CRI|GROUP
Corporate Research and Investigations

ebook

INSURANCE FRAUD CASES UNCOVERED

From fake hospital bills to getting burned by false house fire claims these case studies are examples of why it is important to investigate insurance claims. This ebook is the perfect primer for any insurance fraud professional and companies looking to avoid becoming victims of insurance fraud claims. It provides the tools and knowledge needed to effectively combat insurance fraud.

INTRODUCTION

Insurance fraud is a worldwide problem. It represents a serious crime that can result in serious consequences for fraudsters' victims. Moreover, every type of insurance is vulnerable. In this publication, we examine two insurance fraud case studies, revealing how they were discovered and what went wrong.

The reality is that insurance fraud cases are often committed by opportunists, and sometimes the perpetrators work in teams to conduct such frauds. In fact, there are well-known cases of highly organised criminal gangs committing insurance fraud. But fraud can happen at any point along the process of an insurance claim, by insurance applicants, members/policyholders, third-party claimants or others (including professionals who specialise in pursuing claims for policyholders).

Insurance fraud cases cover a wide range of schemes and crimes, and every scheme represents a potential liability for the victim organisation. Due diligence and fraud prevention programs must extend to insurance fraud at every level to help organisations be better protected.

Insurance fraud is a serious problem, and organiations in the industry need safeguards in place to be protecting from various schemes. When fraud is suspected, experts are needed to unravel the facts – in two recent cases, CRI Group investigators did just that.

INSURANCE FRAUD CONSEQUENCES AROUND THE WORLD

Insurance fraud costs an estimated $40 to $80 billion per year in the U.S. alone. According to Cifas, the UK's leading fraud prevention service, members report a 27% rise in false insurance claims across the UK in the past year, with spikes in household and motor insurance. Cifas members also reported the following:

- Household insurance fraudulent claims have increased by 52%, with claimants aged 31-40 the biggest culprits motor insurance
- Fraudulent claims have increased by 45%, with 21-30 year-olds making up the largest group
- Fronting insurance is on the decline overall, however the share of millennials (21-30 year-olds) committing the offence increased by 18% in 2018.

Insurance fraud is deliberately undetectable, therefore it s hard to place an exact value on the money stolen. According to Alfred Manes' "Insurance Crimes" in the Journal of Law and Criminology, the official number of cases does not correlate with the reality. The Coalition Against Insurance Fraud Annual Report estimates that a total of about $80 billion was lost in the United States in 2006. Insurance Information Institute estimates that the insurance fraud accounts for about 10% of the property insurance industry's incurred losses and loss adjustment expenses.

The National Health Care Anti-Fraud Association's "The Problem of Health Care Fraud" estimates that 3% of the health care industry's expenditures in the U.S. are due to fraudulent activities, amounting to a cost of about $51 billion. David A. Hyman writes in "Health Care Fraud and Abuse" estimates that 10% of the total healthcare spending in the US to fraud—about $115 billion annually.

Consider these statistics:

- According to Federal Bureau of Investigation's "FBI — Insurance Fraud," non-health insurance fraud costs an estimated $40 billion per year - consequently this increases the premiums for the average U.S. family between $400 and $700 annually.
- J.E. Smith's book "The Trillion Dollar Insurance Crook" puts the true cost fraud committed in the US at 33% to 38% of the total cash flow through the system.
- In the UK, the Insurance Fraud Bureau estimates that the loss due to insurance fraud is about £1.5 billion ($3.08 billion), causing a 5% increase in insurance premiums.
- Insurance Bureau of Canada "Cost of Personal Injury Fraud" estimates that personal injury fraud costs about C$500 million annually.
- "Indiaforensic Study on quantification of fraud losses to Indian Insurance Sector" estimates that Insurance frauds in India costs about $6.25 billion annually.

THE 10 MOST COMMON TYPES OF INSURANCE FRAUD

In case you think that fraud is limited to automobiles and healthcare, consider all of the types of insurance that are available – and know that all of them are susceptible to fraud. In fact, insurance fraud investigators from Business insurance have provided a list titled "10 Most Common Types of Insurance Fraud." These cases even include staged home fires and faked deaths:

Car damage

Staged home fires

Health insurance billing fraud

Storm fraud

Faked death

Abandoned house fire

Car accident

Renter's insurance

Unnecessary medical procedures

Stolen car

WHAT IS INSURANCE FRAUD?

It's been called an epidemic and is a scourge of insurance providers, private companies and consumers alike. But what is it, how do companies detect it, and how does an insurance fraud investigator unravel it? In this part one of a three-part series, we will address the first question: What is insurance fraud?

Most of us deal with insurance in various forms throughout our lives. It's a necessity in some cases through which we pay regular premiums in order to be protected from damages or liability from an unknown future event, such as an accident or illness. For large corporations, insurance can be worth millions, covering things like product liability, workers' compensation, business interruption and other serious risks. It's also rife for fraudsters, who often live by the well-known maxim, "follow the money."

Every type of insurance is vulnerable to insurance fraud. Insurance fraud cases can be committed by opportunists – consider claim fraud, where perpetrators invent or exaggerate a claim; or application fraud, where they deliberately or recklessly provide false information when applying for insurance.

There are well-known insurance fraud cases of highly organised criminal gangs with money-making enterprises based on motor-vehicle fraud or health care fraud, for example. But fraud can happen at any point along the process of an insurance claim, by insurance applicants, members/policyholders, third-party claimants or others (including professionals who specialise in pursuing claims for policyholders).

Insurance fraud cases also cover a wide range of schemes and crimes. The following are some of the most common types of fraud involving the insurance industry, according to the ACFE's "Insurance Fraud Handbook":

- **Agent and broker schemes**
- **Underwriting irregularities**
- **Vehicle insurance schemes**
- **Property schemes**
- **Life insurance schemes**
- **Liability schemes**
- **Health insurance schemes**
- **Worker's compensation schemes**

Fraudsters find new ways to pull off their scams, from simply falsifying claims to engaging in mail fraud, identity theft, and forgery, they will make it happen. For example, when looking at just motor vehicle-related insurance fraud, the types of schemes include the following:

- **Vehicle dumping or destroying**
- **False registration**
- **Exaggerated repair costs after a car accident**
- **Faulty airbag replacement**
- **Faulty windshield replacement**

All of the above is intended to enrich the fraudsters at the expense of insurance providers, and, in some cases, other innocent victims. People have even been injured in schemes that involved faked traffic accidents for the purpose of insurance fraud.

INSURANCE INDUSTRY - OVERVIEW

Every type of insurance is vulnerable to insurance fraud. Insurance fraud cases are often committed by opportunists – such as claim fraud, where perpetrators invent or exaggerate a claim; or application fraud, where they deliberately or recklessly provide false information when applying for insurance. There are well-known cases of highly organised criminal gangs with money-making enterprises based on insurance fraud.

Insurance fraud cases cover a wide range of schemes and crimes, intended to enrich the fraudsters at the expense of insurance providers and other innocent victims. With the enormous liability presented by insurance fraud, every organisation should address the risk in their due diligence and fraud prevention programs.

The experts at CRI Group are positioned to help any organisation, including captive insurance companies, domestic, alien, Lloyds of London, mutual and stock companies implement this as part of a risk management plan.

When fraud is detected, CRI Group's investigations cover the full range of insurance fraud cases, from healthcare fraud to disability and even fake death claims. CRI Group's experts are thoroughly trained, for example, to look for the tell-tale signs of fraud through carefully reviewing claims, medical and hospital records, conducting interviews, examining statements and documents and performing on-site inspections. Our agents leave no stone unturned when investigating suspected insurance fraud.

Learn more about how insurance fraud investigation services can help your business.

Case Study:
THE HOUSE FIRE

CRI Group was contacted to investigate an insurance claim for a house that allegedly burned to the ground. When CRI Group's investigator attempted to visit the reported address, he discovered an immediate problem: there was no such house number, and no such house.

With suspicions raised, further investigation led to a different location, claimed by the "victim" – indeed, a there had been a fire incident at a house in the "new" location, but there was one problem – the claimant actually lived in the house next door. For final confirmation that the incident was an attempted fraud, our investigators established that no police report supported the claimant's story.

CRI Group's experts carefully documented evidence, interviewing the subject and witnesses (including the neighbors) to establish a timeline and the facts of the case. Investigators used property records, police reports, photographs, witness statements and other evidence to create an airtight case should the matter be brought to court.

The client was informed of the results of the investigation, including the evidence mentioned above for possible use in court. In the end, CRI Group's agents had used a list of resources including police reports, court filings, database records and other means to establish the truth.

7 RED FLAGS OF FIRE LOSS INSURANCE CLAIMS:

Does the claim include expensive property, often newly purchased without documentation, allegedly destroyed along with the home?

Is sentimental property suspiciously not listed among the missing/destroyed property?

The claimant cannot provide detailed descriptions of the destroyed property or where it was purchased?

Does the documentation provided by the claimant looks altered or irregular?

What the claimant claims in property loss does not match the physical site?

The claimant refuses to answer questions, or gives confused or inconsistent answers?

The claimaint fails to provide additional documentation when asked, even if he promises to do so?

If your answer is yes to any of these red flags, then you may have a case of insurance fraud in your hands.

3 LESSONS LEARNED

- Claims should be verified with **in-person visits and investigations.**
- Witness and other principals should be interviewed, not just the subject/claimant.
- If something seems amiss, it probably is – heed the red flags of fraud.

SOLUTIONS

CRI Group's experts will use all resources available, including police reports, court filings, database records and other means to establish the truth in insurance fraud cases. Investigators properly and carefully collected evidence in a forensic manner for use in court.

Even after the fraud was discovered, CRI Group's investigators worked diligently to gather and document all of the findings to present to the client.

CRI Group worked with the client to analyse risk factors for similar insurance fraud cases and those that might deal in different types of deception.

HEALTHCARE INSURANCE FRAUD - OVERVIEW

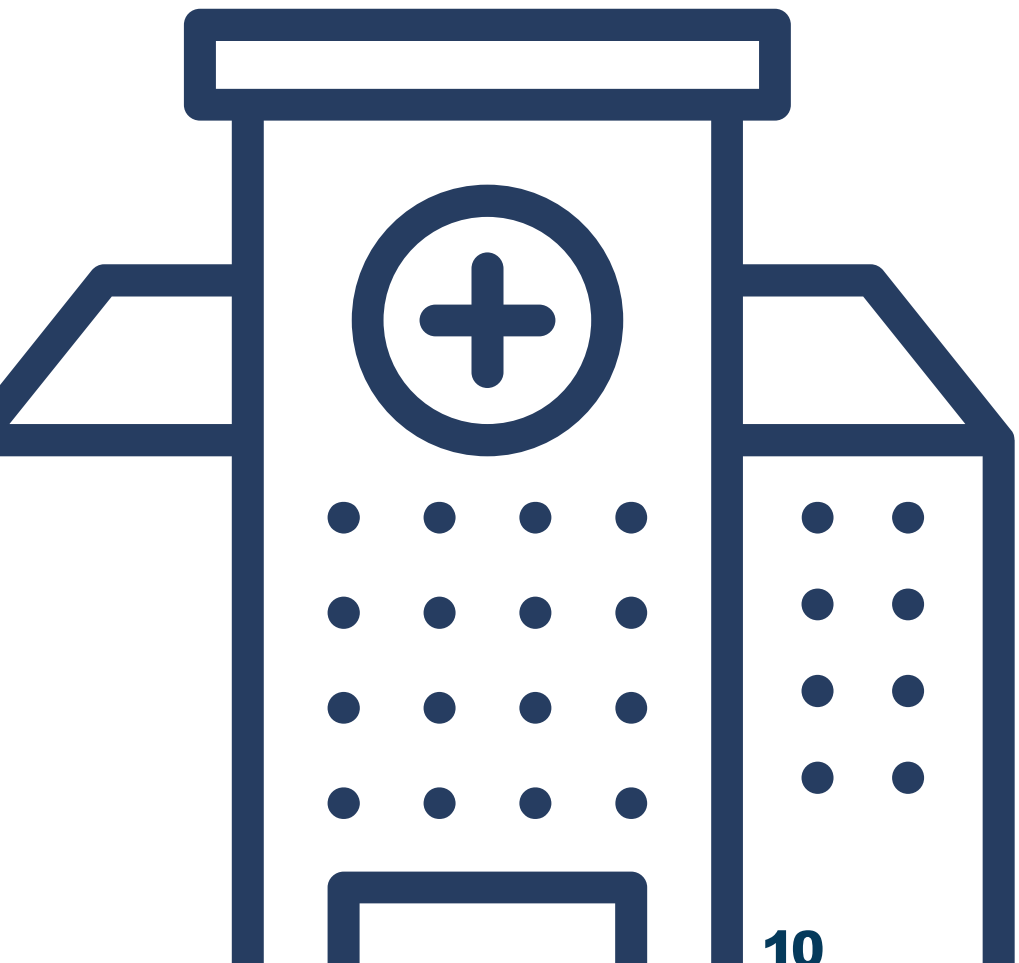
Fraud involving pharmaceutical companies and healthcare providers constitutes a major source of economic waste affecting countries around the world. In spite of increased awareness of the problem and the application of sophisticated anti-fraud mechanisms, individual actors and agencies continue to defraud public and private health systems.

With rapidly ageing populations and the increased costs of providing long-term care placing substantial pressure upon already overburdened health and social care sectors, healthcare spending will continue to increase worldwide. Unfortunately, this will also bring increased fraud schemes, as fraud perpetrators follow the money – and healthcare presents a target-rich environment.

Quantitative data indicates that healthcare fraud has already risen starkly. The World Health Organisation (WHO) estimates that, where losses have been measured and the types of health expenditure have been covered, the average annual cost of fraud totals 7.29% of healthcare budgets (Gee and Button, 2014).

CRI Group's fraud investigators (including forensic accountants and Certified Fraud Examiners) look for red flags and vulnerabilities that may indicate healthcare fraud. CRI Group's experts have uncovered schemes including billing for services not rendered, up-coding of services, up-coding of items, duplicate claims, unbundling, excessive services, unnecessary services, kickbacks and more. In addition, pharmaceutical companies face the threat of counterfeit medications, which can lead to major financial loss, not to mention dangerous consequences for patients.

This is why the strictest measures and prevention strategies are needed for any pharmaceutical or healthcare organisation. Learn more about our solutions for your business.



Case Study:

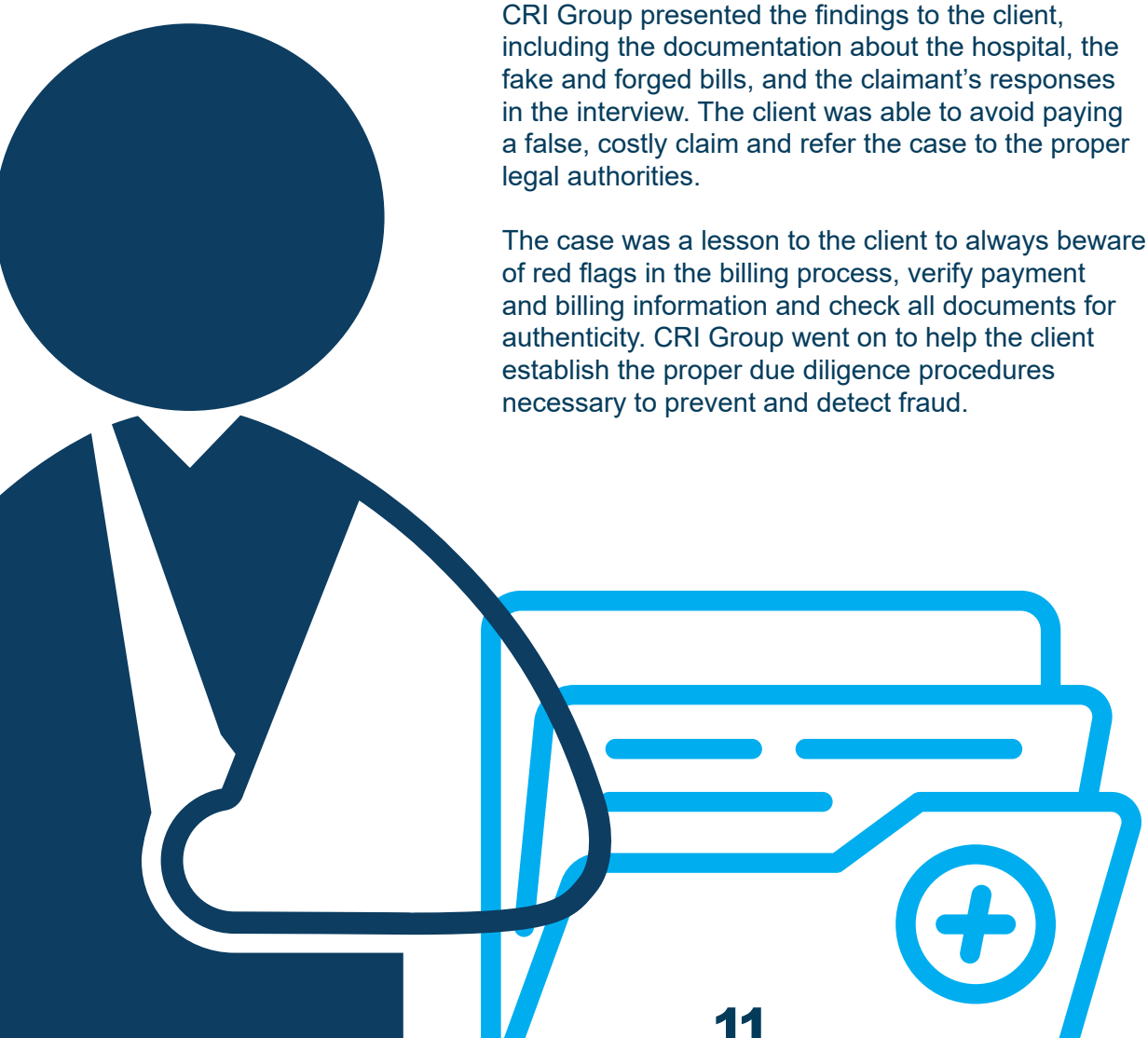
FAKE HOSPITAL BILLS

A CRI Group investigation to verify hospital bills revealed that the hospital in question was closed almost two years prior due to a dispute amongst doctors — and now existed at a different address, which was 10 km away from the address provided by the claimant.

Further inquiries confirmed that there was no record for the invoice and patient in the given dates (or any other dates). In the course of the investigation, it is also determined that the stamp on the bills is a fake, and the names on the bills are phony. When confronted with this evidence by CRI Group's investigators during an interview, the claimant admitted he had fabricated the claim and committed insurance fraud.

CRI Group presented the findings to the client, including the documentation about the hospital, the fake and forged bills, and the claimant's responses in the interview. The client was able to avoid paying a false, costly claim and refer the case to the proper legal authorities.

The case was a lesson to the client to always beware of red flags in the billing process, verify payment and billing information and check all documents for authenticity. CRI Group went on to help the client establish the proper due diligence procedures necessary to prevent and detect fraud.



4 RED FLAGS OF HOSPITAL BILLING INSURANCE CLAIMS:

- The bills appear irregular or documentation is incomplete?
- There is a history of claims by the subject for different, seemingly unrelated health procedures or treatments?
- Dates and locations for hospital visits seem unlikely or cannot be corroborated with verified records?
- The claimant avoids answering questions about the claim, or gives confusing or inconsistent answers?

If your answer is yes to any of these red flags, then you may have a case of insurance fraud in your hands.

For more on INSURANCE FRAUD - including the different types of investigation and their successful factors - check out our “The Unseen Enemy: Insurance Fraud” ebook here!

3 LESSONS LEARNED

- Always beware of red flags in the billing process - the fraudsters tried to exploit loopholes and lack of verification in bill payments
- Verify payment and billing information
- Check all documents for authenticity

SOLUTIONS

CRI Group's investigators checked records and addresses to confirm physical locations for the insurance claims.

When discrepancies were discovered, investigators dug deeper to verify documents. Bills were carefully scrutinised as forgeries and preserved as evidence for potential use in court. The subject was interviewed and, when confronted with the evidence, admitted the false claim.

CRI Group conducted an after-action insurance fraud risk assessment with the client to help find vulnerabilities and uncover other potential fraud cases.

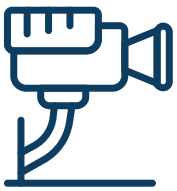
WHAT COMES NEXT?

Insurance fraud cases cover a wide range of schemes and crimes, and the red flags described above are just a few of the issues that insurance fraud investigation companies are trained to look for and uncover in the course of an investigation. In part three of this series, we will examine how CRI Group's insurance fraud investigators proceed when such red flags lead to fraud, and it's time to launch an investigation.

CRI Group's investigations cover the full range of insurance fraud cases, from health care fraud to disability and even fake death claims, always with the goal of providing the best resolution for our clients.

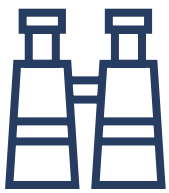
7 STEPS YOU CAN TAKE NOW TO PROTECT YOUR BUSINESS AGAINST INSURANCE FRAUD:

Buy enough coverage to protect your company assets.



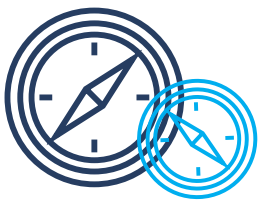
Add surveillance cameras to record “high-risk” areas.

Perform background checks.



Limit access to your inventory.

Check references provided by new hires.



Add dashboard cams to your service or delivery vehicles.

WHEN IT'S TIME TO OPEN AN INVESTIGATION?

When red flags of fraud are uncovered, it's time to begin an investigation. As you can see from the examples above, CRI Group's investigations are based on a thorough approach that includes site visits and leaving no stone unturned. When you work with CRI Group, this is how the process will typically proceed. CRI Group will:

- Assign the appropriate investigators with the right expertise in that area to investigate the claim.
- Contact the parties involved to gather all relevant details about the incident.
- Use all resources available, including police reports, court filings, database records and other means to establish the truth in insurance fraud cases.
- Make site visits, speak to witnesses, take photos and establish timelines as needed to create a full, truthful story of the incident.
- Uncover useful evidence, carefully documenting and preserving it in a way that is admissible in court.
- Present investigation findings to the client, with recommendations on how to proceed. Sometimes, legal action is warranted.

Working with an insurance fraud investigation company like CRI Group provides the advantage of having an independent, impartial and unbiased third-party collecting the facts you need regarding any case that might involve potential fraud.

CRI Group has been safeguarding businesses for more than 28 years, and you will be assured of the quality, professionalism and discreet nature of all investigations conducted by our experts.

Our global presence ensures that no matter how international your operations are, CRI Group's investigations have the network needed to provide you all necessary support, wherever you happen to be. We take great care to ensure that our trained and licensed investigators are the best at what they do.

INVESTIGATING INSURANCE FRAUD IS BEST LEFT TO THE EXPERTS

With the enormous liability presented by insurance fraud, every organisation should address the risk in their due diligence and fraud prevention programs. The best way to do that is to bring in the experts at CRI Group to help implement this as part of a risk management plan.

When fraud is detected, CRI Group's investigations cover the full range of insurance fraud cases, from health care fraud to disability and even fake death claims. CRI Group's thoroughly trained experts are trained, for example, to look for the tell-tale signs of fraud carefully reviewing claims, medical and hospital records, conducting interviews, examining statements and documents and performing on-site inspections.

Insurance fraud is something that no company can afford. With our team of experts, CRI Group will be your active partner in investigating insurance claims through insurance carriers, self-insured corporations, third-party administrators and insurance defense law firms.

CRI Group's investigators and researchers complete numerous insurance investigations each month, supporting clients with detailed evidence that is used in courts of law. The Insurance Claim Investigation Division specializes in the discreet and effective gathering of information to get you the answers you need.

CRI Group handles a wide range of insurance fraud investigations, including, but not limited to:

- Factual Claims Investigations
- Witness Statements
- Workers Compensation
- Background Investigations
- Disability Claims
- Asset Searches
- Motor Vehicle Injury Claims
- Liability Claims
- Medical Audits and Clinic
- Investigations
- Medical Fraud Investigations
- Property Claims | Death Verifications
- Travel Claims
- SIU Services
- Fraud Investigations
- Activity Checks

Explore all of our investigative solutions.

WHY CRI GROUP?

Since 1990, Corporate Research and Investigations Limited “CRI Group” has safeguarded businesses from fraud and corruption, providing insurance fraud investigations, employee background screening, investigative due diligence, third-party risk management, compliance and other professional investigative research services. CRI Group’s expertise will add to the diverse pool of business support services available within your region

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WHY WORK WITH US?

- CRI Group has one of the largest, most experienced and best-trained integrity due diligence teams in the world.
- We have a flat structure which means that you will have direct access to senior members of staff throughout the due diligence process.
- Our multi-lingual teams have conducted assignments on thousands of subjects in over 80 countries, and we’re committed to maintaining and constantly evolving our global network.
- Our packages are easily customisable, flexible and we will tailor our scope to address your concerns and risk areas; saving you time and money.
- Our team of more than 50 full-time analysts is spread across Europe, Middle East, Asia, North and South America and is fully equiped with the local knowledge to serve your needs globally.
- Our extensive solutions include due diligence, employee pre & post background screening, business intelligence and compliance, facilitating any decision-making across your business no matter what area or department.

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Zafar, Group CEO of Corporate Research and Investigations Limited (CRI Group), has been building a 30 years' career in the areas of anti-corruption, fraud prevention, protective integrity, security, and compliance. Possessing both industry expertise and an extensive educational background (MS, MSc, CFE, CII, CIS, MICA, Int. Dip. (Fin. Crime), CII, MIPI, MABI), Zafar Anjum is often the first certified global investigator on the scene when multi-national EMEA corporations seek to close compliance or security gaps.

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