Fraud in insurance

Staying one step ahead

Fraud is a perennial issue for insurers, albeit a manageable one. Fraud attempts continue to become more sophisticated, but insurers manage to stay ahead of the curve. **QBE**'s **Mr Ronak Shah** tells us more.

By Ahmad Zaki

For as long as insurance has existed, attempts at defrauding insurers have also been made. Today, videos can be found online of failed attempts at insurance fraud (i.e., someone jumping in front of a slow-moving car in order to fake an accident and claim damages) but attempts at fraud have only become more inventive and frequent over the years.

"Industry sentiment overall is that fraud trends and frequency of incidents are expanding. The current economic climate of sharp increase in costss and poor economic performance resulting in job cuts, are exacerbating both hard and soft insurance fraud," said QBE Singapore CEO Ronak Shah.

"The increase in cases is also testament to how fraud detection capabilities have been improving. We are constantly enhancing our automated detection capabilities and designing a smarter system based on fraud rules and algorithms to isolate and refer suspicious claims to the special investigations unit, coupled with better training our claims handlers."

A General Insurance Association of Singapore (GIAS) report from last year showed that in Singapore, insurance fraud cases more than tripled from 20 in 2018 to 71 in 2021. The fraud management system put in place by GIAS has also assisted in identifying more sophisticated fraud attempts.

One notable example is of a Singaporean woman who defrauded six insurers in 2020 by making 20 fraudulent travel claims worth over S$14,000 ($10,600). She had used photos of damaged goods, receipts, boarding passes and even police reports that she had found online, all of which had been digitally altered to support her claims.

'Accidents'

Of course, not all lines of business are as susceptible to fraud attempts as others. There are common trends that can be seen throughout the industry over one which lines are targeted more often.

According to Mr Shah, personal lines are a noteworthy target, especially personal accident, travel and motor insurance. So too are people's finances at risk, through phishing attempts carried out via fraudulent emails and websites and social engineering scams where criminals exploit people's trust to steal money.

"In the personal accident and travel spaces, there are scams like those in Nepal, where some nefarious trekking companies collaborate with helicopter companies to scramble unnecessary helicopter rescues, share the exceedingly high booking fees and ultimately defraud insurers. And closer to home in the motor space, there have been incidents where owners of repair workshops stage accidents using their own cars to lodge fraudulent insurance claims. These two examples demonstrate both the cunning and creativity exerted by today's fraudsters," he said.

Beyond the 'regular' fraud activity insurers typically see, he also said that the occurrence of an abnormal event can also lead to insurance fraud.

"Take the recent collapse of Silicon Valley, Signature and Silverline banks in the US, for example. These failures gifted criminals a believable rationale for individuals and businesses to change bank accounts, a common ruse for diverting funds for invoice and other payments into fraudster accounts."

In such cases, however, these fraudsters are not the stereotypical lone bad actors. They are organised criminal gangs with the resources and physical infrastructure to launch an attack or scam when a new opportunity arises. They use call centres, scripts, email communications and white boards to chart their attack strategies, tactics, and hit rate, underscoring the real threat that they pose to consumers, businesses and insurance providers.

GIAS also said at least 20% of all motor claims in Singapore are fraudulent with claimants exaggerating their injuries and/or inflating the damage to their vehicle. Most of these cases are made by organised crime syndicates which stage traffic accidents and recruit hundreds of people as part of their activities.

Pattern of activity

There is a difference between opportunistic and organised fraud. For the former, individuals typically exaggerate the impact or value of a claim, or simply fabricate an event.

"These tend not to be very sophisticated and despite what individuals might believe, they are easy for us to spot," he said. "With regard to organised fraud, the modus operandi adapts over time, with more sophisticated groups tuning in to current events and seeking ways to exploit them. To counter these groups, we have experts who anticipate how criminals might take advantage of these events, which helps us protect our customers."

He also noted that sometimes, these fraudulent claimants research policies in detail and typically have an understanding of coverage, exclusions and documents required.

"Sometimes they prepare their own documents. With so many computer-based tools, the forgeries can look very authentic, but at the same time, our detection methods have also evolved so we have ways and means to identify forgeries," he said.

One step ahead

There are trends when it comes to fraud, although a sizeable portion of fraudulent claims are one-off attempts by lone bad actors trying to make a quick buck.

"Typically, it takes a few attempts to form a trend or a significant concern. Depending on what is analysed from each claim experience, we will assess whether the concerns are industry wide or limited to QBE. In all cases, the concern will be raised, and the necessary defences put in place after analysis," he said.

"When there is a long period of time between such claims, the response time is typically longer. Suitable action includes identifying the parameters unique to the fraudulent claim, identifying the various combination of factors and circumstances, and then designing a process to identify similar occurrences in future."

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