Insurance fraud in Norway

2019 report

Statistics for 2018

Finans Norge

Contents

FOREWORD

1. **Introduction** ... 3
2. **Detected fraud in 2018 – overall figures** ... 4
3. **Detected fraud in personal non-life insurance** ... 5
4. **Detected fraud in sickness and disability insurance** ... 9
5. **Detected fraud in commercial/agricultural non-life insurance** ... 14
6. **Who commits insurance fraud?** ... 16
7. **Insurers' preventive work** ... 18
8. **Definitions** ... 19

Foreword

Insurance is based on mutual trust between policyholder and insurer, where it is assumed that the policyholder will provide accurate and honest information both when applying for cover and when making a claim. Experience from specific cases and surveys of the public reveal that this is not always the case. Each year the insurance industry is defrauded of substantial sums, and not all of this fraud is detected. An increasing focus on preventive action means that more and more cases are being picked up as early as the application stage. This spells major savings for insurers that also benefit customers in the form of reduced premiums.

Frode Bjeglerud
Director

1. Introduction

Finance Norway's statistics provide a picture of detected insurance fraud and the products affected. The aim of this report is to highlight the extent of insurance fraud and its cost.

Insurers uncover numerous cases of insurance fraud every year. The claims that are rejected amount to substantial sums – money that is intended for honest customers. Those who defraud insurance companies are defrauding all those around them.

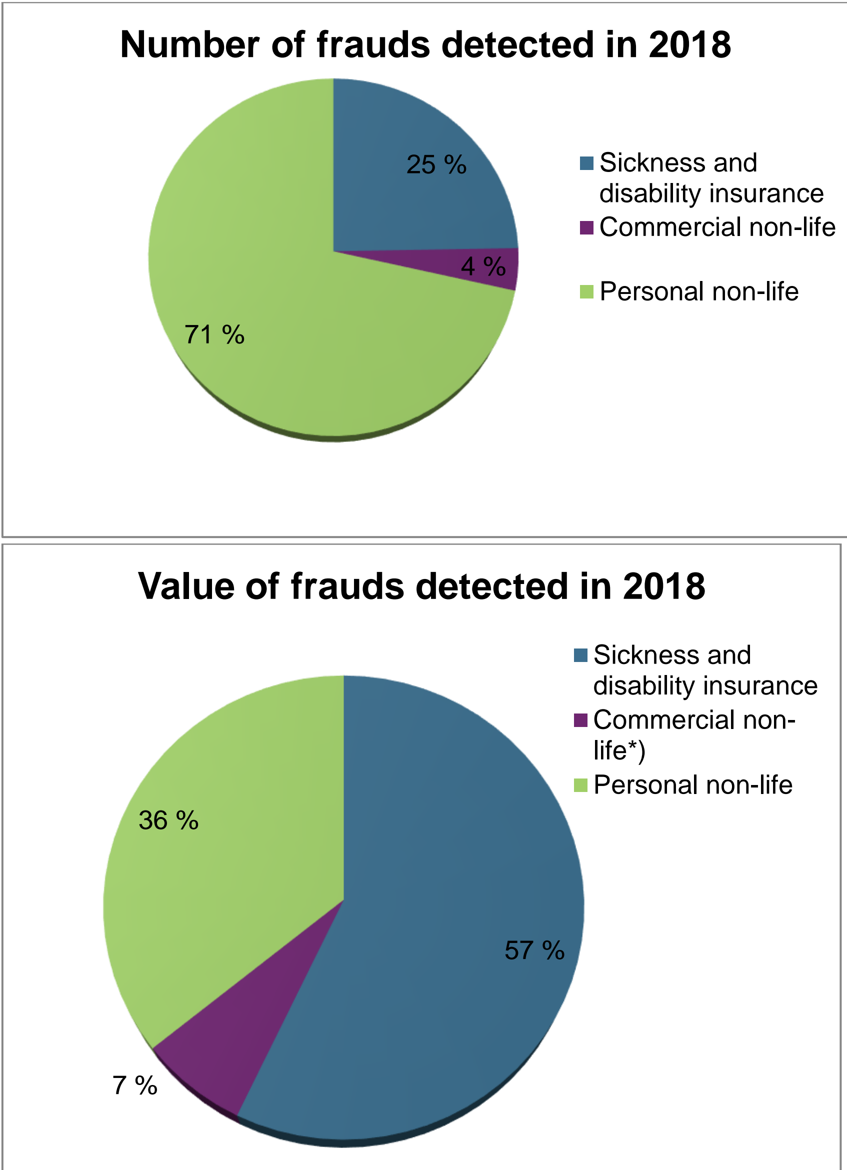
The report is divided into eight sections. Section 2 provides a general overview of the total number of frauds detected in 2018, while sections 3-5 look specifically at fraud in three segments: personal non-life, personal sickness/disability and commercial/agricultural non-life insurance. Section 6 looks at who commits the frauds and where the most frauds are detected. Developments in criminality and new trends in insurance fraud demand a constant focus, both to prevent such crime and to ensure that the industry is not exploited by criminals, and section 7 provides an insight into this work. Finally, section 8 contains a glossary of terms.

The data in the report have been obtained from 29 insurers that are members of Finance Norway. Only cases detected as fraud as set out in the Norwegian Insurance Contracts Act are included in the report.

Claims rejected with reference to the Insurance Contracts Act account for around half of the claims rejected by these companies. Instances of other situations where insurers may refuse to pay out are where the customer has been grossly negligent or contravened the terms of insurance, or where money laundering is suspected (such as where the customer cannot explain the origin of funds). Claims rejected for these reasons are not covered by this report.

2. Detected fraud in 2018 – overall figures

Figure 2.1 – Number and value of frauds detected by segment, 2018

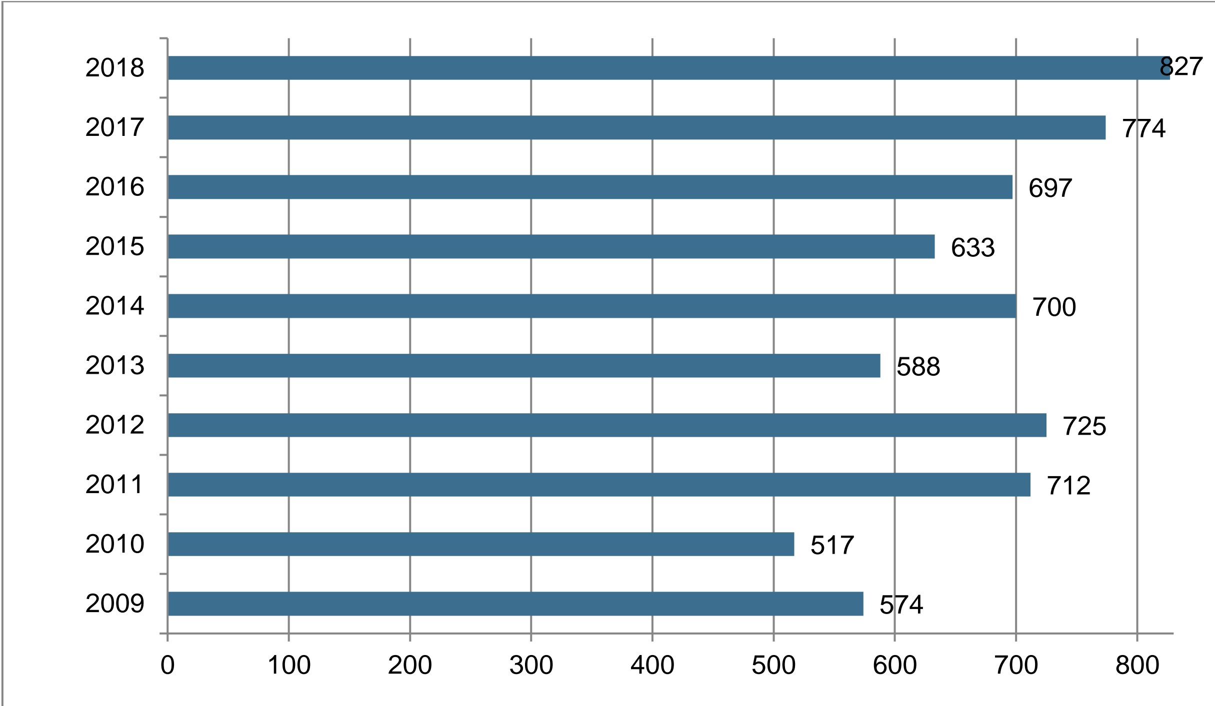


The insurance industry rejected 871 claims on non-life insurance and 286 claims on sickness and disability insurance with reference to the Insurance Contracts Act in 2018. The combined value of these rejected claims was NOK 313.8 million. Fraud was most prevalent by value in the sickness and disability segment, while non-life insurance dominated the number of fraudulent claims.

When it comes to sickness and disability products, a distinction can be drawn between the number of people found to be committing fraud and the number of cases. Thus 252 people accounted for a total of 286 fraudulent claims on sickness and disability insurance in 2018. It is not possible to make the same distinction in non-life insurance, although a person may very well have more than one claim rejected.

3. Detected fraud in personal non-life insurance

Figure 3.1 – Detected frauds, past ten years



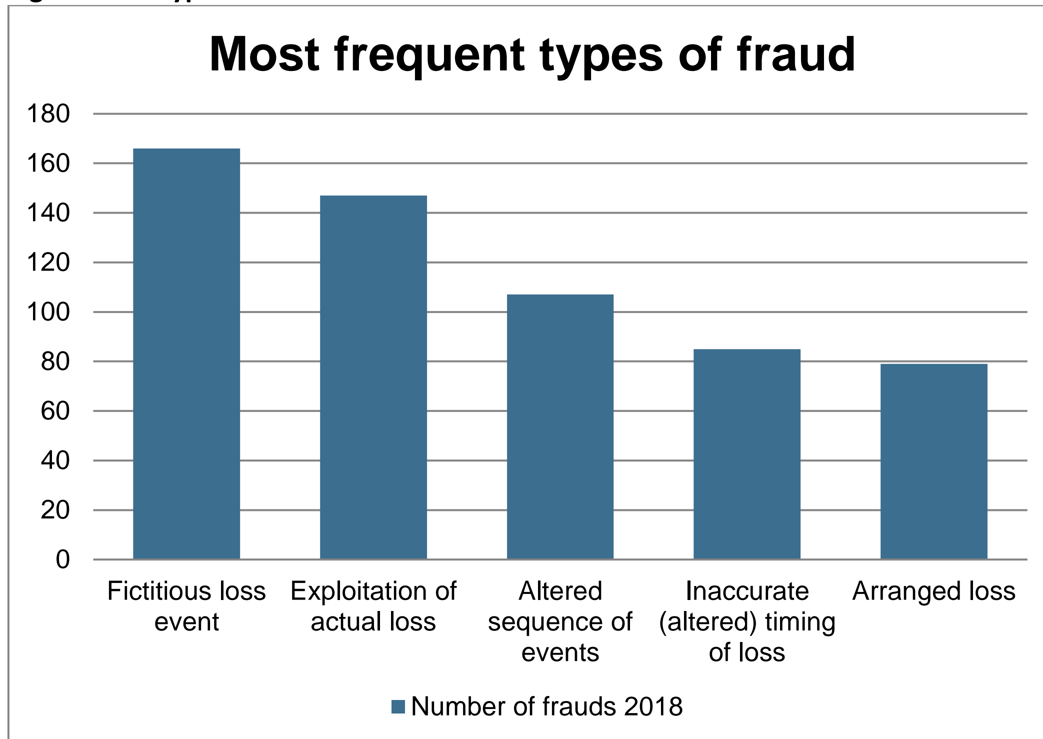
A total of 827 cases of fraud were detected in this segment in 2018, resulting in the rejection of claims with a combined value of NOK 112.3 million. This translates into an average of NOK 136,000 per case. There is considerable variation in the sums involved, however, with the largest being NOK 7.1 million and a median of NOK 39,000 (i.e. there were equal numbers of cases above and below this amount).

The number of frauds detected in a particular area will reflect how much priority the industry is giving that area and the potential volume the area represents.

For the most part, frauds are detected internally by the insurer. One important instrument in this context is the central claims database FOSS[1].

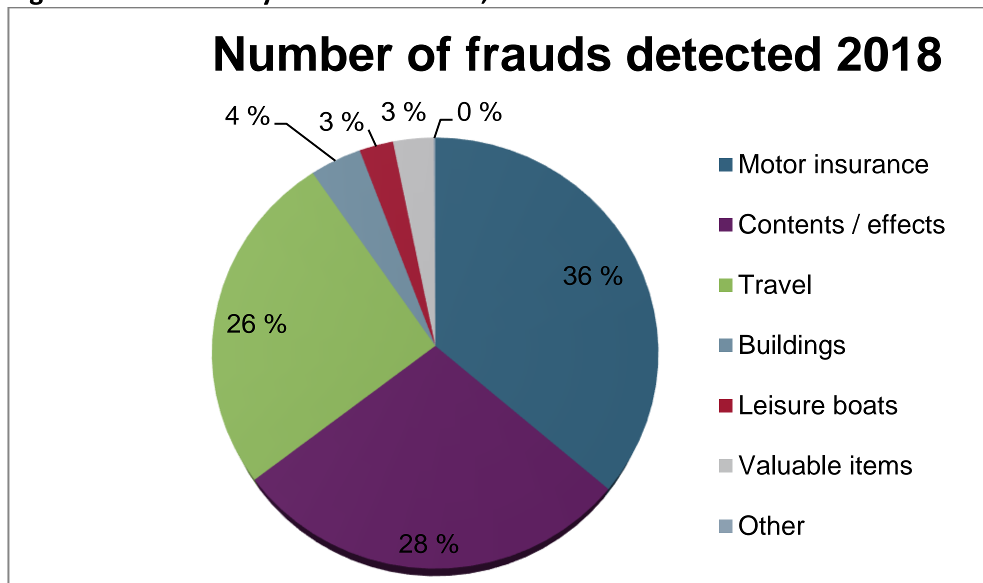
[1] See definition in Section 8.

Figure 3.2 – Types of fraud



Most cases detected are where the customer reports a fictitious loss and/or exploits a genuine loss event. The largest sums relate to arranged losses.

Figure 3.3 – Frauds by class of business, 2018



Motor and travel insurance account for a large share of frauds detected because this is where the most losses are reported. In terms of value, however, buildings insurance is the largest class of business, because frauds often relate to arson.

Table 3.1 - Detected frauds by class of business, past three years. Percentage share

Class	2014	2015	2016	2017	2018
Car/van	29.1	36.3	35.0	32.6	36.3
Contents/belongings	26.3	24.6	27.7	24.9	28.3
Travel	28.6	24.3	28.1	32.3	25.9
Buildings	7.7	7.3	6.0	4.8	3.9
Leisure boats	2.7	2.7	1.3	3.5	2.5
Valuable items	2.0	2.4	1.4	1.6	3.0
Other/unknown	3.6	2.4	0.4	0.4	0.1

Table 3.1 shows that motor and contents insurance fraud are most common. Motor insurance accounted for 300 of the 827 cases in 2018, contents for 234 and travel insurance for 214.

Table 3.2 – Types of loss, private car/van products. Percentage share

	2014	2015	2016	2017	2018
Theft of	25.0	27.4	22.5	20.6	13.7
Material damage/comprehensive (external factors, collision)	54.4	50.0	54.5	57.1	62.9
Fire	5.4	10.0	6.1	3.2	6.8
Theft from	4.4	3.9	7.8	4.0	3.2
False documents	1.5	-	0.4	-	1.1
Accidents involving personal injury	-	-	-	-	-
Other	5.4	3.0	4.5	9.9	8.6
Vandalism	1.5	1.7	1.6	3.2	2.9
Recovery	-	0.9	-	-	-
Liability	2.5	2.5	2.5	2.0	0.7

A total of 300 frauds with a combined value of NOK 37.7 million were detected in connection with private car/van cover in 2018, giving an average of around NOK 126,000 per case.

The insurance industry is still seeing large numbers of arranged losses. The combined value of these cases is considerable. Investigating these cases is complex, and it is difficult to pinpoint just how widespread and organised this crime is.

Figure 3.4 – Types of motor insurance fraud

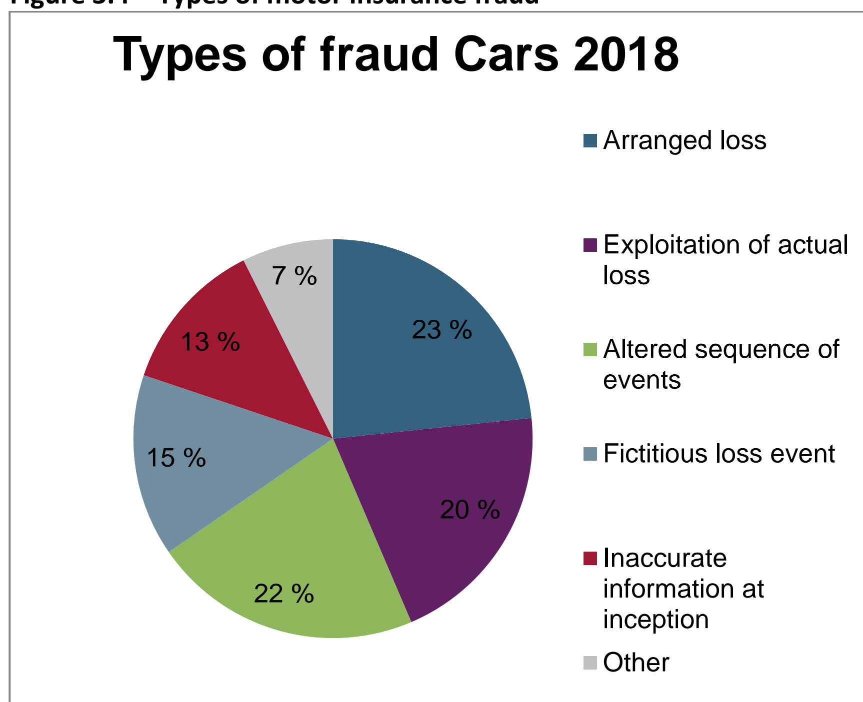


Figure 3.4 shows that fictitious losses and misrepresentation of the sequence of events account for the largest share of motor insurance fraud.

Table 3.3 – Types of loss, contents/effects products. Percentage share

	2014	2015	2016	2017	2018
Theft/break-ins	54.9	54.5	45.1	35.4	42.9
Fire	7.1	4.5	10.4	8.3	5.0
Material damage	19.0	21.2	23.3	30.2	27.4
Water-related damage	2.7	5.8	5.2	4.7	3.7
External factors	9.2	3.2	7.3	10.4	6.8
Other	6.0	5.8	8.8	9.9	12.3
Hold-ups	0.0	3.8	-	0.5	0.9
Vandalism	1.1	1.2	-	0.5	0.9

Thefts and break-ins account for the largest share of frauds in the contents/effects segment. A total of 234 frauds with a combined value of NOK 27.7 million were detected in connection with contents/effects cover, giving an average value of NOK 118,000. Most cases involved genuine losses being exaggerated.

Table 3.4 – Types of loss, travel products. Percentage share

	2014	2015	2016	2017	2018
Loss/theft of luggage	68.5	66.2	70.9	66.4	65.9
Accident/illness	16.0	18.8	15.8	21.2	18.2
Material damage	4.5	1.9	4.1	4.0	3.3
Hold-ups	6.0	4.6	4.6	3.2	2.3
Break-ins	0.5	-	-	-	-
False documents	1.0	1.9	0.5	-	3.3
Other	8.0	6.5	4.1	5.2	7.0

Travel insurance fraud was most commonly associated with theft/loss of luggage. Of a total of 214 cases detected in 2018, 141 related to the theft or loss of luggage. There were also 39 frauds relating to accidents/illnesses while travelling (for example, where the insured was ill before starting the journey). The average value of frauds was NOK 34,000 for accident/illness claims and NOK 37,000 for theft/loss of luggage.

When it comes to frauds involving alleged losses abroad, no one country stands out, with cases more or less evenly split between Europe and the rest of the world. Most involve a fictitious loss event.

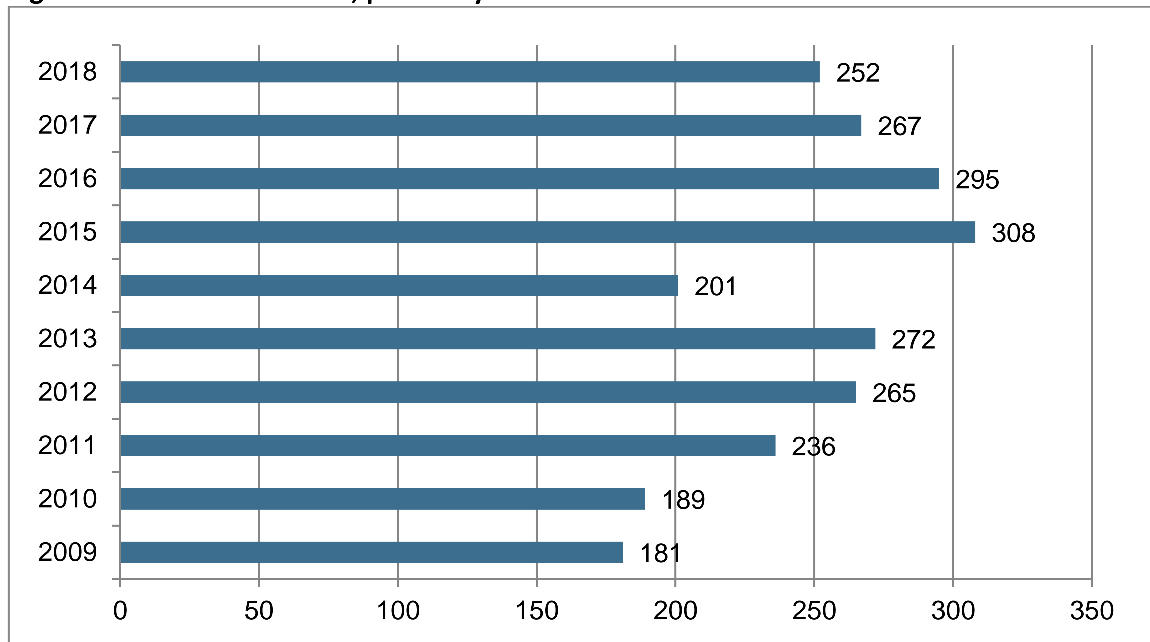
4. Detected fraud in sickness and disability insurance

This section of the report covers personal sickness and disability insurance as set out in Section 10-1/Part B of the Insurance Contracts Act.

Insurers report sickness and disability insurance cases that have been rejected due to fraud. This includes both application fraud and claims fraud, cf. Sections 12-12 and 18-1 of the Insurance Contracts Act.

When drawing comparisons with the statistics for previous years, please note that more companies have been included in the data since 2008. From 2015, the figures do not include fraud detected at the application stage. The data for previous years are not comparable at a detailed level.

Figure 4.1 – Detected frauds, past ten years



The chart above shows the total number of fraud cases in 2009-2018. A total of 252 cases of fraud were detected in the sickness and disability segment in 2018, which is fewer than in 2017. These related to 284 policies (each case can cover more than one policy). By way of comparison, 267 cases relating to 283 policies were detected in 2017.

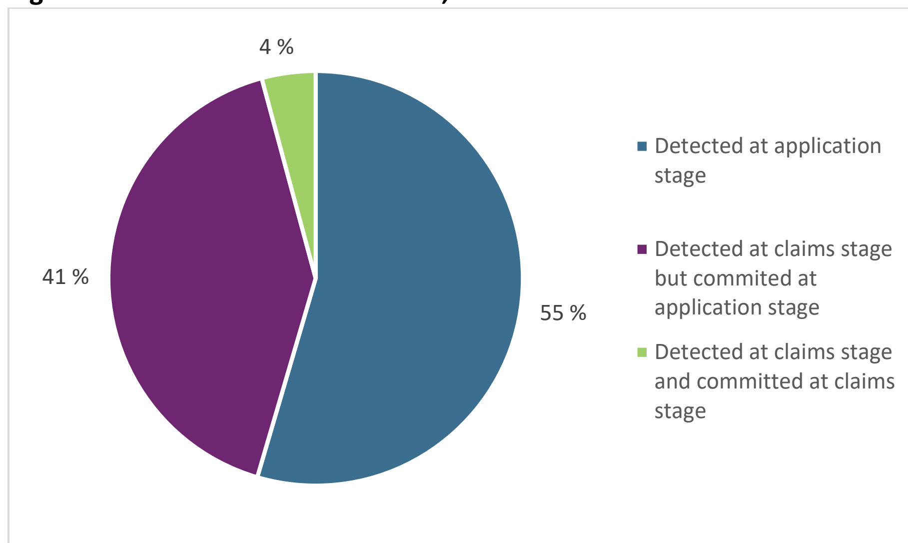
Excluding frauds detected at the application stage, the combined value of the cases detected in 2018 was NOK 179.2 million. The equivalent figure for 2017 was also NOK 179.2 million. The average value of cases detected at the claims stage was NOK 1,444,765 in 2018 and NOK 1,367,697 in 2017.

Insurers put considerable resources into preventing and detecting fraud. Only exceptionally are cases detected as a result of tip-offs from third parties.

The ROFF[2] claims database, which is managed by Finance Norway, is an important tool in insurers' work on detecting fraud.

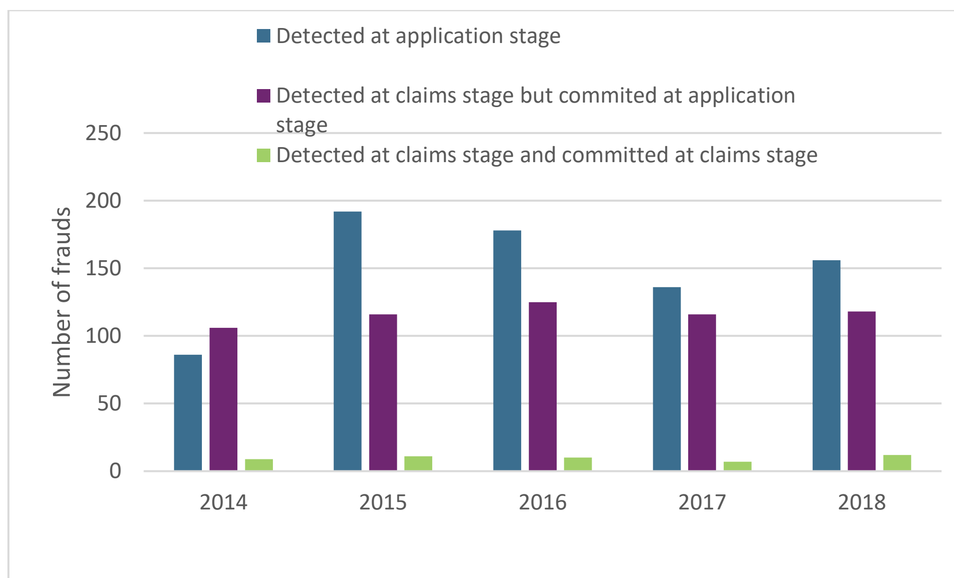
[2] See definition in Section 8.

Figure 4.2 – When fraud is detected, 2018



Detecting fraud at the application stage is a priority for insurers. Experience shows that those who knowingly provide incorrect information when taking out insurance often have fraudulent intentions. The probability of these people claiming on the insurance at some point is high. Figure 4.2 shows that 55% of fraud cases detected in 2018 were picked up at the application stage. The equivalent figure for 2017 was 52%.

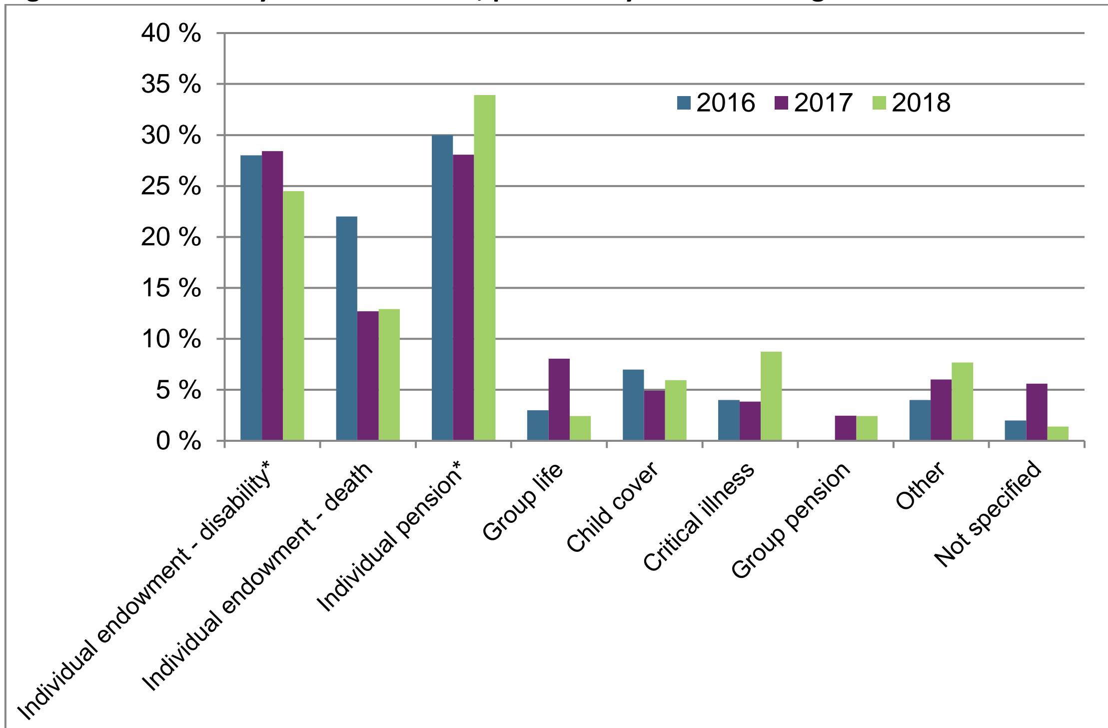
Figure 4.3 – When fraud is detected, 2014-2018



In 2018, 45% of fraud cases were detected at the claims stage, and most of these concerned fraud perpetrated at the application stage. The equivalent figure for 2017 was 48%.

All in all, therefore, 96% of cases detected were application fraud.

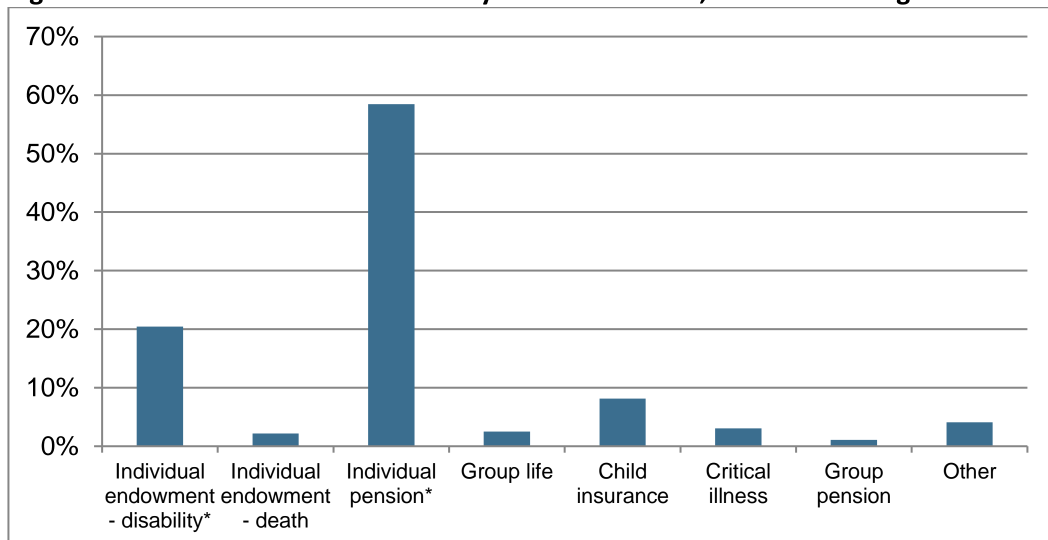
Figure 4.4 – Frauds by class of business, past three years. Percentage share



*Including waiver of premium
**Including accident, health, medical and life insurance

In recent years, the largest number of fraud cases detected has been in individual disability pensions and individual disability endowment products. As Figure 4.4 shows, 2018 was no exception, with these two types of cover accounting for no less than 58% of all cases of fraud in sickness and disability insurance.

Figure 4.5 – Value of detected frauds by class of business, 2018. Percentage share



*Including waiver of premium

Figure 4.5 presents a breakdown of the value of frauds picked up during claims settlement, including both application and claims fraud.

The amount of frauds detected in each class of business can vary from year to year in both number and value. There are several possible reasons for this, but one contributing factor is that insurers may prioritise different areas in different years.

Table 4.1 – Value of detected frauds by class of business, past three years. NOK million

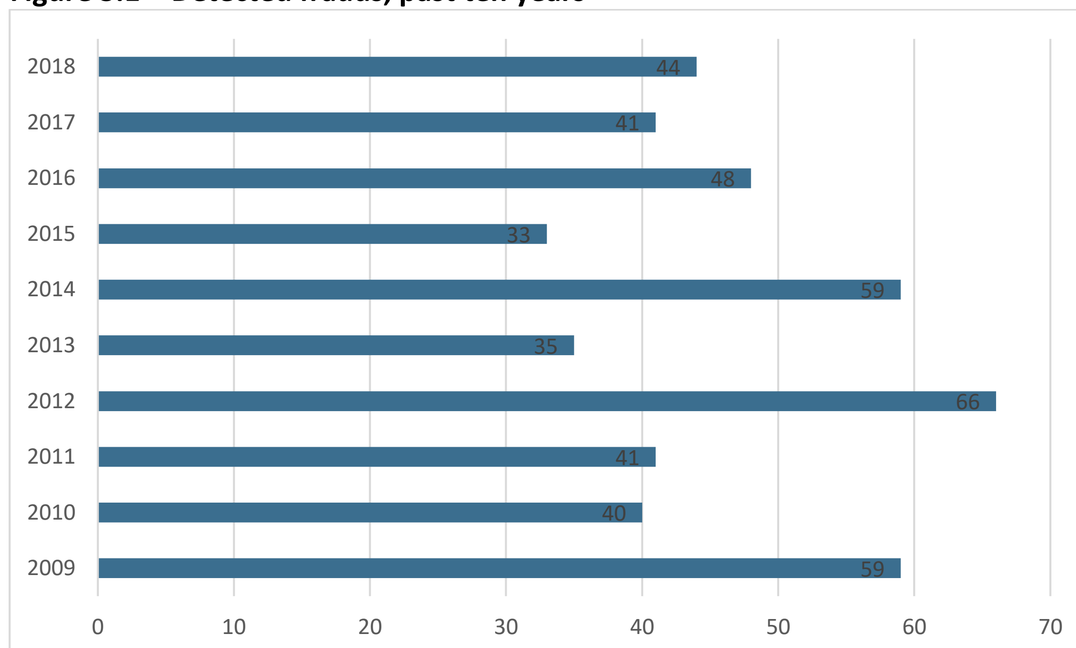
	2016	2017	2018
Individual endowment – disability*	40.7	41.37	36.63
Individual endowment – death	11.7	12.25	3.94
Individual pension*	74.7	75.52	104.76
Group life	7.9	11.02	4.53
Child insurance	39.5	20.65	14.57
Critical illness insurance	4.6	1.60	5.45
Group pension		5.15	1.92
Other insurances of the person		1.39	2.68
Other	5	3.66	1.95
Accident	2.4	4.53	2.61
Health	0.2	2.03	0.10

*Including waiver of premium

Individual pension and individual disability endowment are the two classes of business where the most fraud was picked up in 2018, in terms of both number of cases and value. Frauds detected at the claims stage in these two classes amounted to NOK 141.4 million, or 79% of the total. Table 4.1 shows movements in the value of frauds detected at the claims stage for each type of cover over the past three years, including both application and claims fraud.

5. Detected fraud in commercial/agricultural non-life insurance

Figure 5.1 – Detected frauds, past ten years



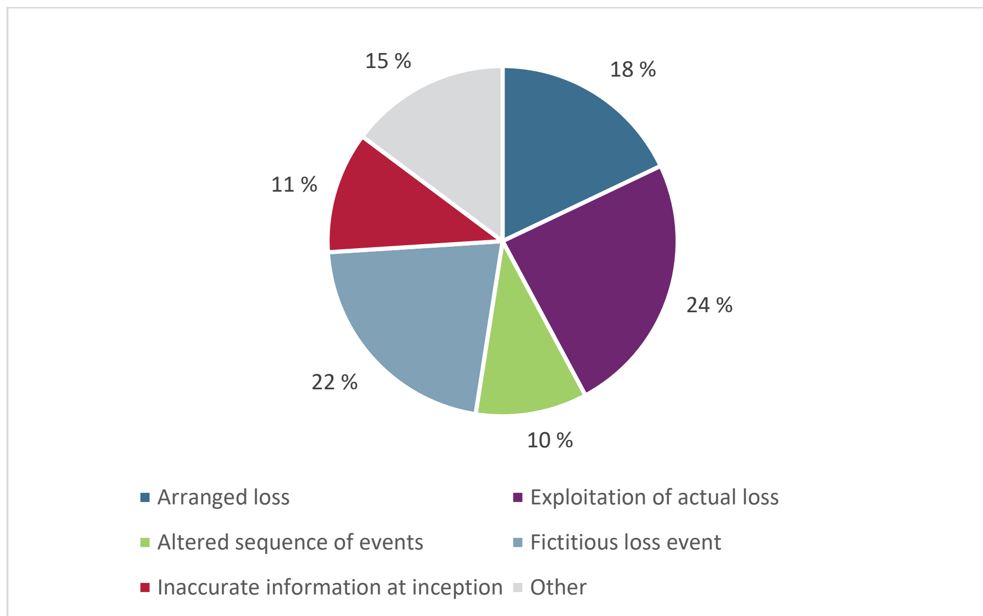
In the commercial and agricultural segment, 44 fraudulent claims with a combined value of NOK 22.3 million were rejected in 2018. The average such claim was NOK 507,000, while the median was NOK 70,000. Thus there was considerable variation, the largest claim being NOK 4.5 million.

Table 5.1 - Detected frauds by class of business. Percentage share

	2014	2015	2016	2017	2018
Car/van	32.2	33.3	27.1	22.0	22.7
Industrial/commercial	27.1	45.5	37.5	34.1	38.6
Transport	-	-	2.1	2.4	4.5
Occupational injury	6.8	-	8.3	7.3	6.8
Travel insurance	10.2	3.0	8.3	2.4	13.6
Contents/belongings	1	-	-	-	2.3
Agricultural	13.6	9.1	4.2	2.4	-
Farm machinery	-	9.1	8.3	4.9	6.8
Livestock	-	-	2.1	9.8	4.5
Other	3.4	-	2.1	14.6	-

Of the 44 cases detected in 2018, the largest concerned occupational injuries and commercial buildings. Most cases in 2018 were in the category “other material damage”, while nine related to theft and three to fire.

Figure 5.2 – Types of fraud, 2014-2018



As the number of frauds in the commercial segment each year is small, the chart above shows the breakdown for the past five years. As can be seen, most cases relate to exaggerated claims following a genuine loss.

Most cases are picked up internally by the insurer, often via the FOSS[3] claims database.

[3] See definition in Section 8.

6. Who commits insurance fraud?

In Norway, annual market surveys show that insurance fraud is more socially acceptable than other types of crime, especially among the young. This is a serious problem for the industry.

Norwegian insurer Gjensidige carries out an annual opinion survey on insurance fraud, which reveals that 15% believe that insurance fraud is understandable or not worth worrying about, and one in three under-30s consider it fine to add a little extra when claiming on insurance.

The young are most tolerant of insurance fraud, and men are more given to insurance fraud than women.

Few cases are detected where the customer is below the age of 20. This is probably because members of this group are largely still insured through their parents.

Figure 6.1 – Frauds detected by age and product, 2018

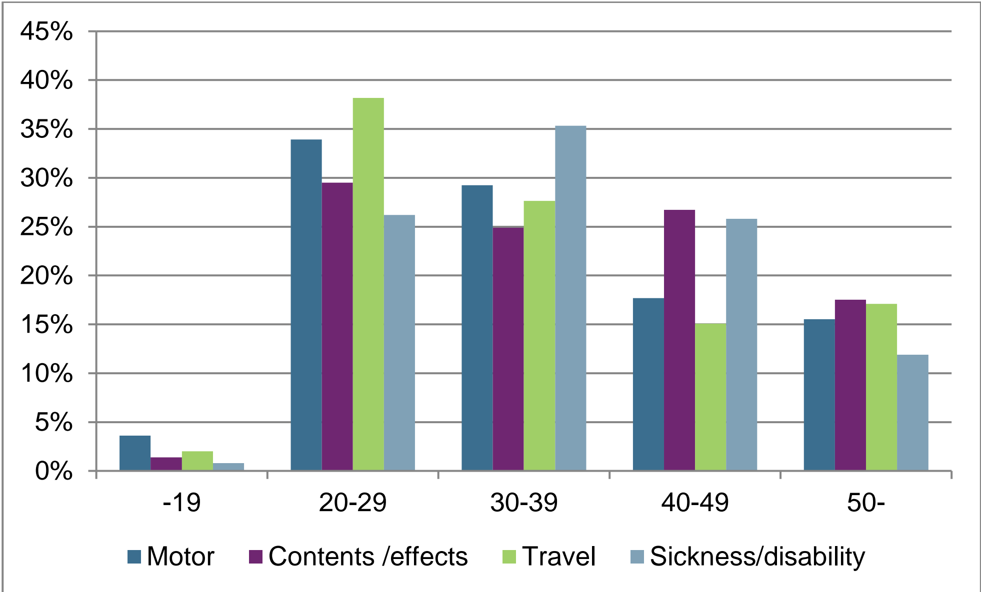


Figure 6.1 breaks down cases of fraud by product and age group. The 20-29 age group is behind the most fraud in travel and motor insurance, while those aged 30-39 account for the largest number of cases relating to sickness and disability cover.

Overall, men were behind 68% of insurance fraud in 2018, and women 32%. Women accounted for 45% of sickness and disability cases, but only 28% of non-life cases.

Figure 6.2 – Breakdown of cases by gender, 2018

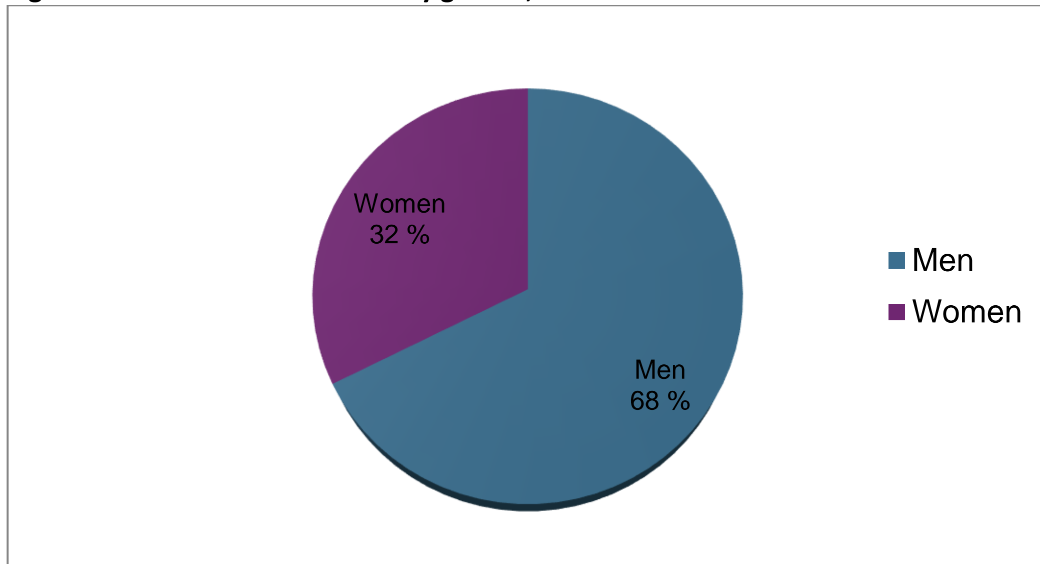
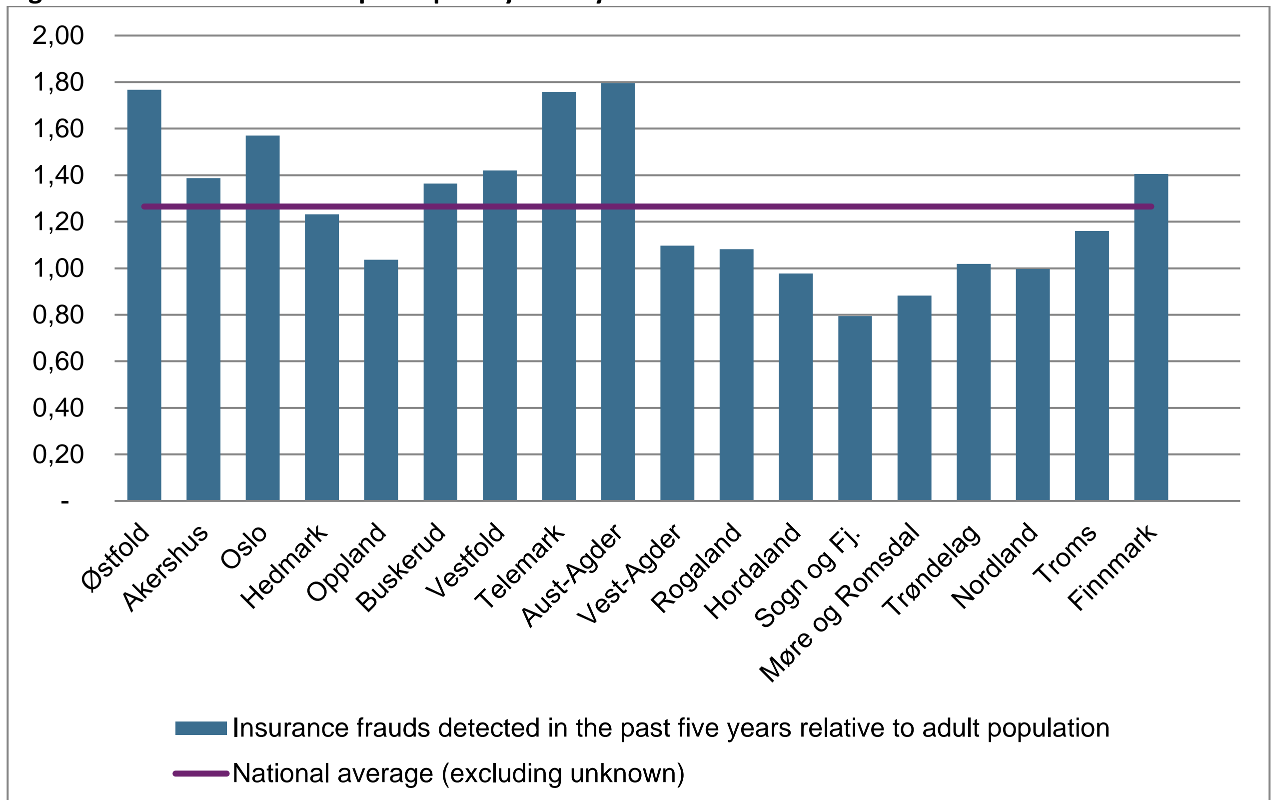


Figure 6.3 – Frauds detected per capita by county



The number of cases of detected fraud in non-life insurance and sickness/disability products as a whole relative to the number of inhabitants in each county[4] is highest in Aust-Agder, Østfold, Telemark and Oslo. Finnmark, Akershus, Buskerud and Vestfold are also slightly above the average, while the county with the fewest detected cases per capita is Sogn og Fjordane. The number of cases detected in some counties may be very small, so conclusions must be drawn with great care, and the figures may also be influenced by insurers' chosen focus areas.

[4] Population aged 18-79 in each county. Source: Statistics Norway.

7. Insurers' preventive work

Insurance is all about sharing risk between large numbers of policyholders. Each pays a small premium, and together these premiums make up a pool that is used to pay out on policyholders' claims. The insurer is responsible for managing this money appropriately and ensuring correct payouts.

It is also important for Finance Norway to work on insurance-related information campaigns, especially when it comes to young people.

Surveys show that young people have the most tolerant attitudes towards insurance fraud. To reach out to this group, Finance Norway has produced three videos about insurance fraud which have been published on social media.

Many young people do not think about the criminal penalties and other consequences of insurance fraud. A conviction for insurance fraud can affect future career opportunities and also travel options (refusal of visa applications).

Insurers work actively to ensure that the range of products they offer is not exploited by dishonest customers or used for money laundering by criminal elements.

Finance Norway works constantly on mapping problem areas in sickness/disability and non-life insurance. Developments, trends and levels are monitored continuously. Together with insurers' investigators, Finance Norway endeavours to ensure that working and investigative methods keep up with the changing face of crime. Effective procedures have been established for the exchange of information and for collaboration with the police, the Norwegian Welfare and Labour Administration, the Norwegian Business and Security Council and various other industry bodies.

Each year, insurers detect numerous attempts at application fraud, where customers deliberately provide incorrect information when taking out insurance. A typical example is where a customer buys a disability policy and withholds information about a pre-existing serious illness.

Social responsibility

There are also cases where insurance fraud is committed in connection with other types of financial crime. These crimes are often committed by organised groups that are highly skilled and mobile. The spoils of insurance fraud are used by these groups to fund other types of crime.

Experience shows that those who fraudulently claim disability payments from insurers also claim disability and other benefits from the Norwegian Welfare and Labour Administration. Tax evasion and abuse of the welfare system are not only a threat to the financial sector but also to society as a whole. The private and public sectors have a joint responsibility to prevent and combat this type of crime.

Consequences of insurance fraud

Fraudulent insurance claims result in higher insurance premiums for all customers.

Those found guilty of insurance fraud lose the right to policy benefits, become uninsurable and risk having to pay compensation and being reported to the police. The insurance system is built on

mutual trust between insurer and insured. Breaches of this trust are serious and are therefore often heavily punished by the courts. Insurance fraud is punishable by up to six years in prison.

Key crime prevention committees under Finance Norway

Committee on Insurance Crime:
The Committee on Insurance Crime (FKF) is an advisory body on fraud and other crimes against the insurance industry. The committee is responsible for loss prevention and loss reduction activities relating to fraud and other crimes in both life and non-life insurance. It monitors the results of the industry's crime prevention work and contributes to the publication of annual fraud statistics. The committee also provides advice and data for information campaigns.

Committee on Money Laundering:
The Committee on Money Laundering (FØKH) is an advisory body for the financial services industry on joint action to combat money laundering and terror financing. This includes introducing and implementing national and international rules in the area. The committee serves as an active listening post, monitoring regulatory initiatives and trends both at home and abroad. Relevant information is obtained and discussed, and the committee reviews applicable rules and formulates common interpretations and attitudes within the industry concerning their application and compliance. The committee has members from both banks and insurers and can make recommendations to member companies.

8. Definitions

- **Insurance fraud:**
  Where a policyholder claims, or attempts to claim, benefits from an insurer to which the policyholder is not entitled. This report covers only cases detected as fraud with reference to the Norwegian Insurance Contracts Act.
- **Application fraud detected at the application stage:**
  Where the policyholder knowingly provides incorrect information when taking out insurance in order to obtain cover the policyholder is not entitled to.
- **Application fraud detected at the claims stage:**
  Where the policyholder knowingly provides incorrect information when taking out insurance in order to obtain cover the policyholder is not entitled to.
- **Claims fraud:**
  Where the policyholder knowingly provides incorrect information about an insurance event to obtain a larger payout than the policyholder is entitled to.
- **Individual endowment – disability:**
  Cover taken out by the individual. A form of life insurance that pays a lump sum following the insured event whatever the cause (sickness or accident). Waiver of premium cover is a periodic benefit following disability that is linked to individual disability endowment products.
- **Individual endowment – death:**
  Cover taken out by the individual that pays a lump sum in the event of death whatever the cause (sickness or accident).
- **Individual pension:**
  Annuity insurance taken out by the individual that pays out in regular instalments.

- **Group life:**
  Cover taken out by the individual or by an employer that pays a lump sum in the event of death or disability whatever the cause (sickness or accident).
- **Child cover:**
  Primarily a sickness and disability product for children that pays out as specified in the individual insurer’s terms of insurance.
- **Critical illness:**
  A form of sickness insurance that pays a lump sum if the insured develops a disease defined in the individual insurer’s terms of insurance. May be taken out individually or collectively.
- **Group pension:**
  Occupational pension cover for employees in both the private and public sectors. A form of life insurance that pays out in regular instalments.
- **ROFF:**
  Database of insurance applicants and policyholders for insurers that are affiliated to Finance Norway and sell life insurance or other insurances of the person where there is a health assessment at inception. Insurers can search the database when selling policies and when processing claims for disability benefits. Insurances of the person on special terms and rejected applications for cover are registered in ROFF. The database does not contain health information, but this may be obtained from the insurer with the applicant’s consent.
- **FOSS:**
  A central database where Norwegian insurers register reported claims. The aim of the database is to streamline non-life insurers’ claims processing in terms of preventing and reducing insurance fraud. The database may only be used when registering claims and paying benefits.