Tightening the grip on insurance frauds finance essay

Finance

OnTightening the grip on insurance fraudsSubmitted to Amity University for the registration of the topic for MBA (Insurance & Banking) in ASIBASSession 2011-2013

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ACKNOWLEDGMENT

It gives me immense pleasure to convey my heartiest thanks Mr. I. J. Jain (Assistant Professor, ASIBAS), who extended his full &invaluable support in providing me with this excellent opportunity to learn through this project. I would also like to thanks Mr. Rajesh Verma (Assistant Professor, ASIBAS) for helping me out in research methodology work. My thanks and appreciations also go to my parents in developing the project and people who have willingly helped me out with their abilities.

DECLARATION

I hereby declare that the project report entitled " TIGHTENING THE GRIP ON INSURANCE FRAUD" submitted to the AMITY SCHOOL OF INSURANCE, BANKING & ACTUARIAL SCIENCE (ASIBAS), is a record of an original work done by me under the guidance of Faculty mentor, Mr. I. J. JAIN, AMITY UNIVERSITY, UTTAR PRADESH, and this project work has not performed the

basis for the award of any Degree or diploma/ associate ship/ fellowship and similar project if anySignature Signature(I. J. JAIN) Ashima SaxenaA2828411005

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INTRODUCTION

Insurance is important for every individual since it is designed to protect the financial well-being of a person and their dependents in the case of unexpected loss. Insurance can be defined as a contract where insurer (insurance company) agrees, in consideration of money, called premium, paid to him by insured or policyholder, to indemnify the latter against loss resulting to him in the event of a certain happening or to pay a certain sum of money in the event of a certain happening. . Put in simple words, insurance is a cover used for protecting oneself from the risk of a financial loss. It is important to understand that risk is a part of any person's life. Insurance is risk coverage against financial losses and should not be taken as an investment instrument.{1. 1} HISTORY OF INSURANCEInsurance has a long history in India. The Insurance sector in India governed by Insurance Act, 1938, the Life Insurance Corporation Act, 1956, General Insurance Business (Nationalisation) Act, 1972, Insurance Regulatory and Development Authority (IRDA) Act, 1999 and other related Acts. The first Indian insurance

company was the Bombay Mutual Assurance Society Ltd in 1870. The first life insurance company to be set up was English company, the Oriental Life Insurance Co. Ltd in 1818. The first general insurance company to be set up was Triton Insurance Co. Ltd in 1850. By the year 1956, when the life insurance business was nationalized and the Life Insurance Corporation of India (LIC) was formed on 1st September 1956, there were 170 companies and 75 provident fund societies transacting life insurance business in India. In 1972, the general insurance business was nationalized and its four subsidiaries named, National Insurance Company Ltd, New Delhi Assurance Company Ltd, Oriental Insurance Company and United Insurance Company Ltd were set up.{1. 2} INSURANCE MARKET - PRESENTWith such a huge population and the integral market area of this population insurance happens to be a very big opportunity in India. Today it stands as a business growing at the rate of 15-20 per cent annually. The insurance sector was opened for private participation four years ago. The insurance market have witnessed vibrant changes which includes presence of a large number of insurers both life and non-life segment. Most of the private insurance companies have formed joint ventures which are well recognized by foreign players across the globe.{1. 3} INSURANCE FRAUDAs long as there has been insurance, there have been insurance frauds. It is apparent that the frauds cannot be eliminated completely but they can surely be managed, controlled and kept in limits. Frauds are the main area of concern for every industry and similarly, insurance industry is also not granted; they are large number of frauds in insurance industry. In common language fraud is associated with dishonesty, breach of trust, misuse, etc. Fraud can be explained as " an

intention to deceive someone, in order to obtain some advantage". Insurance fraud occurs when any act is committed with the intent to fraudulently attain some benefit to which they are not otherwise entitled. E. g. Non disclosure of any material fact with an intention to either get reduced premium rates or get claim settled which otherwise would not have been possible. Insurance fraud is not just committed by claimants. It is committed by claimants, insurance agents, insurance companies, employers, automobile repair shops, hospitals and many others. Insurance fraud is an economic offense that is very widespread and it is committed by persons from all walks of life. The types of insurance frauds are large in number and they exist in all areas of insurance. They range in severity, from slightly exaggerating claims to intentionally causing accidents or damage. Insurance fraud poses a very major problem, and governments and other organizations are making efforts to deter such activities.{1. 4} CLASSIFICATION ON INSURANCE FRAUDSInsurance frauds can be classified as " hard fraud" and " soft fraud". Hard frauds is usually a deliberate attempt either to stage or create an accident, injury, theft, fire , or other type of loss, that would be covered under an insurance policy. A hard fraud is usually committed by faking incidents, accident, illnesses etc. These schemes are one of the most costly forms of insurance fraud and are widespread. This is also committed by executives and employees within the insurance industry. Examples: An insurance agent who accepts premium payments, and fails to remit the funds to the insurance company. Soft fraud is more common than hard fraud, is sometimes also referred to as opportunity fraud, which occurs when the policyholders or claimant exaggerate legitimate claims. This also

occurs during the underwriting process when an applicant provides false information to lower insurance premiums or increase the likelihood of acceptance for insurance. In this kind of fraud, the claimant demands more than what he actually deserve. Around, 90% of the general insurance fraud results from soft fraud. Example: When involved in a collision an insured person might claim more damage than was really done to his or her car. Failing to report an accurate medical history when applying for health insurance. The main rationale behind the study is to know the frauds in insurance sector as it is the important part for any company since major losses occur generally due to frauds.

LITERATURE REVIEW

[1] The insurance industry has faced lots of fraudulent activity. Insurance fraud is indeed not a new problem. For many years there have been individuals who have attempted to sell fake policies and pocket premium payments. In 2003, a survey was conducted by the insurance research council consisting of 1008 US adults and it was found out that one-third of the respondents agreed that it is acceptable to increase the amount of an insurance claim by a small amount to make up for the deductible that would not otherwise been paid. Insurance fraud is present in every type of insurance. It ranges from opportunists failing to reveal their claims history when applying for cover or exaggerating claims by adding extra items to a legitimate claim to highly organised ‘ crash for cash’ crime rings who arrange often dangerous road crashes and claim for phantom passengers and fictitious injuries.

(SOURCE-Insurance Fraud: A public view, Insurance Research Council, June 2009

http://www. ibc. ca/en/Insurance_Crime/documents/KPMG %20Report-Auto%20Insurance%20Fraud%20in %20Ontario%20dated%20June%2013,%202012. pdf)

[2] In general insurance claims fraud, undetected general insurance claims fraud totals £1. 9 billion a year, which adds £44 to the annual costs individual policyholders face, on average, each year. However, the detection of general insurance fraud has improved drastically over the last five years. Over £730 million worth of fraudulent claims were detected and prevented in 2008. This represents a 30% increase in detection since 2007. The insurance industry is detecting more of the frauds that are being attempted. It is done with the help of improved data sharing through the Insurance Fraud Bureau and a more focused approach for detecting fraud which occur cross different insurance companies. The most common and costly form of general insurance claims fraud is opportunistic fraud. Opportunistic retail fraud is one in which individuals exaggerate or increase genuine claims to add to the value of a payout. In a minority of cases opportunistic fraudsters will produce an entire claim, including, for example, deliberately causing damage so as to be able to claim. There have been a number of studies of actual claims data from Massachusetts, US. Derrig et al. (1997) found that investigation of doubtful claims reduced payouts by 18%. Weisburg & Derrig (1999) work also found that claim reductions are common amongst claims with suspected " build-up" (exaggeration). And later Derrig et al. (2006) also noted that negotiation reduced some " build-up" claims – where third-party payments were involved – by 22%. There are other international studies also which

include Artis et al. (1997) and Bermudez et al. (2008) who apply formal frameworks to explain fraudulent Spanish motor insurance claims.

(SOURCE-Association of British Insurer research brief, July 2009

http://www. abi. org. uk/Publications/55680. pdf)

[3] There are approximately 15 fraudulent insurance claims every hour in UK. In 2011, £983m of fraud was detected. This was 7% higher than the value of fraud detected in 2010 and comprises 138, 814 fraudulent insurance claims, which are around 2, 670 every week. The savings for honest customers from detected frauds represented 5. 7% of all claims in 2011, compared to 5% in 2010. In home insurance, insurers detected the largest proportion of frauds, with 71, 000 exaggerated claims. Motor insurance frauds were the second largest area of insurance fraud with 37, 000 frauds. 7% of all motor claims in 2011 were fraudulent compared to 5% in 2010.

(SOURCE-Association of British Insurer research brief, September 2012

http://www. abi. org. uk/Publications/63750. pdf)

[4] In 2008, Canada conducted its first survey of Fraud against business to assist in building in building a broader picture of insurance frauds in Canada. This survey found out that more than 75% of the frauds against insurance companies involved false or exaggerated claims and nearly half of the health insurance companies indicted that police are never or rarely contacted in cases of frauds, while 36% responded they do so on occasion. Less than 20% of the insurers said that police are informed always. The most common

reasons given by the insurers for not contacting police were the incident was too minor (34%) and it was handled in some other way (33%).

(SOURCE-Fraud against Businesses in Canada: Results from a National Survey, by Andrea Taylor-Butts and Samuel Perrault by statistics Canada, 2007/2008

http://www. ibc. ca/en/Insurance_Crime/documents/KPMG %20Report-Auto%20Insurance%20Fraud%20in %20Ontario%20dated%20June%2013,%202012. pdf)

[5] The scope of insurance fraud has been researched many times in recent years. According to the Insurance Information Institute’s Web site, insurance fraud costs in US are about $30 billion each year (Insurance Information Institute [III], 2006). Many of the people believe their insurance policy is an account and they should be able to withdraw from the account at any time. According to a survey conducted by Accenture (as cited in the Insurance Journal, May 25, 2004) 56% of respondents believe people commit insurance fraud because they can easily get away with it. 32% believe fraud occurs because they believe they pay too much for insurance premiums, while 24% think it is to offset deductibles (2004). Commenting about this survey in the Insurance Journal, Lucarini says, " Insurance companies need to better equip themselves with integrated tools and technologies that help prevent and combat insurance fraud" (Insurance Journal, 2004)

(SOURCE-Journal of Economic Crime Management, fall 2006, Volume 4, Issue 2, Nathan L. Taarud

http://www. utica. edu/academic/institutes/ecii/publications/articles/51D7BD77-A6D1-683B-768C71F19F3DE9D4. pdf)

OBEJECTIVE OF THE STUDY

The proposed research study is undertaken to investigate the following objectives –To study the frauds prevailing in the insurance sector from customer point of view. To study the frauds prevailing in the insurance sector from surveyor point of viewTo find out the reasons as to how to minimize the insurance frauds.

SCOPE OF THE STUDY

The proposed research study is limited by following parameters and aims to find out:-The area of research will be confined to only DELHI-NCR. It will be confined to surveyors and individual customers. This duration of the project is from 15. 12. 2012 to 15. 01. 2013.

RESEARCH METHODOLOGY

Hypothesis-

Customer-Ho: There is no significant difference among the frauds observed at different stages. H1: There is significant difference among the frauds observed at different stages. Ho: There is no difference among the frauds committed in respect of distribution channel. H1: There is difference among the frauds committed in respect of distribution channel. Surveyor-Ho: There is no significant difference among the frauds observed at different stages.

H1: There is significant difference among the frauds observed at different stages. Ho: There is no significant difference among the type of insurance policies in respect of fraud. H1: There is significant difference among the type of insurance policies in respect of fraud. Research designThe marketing research undertaken in this project is constructed on the paradigm of Causal research.

Sample design-

A sampling design is a definite plan for obtaining a sample given population. Target population: The target population is (a) the surveyors and (b) the clients who have insurance policy. Sample frame: In this project, a sample frame is confined to DELHI-NCR. Sample unit: In this project, a sample unit is every individual from the target population. Sample size: The sample size in this research project is 50 surveyors and 150 individuals. Sampling method: In the current research study, convenient sampling will used for collection of data.

Methods of Data collection

Survey

Surveys are useful for collecting primary data especially when the data collected is based on the phenomena that cannot be observed directly.

Tools of Data collection

Questionnaire

A questionnaire can be designed specifically to gather the required data and because of its flexibility, it is the most common instrument used to collect primary data.

Personal interview

It is a market research technique for gathering information through face-to-face interaction with individuals and can often lead to much useful information when compared to questionnaire.

Tools for Data analysis

Ms excel

MS Excel organizes and formats the data in the form of rows and columns for better analyses. Data analysis- Customers questionnaireQ1. Which type of insurance policy are you having? Types of insurance policyNo of respondentsPercentageHealth7832Motor10945Fire2310Miscellaneous3213Total150100This question is set to know the type of policy a customer is having. For the purpose of survey the insurance policies are divided into health insurance, motor insurance, fire insurance and miscellaneous insurance. From the above data it is seen that 45% of respondents have motor policy, 32% of respondents have health policy, 13% of respondents have miscellaneous policy and rest 10% of respondents have fire policy. Q2. The Policy was purchased from-Distribution channelNo of respondentsPercentageInsurance company5637Agent3725Broker3624Bank2114Total150100This question reveals the most preferred distribution channel among insurance company, broker, agent and bank. It is noted that 37% of respondents prefer to buy insurance policy from the insurance company, 25% of respondents prefer agent, 24% of respondents prefer broker and 14% of respondents buy insurance policy from the bank.

Testing of Hypothesis using Chi-Square Test

Chi-square symbolically written as χ^2 is a statistical measure used in the context of sampling analysis for comparing a variance to a theoretical variance. It is a non parametric test. It is used to make comparison between theoretical population and actual data. It is applied in statistics to apply goodness of fit. The general formula for Chi-square test is: Chi^2 = sum_{ij} {(O_{ij} - E_{ij})^2 over E_{ij}} ,

Where O= the frequencies observed

E= the frequencies expected

Degrees of Freedom= n-1

Distribution channel

O

E

O-E

(O-E)²

∑(O-E)²/E

Insurance company5637. 518. 5342. 259. 12Agent3737. 5-0. 50. 250. 006Broker3637. 5-1. 52. 250. 06Bank2137. 5-16. 5272. 257. 26Total15015016. 446The table value of Chi- square at 95% confidence level, 5% significance level and three degrees of freedom is 7. 815. The calculated value of χ^2 is 16. 446 much higher than this table value and hence null hypothesis (Ho) cannot be accepted. We will accept the alternative hypothesis (H1). We can thus, conclude that there is difference among the frauds committed in respect of distribution channel. Q3. All the information

regarding insurance policy was disclosed to you-ScaleNo of respondentsPercentageStrongly agree2919Agree5940Neutral5033Disagree128Strongly disagree00Total150100The main objective behind this question is to know whether the information related to insurance policy was disclosed to the customer or not. In other words, the question explains the satisfaction level of the customer regarding the level of information provided to them. From the above data, it is observed that 40% of respondents agree that the information was properly disclosed to them. On the other hand, 8% of the respondents differ that the information given to them was not sufficient. Q4. Have you ever come across any fraud done by insurance company? ScaleNo of respondentsPercentageNever4329Rarely2919Occasionally4631Oftenly2919Usually32150100This question tells that whether the policy holder has come across any fraud or not. 31% of the respondents feel that frauds occur occasionally in insurance industry, 29% of respondents state that they have never come across any fraud whereas 19% of respondents feel that frauds occur oftenly in insurance industry. Q4. 1. Fraud observed by you at which stageStagesNo of respondentsPercentageAt the time of policy giving2221During the policy term3937At the time of claim settlement4442Total100This question attempts to explain the maximum chances of fraud in which stages of insurance policy. 42% of respondents say that the maximum fraud occur at the time of claim settlement, 37% of respondents state that fraud occur during the term of the policy and rest 21% of respondents say that fraud occur at the time of fiving policy.

Testing of Hypothesis using Chi-Square Test

The general formula for Chi-square test is: Chi^2 = sum_{ij} {(O_{ij} - E_{ij})^2 over E_{ij}} ,

Where O= the frequencies observed

E= the frequencies expected

Degrees of Freedom= n-1

Stages

O

E

O-E

(O-E)²

∑(O-E)²/E

At the time of giving policy2250-2878415. 66During the policy term3950-111212. 42At the time of claim settlement4450-6360. 72Total15018. 82The table value of Chi- square at 95% confidence level, 5% significance level and two degrees of freedom is 5. 991. The calculated value of χ^2 is 18. 82 much higher than this table value and hence null hypothesis (Ho) cannot be accepted. We will accept the alternative hypothesis (H1). We can thus, conclude that is significant difference among the frauds observed at different stages. Q5. Was the policy issued before reporting of claim? Policy issued before reporting of claimNo of respondentsPercentageYes7571No3029Total100This question is concerned with the issue of policy before the reporting of claim. In other words, it tells that whether the policy was issued to the policyholder before the claim was

reported by him. From the above data, it is clear that 71% of respondents were given policy before they lodged any claim and 29% of the respondents didn’t get policy before the claim was lodged. Q6. Kind of fraud-Kind of fraudNo of respondentsPercentageFinancial fraud6258Non financial fraud4442Total100The main aim behind this question is to know the kind of frauds present in insurance industry. Majorly, there are two types of frauds-financial fraud and non financial fraud. Financial fraud can be defined as purposeful act of deception involving financial dealings. Non financial fraud is defined as the intent to fraudulently obtain some non-financial benefit or advantage. 58% of respondents suffered financial fraud such as low claim amount or high premium rates whereas 42% of respondents suffered non financial fraud i. e. non disclosure of terms and conditions or scope of cover restricted. Q6. 1. If Financial fraud, then-Type of financial fraudNo of respondentsPercentageQuantum of claim settlement3048Premium overcharged2744Others58Total100This question provides us with some of the types of financial fraud suffered by the customers. It is clear that 48% of respondents feel that one of the biggest fraud committed by insurance company is seen in the " quantum of claim" i. e. that the claim amount given to them is not sufficient. The customer should submit the actual expenses and not the inflated bills and expenses in order to get the exact claim amount. 44% of the respondents think that the insurance companies take increased premium amount from them. Whereas, 8% of respondents feel that there are other types of frauds also like full premium not transferred to insurance company and claim was rejected. Q6. 2. If Non-financial fraud, then-Type of non financial fraudNo of respondentsPercentageNon dis of

T/C1528Non dis of claim procedure1121Scope of cover restricted2547Others24Total100This question is set to know the types of non-financial fraud seen in the insurance industry. From the above data, it is clear that 47% of respondents feel cheated by restricting the scope of cover of their policies. It is also observed that 28% of respondents claim that the terms and conditions of the insurance policy are not properly disclosed to them. 21% of respondents think there is non disclosure of claim procedure and 4% of respondents go for others like fake/fictitious policyQ7. Rate the following points as per the maximum chances of attempting fraud is by (1 being highest)-Maximum chances of fraud by-No of respondentsPercentageInsurance company3020Agent5738Surveyor2114Broker4228Total100This question explains the maximum chances of attempting frauds by any of the stakeholder’s i. e. insurance company, agent, surveyor or broker. As per the data, 38% of the respondents feel that the maximum chances of attempting frauds are done by the agents, followed by broker at 28%, insurance company at 20% and at last surveyors at 14%as their answer. The data analysis - Surveyors questionnaireQ1. Type of surveyor –Type of surveyorNo of respondentsPercentageGeneral surveyor4020Specialized surveyor1080Total50100This question is asked to know whether the surveyor is a general surveyor or the specialized surveyor. General surveyor is the surveyor who surveys all types of insurance frauds irrespective of the type of insurance. On the other hand, specialized surveyor is the one who survey only some types of specific insurance such as health insurance, motor insurance, fire insurance etc. 80% of surveyors are specialized surveyors and

rest 20% are general surveyor. Q2. If specialized surveyor, please mention type of insurance policyType of specialized surveyorNo of respondentsPercentageHealth1433Motor1536Fire921Miscellaneous410Total 100This question is concerned with the type of specialized surveyor. Out of 50 surveyors, 36% of surveyors are specialized in motor insurance, 33% of surveyors are specialized in health insurance, and 21% of surveyors are specialized in fire insurance and rest 10% of surveyors are specialized in miscellaneous insurance. Q3. Have ever come across any fraudEver come across any fraudNo of respondentsPercentageYes4590No510Total50100This question tells that whether the surveyor has come across any fraud or not committed by any of the following i. e. customers, agents, brokers and insurance company. From the above data, it is stated that 90% of surveyor have come across fraud prevailing in insurance industry and rest 10% of surveyor have never came across any fraud in insurance sector. Q4. Fraud observed by you at which stageStagesNo of respondentsPercentageAt the time of policy giving1122During the policy term1530At the time of claim settlement2448Total50100This question attempts to explain the maximum chances of fraud in which stages of insurance policy from the surveyor point of view. 48% of surveyors say that the maximum fraud occur at the time of claim settlement, 30% of surveyors state that fraud occur during the term of the policy and rest 22% of surveyors say that fraud occur at the time of fiving policy. Testing of Hypothesis using Chi-Square Test-Chi-square symbolically written asχ^2 is a statistical measure used in the context of sampling analysis for comparing a variance to a theoretical variance. It is a non parametric test. It is used to make comparison between theoretical

population and actual data. It is applied in statistics to apply goodness of fit. The general formula for Chi-square test is: Chi^2 = sum_{ij} {(O_{ij} - E_{ij})^2 over E_{ij}} ,

Where O= the frequencies observed

E= the frequencies expected

Degrees of Freedom= n-1

Stages

O

E

O-E

(O-E)²

∑(O-E)²/E

At the time of giving policy1116. 66-5. 6632. 031. 92During the policy term1516. 66-1. 662. 7551. 65At the time of claim settlement2416. 667. 3453. 873. 24Total506. 81The table value of Chi- square at 95% confidence level, 5% significance level and two degrees of freedom is 5. 991. The calculated value of χ² is 6. 81 much higher than this table value and hence null hypothesis (Ho) cannot be accepted. We will accept the alternative hypothesis (H1). We can thus, conclude that there is significant difference among the frauds observed at different stages. Q5. Common types of frauds committed by customer-Types of fraudNo of respondentsPercentageNon dis of material facts1530Exaggerated claims2040Submitted the forged documents1224Others36Total50100This question provides us with some of the types of fraud committed by customers. In the above pie chart, 40% of

surveyors state that customers exaggerate claim amount in order to get more claim. 30% of surveyors declare that customers do not disclose the material facts related to insurance policy. 24% of surveyors state that customers submit forged documents and 6% of surveyors go for other options such as health insurance billing frauds, car damage (inflated damages) etc. Q6. Common types of frauds committed by agent-Types of fraudNo of respondentsPercentageNon dis of T/C1938Premium fraud1122Fictitious policies1632Others48Total50100This question reveals some of the types of fraud committed by agents. From the above data, 38% of surveyors state that agents do not disclose the material facts related to insurance policy. 32% of surveyors declare that agents give fictitious policy to policyholders. 22% of surveyors state that agents commit premium fraud and 8% of surveyors go for other options such as misrepresentation, false information etc. Q7. Have you ever come across any alteration made in the scope of policy after reporting of your claim? Come across any alteration in policy after reporting of claimNo of respondentsPercentageYes1530No3570Total50100This question is concerned with any alteration made in the insurance policy after the reporting of claim. In other words, this question tells that whether the policy was altered after the claim was reported. From the above data, 70% of surveyors state that the policy is not altered after the lodgment of claim whereas 30% of surveyors say that the policy is usually altered after the reporting of claim. Q8. Maximum number of frauds seen in which insurance-InsuranceNo of respondentsPercentageHealth1938Motor1734Fire714Miscellaneous714Total

50100This question is set to know the maximum frauds occurring in which type of insurance. For the purpose of survey the insurance policies are divided into health insurance, motor insurance, fire insurance and miscellaneous insurance. 38% of surveyors state that maximum frauds take place in health insurance, 34% of surveyors’ rate motor as the second highest fraud occurring insurance and 14% of surveyors’ state that frauds take place in fire and miscellaneous insurance.

Testing of Hypothesis using Chi-Square Test

The general formula for Chi-square test is: Chi^2 = sum_{ij} {(O_{ij} - E_{ij})^2 over E_{ij}} ,

Where O= the frequencies observed

E= the frequencies expected

Degrees of Freedom= n-1

Insurance

O

E

O-E

(O-E)²

∑(O-E)²/E

Health1912. 56. 542. 253. 38Motor1712. 54. 520. 251. 62Fire712. 5-5. 530. 252. 42Miscellaneous712. 5-5. 530. 252. 42Total50509. 84The table value of Chi- square at 95% confidence level, 5% significance level and three degrees of freedom is 7. 815. The calculated value of χ^2 is 9. 84 much higher than

this table value and hence null hypothesis (Ho) cannot be accepted. We will accept the alternative hypothesis (H1). We can thus, conclude that there is significant difference among the type of insurance policies in respect of fraud. Q9. Rate the following points as per the maximum chances of attempting fraud is by (1 being highest)-Maximum chances of fraud by-No of respondentsPercentageInsurance company48Agent1938Customer1224Broker1530This question explains the maximum chances of attempting frauds by any of the following i. e. insurance company, agent, broker or customers. As per the data, 38% of the surveyors feel that the maximum chances of attempting frauds are done by the agents, followed by broker at 30%, customers at 24% and at last insurance company at 8% as their answer.

Limitations

Time period of the project was two months, which was not enough to conduct this research. Respondents hesitate to give the true response to the questions. Sample size (150) is too small to understand the different types of fraud prevailing in the insurance company.

Finding

The findings seen in the questionnaire given to customers are as follows-The highest number of insurance policy sold is motor insurance followed by health insurance. The customers have maximum trust on insurance company. As a result, large numbers of policies are sold through insurance company only. It is seen that 40% of customers are satisfied with the information given to them regarding the policy. Considerable amount of

people have come across the insurance frauds. Accordingly, the maximum numbers of frauds are seen at the time of claim settlement. Usually, the insurance policy is issued before any reporting of the claim. It is also seen that the maximum type of fraud suffered by the customer/policyholder is financial fraud. In case of financial fraud, customers have to suffer on the quantum of claim amount. In case of non-financial fraud, customers have to suffer on the scope of the insurance cover i. e. the scope is generally restricted. As per customer, agents indulge in maximum types of frauds. The findings seen in the questionnaire given to surveyors are as follows-By and large, the surveyors were specialized surveyor and they were mainly specialized in the motor insurance and health insurance. Maximum numbers of surveyors have come across frauds in the insurance industry and the largest numbers of frauds are seen at the time of claim settlement. It is seen that the most common type of fraud committed by the customer is that they usually exaggerate the legitimate claims in order to get more claim amount. Common type of fraud committed by the agent is the non disclosure of terms and conditions of the insurance policy. Generally, the surveyors do not come across any alteration made in the scope of policy after the claim is being reported. The maximum numbers of frauds are seen in the health insurance followed by motor insurance. As per surveyor, agents indulge in maximum types of frauds.

Suggestions

For reducing fraud for insurance company-Conduct scheduled fraud audits on regular basis. Insurance company should create an internal audit team that is well versed in the company’s workings to recognize those indicators that

would suggest fraud is taking place. Conduct any anti fraud education program and make sure that all new employees are aware of it. Insurance companies are required to have insurer special investigation unit (SIUs) and to report the suspected fraud claims to the fraud division. Special investigation unit is responsible for identifying incidents of potential fraud committed by customers, agents, health providers and other parties. Legal actions to be taken against fraudulent personEmployees of insurance company should look for " warning signals". An effective whistle blow policy should be introduced to certain the fraud. Reducing fraud for customer- Conduct a program to educate public about the consequences of fraud, how to prevent it, recognize and report it. The customer should report activities that suspect any fraud to law enforcement agencies. The customer should ask for proper clarification at the time of buying insurance policy. He/she is required to know the terms and conditions of the policy and also the amount of premium that is to be paid by him. Customer should disclose any material fact which in turn will help them at the time of claim settlement. The customer should know the scope of cover. This can be done by reading the proposal properly and make that the policy which is purchased is as per his needs. Customer should make sure that the premium paid is reaching to the insurance company. Either, the customer can keep a check on the money paid by him or he can send the premium amount directly to the insurance company through online. At the time of claim, the policy holder should give all the necessary documents in order to get legitimate claim.

Conclusion

Insurance fraud is a white collar crime which will never be eliminated as long as an individual has the chance and motivation to " gain something for nothing." The fight against insurance fraud is a permanent battle. One major part of its battle is public education. The general public should be well-informed about the effects of frauds. Besides this, the use of technology can also help in reducing insurance frauds. It will help in preventing claims frauds before it reaches epidemic proportions. Insurance industry should go for technology-based tools to fight insurance fraud which can be useful in helping companies to identify and prevent claim activities. Some fraud-detection techniques screen claims during processing and help prevent improper payments. Together, these techniques are powerful and helpful in lessening the insurance frauds.

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