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Commercial fraud awareness

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The Economy

Since early 2020, it has been widely reported that the COVID-19 pandemic has had a detrimental impact on the UK economy, with speculation that fraud will increase as a result. The Insurance Fraud Bureau (IFB) reported that insurance fraud had already increased by 5% during 2019 and were concerned that the economic climate could see the figure rise further in the coming years. The Association of British Insurers (ABI) statistics show that cost of insurance fraud to the UK economy in 2019 was £1.3b. With fraud already on the rise pre-COVID-19, there is concern across the insurance sector on the volume of fraud that we could see, as people and businesses continue to be financially impacted by COVID-19 issues.

The Office for National Statistics (ONS) published that GDP in the UK had dropped by 9.9% in 2020. This seems a large reduction but, to give it some context, the IFB reported that fraud had increased by 17% after the 2008 recession while the UK GDP only dropped by 2.2% in that period. We must, therefore, expect that fraudulent insurance claims will continue to rise in the coming years as a result of the UK financial downturn, across all lines of insurance business, including Motor, Domestic and Commercial.

It is accepted by many that Domestic and Motor fraud is common and is certain to rise but the perception is that Commercial fraud is not quite so prevalent. It must be said though that the motives for committing fraud are just the same for Commercial as they are in other sectors. That is, it generally comes down to financial greed, need or simple opportunism.

Prior to the pandemic, the full gamut of fraudulent claims was rising in Commercial claims, ranging from exaggerated genuine losses to staged and invented incidents.

Businesses that are experiencing severe financial pressure due to reduced incomes, are incurring ongoing operating costs, despite some Government assistance. There may also be a perceived injustice, if a Business Interruption claim has been rejected by the insurer. As a result, more business owners may be tempted to submit a fraudulent insurance claim, from need and greed, or potentially from a misguided desire for revenge, from their perceived injustice.

We must, therefore, be alive to the notion that business owners may be more likely to be tempted to commit fraud today than perhaps they would have been a year or two ago.

Exaggeration

Fraud can occur on any Commercial claim, ranging from lost money in Goods in Transit, to an exaggerated or staged Escape of Water claim. On a recent Theft of Stock claim, a business submitted a claim for £1,000s in stolen alcohol and cigarettes but could not provide documentation to validate the claim. This lack of documentation and other inconsistencies (e.g. a larger loss than normal trading would suggest) was a concern with no adequate explanation. We made additional enquiries, including obtaining local CCTV evidence which showed the culprit running away with a carrier bag of stolen goods in each hand. This evidenced that a genuine theft had occurred - but the size of the claim submitted by the policyholder would have required a large vehicle to carry the claimed items away. Fraud by exaggeration was proved and the Police were involved to pursue matters further.

This is no different from a Domestic policyholder exaggerating a burglary claim by adding a laptop computer, for instance, or an additional piece of jewellery. Some will take the opportunity of a genuine incident to exaggerate what they have lost for their own financial gain. Perhaps 'Exaggeration' is the most common type of insurance fraud and one that is often difficult to prove.

Fabrication

As well as exaggerated genuine incidents, we also see staged incidents where policyholders will fabricate a claim.

On Domestic claims, we may be presented with damage claims that appear staged, perhaps for expensive sofas or flooring, in the hope that Insurers will provide them with new replacements. These are investigated and are often shown to have been created deliberately. Paint being thrown about was common, until we started forensically examining the paint splatters, showing it could only have happened on purpose.

In Commercial, we are often presented with claims from landlords who allege that their tenant has caused malicious damage to their property. Many such claims will be repudiated as arising from general wear and tear but some require investigation, especially when there are inconsistencies or changes of story. The motive for these sofa claims on the Domestic policy or these landlord claims on the Commercial policy is the same. The policyholder is hoping that Insurers will replace/reinstate, in the belief that the worst that could happen to them is that Insurers might decline their claim.

We saw a claim from a business owner faced with the prospect of paying over £10,000 for a new specialist coffee machine for their premises. The machine had failed from an indeterminate cause but they made an insurance claim, stating their machine had been accidentally damaged, attempting to save themselves over £10,000, at the insurer's cost. The fraudster will have the view that it is worth trying to claim in the first instance, if they believe that the worst scenario is that the claim might be turned down. Where fraud is proved, however, many insurers will now consider further action and Police involvement. Safe collection of evidence is, therefore, vital and the early involvement of a Loss Adjuster's Special Investigation team can be key to successful prosecutions.

Combatting fraud

Claims like the above examples do occur but there are many ways to defeat the fraudsters. We look to obtain detailed information that describe and evidence the accident/claim circumstances. Once we have details from the claimant, each circumstance can then be checked and verified. We can request the service history for 'damaged' machines. Most will be under warranty or contract, so this should be available. The service history will show if the machine was already in need of replacement anyway. Whilst this in itself may not prove that it was then damaged deliberately, it can sometimes show that

the item had failed due to age, wear and tear and can also lead us to be able to recommend further enquiries, if suspicions are aroused.

Many policyholders do not realise it but investigators generally have specialist suppliers who can be called upon to inspect and report, to check whether damage is consistent with the circumstances claimed. A colour logo printing machine for T-shirts was claimed to have failed following rainfall entering a premises and 'soaking' the machine but, after testing by a specialist engineer, there was no evidence of any water in, or even on, the machine in question. The machine had simply failed. The owner cried, possibly out of embarrassment or despair, once the test results were put to him, bringing that claim to a swift conclusion.

We should also consider the ongoing battle against Organised Fraud or Crime Groups (OCGs). There are currently estimated to be 12,000 OCGs operating in the UK. The National Crime Agency is under capacity and can only target approximately 10% of the known OCGs at any one time. OCGs are not immune from targeting the insurance industry to commit fraud and they also target the industry to launder money. It is key, therefore, that we "Know Our Customer". Background checks at claims stage, as well as at proposal/inception, can reveal much about a policyholder/claimant and bear in mind that OCGs are most likely to operate in the Commercial space.

What can you do as a claims handler or loss adjuster?

Concerns and suspicions of potential fraud can be identified by using data research solutions. Whilst it remains essential that genuine claims are processed and paid in an efficient manner, open source investigations can provide detailed financial background and 'know your customer' checks. These open source intelligence tools (OSINT), along with the traditional in-house fraud risk identification processes, can alert the vigilant loss adjuster to risks and concerns and also provide evidence to show misrepresentation at inception/renewal, along with potential non-compliance with policy terms and conditions. Background checks help identify struggling businesses which may have motive for seeking financial gain, whether by fair means or foul, enabling additional and more detailed enquiry.

Covid-19 left many companies short-staffed, as employees were laid off, or went on furlough. This left the staff who remained, largely unsupervised and with little oversight. Others were left having to complete functions incompatible with their skills and usual duties, increasing opportunities for opportunistic fraudsters, as well as organised crime networks, to take advantage.

Government support during the pandemic has continued for longer than most expected but as it comes to an end now is the time to be most vigilant. As support for businesses peters out, the financial hardship suffered by some could drive opportunistic fraud in this sector.

Don't look only for suspicious fires that destroy a business. (This was traditionally the fraud of choice when a business was in trouble but is not so common now as we have all become much better at investigating those claims.) We must be alive to new trends and all claims handling staff should be aware that a policyholder is just as likely to exaggerate an Escape of Water claim for expensive items on their Commercial policy, as they are on their Domestic Contents policy.

There is no Claims and Underwriting Exchange (CUE) for Commercial claims but that doesn't mean that insurers can't speak. To detect and prevent crime and/or to aid the prosecution of offenders, the sharing of relevant information can greatly assist an investigation. A claim resulting from the flooding of a wine bar in Leeds was progressing normally. Accounts were provided by their accountant to support the BI claim and suspicions arose. Investigations commenced and it was found that the Wine Bar had never traded. Further, as the enquiry continued, it was picked up that claims were being made across four different insurers, for the same damage. Information was shared, the fraud was uncovered and was foiled.

Claims handlers and loss adjusters should carefully study policy terms and conditions, including Warranties and Endorsements, to ensure both compliance and that no misrepresentation was made when the statements were made. We must use all the tools in our armoury, engaging fraud investigation when concerns arise, to consider; to advise on potential referral to insurers; and to investigate as required. The raising of fraud awareness within our Commercial claims teams, to identify the risks and concerns in this sector, and a collaborative approach across the Insurance Industry, are vital to combatting fraud.