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INSURANCE FRAUD

Rising problem in non-life segment

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In the city of Hyderabad, an affluent customer of Bajaj Allianz General Insurance was hospitalised with viral pyrexia and enteric fever. After being admitted for a week, he was discharged, after which he approached them for the claim reimbursement.

Upon scrutiny, it was realised that the claim amount for the mentioned ailment was higher than the usual amount, triggering suspicion. An investigation and loss mitigation team visited the hospital to verify the medical records. After repeated follow-ups by the in-house team and ambiguous responses by the hospital authorities, the team was unable to procure any documents to support the treatment.

Eventually, the hospital authorities said they could not provide any documents, stating that due to a shift in the management, retrieving the bills was not possible. Finally, a search on social media websites turned out to be fruitful — the official had updated images of his presence at a ceremony on the same day he'd claimed to be admitted in the intensive care unit for treatment. He was not only away from the hospital, attending a formal ceremony, but also looked physically sound and healthy.

Rising issue

Sanjiv Kumar Dwivedi, vice-president, fraud prevention and loss mitigation, Bajaj Allianz, believes risk management in insurance is crucial. Insurers lose about six per cent of their revenue annually due to fraud & abuse (exaggeration of claims).

General insurance companies have been facing several such suspicious claims. These include fake hospital bills, exaggerated claims and fraudulent pathology lab reports. Non-life insurers are cracking the whip on these fraudsters, giving out red flags for certain instances and also tracking social media activities of those suspected.

K K Mishra, managing director, Tata AIG General Insurance, said with multiple hospitals across the country and different rates, there are people out to make quick money through insurance purchase. "At this point, the problem also is that there is no law which classifies insurance fraud as a criminal offence. Steps are being taken to build up a data bank of hospitals by the Industry and Insurance Information Bureau of India," he said.

Tata AIG has placed 18 'red flags' in automobile insurance and 15 in health insurance. Mishra said they also look into the operation costs in a standard hospital. If an individual presents a much higher bill from an unknown place, contrary to what is usually charged, they investigate.

Sanjay Datta, head of underwriting and claims at ICICI Lombard General Insurance, said the fraud numbers are high in motor and health insurance. "We are trying to identify areas where such fraud claims originate from, so that these regions can be avoided. There are several pockets from where such instances take place, including exaggerating repair bills for their cars, among others," he said.

A study by Accenture found 24 per cent think exaggeration of claims is perfectly normal. And, 11 per cent of people with insurance also feel that fabrication is also fine. More alarming, 92 per cent of those surveyed claimed to have come across fraud in some form or the other.

Methods

Motor and health insurance are the two prominent segments that have seen a spurt in fraud. In the former, fake policies are created, as there is no mechanism to verify if a document is genuine. Dwivedi said there are touts which fraudulently create letterheads of insurance companies and sell these as motor insurance documents.

Tampering with the date of loss has also become common. Rajagopal G, head of operations and claims, Bharti AXA General Insurance, explained that in the health insurance segment, a common malpractice by policy holders is concealment of pre-existing diseases, failure to report relevant information or providing false information regarding the state of health or purpose of hospitalisation.

He said they also encounter cases where the insured tries to get routine diagnostic investigation bills passed as treatment for some ailment. The company has a data analytics team to spot and negate fraudulent claims early.

Response

Others are looking to take the help of technology for motor insurance. Bajaj Allianz plans to introduce QR codes (a type of matrix barcode). It also makes use of technology like simulators to reconstruct accidents and figure out the reality of claims.

Claims investigation teams are also getting sophisticated. Bajaj Allianz, for instance, hires forensic specialists and investigators, beside medical officers in their team.

Steve Hollow, deputy chief executive of SBI General Insurance, said the approach is to create and integrate a fraud & investigation framework across all claim portfolios — motor own damage, motor third party, motor theft, personal accident, health, commercial line, property claims — by identifying industry standard fraud triggers, a standard investigation process and governance control.

Hollow said some of the triggers for investigation could include late-night accidents, claims immediately after buying a new policy or a loss not matching the vehicle damage.

For instance, they had a truck accident reported, where the right side of the vehicle was damaged in a highway collision. However, the cleaner was reported dead due to impact, not the driver. Further investigation and a medico-legal scrutiny proved the cleaner and not the driver was at the wheel at the time of the accident. The intention was to suppress the fact that the actual driver was not having a driving licence at the material time of the loss.

While insurers had decided to have a common data exchange platform through credit information company Cibil, sectoral sources said it had not taken off. This is because insurers are reluctant to share customer data, for fear of these being poached by a rival company.