



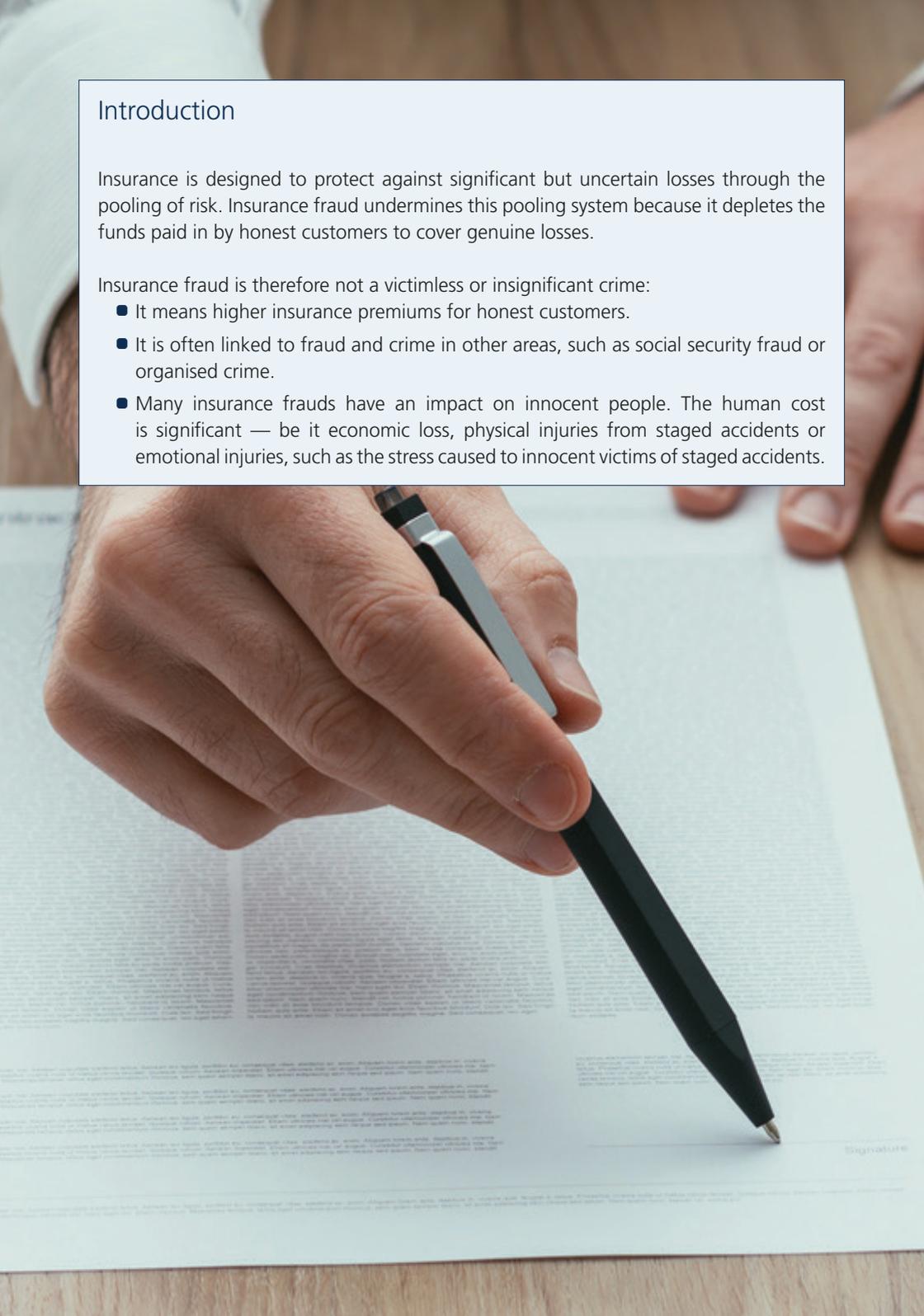
Insurance fraud: not a victimless crime

Introduction

Insurance is designed to protect against significant but uncertain losses through the pooling of risk. Insurance fraud undermines this pooling system because it depletes the funds paid in by honest customers to cover genuine losses.

Insurance fraud is therefore not a victimless or insignificant crime:

- It means higher insurance premiums for honest customers.
- It is often linked to fraud and crime in other areas, such as social security fraud or organised crime.
- Many insurance frauds have an impact on innocent people. The human cost is significant — be it economic loss, physical injuries from staged accidents or emotional injuries, such as the stress caused to innocent victims of staged accidents.



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What is insurance fraud?

Fraud can affect all types of insurance: non-life, life and protection or health. It occurs when at least one of these conditions is met:

- 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.
- Otherwise being misleading or untruthful in dealings with an insurer with the intention of gaining a benefit under the insurance contract.

Insurance fraud is a significant problem. According to the US Association of Certified Fraud Examiners, it is second only to tax fraud in the most common forms of fraud globally.

Fraudsters, including professionals who enable fraud, are highly mobile and often pursue the path of least resistance; when fraud controls are tightened in one area, they look to exploit opportunities in another.

Recent trends

Insurance fraud is constantly evolving, shaped by the technology at the fraudsters' disposal. In recent years, cyber-enabled fraud has become more prevalent as more insurance business is conducted online.

A related trend has been the significant growth in identity fraud, such as a fraudster using personal data to impersonate an innocent policyholder and take out a policy in their name.



Acts of insurance fraud can be categorised according to:



Severity

“Soft” frauds tend to be committed by those who, for example, see an opportunity to invent or exaggerate a claim or who — deliberately or otherwise — provide false information when applying for insurance.

“Hard” frauds are, for example, those linked to highly organised criminal gangs. In recent years, these have included staged accidents (“crashes for cash”) or fraudulent policies sold by illegal advisers (“ghost-broking”).



Source

When fraud is committed from within the insurance company or insurance company network it is classified as an internal (or insider) fraud. An example might be a claims handler colluding with a policyholder to pay fake or exaggerated claims.

External insurance frauds are those committed by the policyholder or by a third party claiming against an insurance policy.



Stage in the insurance process

Fraud may occur at various points in the insurance process. For example, it may take place during the underwriting process if a customer misrepresents themselves in their application or deliberately conceals existing contracts with the same cover.

Fraud occurs most often during the claims process, when a customer exaggerates or makes a false claim on their policy, for example by fabricating supporting evidence such as repair bills or receipts for lost items.

What is the scale of insurance fraud?

Fraud is a significant problem all over Europe. The level varies between countries due to a variety of factors including, but not limited to: the size of the market; the type of products available; the degree of investment in counter-fraud systems and checks; the legislative and regulatory framework; and prevailing cultural attitudes.

Estimating fraud is challenging. Providing an estimate for the whole of Europe is even harder, as different approaches are used in different countries:

- Some markets collect estimates of detected and undetected fraud by business line.
- In other markets, efforts are concentrated on providing an estimate of the total amount of insurance fraud.
- In some markets, regulators operate databases to collect data on fraud¹.

Despite the difficulties, estimating the amount of insurance fraud in Europe is worthwhile:

- It highlights the potential savings for honest consumers and insurers if fraud can be detected successfully.
- Given the mobility of insurance fraudsters, both within and across borders, fraud statistics from one state can alert others to methods and trends that could be replicated in their markets.
- The statistics show the work many markets have put in to better quantify the problem. Even five years ago, many markets did not systematically collect and publish data on fraud.

Estimated cost of fraud in Europe — 2017

Many of Insurance Europe's member associations collect precise data on successfully detected fraud. This shows that €2.5bn of fraudulent claims were detected in 2017. Insurers in some of these countries also estimate the amount of undetected fraud.

Some markets that do not collect data on detected fraud instead provide estimates of the total amount of fraud.

Combining the available figures for detected and undetected fraud, it is estimated that there were approximately €13bn of fraudulent claims in Europe in 2017.



¹ An example, in Italy, is the IVASS AIA database, <https://www.ivass.it/media/avviso/new-phase-ai/>

Estimated cost of fraud by country — 2017²

Belgium

- Fraud is estimated to cost the insurance industry more than €500m a year, or €125 per household.
- Between 1% and 3% of claims are investigated for fraud, varying by business line.

Czech Republic

- Total fraud is estimated at €47.3m. This is made up of €15.3m in property, €13.8m in motor, €10.3m in liability and €7.8m in other business lines.
- The highest average fraudulent claim was in motor, at approximately €5 000.

Denmark

- There is approximately €32.75m of detected fraud a year, with estimated undetected fraud levels around 10 times that (€300m).
- Around 1% of all claims are investigated for fraud and the average value of a fraudulent claim is around €8 800.

Finland

- Between 5% and 10% of claims are investigated for fraud, depending on the business line.

Germany

- While there is no official data in the German market, the German insurance association (GDV) estimates that fraud accounts for 10% of all claims expenditure.
- According to research carried out by the GDV, around 9% of all claims are deemed “dubious”, meaning they warrant further investigation.
- Approximately 7% of motor, 9% of property and 16% of general liability claims are treated as “dubious”.
- The average fraudulent claim tends to be higher than the average genuine claim.

France

- According to France’s agency against insurance fraud (l’Agence de lutte contre la fraude à l’assurance or ALFA) there was €127m of detected fraud in motor insurance and €125m in property.
- ALFA estimates undetected fraud at €125m in motor and €150m in property.
- The average fraudulent claim in motor is €5 096 and in property €11 437.
- ALFA estimates the fraud rate to be under 1% of motor claims and under 1.5% of property and casualty claims.
- It estimates that fewer than 5% of detected cases are referred to the police.
- Its estimates show €252m was saved through successful fraud detection.

² Estimates are from national insurance associations and their members, unless otherwise stated

Ireland

- In non-life, insurers detected €76m of fraud.
- Undetected fraud in non-life is estimated to total around €200m.
- Around 8% of all claims are investigated for fraud and around 4% of all claims are found to be fraudulent.

Italy

- Out of a total of 2.84m claims, 55 000 (or 1.9%) were found to be fraudulent, amounting to €220m.

Portugal

- 16 400 fraudulent claims were detected, saving €42.8m.
- The proportion of fraudulent claims varies from 0.4% in life insurance to 2.1% in property.
- Although workers compensation is the business line with the highest number of suspicious claims (ie, claims that lead to fraud investigations), the cost of fraud is highest in the motor and property lines. In motor, the average fraudulent claim was €2 715, while the average amount paid for those claims was around €926. In property, the figures were €3 801 and €2 013 respectively.

Slovenia

- Insurance companies detected €20m of fraudulent claims.
- Undetected fraud is estimated to total €90m.

Spain

- The volume of fraud is estimated to be €460m annually in non-life lines and life products.
- The average value of a fraudulent claim is €3 700 for motor (bodily damages), €584 for property, €21 000 for life and €3 400 for general liability.
- For every €1 invested in fraud detection, it is estimated that €35 is kept out of the hands of fraudsters.

Sweden

- €50m of fraudulent claims were successfully detected, which amounts to less than 1% of all claims.
- 7 000 claims were investigated for fraud.

UK

- Detected non-life claims fraud totalled €1.5bn.
- Undetected fraud is estimated to cost around €2.275bn.
- The average value of a fraudulent claim in motor is €13 500, in property €5 200, for general liability €23 725 and across all non-life business €13 175.

What are the consequences of fraud?

Fraud has an impact not only on insurers but also on their customers, with honest consumers facing higher insurance premiums as a direct consequence of fraud.

Having to investigate fraud reduces the resources insurers have to deal with genuine claims quickly, so again has an impact on honest customers.

Certain types of fraud put human lives at risk, such as “crashes for cash” or fraud-related arson, meaning that insurance fraud also puts a strain on society’s resources.

And fraudsters are often linked to organised crime, so insurance fraud funds and facilitates other serious crime.

Consequences for an insurance fraudster include:

- cancellation of the insurance policy
- the insurer seeking to recoup costs incurred (eg, for experts in assessing the claim)
- inability to obtain insurance and other financial services, such as loans or mortgages
- police investigation
- prosecution, a criminal record and a custodial sentence
- a detrimental impact on future job prospects
- a breakdown of family relationships and social stigma

Examples of consequences for fraudsters

Czech Republic

A Czech insurer successfully detected an internal fraud in which a member of a fraud ring was employed as a loss adjuster on foreign claims. The fraud ring consisted of three main fraudsters filing claims for fictitious car accidents, with falsified police reports, for estimated total damage of almost €4m. The insurer spotted that, in spite of large, material damages to the vehicles, no health damages were claimed. In court, the insurer successfully proved a total fraudulent value of approximately €1.6m. The main fraudster died during the court proceedings, but the loss adjuster was sentenced to 7.5 years in prison and ordered to pay €38 000 and the third fraudster was sentenced to 6.5 years in prison with the same financial penalty. The two surviving fraudsters were obliged to pay back the €1.6m.



Netherlands

A goldsmith who had an occupational disability insurance policy had to stop working due to a shoulder injury. The insurer paid him every month for six years until they received an anonymous tip-off saying he was an internationally renowned surfer. The insurer investigated and found pictures of him surfing in very windy conditions. The insurance company ended all payments, reclaimed what they had paid and registered the personal data of the goldsmith in the national insurance fraud database.



Norway



A 30-year-old man made a claim on his occupational insurance for an injury caused by an accident in 2008. The insurance company granted 100% occupational injury compensation in 2009. At the same time, the same person claimed a disability pension from both his insurer and the national welfare association (NAV). The insurance company became suspicious when the man set up a new company in 2011 and

was observed working on a construction site, operating heavy machinery and carrying heavy objects. The insurance company tipped off the NAV and fraud was established. Over the lifetime of the payouts this man would have received, the Norwegian insurance association estimates that the cost to society would have amounted to over €2.5m, or €71 000 per year.

Slovenia

A suspect in a fraudulent insurance claim stands accused of cutting off her hand with the help of her family to benefit from an insurance pay-out. The suspect took out injury insurance and soon afterwards “had an accident” in which her hand was cut off. The suspect stood to gain about €400 000 in compensation and monthly payments of about €3 000 from the policy. Police say the group, including family members, deliberately cut off the woman’s hand.



Spain

An insured claimed that his vehicle was stolen in Benidorm, Alicante. The car had been insured for only three months and the client had filed other large claims in the past. In fact, the car had been involved in a major accident in Portugal months earlier and been sold as scrap by its original owner. The insured had bought it second-hand.

When the insurer discovered the car’s history, the insured tried to demonstrate that the vehicle was “fit-for-purpose” by providing documents showing that an oil change had been

carried out on the car. However, after analysing the data in the car's electronic keys, the insurer discovered that the stolen car had only done 5 503km, while the documents concerning the oil change clearly stated that the work was done on a car with 18 300 km on the clock, so it was a different car.



Sweden



A Mrs X called the emergency services to report that her husband had drowned in the lake close to their summer house. The emergency services declared death by drowning and the case was closed. The insurance company, however, suspected fraud, since Mrs X had signed a life insurance for Mr X six months earlier worth 5kr2m (€210 000). It took almost half a year before the insurance company managed to persuade police and prosecutors to investigate the case as a crime instead of a

drowning accident. In addition to being convicted for murder, Mrs X was later convicted of insurance fraud.

UK

A cyclist claimed £135 000 (€154 000) compensation from a council for injuries he said he sustained when he fell off his bicycle after hitting a pothole. However, evidence showed that the accident happened when he fell off on a slippery road at another location. He was jailed for three and a half years.



The City of London Police's Insurance Fraud Enforcement Department (IFED) launched an investigation into a bishop after a referral from an insurance company raised suspicions that he had tried to make a fraudulent claim. The IFED discovered that the bishop had fraudulently bought an insurance policy using the details of a person in his local community. Days later he called the insurer, pretending to be the policyholder, and said that he had crashed his car into a premium car, taking full responsibility. The car that was crashed into actually belonged to the bishop, so the fraud was a combination of a staged accident and identity theft. Subsequent to the IFED's investigation, the court found the bishop guilty of fraud and money laundering and he was sentenced to 10 months in jail.

A 19-year-old was jailed for selling fake motor insurance through the Gumtree website. When some individuals who had purchased policies through the website were stopped by police, checks revealed that their vehicles were uninsured. Another customer contacted the police to report that they had been defrauded after purchasing what they believed to be genuine car insurance from Gumtree that — on closer inspection — proved to be a fake policy.

Myths versus reality

A little bit of fraud doesn't hurt anyone

False

Insurance fraud is often linked to serious organised crime and can fund the wider activities of criminal gangs. Many orchestrated frauds such as "crashes for cash" have implications for innocent road-users and put other people's lives at risk.

Nobody will find out if someone commits fraud

Untrue

Insurers are committed to doing everything they can to detect, disrupt and prosecute anyone attempting to fabricate a claim. Insurers are becoming increasingly effective at sharing intelligence and information about committed frauds to prevent them from reoccurring. This includes naming and shaming fraudsters.

Only fraudsters pay for insurance fraud

Incorrect

Insurers collect and administer their customers' premiums to spread risk across the population. The bill for insurance fraud, ie, the fraudulent claims payouts and the cost of insurers' prevention efforts, is picked up by honest customers.

Insurers are "fair game"

False

Insurance fraud is a serious crime that can result in major consequences for fraudsters, who may find their future job prospects affected, find it harder to obtain insurance and even face the prospect of imprisonment.

Insurance fraud is growing

It's more complicated than that

Insurers are using increasingly sophisticated techniques in order to successfully detect more and more fraud. At the same time, fraudsters are making use of technology, third parties and other "blind spots" to perpetrate criminal acts. Detected fraud is growing, but so too are potential blind spots. What is certain is that the problem of fraud persists.

Insurance fraud is easy to commit

Not true

While many frauds are committed by opportunists, the more elaborate frauds require planning, knowledge and expertise. Insurers continue to strengthen their systems and checks, as well as to collaborate with other stakeholders to fight all types of frauds.

The police don't care about insurance fraud

Wrong

Insurers cooperate with law enforcement agencies in many countries, as people who commit insurance fraud often commit other offences, such as tax fraud or defrauding social services. Fighting fraud is in the common interest of everyone except those that commit it.

Fraud stays the same

It's more complicated than that

Cyber-enabled insurance fraud and identity fraud are two growing areas and insurers are aware of the changing nature of fraud. Insurers are increasingly making use of advanced analytical software to identify cross-industry patterns and alert the industry to fraudulent networks, for instance.

What is the industry doing to combat fraud?

The insurance industry is proactive in fighting fraud in various ways:

- dedicated investigative groups
- cooperation with law enforcement agencies
- provision of specialised anti-fraud training
- the use of technology and data analytics (including anti-fraud databases)³
- information campaigns

Below are just a selection of national initiatives, showing the many similarities in activities between markets.

Investigative groups

- In France, insurers have had a national body (l'Agence de lutte contre la fraude à l'assurance, ALFA) since 1989 to investigate suspicious insurance claims. ALFA also aims to promote counter-fraud activities, creating tools to assist the industry in combatting 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 special investigation units that are charged with detecting insurance fraud. The insurance association, Insurance Sweden, encourages these units to report detected or suspected frauds to the police.



³ Countries maintain different types of databases to fight fraud. Some use claims registers, which record all claims made on policies. Others have dedicated anti-fraud databases, which keep more detailed data on detected fraud.

- In the UK, the Insurance Fraud Bureau (IFB) focuses on detecting and preventing organised and cross-industry insurance fraud. The IFB coordinates the industry's efforts to identify 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 cheatline. The impact of the IFB has been hugely positive since its launch in July 2006, with around 1 250 arrests and 640 convictions secured.
- In Norway, a law passed in 2009 permits the insurance industry and the national welfare association (NAV) to alert each other to cases of suspected fraud, as many who are caught engaging in insurance fraud also have a record of fraud elsewhere. In addition, the financial services association, Finance Norway, organises fraud seminars and working groups with representatives from both the NAV and the insurance industry.

Cooperation with law enforcement agencies

- Transnational law enforcement agencies Europol and Interpol, in cooperation with national insurance associations, have initiated international efforts to train concerned parties (law enforcement agencies, insurers). These efforts are important, as evidence shows that many such parties are often unaware, for example, of the simple visual checks that can be made to identify possible stolen private or commercial vehicles.
- In Denmark, insurers are urged to report every documented fraud to the police. In addition, the insurance association, Insurance & Pension Denmark, 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 France, ALFA signed an agreement to exchange information with the Ministry of the Interior in March 2019. An independent policeman joined the association to facilitate the exchanges.
- In Finland, Finance Finland began a project in 2018 with the National Bureau of Investigation to increase the exchange of information between the police and insurance companies.
- In Croatia, the insurance association created a Protocol on Cooperation to Combat Insurance Fraud in 2002. The Protocol formalises cooperation between insurers and between insurers and third parties such as the police, judiciary and other agencies. The Protocol has an international reach and several other national insurance associations in the region, including Austria, the Czech Republic, Slovenia and Hungary, are signatories to it.

- In the UK, the Insurance Fraud Enforcement Department (IFED) is funded by insurers. It is a bespoke unit within the City of London Police that is wholly dedicated to combatting insurance fraud. It takes referrals in respect of all classes of insurance. Since becoming operational in January 2012, the IFED has secured more than 420 convictions, issued around 480 cautions and recovered assets worth more than £2.6m (€3m). It also plays a key role in deterring and preventing fraud through awareness campaigns and publicising successes.
- In Ireland, the insurance association, Insurance Ireland, liaises with the police on criminal activity linked to insurance fraud, including tracing claims and uninsured and unidentified vehicles. This connects into the International Association of Auto Theft Investigators (IAATI) in relation to stolen vehicles. Insurance Ireland is also looking to create a joint investigation group with the police, along the lines of the UK's IFED (see above).
- In Spain, almost all insurance undertakings have appointed fraud representatives, who have access to a confidential extranet containing data from the police about current investigations.
- In Belgium, the insurance association, Assuralia, issues to the local and federal police at least twice a year a list of contact persons inside each insurance company. The insurance sector also organises training sessions to raise the awareness of the local and federal police of insurance fraud, as well as to develop and maintain a network.
- Since August 2016 in the Netherlands, insurers use a counter-fraud tool called "direct liability for perpetrators". Besides cancelling policies and registering personal data in the national insurance fraud database, a special foundation, SODA, can claim damages of €532 (half the average cost of a simple fraud investigation by an insurer) from fraudsters who are caught. Over 70% of all these claims are paid. The foundation is facilitated by the Ministry of Justice & Security and operates under the supervision of the national police.

Provision of specialised anti-fraud training

- Insurance & Pension Denmark organises seminars on insurance fraud for its members. Seminars focus both on general insurance fraud and also on specific areas such as: car immobilisers and car keys; luggage handling at airports; fraud via the internet freight exchange that allows freight companies to search a database of available freight that needs to be delivered and advertise their available vehicle capacity; codes of ethics for investigators; and fraud in household contents insurance. Training is provided to those working in fraud detection, including insurance investigators and claims 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 such as the City of London Police Training Academy conduct specialist training for counter-fraud staff. Many insurance companies run training schemes at induction and throughout employees' careers and appoint "fraud champions" who act as advocates to emphasise the importance of counter-fraud work and spread awareness of good practice throughout an organisation. The Association of British Insurers also publishes "[Effective Counter Fraud Practices](#)", a checklist for smaller insurers and partners.
- Finance Finland has been organising seminars and training with the police, other authorities and the media for 35 years. It also publishes "Good practice guidelines for insurance investigation", a manual intended for training, as well as for use by fraud investigators.
- In Sweden, Larmtjänst, the anti-crime arm of Insurance Sweden, organises annual introductory training for new investigators in the insurance industry. Larmtjänst also arranges annual conferences to exchange best practices between investigators and other experts in insurance-related subjects. In 2018, Insurance Sweden issued guidelines for investigation units to safeguard high standards and good ethics in investigations.

The use of technology and data analytics (including anti-fraud databases)

- Insurers across Europe increasingly make use of big-data tools to detect cases of fraud by cross-matching data from different databases (eg, tax authorities' data).
- In Spain, the insurance association, UNESPA, has set up two databases: one of all motor insurance claims, which was established in 2011; and another of claims in property insurance, which was set up in 2019 but will begin operating in 2020. They contain data from all insurance undertakings and help insurers to detect fraud at an early stage. These databases are shared with the police.

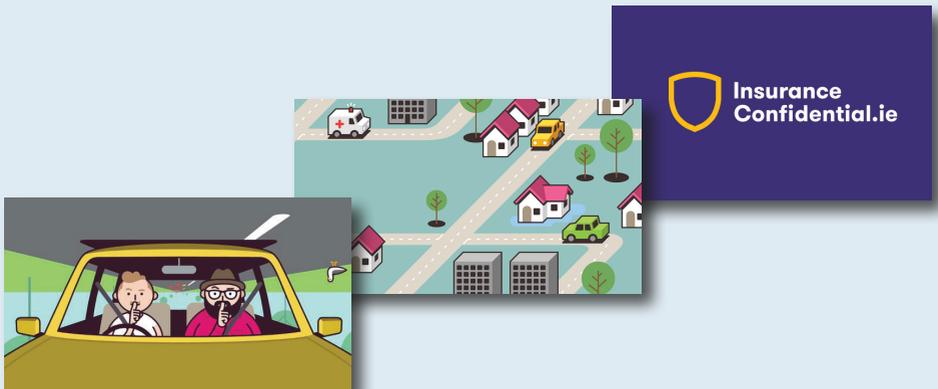
- In Sweden, insurance undertakings use advanced key-readers to confirm that car keys submitted in support of a claim for a stolen vehicle indeed belong to the car alleged to have been stolen. Insurance companies have also started to introduce automated anti-fraud tools in claims processes.
- In France in 2019, ALFA launched a detection tool to help the market fight organised crime in motor insurance. French insurance companies submit their data on contracts and claims to a third party, which complements it with data from other sources, such as expert reports and data from third parties, and then generates alerts highlighting insurers to potential cases of fraud.
- In the UK in 2018, the Insurance Fraud Register (IFR) was launched by the Insurance Fraud Bureau in collaboration with the Association of British Insurers. It is the UK's first database of proven fraudsters and records details of all first- and third-party and supplier frauds in all types of insurance and at all stages in the insurance process. Around 80% of the general insurance market are currently members and it contains over 25 000 records. Members regularly report matches and have been able to identify significant numbers of potential risks for further investigation.
- In Slovenia, all insurance companies collect, analyse and share anti-fraud intelligence. For every suspected case of fraud, an inquiry is sent through an exchange network to all other insurance companies, which can cross-check in their own databases whether they also have suspicious cases or a history of claims for the individual concerned. There are plans to develop an automated system warning companies about suspicious cases.
- In Italy, an Integrated Anti-Fraud database (AIA) for motor insurance was launched by the regulator in 2017. Bringing together data from seven different sources, it contains data such as vehicle registrations, drivers' licences, insurance policies, injured parties, witnesses, loss adjusters, etc. and it works on the basis of fraud indicators. Providing data is compulsory for insurance companies, which can then use the database to assist them in detecting fraud.
- The largest insurers in Belgium use integrated solutions based on artificial intelligence that employ a scoring system to detect suspicious files.

Information campaigns

- In Norway, many customers, especially the young, do not understand that “adding on a little bit” is insurance fraud and a serious crime. Finance Norway, together with its member companies, therefore produced a series of three short films in 2017 for use on social media. The aim is to reach out to youngsters and inform them about the consequences if they defraud their insurer. These films have been viewed more than 700 000 times.



- Insurance Ireland established the “Insurance Confidential” hotline for reporting suspected fraudulent claims in 2003. It is used thousands of times a year, with over 90% of reports anonymous. By the end of 2017, 11 351 of the cases had been deemed worthy of being referred on to insurers for investigation. Insurance Confidential has grown far beyond its initial hotline service to act as a hub for Insurance Ireland members, including the 10 main non-life insurers, to pool data on fraud trends, statistics and



other items of mutual interest. Insurance Confidential also administers an Anti-Fraud Forum (AFF) for the special investigation units of insurance companies. Currently, there are AFF groups for claims, sales and underwriting, and health insurers. They meet to discuss issues, make presentations, plan annual training events for special investigation units and plan Insurance Ireland's annual fraud conference.

- In 2018, the Association of British Insurers and the Insurance Fraud Bureau commissioned behavioural science research into nudging insurance customers towards greater honesty with a view to changing behaviour and attitudes to fraud.
- In 2017–18, Insurance Sweden financed an independent expert commission to evaluate topical crime trends, including the dramatic increase in fraud cases over the last decade. The commission presented various proposals to curb the trend, which received wide media attention, and many of the proposals have been acknowledged by the government and relevant authorities.

What could help in the fight against fraud?

Fraud is a systemic issue that requires a collaborative approach to reduce its impact. The various national experiences of fighting fraud suggest that the efforts of insurers and other interested parties should be focused on four key areas:

- consumer information and education
- gathering and sharing intelligence
- enforcement
- investment

Consumer information and education

Most insurance customers are honest and do not set out to commit fraud. Nevertheless, fraud can be committed by consumers who do not necessarily know that what they are doing is fraudulent. For example, they may see exaggeration of an otherwise genuine claim as part of the negotiating process. Others may commit fraud due to the (mis)perception that insurance is “fair game” or because they see insurance as a “grudge” purchase and want to receive something in return for the premiums they have paid.

More should be done by insurers to focus on prevention in their earliest interactions with customers. As part of the application process, insurers could distribute more information to policyholders about what constitutes fraud, as well as spelling out the consequences. Additionally, insurers could make more use of hotlines for reporting fraud and of media campaigns to promote awareness of the amount of fraud and who ultimately pays for it.

Insurers could also make use of behavioural science techniques, such as “nudges” that give statistics for other customers’ honesty at the application stage to prompt consumers to be more honest or “reciprocation” to show what customers get from being honest. The Association of British Insurers has recently been testing these techniques.

Gathering and sharing intelligence

One of the most important weapons in the fight against fraud is the ability to exchange information efficiently.

- Insurers benefit from information collected and stored centrally as a means to fight fraud, with good examples including the Integrated Anti-Fraud (AIA) database in Italy and the Insurance Fraud Register in the UK.
- Extending information-sharing across borders can also assist the fight against fraud. For example, the Nordic countries have established a platform to regularly meet and discuss

trends, issues and common challenges, since trends in one country have been seen to spread to neighbouring countries.

- In addition, insurers benefit if there is collaboration on intelligence-gathering across financial services and other sectors, including the public sector. With identity fraud, for instance, intelligence gathered by banks or leasing companies can assist insurers with early identification of potential fraudsters.
- The 2018 EU General Data Protection Regulation is not considered a barrier to information exchange.

For intelligence sharing to be possible, it is vital to have a data protection framework that recognises that legitimate data-sharing to counter fraud is in the public interest and therefore justified.

Enforcement

- Regulatory bodies and law enforcement agencies must be credible deterrents against fraud. In the Netherlands, since August 2016, insurers have worked with the national police and the Ministry of Justice & Safety on a foundation, SODA, which claims indirect damages from fraudsters. Insurers can cancel the policy that is found to be fraudulent and register the fraudster's personal data in the national warning system. They hand over information on proven fraud cases to the foundation, which claims a standard amount of damages.
- It is important that the judiciary plays its part in underpinning deterrence by handing down sentences that reflect the significant harm inflicted by insurance fraud.

Investment

Good counter-fraud governance is vital. Countering fraud should be a board-level issue for insurers. Insurance companies should establish a culture and strategy for tackling fraud and this requires serious, ongoing investment, such as:

- Hiring and training fraud investigators so that they have the appropriate level of experience and expertise.
- Investing in counter-fraud measures adapted to the way insurance is bought, sold and used. As more insurance business is conducted online, insurers are increasingly making use of big-data analytics and artificial intelligence to spot patterns and improve early detection of fraud.
- Industry initiatives like cheatlines or shared databases also need to be supported by investment from insurers. In the UK, for instance, the Association of British Insurers estimates that its members invest at least £250m (€285m) a year in countering fraud. This includes putting in place major initiatives, such as the Insurance Fraud Bureau and the Insurance Fraud Enforcement Department.



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