A typological study of motor insurance fraud in Spain

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Co-operation between motor insurance companies so as to analyse the incidence of fraud is relatively recent in Spain.

The first data which were collected to analyse fraud typology are based on data given to the Sector Convention which was organised by the ICEA, and were published in 1995 and 1996.

There follows a summary of some of the conclusions which can be drawn from an analysis of 5,498 frauds which were detected by a Spanish insurance company in 1996.

A) The most frequently used methods to attempt fraud

Although the cases of fraud, or attempts to defraud, are many and varied, all have a common denominator: the falsification or concealment of information or circumstances in the notification or settlement of a claim, with the aim that the insured, or a third party, should obtain compensation which they would otherwise not receive.

Below is a list of the most common cases of fraud, which although not by any means exhaustive, gives a clear picture of many of the cases which occur.

1. False declaration to benefit a third party. - This is the most usual case of fraud, and was a factor present in 30% of the cases. This consists of the falsification of the claims form in which the insured declares himself to be the responsible party in order to «do someone a favour».

2. False declaration on the part of the insured so as to circumvent cases excluded in the policy. - This is again a very common case, and was a factor in 27% of the frauds which were detected. This includes all the cases in which facts or circumstances are concealed when a loss whose consequences would be excluded by the policy is declared.

3. False declaration so as to obtain benefit for the insured himself. - In this case it is the insured himself who intends to profit directly, and this was detected in 11% of the frauds which were uncovered.

4. Taking out a policy after the occurrence of the accident. - This was a factor in 6% of the frauds and implies the misleading and/or complicity of some employee or agent of the insurance company.

5. Others. - At lower percentage levels, there are other methods such as: concealment of alcohol intoxication (3%), false habitual driver (2%), repair-shop fraud (2%) and occasions when both implicated parties intend to claim (1%).

B) Circumstances which lead to the suspicion of fraud

It is practically impossible to determine all the situations, facts and circumstances which might be construed as signs indicating the possibility of fraud. Some aspects and situations which might be considered suspicious and would normally lead to investigation are given below:

1. Through loss adjusting. - This alone, or together with other methods, led to the detection of 61% of the frauds. When the adjustment was carried out it was found that:

– The damage did not concur with the mechanics of the accident.

– The configuration of the damage (height, trajectory etc.) did not tally.

– The traces of paint were not as they should have been.

– The age of the damage (rust, dirt, etc.) proved that this had occurred before the declared date.

– Strange deposits (grass, cement, earth, etc.) were found which did not concur with the way the accident was declared.

2. Through the account of the accident. - This was the second biggest factor in terms of suspicious circumstances and was a factor, by itself, or together with others, in 52% of detected cases. Special attention should be paid to this and the necessary clarifications should be requested when case details are being taken.

3. Very high levels of damage to the other vehicle. - This was a factor in 25% of the frauds which were detected.

4. Nervousness or contradictions when reporting an accident. - This aided in the detection of 9% of the frauds. This implies that it is necessary to employ a serene and firm attitude when clarifying the causes and consequences of the claims.

5. Others. - At lower percentage levels, there are other circumstances such as: time and date of the accident (6%), issue date of the policy close to the date of the accident (5%), notification by repair-shop (4%), etc.

C) Investigations and most efficient procedures

It is important to note that the investigation of possible frauds SHOULD NOT become an obsession to the detriment of client service, or lead to the non-fulfilment of contractual obligations.

It must be remembered that the vast majority of the insured DO NOT DEFRAUD, and that only those cases which have been adequately proved should be considered as definite frauds.

The most efficient methods and procedures are as follows:

1. Check the damage - this simple procedure uncovered 54% of the cases which were detected. This demonstrates the importance of adequate claims adjusting, extending even to all the vehicles which were involved in an accident when fraud is suspected.

2. Contact the other company - This has also proved to be a very efficient procedure, and led to the detection of 17% of the frauds.

3. Visit the site of the accident - this research led to the discovery of 14% of the fraudulent cases, showing the importance of this task.

4. Investigate whether the date of the accident is previous to that declared - this action led to the discovery of 9% of the frauds.

5. Others - at lower levels there are other types of investigations such as: localisation of witnesses (8%), information from recovery vehicles (4%), information from repair-shops (4%), etc.

We believe that the publication of data such as these and those provided by industry associations will help to reduce, or at least contain, motor insurance fraud.