Appearances are deceptive

Insurance fraud in Slovenia

Everything will be alright.

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Contents

1. Foreword *3*
2. Summary *4*
3. Basic information regarding insurance fraud in Slovenia *6*
4. Research *15*
5. Insurance fraud trends *20*
6. Fraud schemes *23*
7. Fraud reporting hotline *25*

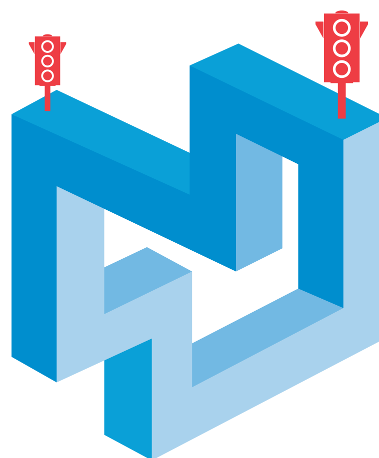
Foreword

The insurance industry is based on trust between an insurance company and its policyholders. That trust is being increasingly tested due to cases of insurance fraud. In order to maintain this trust, activities focused on the continued fight against insurance fraud are essential, since this is the only way we can protect honest policyholders from higher insurance premiums.

The world is becoming increasingly complex and intertwined, which is reflected in the boldness of insurance fraud schemes. Therefore, advanced technologies built on long years of experience will be of increasing importance in the future.

In order to maintain and strengthen the trust between an insurance company and its policyholders, it is important to understand that insurance fraud is not a phenomenon that only affects honest policyholders; it also affects the entire insurance industry and harms all parties involved.

There are many good solutions and practices in place on well-developed insurance markets. Zavarovalnica Triglav has therefore begun to introduce those solutions and practices in its operations. The company has introduced a number of new features in recent years to prevent, detect and investigate insurance fraud, which allow it to promptly and accurately detect complex cases of fraud involving several participants over a longer period of time that even a well-informed appraiser cannot detect. By using systematically developed indicators during the actual underwriting of an individual insurance policy, the company will be able to quickly and reliably warn of the increased risk of fraud when assuming insurance risks and thus bring attention to obvious irregularities.



The good news is that Slovenian insurance companies have been dedicating an increasing amount of attention to preventing insurance fraud in recent years. One step was to upgrade systemic frameworks, while the next step in this area is to ensure the appropriate regulation of data exchanges, which will contribute to the increased effectiveness of insurance companies in the detection and investigation of insurance fraud. Since information is an extremely sensitive subject in this day and age, security standards are introducing additional safeguards against the abuse of policyholders' personal and other confidential data. The legislation in force has yet to strike the right balance in this area. For this reason, cooperation between insurance companies, the police and prosecutors is limited, while the situation in international investigations is even more complicated. Fraudsters exploit the entire official framework to their own benefit, paying no regard to national borders and other legal restrictions. For this very reason, clear guidance on the detection of insurance fraud is required. This would mean that appearances might not be so deceptive in the future.

Summary

In Slovenia, insurance fraud is viewed differently to other cases of fraud, as many people believe that insurance fraud is less of an issue and that the individual is not subject to any consequences. Decisions to commit insurance fraud may be made for various reasons, usually due to a pressing need for money, financial difficulties or a random opportunity.

Most common forms of insurance fraud

This document presents the most common forms of insurance fraud, categories of fraud, key data regarding the detection of fraud at Zavarovalnica Triglav and specific examples of fraud schemes. It also includes the results of research on the perception and understanding of the consequences of insurance fraud. The aim of the research was to determine the general public's attitude towards insurance fraud in Slovenia and a general understanding of the subject of fraud. Even though our knowledge has been gained over long years of experience, we also asked experts from different areas for their opinions on insurance fraud.

There are many good solutions and practices in place on well-developed insurance markets. Zavarovalnica Triglav has therefore begun to introduce those solutions and practices in its operations in recent years with the aim of detecting incidents of fraud promptly and accurately. Zavarovalnica Triglav established the Fraud Prevention, Detection and Investigation Department (FPDID) in 2010, thereby becoming the first Slovenian insurance company to use software that automatically recognises various incidents of suspicious claims.

Zavarovalnica Triglav has adopted a zero tolerance policy for fraud, and every employee has the opportunity and obligation to report fraud through various channels (anonymous reporting, and reporting via email or telephone).

The activities and success of the FPDID are mainly reflected in the encouraging rise in the number of cases of fraud detected.

The Slovenian insurance industry is expected to follow the technological development of the company in the future. By that we primarily mean the progress made by insurance companies as they will have rapidly improving software for detecting and preventing fraud at their disposal. On the other hand, insurance fraud will continue to occur in areas where less information and fewer advanced technologies are available. The future will see less personal contact with policyholders in some segments, as the role of internet sales continues to expand. At the same time, this means an increase in new opportunities for fraudsters.

We are pleased that Slovenian insurance companies are dedicating an increased amount of attention to preventing insurance fraud. We are also striving to ensure increased effectiveness in detecting and investigating insurance fraud through systemic frameworks.

Reporting fraud through various channels

General information about insurance fraud in Slovenia

Insurance fraud is a pressing social issue in Slovenia and throughout the world. The underlying motive for every case of fraud is undoubtedly a pressing need for money. Some choose to commit insurance fraud due to financial difficulties, while for others it represents an opportunity that they choose to exploit. The most contentious reason is a premeditated decision to defraud an insurance company, primarily by organised crime groups.

In Slovenia, insurance fraud carries a punishment of up to one year in prison if the act was merely planned and not yet carried out. If the fraudulent event has already occurred, the perpetrator may be sentenced to up to three years in prison. If the insurance fraud was committed by an organised group, the individuals involved may receive even higher sentences.

Slovenes view insurance fraud differently to other forms of fraud. **The prevailing public opinion is that insurance fraud is a "crime with no real victim", and that claims filed by fraudsters only harm insurance companies.** The majority of Slovenes are also mistrustful of insurance companies as a rule because they believe that insurance companies already exploit their position in one way or another. It is therefore deemed less contentious if individuals seek their own way to extract the maximum benefit from insurance companies in specific cases, even if that act is not completely honest.

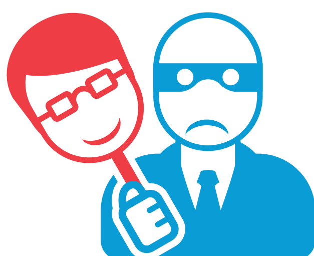
According to the Criminal Code of the Republic of Slovenia (Article 211 of the KZ-1), insurance fraud is deemed a criminal offence if the perpetrator provides false information or omits material information when entering into an agreement, concludes illegal double insurance or enters into an insurance agreement following the occurrence of an insurance or loss event. In order to criminally prosecute a perpetrator for such conduct, it is first necessary to prove that they intended to gain some unlawful material benefit for themselves or another person in that way.

FORMS OF INSURANCE FRAUD

Fraud can be categorised as **planned** and **opportunistic**. The absence of a full insurance case is characteristic of the former. If during an investigation the signs of a criminal act are identified and proven, criminal charges are brought against the perpetrator, as the latter's intent in this form of fraud is evident. An intentional act of this kind can lead to a custodial sentence.

The reporting of false circumstances is most characteristic of opportunistic or "soft" fraud, the aim being to secure the highest possible payment from an insurance case. This form of fraud is difficult to prove, as all the signs of a criminal act must be specified. Such cases are typically resolved under contractual provisions in court proceedings. This form of fraud is more expensive to insurance companies in terms of costs, and significantly more prevalent than planned fraud.

TYPES OF FRAUDSTERS



1. OPPORTUNISTIC FRAUDSTERS

- The most common perpetrators of insurance fraud.
- They alter their claims so that the damage reported is greater than the actual damage sustained.
- They provide erroneous data (e.g. the location) regarding a loss event.
- It is relatively simple to detect this form of fraud. However it is difficult to prove.

2. DELIBERATE FRAUDSTERS

- They cause damage or even harm themselves intentionally with the aim of claiming compensation.
- They frequently change insurance companies, hinder proceedings and repeat the same acts of fraud.
- It is easy to identify them but difficult to prove the fraud.

3. ORGANISED FRAUDSTERS

- These persons are the most willing to commit fraud and operate in a coordinated manner.
- They link themselves with insurance company employees and other experts.
- It is difficult for insurance companies to identify them and prove the fraud.

SITUATION AT ZAVAROVALNICA TRIGLAV

Zavarovalnica Triglav has implemented a number of measures in recent years aimed at preventing and detecting insurance fraud. We have thus:

- **introduced advanced strategies that limit and prevent fraud;**
- **invested in various software programs aimed at detecting fraud;**
- **set up a specialised department, the Fraud Prevention, Detection and Investigation Department (FPDID).**

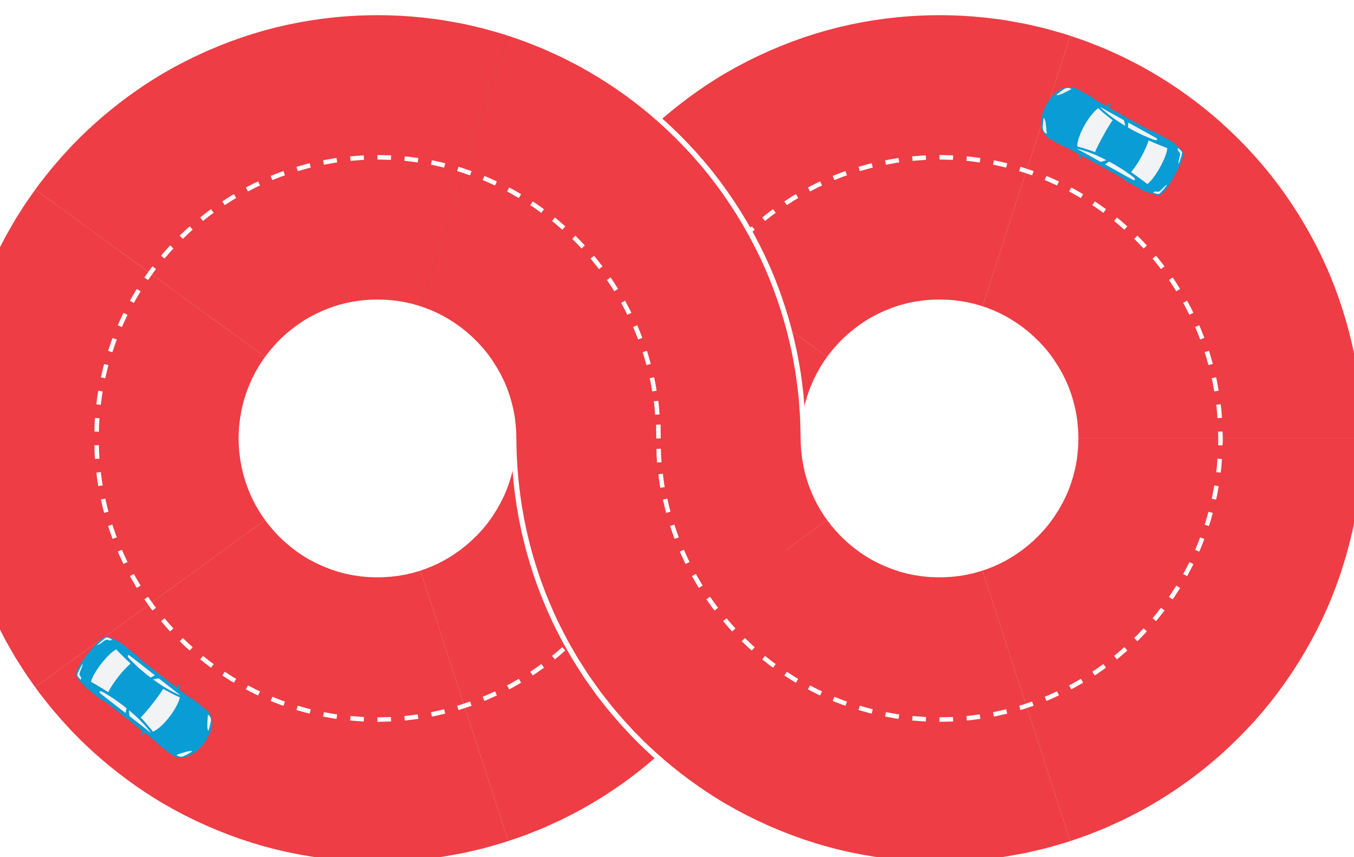
In special cases, we also work with private detectives and join forces with government authorities.

Insurance fraud arises in every insurance category, typically when underwriting or renewing insurance policies, and during the settlement of claims. The most frequent form of fraud is calculated fraud in the area of motor vehicle insurance, where an individual exploits an opportunity and reports damage that exceeds the actual damage sustained, intentionally damages or destroys an insured object, insures an object after a loss event has occurred, provides false data, submits false or altered documents, etc. In practice, we continue to see too many attempts of opportunistic fraud by persons who have never committed such an act, but may have been driven to do so by a weakened financial situation, which of course does not justify the act itself. It is truly unbelievable how some people are willing to risk putting their reputation as an honest person on the line for such small amounts. They cause damage to other policyholders and themselves, as they cast a shadow of doubt over honest policyholders who are otherwise worthy of trust. Of particular concern is the fact that the majority of the general public continues to accept such acts as something normal, passing judgement only on very rare occasions.

Damir Dragar, *Director of the Car Insurance Claims Department*

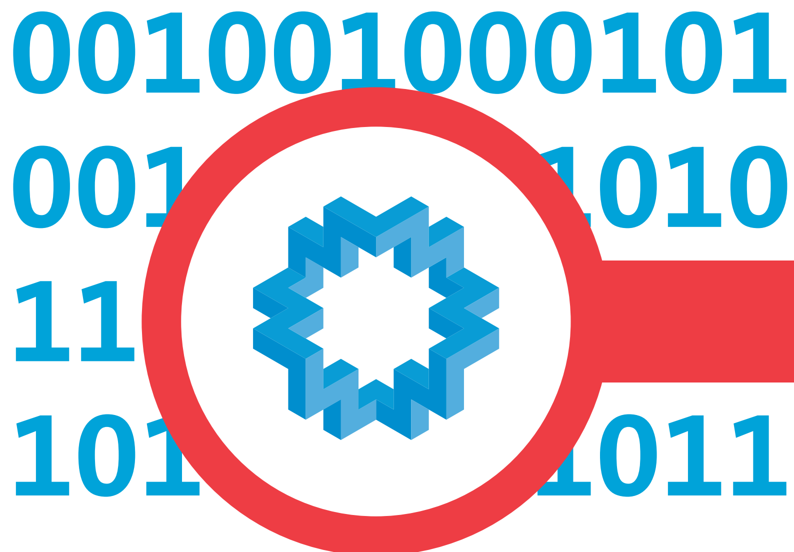
FRAUD PREVENTION, DETECTION DEPARTMENT AND INVESTIGATION

The FPDID has become a key systemic tool for preventing, detecting and investigating fraud.



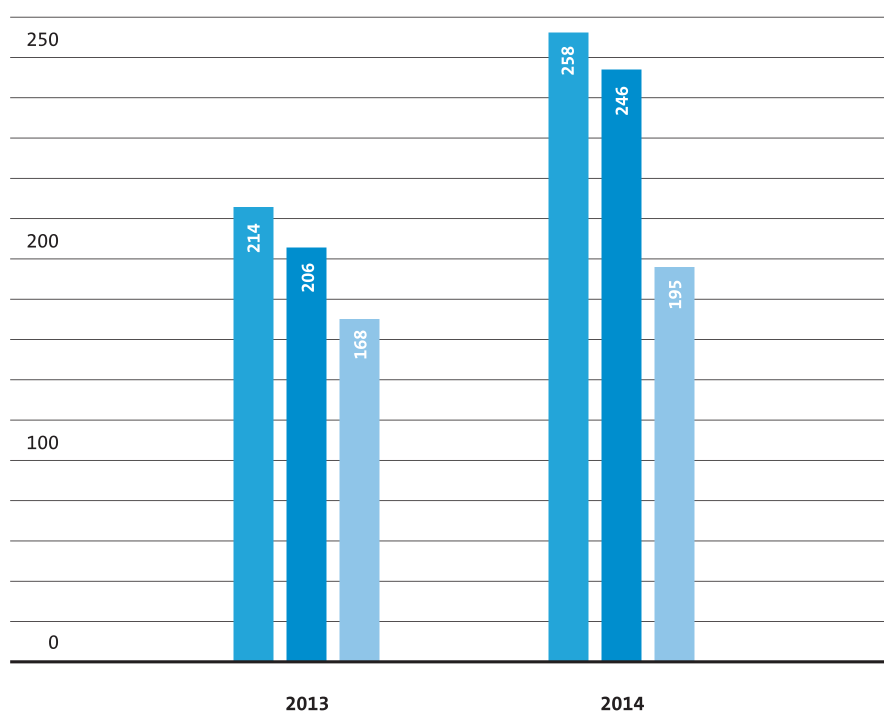
By establishing a new system, the FPDID handled around 600 cases in 2012. **The number of such cases was down 8% in 2013, while the number of cases handled in 2014 was up 4%.** The increase in the number of cases handled can be attributed primarily to the increased scope of work with advanced software and cooperation with other departments at Zavarovalnica Triglav, and the start of efforts to raise public awareness about the consequences of insurance fraud.

As early as 2012, we introduced a new feature within the FPDID, and became the first Slovenian insurance company to use 'POP module' software, which automatically recognises various incidents of suspected fraud. Through IT supported identification, analysts are able to transparently categorise individual suspicious cases by one or more key fraud indicators, numerous points of suspicion, types of insurance, values, etc.



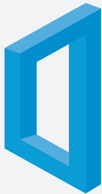
There was a 19% year-on-year increase in confirmed cases of insurance fraud in 2014.

Number of suspected fraud cases and instances of insurance fraud

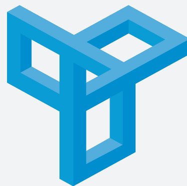


Confirmed suspected cases of fraud Insurance fraud Motor vehicle insurance fraud

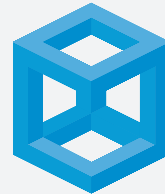
IN MOST CASES WE DEAL WITH THREE SEPARATE FORMS OF FRAUD



Misrepresentation of a loss event.



Submission of forged or altered documents, or completely false documents.



Inaccurate submission or exaggerating loss claim amounts.

“Insurance fraud was considered commonplace in the past. No one dealt with the problem or took steps to raise public awareness. It is extremely important that the general public knows that the few people who carry out such illicit acts are benefiting at the expense of those who do not. The problem does not lie with individuals who attempt to falsify damage to vehicles incurred in parking lots due to a combination of circumstances, but with well-organised groups of people who have benefited from the reporting of staged traffic accidents for a number of years.”

Jože Škrilec, *automotive industry expert – forensics*

In the area of car insurance we recorded a 20% growth in the value of confirmed cases of fraud and a 4% growth in the average value of fraud in comparison with the same period in 2013.

Confirmed suspected cases of fraud and insurance fraud

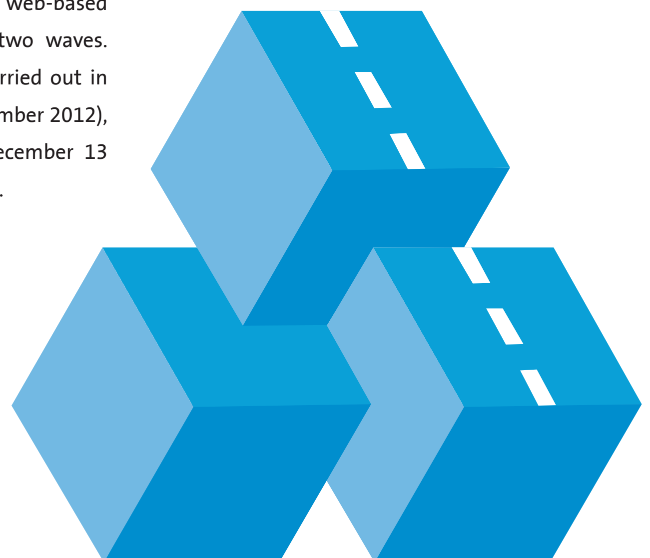
Research

Zavarovalnica Triglav's aim was to determine the general public's attitude toward insurance fraud in Slovenia and the consequences of their behaviour or specific conduct. In-depth awareness would support our continued fight against insurance fraud in Slovenia. We therefore polled the general public within the scope of the project "Research on the perception and understanding of the consequences of insurance fraud" in cooperation with the company Valicon.

RESEARCH ON THE PERCEPTION AND UNDERSTANDING OF THE CONSEQUENCES OF INSURANCE FRAUD

The first phase of the research was carried out even before Zavarovalnica Triglav had implemented activities to raise the awareness of policyholders and other stakeholders about the meaning and costs of insurance fraud. The latter were presented as part of internal and external communications, and by presenting the effects of the systematic introduction of the Fraud Prevention, Detection and Investigation Department. Following the completion of the second phase, we compared the appropriateness of our work and thus gained valuable information for future guidelines in this area.

A representative sample of 1,054 members of the general public (aged 20 to 65) was included in the research. The web-based research was carried out in two waves. The first measurement was carried out in September (from 4 to 10 September 2012), the second a year later in December 13 (from 11 to 14 December 2013).



First measurement
(4 to 10 September 2012)

The key findings of the first polling of the general public within the scope of the project "Research on the perception and understanding of the consequences of insurance fraud" were as follows:

- Slightly less than **one quarter** of those surveyed believe that anyone offered the opportunity to commit insurance fraud would do so.
- A total of **40%** of those surveyed know someone who has previously committed some form of insurance fraud.
- The majority of people do not take advantage of opportunities to prevent fraud. For example, 59% of those who have previously found themselves in a situation to prevent intentional insurance fraud did nothing about it, 28% called on the perpetrator not to commit such an act, while **only 13% reported the perpetrator to the insurance company in question.**
- According to those surveyed, the most contentious act among cases of insurance fraud was "intentionally causing damage with the aim of exploiting insurance benefits" (according to **95%** of those surveyed), while only 48% of those questioned deemed "exaggerating the amount of damage incurred" to be fraud.
- A total of **71%** of those surveyed believe that the perpetrators are people who are prone to dishonest behaviour. More than a third (37%) believe that fraud is committed by people in distress.

A total of 80% of those surveyed believe that entering into an insurance policy after an actual loss event has occurred is a criminal act of insurance fraud.

Second measurement
(11 to 14 December 2013)

The second measurement "Research on the perception and understanding of the consequences of insurance fraud" was carried out after the raising awareness campaign had been completed. Findings among the general public were as follows:

- A total of **41%** of those surveyed between the ages of 20 and 65 acted appropriately in specific cases of insurance fraud. That proportion was up 14% on the first measurement.
- In 40% of cases, people would state that they do not condone fraud. In **10% of cases, they would report the matter to the insurance company** in question, while people would report fraud to the police in 5% of cases.
- More than **one third** of those surveyed have already found themselves in a position in which they learned that someone had committed insurance fraud.
- The main reason for dissatisfaction with settled claims is insufficient compensation. This belief is shared by **58%** of those surveyed.
- A total of **80%** of those surveyed believe that entering into an insurance policy after an actual loss event has occurred is a criminal act of insurance fraud.

Classification of cases of insurance fraud when a case is identified as fraud

	Before	After
Intentionally causing damage	95%	93%
Completely fabricated event	97%	95%
Filing claims for events that the insurance does not cover	83%	84%
Underwriting insurance policies after damage has been sustained	82%	80%
Non-disclosure of information when underwriting insurance	67%	72%
Concealing information in the claim for the reimbursement of damage	57%	63%
Listing higher values than the actual damage in the claim for the reimbursement of damage	52%	60%
Exaggerating the amount of damage incurred	46%	48%
All eight instances constitute forms of fraud	**26%**	**30%**

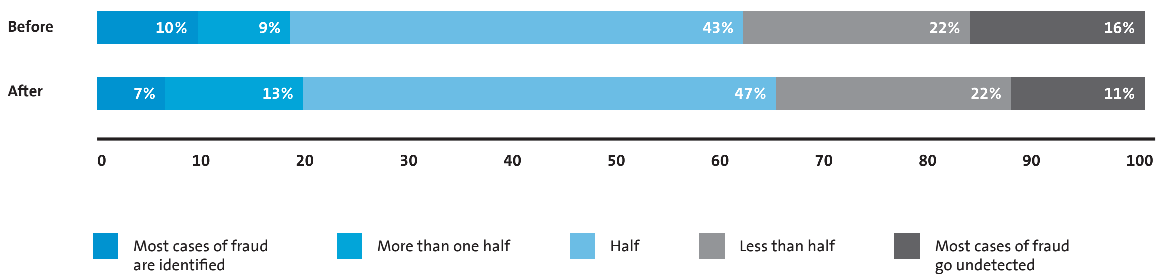
Changes in positions regarding insurance fraud or insurance companies

% accounts for the proportion of those surveyed who (completely) agree with the statement

	Before	After
If someone succeeds in defrauding an insurance company, it is a result of the latter's poor work.	53%	47%
People are not aware of the fact that insurance fraud is a criminal offence.	58%	64%
If people were aware of the fact that insurance fraud is a serious criminal offence there would be less cases of fraud.	54%	57%

Efficiency of insurance companies in identifying fraud

Insurance companies now identify 5% more cases of fraud.



Reactions prior to the fraud event – when an insurance agent/someone else hints of insurance fraud

	No previous experience		Previous experience	
	Before	After	Before	After
General public	94%	95%	6%	5%
Nothing	22%	22%	67%	65%
Expressed disapproval	45%	50%	30%	27%
Reported to the insurance company	27%	24%	4%	8%
Reported to the police	6%	4%	0%	0%

Reactions after the event – when someone has already committed insurance fraud

	No previous experience		Previous experience	
	Before	After	Before	After
General public	65%	69%	35%	31%
Nothing	14%	13%	45%	47%
Expressed disapproval	59%	64%	49%	49%
Reported to the insurance company	17%	16%	4%	3%
Reported to the police	10%	7%	2%	2%

As an external investigator and detective, I can attest to the fact that the results of the research are confirmed in the field. The majority of perpetrators who attempt to defraud an insurance company do so consciously: when a certain event occurs, they attempt to extract something from an insurance company. They decide to commit fraud because they think that the punishment for such an act is not sufficiently severe and they believe that such an act is not morally dubious. The majority of investigations are conducted in the area of motor vehicle insurance fraud, where individuals invent some event, such as a traffic accident. Cases of organised fraud also arise in cooperation with employees. The number of cases of accident insurance fraud has risen recently. In such cases, an individual is actually injured in one location and then files a civil liability claim against a dwelling or other insurance policy.

Janko Trivunovič, *private detective*

Insurance fraud trends for Slovenia (2015-2020)

The Slovenian insurance industry follows Western European trends with a delay of several years. The Slovenian insurance industry is expected to follow the technological development of the company over the next five years, and shift towards the development of innovative tools aimed at adapting insurance premiums in the motor vehicle insurance segment.

Insurance companies will have at their disposal an increasing amount of data regarding policyholders and their habits, transactions and other circumstances. On the one hand, this will facilitate more in-depth individual treatment and the adaption of insurance premiums and products to a specific policyholder. On the other hand, the processing of claims for damages will become simpler and faster for policyholders, while insurance companies will also contribute to a reduction in the possibility of traffic accidents occurring.

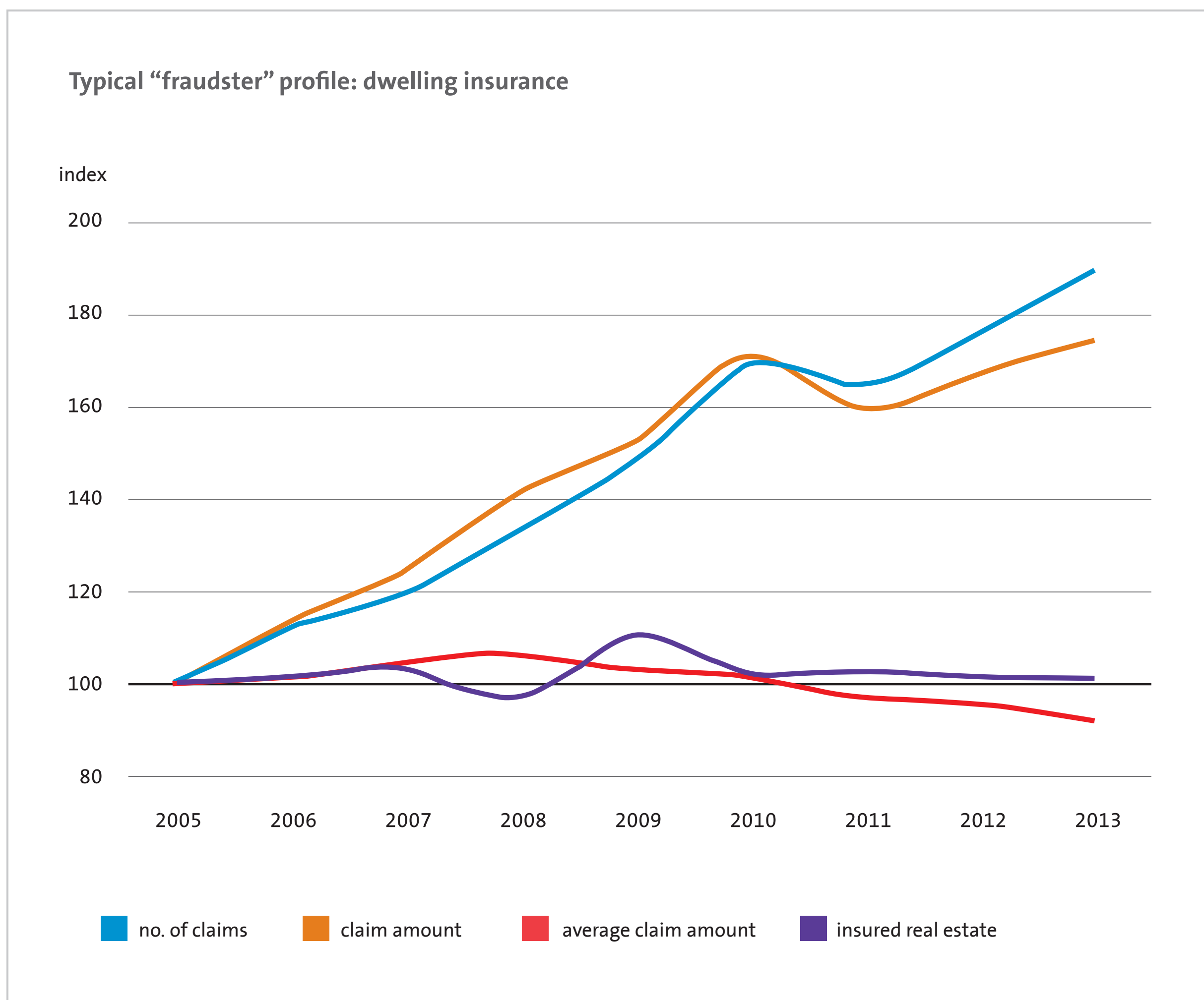
The development of smart devices, which play an increasingly more visible role in an individual's daily life, has already had a significant impact on insurance products. Modern equipment installed in today's cars facilitates access to a large collection of data about a car's history, driving style, number of kilometres driven, etc.

We can expect location services to become standard in the near future, which will facilitate the recreation of the actual course of events. This will also lead to additional control over and the automation of traffic, which will limit opportunities, primarily for opportunistic insurance fraudsters. This is particularly true in areas where the most information will be available from sources independent from policyholders.

Insurance fraud will occur in areas where there is less information and if the damage sustained depends primarily on a subjective assessment. Currently, this trend is extremely pronounced in Spain, where the underwriting of non-life insurance (dwelling insurance) has stagnated over the last decade, while the amounts and number of claims have risen sharply.

For a clearer illustration, we present the typical profile of fraudsters who have exploited this type of insurance, as there is less information regarding loss events in the area of dwelling insurance than in the motor vehicle insurance segment that can be corroborated by other sources. For this reason, the moral risk of the abuse of trust by a policyholder is that much higher.

Illustration of changes in the underwriting of dwelling insurance and the associated claims. Large gap illustrating potential cases of fraud in this insurance category.



Source: Spanish Private Insurers' Association; How the Economic Crisis Changes the Face of Fraud

The trend of technology's ever increasing impact on everyday life also brings new opportunities for fraud, as it is considerably easier to enter false data into a device than it is to provide the same directly to an agent, while opportunities to defraud policyholders also emerge.

New sales channels will be developed in parallel with the development of technologies. Internet sales and sales via mobile applications are expected to take on an increasingly important role in the simplest forms of insurance.

So-called "ghost brokers" are encountered frequently on markets where digital sales channels are more developed via web pages that falsely promise incredibly inexpensive insurance in exchange for immediate payment. Trends indicate that insurance fraud schemes will become more calculated and better planned with the development of highly advanced products and controls. As a result, such efforts on the part of fraudsters will demand a correspondingly higher claim. We can expect the amount of claims for damages to continue to rise in the context of individual cases of insurance fraud.

Fraud schemes

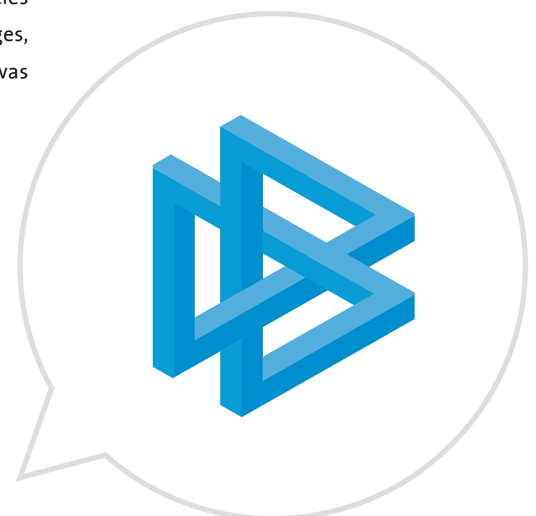
Zavarovalnica Triglav encounters fraud schemes every day, while the number of such schemes continues to rise. The company currently has 350 recorded fraud schemes, the majority of which involve the false or inflated insurance claims and the submission of falsified documents. For easier presentation, we have selected several of the most typical and obvious cases of motor vehicle insurance fraud.

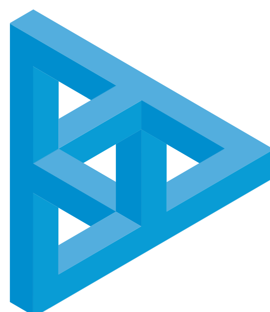
CASE 1: INCONSISTENT DAMAGES

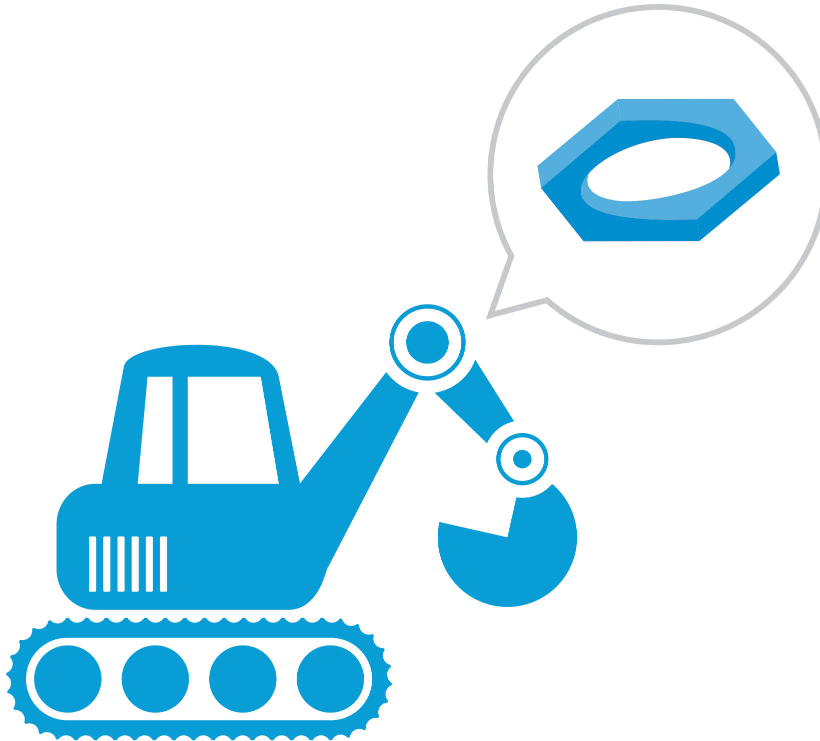
Those involved in an accident filed claims for damages that were inconsistent with the actual damage sustained to the vehicles involved.

The parties claimed that a smaller car caused the accident in question, causing damage to a higher-priced vehicle. After examining the damage to the vehicles involved and the claim filed for damages, it was obvious that the damage was inconsistent with the claim.

The fraudsters attempted to repair or gain as much as possible for the damage to the more expensive vehicle at the insurance company's expense. The less expensive vehicle is alleged to have incurred EUR 150 in damages and the more expensive vehicle EUR 9,000 in damages.







CASE 2:
FORGED CHASSIS NUMBER

In this case of fraud, a forged chassis number was first attached to a work machine, which was then insured. The fraudsters then used a previously damaged machine to which they attached the forged chassis number of a machine that was actually insured, and filed a claim for damages with the insurance company.

CASE 3:
FALSIFIED INVOICES (POST-DATING)

A policyholder insured a machine for repairs abroad. The problem was that the machine in question was already abroad for repairs when the insurance policy was underwritten. These costs were not covered by the policy in question. For this reason, the policyholder decided to falsify invoices by altering the associated dates with the aim of proving to the insurance company that the damage did not occur until after the insurance policy was underwritten. We detected the fraud in this case by comparing submitted documents with those received directly from the foreign company that performed the repair work.

Fraud reporting hotline

In 2009 Zavarovalnica Triglav adopted a zero tolerance approach to fraud, thereby clearly communicating its commitment to actively ensuring fair, responsible and lawful operations.

The company's fraud management policy is based on three pillars:

- **prevention,**
- **detection, and**
- **investigation of fraud.**

Pillars of defence against fraud extend to all of the insurance company's operational processes, and facilitate the handling of incidents of fraud throughout its operations.

Through the management of insurance fraud and other types of criminal acts, the company reduces its own costs and the costs incurred by policyholders. You too can also contribute to the more efficient prevention, detection and investigation of fraud.

LET US KNOW OF ANY ATTEMPTS TO COMMIT FRAUD OR ACTUAL CASES OF FRAUD BY:

+386 1 474 7444

sporp@triglav.si

http://www.triglav.eu/en/reportafraud