Face to Face
Fraudulent relationships in general insurance

What you don’t know may be hurting you...
This is the second in a series of articles prepared by PwC Jamaica which considers how general insurance companies can respond to the rising threat of fraud. In our previous article, we examined the likely erosion of profit of the general insurance industry as a direct result of fraudulent activities and suggested a framework that insurance companies could use to begin to mitigate those risks. In this article, we take a look at the elaborate ‘web’ of relationships which exist, or are created, from insurance contracts and transaction processing. We also examine how the management of these relationships is a critical component of an insurance company’s arsenal against fraud.

Fraud is on the rise! The risk and incidence of fraud invariably increases at a time of recession or economic downturn and according to the latest Economic Crime Survey (ECS) carried out by PricewaterhouseCoopers, it is estimated that in excess of 6% of a company’s overall turnover is lost to fraud.

The complex nature of insurance transaction processing, including the extent of reliance on third party service providers, such as assessors, brokers, et. al., makes insurance companies highly susceptible to fraud within and along its value chain.

While the typical insurance contract is between an insurance carrier and the insured party, numerous potentially ‘independence impairing’ relationships exist, given the need to place reliance on information which has to be provided by other stakeholders. These relationships include those between and among insured parties, the company’s employees, insurance brokers and agents, repairers, damage assessors, investigators and other third parties.

In a typical general insurance claim there are a number of relationships and participants and the flow of information or funds between them opens the door to the potential of fraud, most notably through collusion. Imagine a case where the insured party pays a ‘willing’ damage assessor a sum of money to verify damages in excess of the actual amount – thereby allowing for the exaggerated claim to go through to payout. Given the nature of the industry, the insurance company relies on the trustworthiness of the damage assessor; however, this creates opportunity for deception. A recent UK ABI study found that claim exaggeration, where various mechanisms are employed to purposefully inflate the amount or value of an otherwise legitimate claim, accounted for 85% of fraudulent claims. Many of these frauds may have been facilitated by collusion between insured parties and employees and/or third party service providers.

Compounding the web of interrelationships which exists and acts as a breeding ground for fraud are the broader factors which create the greater impetus for fraudulent collusion, in particular the economic downturn. There is some correlation between fraudulent claims and a period of recession. The risk during such periods is
not just from customers; it includes management, staff and those who operate along the value chain who are also feeling the crunch and are looking out for 'opportunities' for fraud.

**What can you do - Protection mechanisms against “the enemy within”**

There are steps you can take to mitigate the risks discussed above. These include:

- Establish an appropriate fraud prevention and detection framework. The components of this framework include assessing the fraud culture of your company, performing fraud risk assessments and fraud audits and should include the implementation of a “whistle-blower” policy and mechanism, to facilitate reporting of suspicious activities and suspected fraud. We have a free-to-use fraud diagnostic tool available for you at [www.surveymonkey.com/s/FraudDiagnostic](http://www.surveymonkey.com/s/FraudDiagnostic). Take the test and see where your organisation currently stands.

- Identify your specific areas of vulnerability and implement anti-fraud controls to mitigate those risks. These controls may be preventative or detective in nature. These controls should include identifying the specific “red flags” for the schemes and implementing mechanisms for identifying those “red flags” and escalating them to an appropriate level within the organisation. For example, if you rely heavily on external damage assessors, you could require that photographs of damages be taken by the assessor using equipment that prevents or facilitates detection of tampering of images. Your employees could conduct random inspections and investigate any cases where the inspections yield results which are inconsistent with the images received. Alternately a sample of damage assessments could be anonymously checked by another assessor or an internal staff with the required expertise.

- Establish robust anti-fraud controls with respect to your employees by having sound recruitment policies and ongoing training. In addition, consider the strength of the related policies at your third party service providers and periodically obtain audit reports for these areas.

- Develop and implement independence and ethics policies and requirements for your employees and establish whether similar policies exist at your third party service providers. These policies should include restriction from processing or handling policies and transactions pertaining to connected persons. Breaches of these policies should carry relevant and appropriate consequences.

- Require that your employees and third party service providers declare their relationships. Also revise insurance application forms to include questions for the insured party to declare knowledge of relationships at the insurance company or third party service providers. Require an annual declaration on renewal of the policy. Develop a database of connected persons to facilitate discovery of and availability of a record of key related party information. Implement appropriate penalties and sanctions for non-disclosure. Ideally, the core insurance application should facilitate flagging of the policies of connected parties in order to facilitate specific monitoring.

- Conduct robust statistical evaluation of claims history and other statistical information by broker, agency, claimant, third party, etc. Investigate unusual relationships.

- Maintain and improve dialogue with industry partners regarding customers, third party providers and former employees to ascertain if, for example, individuals have been convicted of fraud.

In the next article, we will explore the risks of Management Overrides. In the meantime, if this article raises any concerns for you about your organisation or if you would like any more information on anything discussed above, please feel free to contact any member of our team using the information overleaf.

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