



## Learning Series - #28



### Understanding Insurance Fraud

Fraud is an intentional misrepresentation or concealment of a material fact or a reckless disregard for the truth. It has a direct financial impact on a company's expenses and profits, which in turn negatively impact clients and shareholders. It is estimated that most organizations lose about 5% of revenue and every American nearly \$1,000 to insurance fraud each year. Beyond financial losses, it also has far-reaching consequences, going from poor customer experience due to restrictive fraud-prevention measures, to operational impact associated with mitigating fraud and reputational risk, since failure to establish trust, can permanently damage a brand. Insurance underwriters can help prevent fraud by identifying red flags during the underwriting process.

#### Motives

**Claim benefits:** increase benefits by billing services not rendered, duplicating claims, excessive or unnecessary services, faking a death, faking a person, forgery, etc.

**Money laundering:** process of using insurance premiums to convert proceeds from criminal activities (drug trafficking, terrorism, illegal arm sales, prostitution, smuggling, counterfeiting, insider trading, etc.) to a format that looks clean and legitimate.

**Broker compensation:** most financial advisors are paid largely on a commission basis.

**Tax avoidance:** products such as permanent life insurance can provide a shelter from taxes.



#### Parties Involved



Fraud can be attempted by the:

- **Insured:** misrepresentation to qualify for coverage otherwise not eligible, stacking (multiple small applications to reduce underwriting scrutiny);
- **Policy owner:** “borrowed life” where a 3rd party owns a policy without insurable interest, misrepresentation;
- **Financial advisor:** ghost writing (license revoked but partners with a licensed agent), churning/twisting (excessive applications/replacements to generate commissions), rebating (refunding part of premiums to insured), financial misrepresentation;
- **Underwriter:** collusion with advisor/vendor to approve risks outside of acceptable risk criteria or to generate additional fees to providers;
- **Vendor:** generate unnecessary fees;
- **Any person directly or indirectly involved in the new business process (case coordinators, paramedical examiner, attending physician, inspection report examiner, etc.):** deliberate breach of confidentialities, sale of confidential information to unauthorized parties, misrepresentation.





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## Understanding Insurance Fraud (cont'd)

### Red Flags

Red flags are indicators that should incite underwriters to review an entire risk more closely, they are not a proof of fraud by themselves.

Concern	Potential Red Flags
 Misrepresentation	<ul style="list-style-type: none"> <li>- Unsigned or undated forms</li> <li>- Inconsistent signatures on application and paramedical exam</li> <li>- Missing, incomplete or vague answers</li> <li>- Lack of insurable interest</li> <li>- Undisclosed pending/multiple applications</li> <li>- Vague occupation (consultant, importer, etc.)</li> <li>- No credit report/Equifax match</li> <li>- P.O. box address</li> <li>- Conflicting or inconsistent information</li> <li>- Physician with same surname as insured</li> <li>- Ownership not consistent with purpose</li> <li>- Suspicious or unverifiable income and net worth</li> <li>- Multiple MIB hits including recent extended application activity</li> <li>- Bankruptcies/lapses history</li> <li>- Reluctance to provide financial information</li> <li>- Ownership change shortly after issue</li> <li>- Similar handwriting observed on multiple documents/applications despite different agents</li> </ul>
 “Borrowed life”	<ul style="list-style-type: none"> <li>- Older age and high insurance amount</li> <li>- 1<sup>st</sup> time insurance purchase</li> <li>- Premium financing</li> <li>- Unclear source of premiums</li> <li>- Lack of insurable interest</li> <li>- Lack of financial justification (premiums exceeding applicant's means)</li> <li>- Unrelated 3<sup>rd</sup> party payor</li> <li>- Same owner for different policies/insured</li> </ul>
 Money laundering	<ul style="list-style-type: none"> <li>- Beneficiary changes</li> <li>- Large cash transactions</li> <li>- Need inconsistent with product</li> <li>- Excessive transactions or early surrenders</li> <li>- Minimal identifying information provided</li> </ul>

### Underwriting considerations

- Trust, but verify. In the presence of red flags, ask questions and/or ask for additional evidence.
- Internet search is a powerful tool. All kinds of information can be accessed freely in a matter of seconds, from financial, business records, criminal history, ownership information, identifying details (DOB, phone numbers, addresses, etc.), newspaper articles, agent license confirmation, occupation details (LinkedIn), lifestyle from social media, Google maps/street view to verify locations, etc.
- Lab slips provide useful information that can be used when investigating possible fraud and collusion (names of the insured and agent, amount of coverage, signature of the insured, multiple carrier names if applying at multiple companies).
- Information from the Medical Information Bureau (MIB) can also help detect fraudulent activity. The Insurance Activity Index (IAI) provides details on other applications, and MIB codes can help detect material misrepresentations. Extensive MIB activity can also help detect patterns of stacking, early lapse, churning, or rebating.
- Inspection reports, telephone inspections/interviews, and criminal records are additional investigative tools that can be valuable. Clients are often more forthcoming about their medical history during telephone interviews than when the agent is present.
- While one potential red flag may be nothing, multiple red flags should incite the underwriter to investigate thoroughly.
- Finally, fraud concerns should be communicated to management, and underwriters should follow their company's fraud risk management guidelines and plan.

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