

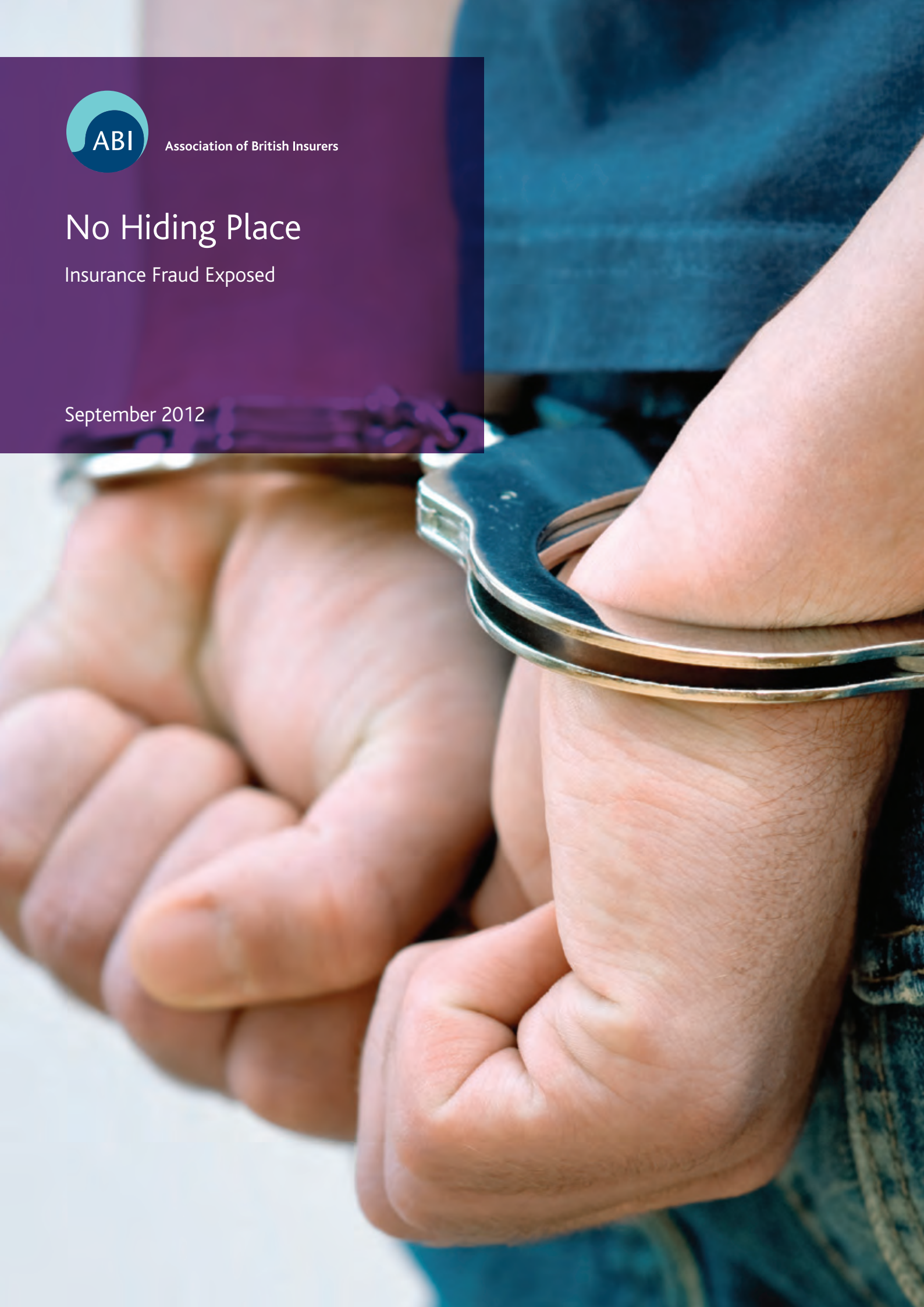


Association of British Insurers

No Hiding Place

Insurance Fraud Exposed

September 2012



Executive summary

Every hour of every day 15 fraudulent insurance claims are exposed in the UK. Insurance fraud – whether inventing or exaggerating a claim or lying to get cheaper cover – is a serious criminal offence that affects every honest insurance customer, adding an extra £50 a year to their premiums.

Last year insurers uncovered 139,000 dishonest claims worth nearly a staggering £1 billion. This is why we invest around £200 million each year to identify fraud. As well as improving their own anti-fraud systems, firms fund industry initiatives such as the Insurance Fraud Bureau (IFB), a not-for-profit organisation specifically focused on the detection and prevention of organised and cross-industry fraud, and the Insurance Fraud Enforcement Department (IFED), a specialist police unit dedicated to the identification and prosecution of insurance fraudsters.

However, despite this huge investment and the considerable successes of the IFB and IFED to date, we estimate that an additional £2bn of insurance fraud is still undetected. The Insurance Fraud Register (IFR), launched on 13 September 2012, is the latest weapon in insurers' armoury to combat fraud. By bringing together all data on known fraudsters held across the industry, the IFR will enable insurers to weed out insurance fraudsters who have committed fraud against other insurers in the past. It will also be the conduit through which insurers share data with other industries – so an insurance fraudster might not just find it more difficult and more costly to get insurance, but may also find it more difficult and more costly to access other financial services and products.

Reducing and deterring fraud remains a priority for the insurance industry. It is an on-going battle as the fraudsters continually look for new ways to de-fraud insurers and honest customers. The industry makes no apologies for its zero tolerance approach to weeding out the cheats. Honest customers expect nothing less.

Insurance fraud explained

Insurance fraud cuts across every type of insurance. It ranges from opportunists failing to disclose their claims history when applying for cover or exaggerating claims by adding extra items to a genuine claim to highly organised 'crash for cash' crime rings who contrive often dangerous road crashes and claim for phantom passengers and fictitious injuries. Insurance fraud may be committed by the policyholder or a third party claiming against an insurance policy and may be aided and abetted by so-called professionals, including claims management companies.

Case Study

Mrs. G rang her motor insurer to make a claim and said her car had been involved in a minor accident. Her son had been driving and had hit a stationary vehicle while he was trying to park. This had happened outside her son's university hall of residence, in a city that was nearly 200 miles from where Mrs. G lived. Mrs. G added that her son had 'been parking in the same spot every day for months' and she said it was 'particularly annoying that he had an accident on the last day of term'. In the light of Mrs. G's comments, the insurer rejected her claim and 'voided' the policy (treated it as if it had never existed).

When Mrs. G had applied for the insurance, she had said she was the main driver and that her son only used the car 'very occasionally'.

The insurer said it was now evident that her son was the main user of the vehicle and that Mrs. G had been 'fronting'. This term is used to describe the situation where a car that will be used principally by an inexperienced driver is insured in the name of an experienced driver, in order to obtain a cheaper premium.

Mrs. G referred the matter to the Financial Ombudsman Service who asked the insurer to send a copy of the recording it had made of Mrs. G's phone call, when she applied for the policy. During that call, the insurer had asked Mrs. G a series of clearly-worded questions. Her answers were equally clear and unambiguous and established that she was the main driver of the car. The Financial Ombudsman dismissed Mrs. G's complaint.

Case Study

Insurers, working with Bedfordshire Police and assisted by The Insurance Fraud Bureau, helped uncover one of the UK's largest ever staged vehicle accident gangs. Operation Exhort investigated 180 suspected staged and induced accidents, linked to 230 high-value insurance claims worth over £3.2m. The investigations uncovered a 39-strong criminal gang whose frauds involved legal, medical and motor trade professionals, and a claims management firm which provided a seemingly legitimate front for the fraudulent claims. In total 37 people involved were convicted.



Scale of insurance fraud

Every hour of every day 15 fraudulent insurance claims are exposed in the UK. In 2011, £983m of fraud was detected – money that would otherwise have been lost to fraudsters. This was 7% higher than the value of fraud detected in 2010 and comprises 138,814 fraudulent insurance claims – 2,670 every week. The value of savings for honest customers from detected frauds represented 5.7% of all claims in 2011, compared to 5% in 2010.

Home insurance was the area where insurers detected the largest proportion of frauds, with 71,000 bogus or exaggerated claims.

Dishonest personal motor insurance frauds were the second largest area of insurance fraud with 37,000 frauds uncovered. They were also the most costly, totalling £441m. 7% of all motor claims in 2011 were fraudulent compared to 5% in 2010. This reflects the rise in fraudulent whiplash claims, often encouraged by a small minority of corrupt professionals.

Case Study

Following a car accident, Mrs. S claimed that, as a result of the accident, she was severely disabled, unable to work and required between five and eight hours of care and assistance every day. At the time, Mrs S. was in receipt of incapacity benefits and the claim overall was valued in excess of £650,000. Evidence in support of Mrs. S's claim was given by her husband and a daughter, who both provided signed statements to the court confirming Mrs. S's allegations.

The insurer obtained surveillance evidence which proved that not only was Mrs. S not disabled as she claimed, but that she was actually working. The insurer rejected the claim and took Mrs. S to court for contempt of court proceedings.

The insurer won the case and all three family members involved in the case were sentenced to serve between three and six months imprisonment. Premeditated fraud includes deliberately planned frauds, often carried out by organised gangs, such as 'crash for cash' staged accidents.

Insurers incur costs in investigating suspected frauds, which also impacts on their ability to deal with genuine claims quickly. For honest customers, this leads to higher premiums. The ABI estimates that fraud adds, on average, an extra £50 a year to the annual insurance bill for every UK policyholder. Insurance fraud is also known to fund and facilitate other serious crime such as money laundering and in some cases, such as staged motor crashes, puts people's lives at risk.

The Insurance Fraud Register – the latest weapon in the war on insurance cheats

The industry continues to strengthen its systems and controls against all types of fraud. The most recent development is the establishment of the Insurance Fraud Register, which is due to begin operations in September 2012. This initiative, which has been commissioned by the ABI to be delivered and administered by the IFB, is the first single industry-wide central database that will contain details of all known insurance fraudsters. The database is operated by the IFB and stores details of people who have made either fraudulent claims or deliberately lied or withheld relevant information when seeking insurance. Insurers will be able to search the IFR across all types of insurance and at all stages of the product lifecycle to detect and prevent fraud in the underwriting of insurance products, and when processing claims.

The IFR will form part of the comprehensive package of analytics used by the IFB and will provide a single source of insurance intelligence. This information will feed into the work of the Government's anti-fraud agencies.

In developing the IFR, insurers have been extremely mindful of the need for appropriate checks and balances to ensure the data is accurate. The Information Commissioner's Office has been consulted and kept informed of developments. Only insurers that can demonstrate compliance with strict Membership Rules and the Information Sharing Agreement will be able to use the IFR. Information loaded onto the IFR must meet a strict definition of fraud and insurers will be required to inform the individual that they are in breach of the fraud condition. The IFR will not contain details of retrospective frauds and records will be automatically deleted after five years. Individuals who raise objections to appearing on the IFR may appeal.

The IFR is not an automated decision-making tool but may be used as part of a wider decision-making process for underwriting and claims management. An insurer who searches the IFR may use the information returned to inform a decision as to what action to take, not as the sole basis for any decision.

The IFR reinforces the clear message that the industry is intensifying its crackdown on fraud, and that the consequences for fraudsters may include finding insurance more expensive and finding it more difficult to get insurance, credit and other financial products.

Industry initiatives to protect honest customers

The IFR joins the range of industry initiatives to tackle insurance fraud. The insurance industry's counter fraud strategy is wide-ranging and its pursuit of insurance fraudsters is relentless and unerring. Insurers routinely exchange information on customers' application and claims history to help them identify potential frauds. Insurers are transparent and clear about this and operate in full compliance with data protection and privacy requirements. Proposal, claim and renewal forms draw attention to the sharing of data, and remind customers to be honest in disclosing all relevant information.

Committing insurance fraud will have long and serious consequences. Fraudsters could face criminal prosecution and a prison sentence. At the very least, they can expect to find it harder to get, and pay more for, insurance in the future. Known fraudsters may also find it more difficult to obtain credit and other financial products in the future.

Case Study

A group of about 30 men commissioned a coach to take them to a greyhound racing meet. During the journey one of the men alerted the driver to a rear impact. The driver stopped and it was noticed that a car following the coach had a dent. The coach was undamaged and the coach driver did not detect any impact.

Following the incident, all 30 passengers claimed to be injured and the trip was called off. It later transpired that no bookings had been made with the greyhound racing track as had been claimed.

IFED arrested four of the men on suspicion of conspiracy to commit fraud.



Insurers remain committed to paying all genuine claims as quickly as possible, and need to strike a balance between investigating potential frauds and ensuring that genuine claimants do not face delays as a result. Insurers do all they can to ensure that genuine claimants get their claims paid as quickly as possible.

To protect honest customers the industry has invested, and will continue to do so, significant resources in deterring and detecting insurance fraud. This includes:

- Funding the Insurance Fraud Bureau (IFB), which is specifically focused 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. 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.

Case Study

In May 2012, three suspected identity fraudsters were arrested by the Metropolitan Police marking the IFB's first involvement in one of the UK's biggest investigations into identity fraud.

Working alongside the Metropolitan Police's Amberhill Unit, the IFB has started to investigate the insurance records of suspected identity fraudsters – people who have obtained a genuine driving licence using false or forged documents.

As part of a pilot project, the IFB is investigating the insurance histories of 579 suspected identity fraudsters across the UK. IFB intelligence has already linked that sample of people to insurance claims now considered to be at 'high risk' of fraud, amounting to potential frauds worth in excess of £170,000. The IFB has issued alerts to its customers who may be affected by the frauds as investigations continue. The IFB also encourages people to anonymously report any suspected or known frauds through an insurance cheatline and through its website (0800 422 0421 or www.insurancefraudbureau.org/report).

- Developing and running industry-wide databases, such as the Claims and Underwriting Exchange, that enable insurers to exchange information to help identify possible fraudulent behaviour.
- Funding the Insurance Fraud Enforcement Department. IFED became operational on 3 January 2012 and forms part of the City of London Police, the lead police force for economic crime and insurance fraud. It investigates potential frauds referred by insurers across all types of insurance. In the first six months of operation, IFED received 318 referrals from 43 different insurers. Detectives have made 120 arrests and investigated more than £8m of suspected insurance fraud.

Case Study

IFED's first conviction came from information inadvertently provided by the claimant. A man telephoned his insurer to report that he had reversed into a lamppost, causing whiplash injuries to his two passengers. However, his account of the accident quickly unravelled when, believing he had terminated the call, the man loudly boasted to friends about his lies and how he was going to make money from his insurer. When detectives went to see him he flatly denied any fraud until he was played a full recording of the phone call.

- Funding a new database which will be built by the Driver and Vehicle Licensing Agency, which will make it much more difficult for potential fraudsters to give inaccurate information about their driving entitlements and offences in order to get lower premiums. This is due to become operational in 2014.



Conclusion

Whether opportunist or organised, the insurance industry makes no apologies for its tough stance on tackling insurance fraud. Honest customers should not have to pay the price for fraudsters through higher premiums. The majority of insurance customers are honest and insurers are determined to do everything possible to protect their interests. The initiatives pursued by the industry all play a part in reducing insurance fraud and the industry will maintain its focus to ensure that the consequences for those who commit fraud are severe.

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