the habit of thoroughly cross-checking documents tendered in support of claims. Practice has shown that painstaking effort in verifying substantiating documents at the purported sources do pay off as various scams have been reportedly foiled through this process.

Occasionally, fraudsters do arrange the scheme by planting their agents at sources that the underwriter may be targeting for verification. This is one of the reasons why the underwriter should not limit his search to a particular source but go further to check-out all channels that the documents being tendered might have passed through such as the Port, Bank, Hospital, Custom, Local Government, Licensing Office etc. Such efforts have unearthed mischievous plans to defraud insurers.

### **Collusion**

In committing insurance fraud, the *modus operandi* on most occasions revolves around a ring of unscrupulous elements including, but not limited to, insurance consumers, staff of insurance companies, insurance intermediaries, risk surveyors, superintendent firms, loss investigators/adjusters, medical doctors and law enforcement agencies. Measures expected to be put in place by an underwriter to combat this menace should include:

- ◆ Subjecting all cases to standard operating procedure irrespective of perceived social status of parties involved
- ◆ Implementation of sound recruitment process
- ◆ Close scrutiny of ancillary reports from external independent agents
- ◆ Referrals of reports for second opinion in case of any doubt
- ◆ Maintenance of security list on business associates

### **Exaggeration**

The tendency on the part of claimants to inflate claims is so prevalent in the industry to the extent that one wonders why an average policyholder feels no qualms in inflating cost of claims after suffering a genuine loss. This phenomenon has been ascribed to the natural tendency of the public to view any occurrence of insurance claim as an opportunity to make quick money.

Strict application of the principle of indemnity is a ready-made approach in solving this problem. The underwriter should equip herself with first hand information and knowledge of relevant prices of subject matter of claim and display this before the claimant in handling any demand for inflated loss payments. Of particular importance in this regard is the reliance placed on automobile engineers and loss adjusters often engaged by insurance companies and so far as they are credible and competent, this problem is bound to be checked successfully.

### **LEGAL PERSPECTIVE**

As has been stated, fraud is basically a criminal act. The common aphorism that “crime does not pay” seems to have lost its appeal in the present times.

It is a common knowledge that any meaningful assertion must be backed by proof. In any criminal prosecution, fraud must be proved beyond any reasonable doubt but in insurance the burden of proof is not so high. Circumstantial evidence is also admissible as proof of fraud by an underwriter in turning down a claim. The Court of Appeal case of *Aswani Textile Mills v. Royal Exchange Assurance and Other* (10) created a reference point in this regard and to date there has not been any contrary view on this subject.

Insurers are however often reluctant to prosecute identified cases of fraud probably because of the tenuous nature of litigation in this part of the world. Interestingly, however, we have seen instances where insurers have been dragged to the courts for repudiating claims on fraudulent grounds!

## **CONCLUSION**

We have tried in this brief session to examine the impact of fraud on the operations of insurance companies within our environment. One indisputable inference that could be drawn from this exercise is the fact that the incidence of fraud have impacted negatively on the business of insurance and would continue to be so until a final solution is found towards a drastic reduction of this nefarious activity.

The issues raised herein principally dwell on the various ways and means of identifying fraudulent practices while proffering steps or measures that are capable of giving the underwriter a greater control over the problem in each offices' claims administration departments.

I will however like to point out that the Nigerian insurance market is still lagging behind in the modern approach of tackling this issue of fraud. The main area of strength that has given developed markets like U.K. and America an edge over Nigeria is the extent of the use of Information Technology to manage data exchange. As far back as 1987 the British Market started operating a computer database code-named **Motor Insurance Anti-Fraud and Theft Register (MIAFTR)**. This initiative was also followed by the establishment in 1994 of another computerised database known as **Claims and Underwriting Exchange (CUE)** for the household insurance market. These tools have greatly assisted the U.K.

market to control fraud with record success of over 50% reduction in incidence of fraud within two years of introduction.

The Nigerian market needs to embrace the use of information technology more aggressively and also change its attitude to information exchange. The lack of clearer understanding of the dynamics of competition has prevented most operators in our market from releasing relevant information to bodies like the Nigerian Insurance Association which has been trying to fashion out a databank for the benefit of member companies of the association for sometime.

It is hoped that we will rededicate ourselves to finding a lasting solution to the issue of fraud in our environment by committing our minds to the genuine implementation of some of the principles that will be agreed upon at the end of this workshop in our various offices.

Thank you.

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