Fraud issues

Part of the claims handler's role is to help identify and fight fraud.

- Undetected general insurance claims fraud total £2.1billion per annum
- This adds £50 to the average premium

Key Investigation Indicators

The ABI Fraud Bureau has identified six key investigation indicator groups to help identify claims that may merit closer investigation. These are:

- Policy issues (recent inception, changes, newly added items)
- Attitude of the customer (aggressive, pushy, unwarranted complaints, evasive, etc)
- Suspicious documentation (too much, too little, altered, home-made, unprofessional, etc)
- Suspicious circumstances (unlikely coincidences, implausible events, etc)
- High value loss (either a single item, many items, value compared to policyholder's financial circumstances, etc)
- Any other indications (gut feel, tip off, etc)

Referral Process

Where key indicators are identified, it is recommended to follow the procedures agreed with insurers for combating fraud. This may begin with:

- Referral to the insurer's anti-fraud team
- Arranging for a loss adjuster or specialist investigator to visit
- An investigative telephone interview by a trained ITI specialist
- Screening against agreed criteria

Customers should not be advised that they are under investigation. For those who are fraudsters, it may lead them to conceal the fraud; for those who are genuine claimants, it may be perceived as an unjustified slur on their character.