

A close-up photograph of a person in a dark blue suit and white shirt, holding a magnifying glass over a document. The person's hands are visible, and the magnifying glass is held over the document, suggesting a detailed inspection or investigation. The background is a blurred office setting.

The fight against insurance fraud Singapore

Fraud is a constant challenge for every insurer. Fraudulent claims place a multi-billion-dollar financial burden on the insurance industry every year and ramp up premiums for the average insured by tens of dollars per policy.

While fraud detection rates are on the rise due to increasingly sophisticated processing capabilities and the introduction of AI technologies, it remains one of the most significant disruptors to the effective operation of the insurance market.

Unsurprisingly, insurance fraud is a global issue. In the U.K., for example, almost 470,000 insurance frauds were detected by insurers in 2018, according to the Association of British Insurers (ABI), composed of 98,000 fraudulent claims and 371,000 dishonest insurance applications, with fraudulent claims valued at £1.2B. In the U.S., the FBI reports that insurance fraud (excluding health insurance) costs over \$40B annually.

A 2017 Global Claims Fraud Survey report by Reinsurance Group of America (RGA), ranked Asia Pacific as one of the regions most highly exposed to insurance fraud. In this report, we look at the fundamentals of fraudulent insurance activity, before examining both 'hard' and 'soft' fraud and providing recent examples of each in the context of the Singapore insurance market. In the latter part, we outline some of the issues and challenges faced by the market and conclude by detailing a series of steps that companies can take to limit its impact and help the insurance industry fight back harder.

A question of faith

Utmost good faith is what all insurance contracts are based on – however, this is a two-way street between the insured and the insurer. First, the insured is obliged to disclose any relevant information to the insurer prior to the purchase of a policy. This is to ensure that the insurer is fully aware of

the risks that may be involved and to enable them to assess the extent of any loss should it occur. The insurer, on the other hand, must ensure that the policy clearly stipulates the coverage and is bound by the law to honor the contract. Both insured and insurer must work together openly and ethically in the event of a claim.

Insurance fraud is alleged when at least one of the following is apparent:

- Misrepresentation in the form of concealment, falsification or dishonesty
- Intent to deceive
- Aim of gaining unauthorized benefit

Insurance fraud costs the industry billions across the globe and millions of dollars in Singapore. This loss is detrimental not only to the insurance companies, but also to the consumer. Increased claims payouts translate into increased premiums to make up for the shortfall. Furthermore, operating costs of an insurance company, which include the costs of fighting fraud, are also factored into the consumer's annual insurance premiums – for example, in the U.S., the \$40B loss figure reported by the FBI costs the average family between \$400 and \$700 per year on their insurance

Insurance fraud is broken down into two main categories, 'hard' and 'soft' fraud. The latter is usually opportunistic and committed by inflating a legitimate claim in order to receive a bigger payout. For example, when claiming for the theft of a wallet while overseas, the insured may overstate the amount of money in their wallet.

Hard fraud, on the other hand, is premeditated and takes place when a person or group of people executes a deliberate plan to deceive an insurance company with the intention of getting a significant payout. This amount could be a one-time payment or several small claims that add up to a substantial sum of money.



Hard fraud in action

An example of hard fraud took place in Singapore involving a man who faked his mother's death in order to claim S\$3.77M in insurance payouts.

The perpetrator was meticulous in his approach and had conducted extensive internet research to find out which life policies provided the highest payout upon death of the insured and what documents were required to verify the claim. Over the course of nine months, he bought several insurance policies and travel insurance for his mother – and even chose the specific method of death because the involvement of the use of public transport doubled the death benefit coverage.

Two months later, mother and son travelled to Pakistan, where he, with the help of his relatives and their contacts, managed to gather forged documents stating that his mother had been killed in a traffic accident.

Once these were in place, he asked his mother to hand over her Identity Card and passport. He returned to Singapore on his own and reported her death to the Immigration and Checkpoints Authority. He then submitted claims to the insurance companies he had bought the policies from.

However, discrepancies in his claim documents prompted the insurer to further investigate and his mother was eventually found alive and well in Pakistan.

Types of insurance fraud in Singapore

Travel

There has been an upward trend in cases travel insurance fraud which has been linked to the rise of budget airlines and cheap airfares. With better understanding of how travel insurance works, some individuals have become bolder in the way they file false claims in hopes of getting a free holiday at the expense of the insurance company – even in cases of theft claims making a police report of an incident that did not take place.



An example of a fraudulent travel claim involved a group of fraudsters who claimed that they had been robbed while overseas. They submitted a claim upon arrival in Singapore, but claims personnel found it strange that one of them still had their credit card to pay for their return trip. Upon further investigation, it was found that the group had purchased travel insurance policies from eight different insurers.

Medical

Medical fraud remains rampant in Singapore despite the Singapore Medical Council implementing a rule in 2016 which stated that medical care providers would no longer be able to share a percentage of the fees paid to third-party agents in exchange for patient referrals.



In a recent case, two insurance agents and a chiropractor devised a plan to cheat an insurer by submitting falsified claims. It is alleged that the chiropractor enlisted patients with existing conditions to purchase insurance from the two agents involved. The patients would then submit a claim to the agents soon after the inception of the policy, claiming that they had sustained an injury from a fall. The chiropractor supported these claims in his medical report and sold treatment packages to these patients which were paid for by the insurer under false circumstances.



Motor

The General Insurance Association of Singapore estimates that at least 20 percent of all motor claims are fraudulent with claimants exaggerating their injuries and/or inflating the damage to their vehicle. Organized crime syndicates which stage traffic accidents also exist in Singapore and have recruited hundreds of people as part of their fraudulent activities – many of whom are now aware that they are a part of a larger syndicate.



The largest motor fraud case to date involved an owner of a car workshop abetting the submission of fraudulent claims amounting to S\$1.6M. He had received more than S\$300,000 in payouts from insurers as part of his plan.

The owner and his associate staged fake accidents with cars that were sent to the workshop. His associate recruited people to submit claims either as the drivers or passengers of the staged accident. In exchange for allowing their cars to be used in these ‘accidents’, the car owners received free repairs and cash.

These fraudulent claims were submitted to 13 insurance companies and went undetected for four years until the companies unearthed the situation and alerted the police.

The mastermind of the syndicate was sentenced to nine years in jail, while more than 50 people were found to be involved and were convicted.



On the fraud offensive

According to the 2017 Global Claims Fraud Survey report by Reinsurance Group of America (RGA), three to four percent of global claims, or one in 30 claims, are fraudulent. Asia, as mentioned, is the region with the highest percentage of fraudulent claims at approximately four percent. However, of the fraud cases identified, only less than two percent have resulted in prosecution.

Most fraud cases are dismissed as misrepresentation to deny the claim. High litigation costs and uncertain outcomes have deterred companies from pursuing suspected fraud cases. This reluctance to further investigate suspected fraud cases has resulted in the inability to quantify the exact loss that fraud costs the industry yearly.

Issues and challenges

Lack of data / sharing data (PDPA)

With the introduction of the Personal Data and Privacy Act (PDPS) in Singapore, insurers are not able to share data about their insured as openly as before, which makes it difficult to check the policy purchase history of the insured across insurance companies.

Limited resources

Insurance companies do not have the resources to investigate every suspected fraudulent claim. Most of the time, these involve small claim amounts and investigations take time, money and effort. Without solid evidence, the insurer could risk being sued for bad faith.

Evolving modus operandi

Claims fraud is constantly evolving as fraudsters become increasingly creative and have more access to information, making it harder to detect as there are no set patterns to follow. With technology at their fingertips, the fraudsters are becoming smarter and are becoming more opportunistic. As such, insurance companies must constantly be on high alert and stay up-to-date on fraud trends.

Reputational impact

Being in the news for failing to detect fraud does not reflect well on any company. The fact that they have been taken advantaged of and could allow for it to happen (sometimes over the course of several years), would be an embarrassment and demonstrate a lack of internal management and audit. As such, some insurance companies are unwilling to raise the alarm on fraud when it happens to them.

Advances on the fraud frontline

At Crawford, we have learned from decades of experience in helping our clients address fraudulent claims activity head-on, and supporting efforts at the industry level, that there are five key stages in tackling insurance fraud:



Forensic evidence

As fraudsters become increasingly sophisticated in their activities, so insurers must apply a similarly sophisticated approach to exposing those activities. Data is critical to this and forensic-level accounting is often required to produce the granular insights necessary to bring suspicious claims activity to light.



Recognising fraud

Your first line of defense in the fight against fraud is your claims personnel. They must be able to recognize and identify fraud-related red flags when conducting claims assessments, including:

- Insured has a history of making several claims
- Claim is made shortly after policy is purchased
- Insured unable to keep his/her story straight
- Insured unable to provide documents/documents are suspicious
- Insured provides all necessary document promptly without being asked to provide it – the claim is too perfect



Access to information

Whether it is internal data or a shared data amongst the insurance industry, information should be shared for underwriters to better assess the risks involved.



United front

It is not possible to win the war against fraud while working in silos. This is an industry-level issue and as such insurers must work together with industry associations, legal bodies and the government in order to win the war against fraud.



Data analytics

With the development of Artificial Intelligence, machine learning and data analytics have become an integral part of the fight against fraud. Data analytics allow insurers to effectively detect, manage and report fraud promptly, saving the insurer from a potentially large loss.

How Crawford can help

The identification of fraud and successful prosecution when required demands a multi-faceted approach which spans the full insurance process. At Crawford, we have developed a data-led solution which combines sophisticated technology and analytics with our comprehensive counter fraud claims handling experience.

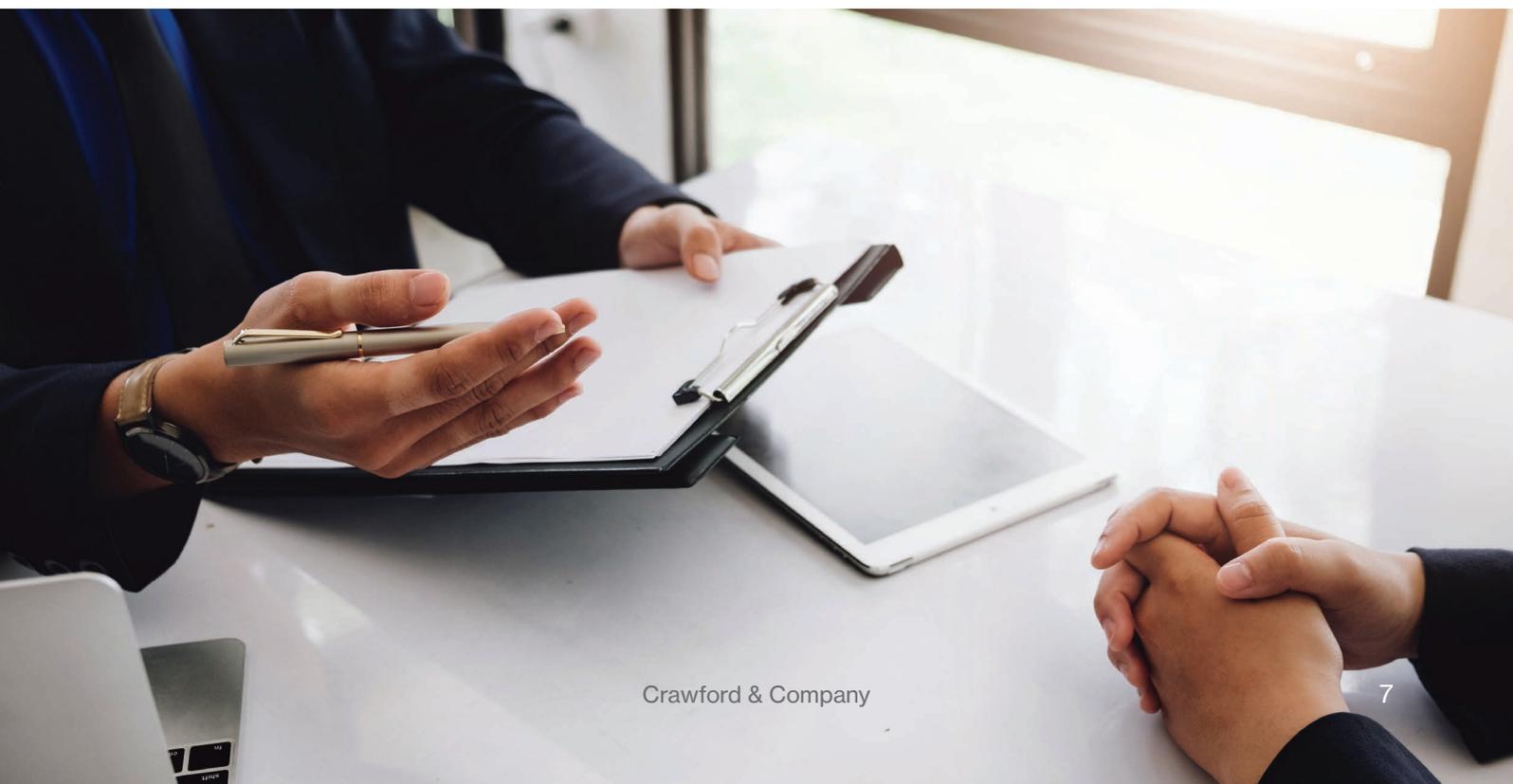
The **Crawford Investigation Services** team brings together special investigators, claims handlers and solicitors to provide on-site analysis, evidence collation and claims handling services specific to each claim type and value. Our aim is to help our clients to contain fraud costs before they cost them or their business.

The range of services, scope of data, access to technology and depth of expertise within our team enables us to support our clients across Asia and beyond on a number of fraud-related fronts. These include:

- Defining a clear counter fraud strategy
- Sharing and development of best practices
- Bulk data washing against cross-class claims datasets
- Performing flexible claims investigations and/or total claims outsourcing
- Controlling costs and reducing claims spend
- Improving brand image

We are able to undertake cross-border investigations throughout the region and our services cover the following areas:

- Death and disablement claims
- Suspicious claims
- Suspect medical claims
- Unexplained deaths
- Authentication of documents



Contact us

Discreet, thorough investigations are our hallmark, with our investigators – all highly trained professionals with vast experience, including law enforcement expertise – working-around-the-clock to detect any foul play surrounding suspicious claims. Crawford can also conduct in-depth training for you and your team on how to detect fraudulent activity.

Our team also observes the highest ethical and legal standards and provides accurate and data-driven reports. All relevant information is made available to our clients and we deliver comprehensive, detailed incident and casualty reports in a usable and consistent format.

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About Crawford & Company®

For over 75 years, Crawford has solved the world's claims handling challenges and helped businesses keep their focus where it belongs – on people.



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Managed
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Catastrophe
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9,000 employees | **50,000** field resources | **70** countries | **\$18B** annual claims payments

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