ZURICH

Detecting fraud earlier so you don't pay later

Preventing fraudulent claims

Insurance fraud – a major issue

While the vast majority of claims are genuine, claims fraud is regrettably a feature of most insurance products. Zurich has an obligation to all of its customers to ensure that we have processes in place to identify and investigate suspicious claims.

How serious is the threat of fraud?

- The Association of Chief Police Officers estimates that it is likely that fraud represents a £20 billion annual loss to the UK – the equivalent of £330 for every person in the country. (Source: The Nature, Extent and Economic Impact of Fraud in the UK, ACPO Fraud Report 2007)
- Research by the Association of British Insurers discovered that fraudulent insurance claims are now costing insurers over £4 million every day, estimating the annual cost of insurance fraud to be £1.6 billion (Source: Association of British Insurers, 2007)

This translates to an approximate increase of 5% on premiums.

Many statistics are published about the perceived level of fraudulent activity within the UK but, in reality, nobody knows exactly how much fraud costs.

Estimates tend to be conservative, but what is certain is that detecting and preventing fraudulent claims is in the best interests of our customers, by helping keep their premiums from rising unnecessarily.

What is insurance fraud?

There has been much discussion over recent years about how to define insurance fraud. The Government has now resolved this debate following the introduction of the Fraud Act 2006 in England, Wales and Northern Ireland. In Scotland there has always been the substantive common law crime of Fraud and the elements required to prove Fraud are now identical in all UK countries.

The Act sets out clear definitions of Fraud in relation to making false representation, failing to disclose information or abuse of position.

The first of these offences, as detailed in Section 2 of The Fraud Act 2006, would relate to a fraudulent insurance claim and states that:

A person is in breach of this section if he

a) dishonestly makes a false representation, and

b) intends, by making the representation –

i) to make a gain for himself or another, or

ii) to cause loss to another or to expose another to a risk of loss.

This legislation has repealed previous offences under the Theft Act of Theft by Deception and Obtaining a Pecuniary Advantage, which often presented difficulty when considering appropriate charges against offenders.

Our definition

Putting it into a working context, Zurich's definition of fraud is:

'The deliberate and dishonest withholding or misrepresentation of material information to gain financial advantage.'

To help explain this, the following is a glossary of the terms used in this definition:

Deliberate

With intent/intentional. This distinguishes from instances where wrong or inaccurate information is supplied inadvertently.

Dishonest

This defines behaviour, character, state of mind, and nature of intent. It covers lying, falsehood, untruths and deception.

Withholding or misrepresentation

This means providing false information about a claim in words, writing or conduct, including misleading, omission or failure to provide relevant facts.

Material information

Information that is relevant to our ultimate liability or acceptance/terms of the risk.

Financial advantage

This means benefiting (including services, money and/or goods) over and above the entitlement for genuine claims or beyond the contractual/legal liability, including inflation or exaggeration of a genuine claimable loss.

How Zurich combats fraud in insurance

At Zurich, we strongly believe in embedding fraud detection within all areas of claims handling, providing staff with the knowledge and tools to ensure that all suspicious activity is properly and thoroughly investigated.

Examples of this include:

- Zurich has a dedicated **Claims Investigation Unit (CIU)**, a team of 30 professionals whose full time roles focus on the investigation of suspicious claims, raising awareness amongst staff and customers, and gathering and sharing intelligence.
- In addition, over 25 full and part time fraud handlers/co-ordinators are established at our claims handling sites to ensure that all suspicious claims are referred for investigation.
- We have a panel of approved suppliers and solicitors who complement the work we do in-house.
- Training is regularly delivered to all claims staff to make sure they know what fraud looks like and where they should refer the claim to.
- We contribute to industry initiatives, such as the Insurance Fraud Bureau, to ensure that Zurich is strongly represented.

Types of fraudulent claims

Types of fraudulent claim are broadly categorised as follows:

Fictitious losses or incidents

Losses or incidents that simply did not occur, but a policyholder or third party claims they did and **deliberately** presents a completely false set of circumstances supporting the existence of a loss or incident, for their **financial advantage**.

Exaggerated losses or personal injuries

These originate from genuine losses or incidents, where a policyholder or third party **deliberately** exaggerates or misrepresents the true extent of their actual loss or personal injury, above and beyond what they would be ordinarily entitled to, for their **financial advantage**.

Non-disclosures or misrepresentations of material facts

This relates to situations where a contract of insurance exists or not and a policyholder or third party **deliberately** fails to disclose, or misrepresents material facts that would have bearing on either a claim or the terms and conditions of a policy of insurance, for their **financial advantage**.

Motor fraud – staged/induced accidents

'Crashing Cars for Cash'. 10 years ago, you may have thought this was referring to stunt driving or stock car racing but, nowadays, the phrase has taken an altogether different and alarming meaning.

Organised fraudsters have found a way of turning what appear to be genuine motor accidents into a means of securing significant payouts from insurers. By conning innocent motorists into crashing into the rear of their vehicles, these gangs of fraudsters have created a lucrative business, which poses a significant threat to public safety.

According to research conducted by the Insurance Fraud Bureau:

- There have been over 22,000 induced/staged accidents in the last 6 years.
- The amount of gangs involved in these scams has risen from 4 in 2003 to over 40 now, with around 3 new gangs surfacing every month.
- Each gang is capable of staging 300-400 crashes a year.
- Each crash can result in claims totalling over £30,000.
- The crime nets gangs over £200million a year.
- An estimated 20,000 staged/induced accidents will occur before the end of 2008.
- Hot spots have been identified throughout the country – this is a nationwide problem.

Gangs will target vehicles they believe to be insured. The classic scenario is a deliberate and unexpected 'slam on' at a roundabout or junction resulting in the innocent motorist crashing into the rear of the gang member.

In many cases the driver will not be who he claims to be and will assume the identity of the real owner of the vehicle. There will be a reluctance to involve the police at the scene and a desire to exchange details and vacate the accident scene quickly.

The claim will be presented for (exaggerated) damage, hire costs, recovery charges (when the vehicle is often driven from the scene) and personal injury. They may also try to claim for personal injury for people who weren't even in the car.

At Zurich, we are taking a firm stand against this activity and using many techniques to identify these bogus claims. Our customers and their drivers have to be vigilant and be made aware of the risk to their safety and how gangs are using them directly as a way of making money illegally.

Top tips for preventing fraudulent motor claims

If you or any or your employees believe they have been involved in an induced accident they need to:

- be calm;
- telephone the police;
- take a detailed note and photographs, if possible, of the scene, the vehicles, the damage, the people involved, without risking their own safety;
- note specifically how many passengers were in the other party's vehicle and their approximate ages;
- highlight their concerns to Zurich as early as possible, as it provides us with the best opportunity to investigate the claim and prevent fraudulent payment.

Such is the sophistication of these gangs, that detection of the claims presents insurers with several challenges. Many of the criminals behind the gangs operate with several aliases from a variety of addresses and employ contract drivers who will often assume the identity of other individuals. Claims are often presented via Accident Management Companies or Solicitors with this additional layer being used to help conceal the identities of those involved.

We need the public to help the Industry to rid this activity from our roads. If anyone has any information they would like to share, then please contact Zurich's Claims Investigation Unit on 01489 562478. Alternatively, the Insurance Fraud Bureau hosts a Cheatline which can be contacted on 0800 328 2550.

Liability fraud – fictitious/ exaggerated injuries

Staged or Induced Motor Accidents target the legal liability aspect of the 'innocent' party. If the third party is able to show on paper that someone was at fault for an accident, it enables them to try to claim damages from that party.

Personal Injury claims against employers or local authorities carry a similar risk in terms of fraudulent activity. Some people will invent incidents and/or exaggerate the effects of a genuine claim in an attempt to secure payment beyond which they are entitled to.

Examples of this range from individuals greatly embellishing an injury suffered at work, right through to organised activity where people are encouraged to invent an injury and initiate a claim, often against local Councils. Both of these are clear instances of fraud.

Networked fraud clearly presents wider challenges in terms of identifying patterns, individuals and linked aspects of the claims and we continue to push the boundaries of investigation and data sharing to prevent such fraudulent claims being paid.

Fraud in the workplace is not uncommon, with some employees seeing opportunities to invent accidents for financial gain. This practice is then often copied by others who are drawn by the attraction of trying to get something for nothing.

Identifying fraudulent claims

Intelligence gathering and sharing is key to identifying organised fraudulent activity and the introduction of the Insurance Fraud Bureau provides insurers with a mechanism for collating, sharing and co-ordinating activity.

At Zurich, we have strengthened our procedures and resource and have teams working exclusively on these claims, linking up with our Intelligence Team, other insurers, suppliers and the police.

Fraud Detection

'Manual Fraud Risk Indicators' or 'Red Flags' are common profiles that suggest, or indicate, that fraud may be present. These are used by all Claims Handlers across all lines of business during the life cycle of a claim as part of the process of assessing the risk of fraud being present.

Claims Handlers screen all claims as a matter of course for the presence of any 'Red Flags'. Once a claim is deemed to be suspicious, it is referred to a local Fraud Co-ordinator who will then review the claim and make a decision on the most appropriate next steps, including:

- Appointment of a CIU Claims Investigator (for a face-to-face or telephone interview).
- Seek advice or guidance from the CIU Legal Advisor.
- Appointment of an external investigator, loss adjuster, supplier or expert.
- Conduct specific lines of desktop enquiry.
- Recommend that the claims handler completes specific lines of enquiry or obtains further information.
- Recommend that the claim should proceed to settlement.*

*Not all claims that are identified as potentially fraudulent and referred to a Fraud Co-ordinator, will actually be the subject of further investigation. It is not uncommon for claims that initially display fraud indicators to subsequently turn out to be entirely genuine.

Best practice when handling suspicious claims

Recording Data

Keeping data has a number of benefits, including prevention of repeat incidences and measuring the scale of the problem.

A simple spreadsheet is adequate, as this can be filtered or sorted quickly to view the data in a number of different ways. You should ensure that adequate data is recorded, including full claimant details, witnesses and an accurate description of the location of any incident.

Securing Evidence

Securing evidence to a criminal standard is an essential part of any investigation process. Our in-house investigators are skilled in this, many being former police officers with vast and varied amounts of experience. Much of the key evidence to prove a fraud is only available at the onset of a claim, particularly when it is fresh in the mind of witnesses. Many claims undergo some form of investigation prior to referral to insurers and it is at this stage that key evidence must be secured.

Whilst the burden of proof in Civil court is the 'balance of probabilities', where fraud is involved the standard increases to approach that of the Criminal courts, which is 'beyond all reasonable doubt'. In order to succeed with a plea of fraud, the standard of evidence must also be high to avoid unnecessary costs.

When fraud is suspected, customers are advised to refer the matter directly to the relevant Fraud Co-ordinator at an early stage for advice.

Industry databases

CUE, MIAFTR and MID

All our claims handlers have access to the various databases that have been established by the industry to combat fraud and deter repeat claimants.

These include:

- CUE PI (Claims & Underwriting Exchange Personal Injury)
- CUE Motor
- CUE Home
- MIAFTR (Motor Industry Anti-Fraud and Theft Register – total loss vehicle claims)
- MID (Motor Insurance Database)

IFIG – Insurance Fraud Investigators Group

Zurich is a member of both the Insurance Fraud Bureau and the Insurance Fraud Investigations Group (IFIG), a group of more than 100 investigative bodies that share intelligence in accordance with the Data Protection Act and the National Intelligence Model, as used by the police.

Medical/Accident Records – Liability Claims

It is important to secure as much evidence as possible at the onset of a claim, including medical records and accident registers. In the case of sensitive personal data, such as a medical record, the explicit permission of the claimant will be required before the records will be released. It is useful to do this as early as possible, as part of the routine evidence gathering, and prior to the claimant being aroused of any suspicion.

Accurately record everything that happens for future reference. If you fail to keep an accurate record and the claimant misrepresents what really happened, you will have nothing to defend with. In court, the claimant's evidence will carry considerable weight, unless we are able to defend with sound evidence or the information at our disposal will tend to discredit the claimant.

Ensure that members of your staff are fully conversant with what to do in the event of an accident at work. If a record has not been made in the register, the claim will be treated as requiring strict proof of loss.

Questioning claimants and witnesses

Secure an accurate written account of the claim at the earliest opportunity. Anyone attempting to perpetrate a fraud will rarely wish to commit themselves in writing to a detailed account. Ensure that sufficient questions are asked to cover all aspects of the claim and be robust in the event that the claimant declines. If this is secured at an early stage, it will provide a strong position in the event of contradictory information coming to light.

Statements

Written statements from each person interviewed are always valuable, including negative accounts. There have been frequent instances when people have denied seeing or doing something, then later changed their minds because the question and answer was not committed to writing.

Verify everything, including identity

The simplest piece of information can be the key to uncovering a fraud. There will always be a lie in the evidence and the challenge is to find the discrepancy to uncover the fraud. It is, therefore, essential to verify every piece of information provided to establish evidence, which is, in any case, good claims handling.

There are many documented instances where the claimant has proved to have a fictitious identity, used either to infiltrate an organisation to steal or to conceal a chequered claims history. Obtaining false identity documents is a relatively simple matter over the Internet and the cost is often nominal.

Even employees slip through the net when it comes to background checks. Make sure that you know who you are employing by carrying out thorough checks to verify background and employment history. Some fraudsters will target an organisation and plant associates in an organisation with poor checks in place to prevent theft.

It has been known for employees to recruit fictitious staff and then take payment for work that they are alleged to have carried out. Unscrupulous employees have been known to form allegiances with suppliers to steal from their employers.

Working together to prevent fraudulent claims

Zurich is committed to protecting its customers' interests by using the best techniques and systems available to identify and investigate all fraudulent activity. Using the proactive fraud detection expertise in our specialist Claims Investigation Unit, we are constantly working behind the scenes to help prevent the costs of fraudulent claims and, in doing so keep, customers' premiums from rising as a result of such claims.

We hope that we have demonstrated in this booklet how we work to prevent fraudulent claims and, just as importantly, how customers can also play their part in stopping this illegal and costly practice.

For more information

If you require further information about anything contained in this booklet, please contact:

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