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OF LOSS ADJUSTERS

Simplifying the complexity of international claims investigations

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Charles Taylor provides a growing range of insurance services, claims and technology solutions across the global insurance market, particularly in complex situations requiring specialist expertise. Their services and solutions support every stage of the insurance lifecycle and every aspect of the insurance operating model, across all major commercial insurance lines as well as technical areas of personal insurance.



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In this publication, we outline the various challenges presented by international claims investigations and the headline trends we have identified during the past year. We also describe some recent cases to exemplify how these trends manifest themselves in real life claims and how they can be addressed.

Introduction

From Afghanistan to Zimbabwe there are almost 200 countries worldwide. For a domestic insurer trying to investigate claims in this disparate patchwork of international territories, the challenges are significant.

Estimates vary, but global industry regulators and commentators consistently state that a double-digit percentage of all insurance claims contain a fraudulent element. It is our considered opinion, backed by many years of experience, that international investigations have an even greater exposure to fraud. This is because a large proportion of these claims involve multiple jurisdictions and legislative frameworks, making the associated fraud investigations highly complex.

Fraud remains a top concern for insurers worldwide. The Reinsurance Group of America's 2024 Global Claims Fraud Survey highlighted the ongoing challenges insurers face in managing fraud. Three quarters (74%) of the survey's respondents indicated that the number of fraud cases was either holding steady or increasing compared to previous years.

Challenges

The overarching challenge that international investigations present is that each country has a different legislative framework, its own regulatory set up and varying levels of corporate governance.

This immediately makes it extraordinarily difficult for a domestic insurer to develop the breadth of technical knowledge and cultural understanding required to handle claims effectively in multiple international territories. And this is before considering the logistical demands of managing people on the ground.

One recent article in *Forbes* put the prevalence of fraud at 20% of all insurance claims in the US. And that is in the country with the most rigorous counter-fraud legislation and protocols in the world. Our experience suggests that fraud runs at almost double this percentage in more immature insurance marketplaces. According to our own data, Nigeria, India and Pakistan carry the highest risk of fraudulent claims for insurers. Other high-risk countries include Cameroon, South Africa, Kenya, Uganda, Sri Lanka, Afghanistan, Romania and Bulgaria.

In addition to the maturity of the local insurance market, there are also a number of other factors that contribute to the prevalence of fraud, as detailed further down.

The infrastructure within a country has a massive impact on the ability of an investigator to complete their work. Issues range from the quality of basic transport networks to the availability of internet connections and telecommunication signals. We managed one investigation in which the investigator spent four days travelling on foot to secure the documentation needed to validate the claim because they had to traverse rough and remote country which had no roads or vehicular access.



Where carriers work with third party providers to investigate their overseas claims, the initial vetting and contracting process is hugely important to ensure individual investigators have the correct licences and work to pre-determined protocols and procedures. It takes time to develop such partnerships and to establish the trust and longevity that is essential to their performance over the long-term.

In instances where investigators are instructed on an ad hoc basis, it is almost impossible to deliver a consistent, effective and transparent level of service. And without an established operational structure, managing the cost attached to individual claims investigations becomes hugely problematic.

In addition, the application of pre-determined standards is central to ensuring the work done by investigators stands up to scrutiny. If an investigator does not have a detailed technical knowledge of the legislation and protocols within a certain country, they may invalidate the investigation. If they do not operate within the mandatory parameters, their findings will be discredited and could be inadmissible if the case goes to court.

This means it is essential that international investigators - wherever they operate - work to consistent benchmarks such as the International Association of Special Investigation Units' Code of Ethics and perhaps to an even higher standard.

In the course of investigations, it is not uncommon to come across corruption and collusion. Complicit parties can range from police officers and regulators to health practitioners and members of the public. Wherever this is uncovered, carriers need to be sure investigators have not engaged in any way, and that they report the incident and record it in their risk register.

If investigators are not beyond reproach, then their findings will not be robust enough to stand up to scrutiny and empower carriers to decline claims on the grounds of fraud. Nor will they be able to bring successful prosecutions via local agencies.

One of the major issues for domestic carriers investigating claims in international markets is their ability to provide an in-person and timely response. Trying to communicate remotely via telephone and email is simply unworkable. It delays the information gathering process and makes it more difficult to interrogate the facts of a claim.

Language and cultural barriers also present a problem for investigators coming into a country from overseas. If they cannot communicate fluently or do not follow the correct social protocols, it can antagonise those they are there to question.

Seasoned local investigators are much better placed to engage effectively with officials and members of the public and their importance in delivering reliable results cannot be overstated. But building a network of trusted partners that offers a genuinely global reach takes time and significant investment.

And overarching all these challenges is the need to deploy investigators quickly. The longer a claim goes unexamined, the more difficult it is to track down and speak to witnesses, to locate the officials in question and/or to secure original documentation and evidence.

Indeed, identifying false documentation is an enormous challenge. In many countries street vendors will draft fake documents to order and in plain sight. While experienced local investigators can generally weed



out these fakes on examination, it is not so easy for internal investigators at a domestic insurer who may be seeing documents from a particular country for the first time and in a foreign language.

Technology is having a significant impact on the ability of claims teams to validate documentation and to identify electronic files that have been altered or generated by artificial intelligence (AI). These advancing systems are already an important part in an insurer's armoury. But the sophistication of the IT has to be matched with the experience of human IQ to investigate the documents flagged for attention and to bring a successful investigation to fruition.

The use of technology - both by fraudsters and investigators - is a fast-evolving area of claims investigations and is one of the trends highlighted in the following section.

Key Challenges

- Varying regulatory and legislative environments
- Different levels of local infrastructures
- Vetting and contracting individual investigators to ensure they have the correct licences and work to pre-determined protocols and procedures
- Delivering a consistent, effective and transparent level of service
- Managing investigation costs
- Providing an in-person and timely response
- Language and cultural barriers
- Deploying investigators quickly
- Identifying false documentation

Current and developing trends

Large increase in opportunistic fraud across all lines of business

Many individuals and organisations continue to see insurance as an easy target and in difficult times take the opportunity to inflate or falsify claims. For instance, many national economies throughout the world are struggling and this has a knock-on impact on the prosperity of individual citizens. In addition, conflicts such as the war in Ukraine have exacerbated inflationary pressures and hit consumers hard. This loss of purchasing power is often reflected in claims activity. This highlights the importance of equipping carriers to identify fraud effectively while ensuring that genuine claimants receive prompt payment.

Jump in high-value organised travel insurance scams

The increased incidence of organised travel insurance scams suggests the travel insurance market is now being more actively targeted by criminal gangs. In the past year, we have uncovered 13 organised travel insurance frauds - those that involve multiple parties working in unison.

A typical scenario would see an individual claiming they had to cancel an expensive holiday because they had had an accident and were unable to travel. They might provide falsified documentation from booking



agents, travel companies and/or medical facilities to substantiate their claim. In reality, the trip was never booked and no one actually travelled anywhere, as the customer's identification was false.

Clients want to validate more high value claims

When signing off settlements that run to six, seven or even eight figures, insurers want to be certain. Increasingly they are turning to third-party experts to validate their own processes and to reaffirm that liability applies under the contract of insurance and that the particulars of the claim, such as the supporting documentation, are genuine. This trend to validate high value claims has been particularly prevalent in the life insurance sector.

Development of forensic document analysis software

AI poses a huge challenge to claims investigators because of its power to create false documents and images. Such documentation has historically been seen as a cornerstone of genuine claims validation by the insurance industry. But we can also harness AI to deliver huge improvements in fraud detection rates.

For instance, to cope with this industry wide problem, Charles Taylor has implemented its own platform, which is called "Detect" and is powered by technology from Fraud Detection Softwares (FDS). Operating in real time, the software inspects the metadata of each file and determines if it has been altered from its original state in any way and identifies all AI generated documents/images. The system verifies data in relation to the policyholder's address and/or loss location, as well as checking if documents have been through suspicious software or editing programmes. It can analyse the source code of PDF files to detect those that have been manipulated and will identify documents that have been used in other internal or external claims.

Collaboration between automated fraud detection software and investigation staff

It is essential to have automated fraud detection software embedded in claims handling processes. But flagging up claims that are suspicious is only one half of a successful investigation. These cases then need to be investigated to determine if they are fraudulent. And that means having a well trained and resourced team of experts with the capacity to conduct these investigations. IT is transforming the claims investigation sector, but it must be accompanied by human IQ to realise its potential.

Need for a technology solution to assist with open source intelligence and social media investigations

Examining open source and social media data is a powerful and effective approach in many claims investigations - particularly casualty claims. But in recent years, the volume of material, especially video footage, has become overwhelming and conducting a thorough search takes up an enormous amount of time. Charles Taylor has developed a proprietary technology solution that scans data and aggregates the most relevant information into reports for investigator review. The ability to pinpoint useful evidence amongst the vast library of open source and social media data is going to be an increasingly important differentiating factor for claims investigators. It is also necessary to develop solutions that have the ability to capture country specific social media and open source channels which may not necessarily be available when attempting to search out of country.



Case study 1

High net worth/homeowner policy

This unusual and high value claim involved a criminal who befriended an art collector over two years and then stole their \$2.4m Renoir painting. The criminal struck up the friendship based on a mutual love of art. They ultimately persuaded the collector to sell the painting, but never made good on the payment. The collector was based in Canada and the thief was in France. The criminal persuaded the collector to sell the painting and to show good faith said they would give them jade statues worth \$500,000 as collateral. The statues were delivered, the painting was transported to France, but the payment was never made.

The carrier instructed us to confirm the quality of the jade statues, and our investigations showed they were actually worth around \$5,000 - just one hundredth of what the criminal had stated. We registered the painting with art industry and law enforcement bodies to ensure it would be identified as stolen if it ever appeared on the open market.

Our international investigations enabled us to verify to the carrier that the theft had taken place, that the policyholder had owned the painting, and that the criminal had stolen it from them.

Case study 2

Life claim

We were contacted by a life insurer that had received a claim for \$750,000 for an individual who had died in Romania. The carrier had instructed a third party to investigate the claim, but they had been unable to secure sufficient documentary evidence to support it. The carrier then instructed Charles Taylor to re-investigate the claim.

We completed local on-the-ground enquiries, which entailed making multiple in-person visits to the death registrar. We were able to obtain written evidence that the death certificate that had originally been presented had been altered to show falsely that the individual had died within the policy period. In fact, they had died two years prior to the policy's inception and we secured written confirmation of this from the death registrar.

We also established that the document had been used to make an identical claim with another insurer, taking the overall value of the fraud saving to \$1.5m for both carriers.

Case study 3

Travel insurance medical claim

This \$15,000 claim related to costs incurred by the policyholder in Iraq, apparently after he and his wife had suffered an accident whereby both had fallen down a flight of stairs. His wife, who was standing beside him, had allegedly tried to grab the policyholder as he fell and in doing so, had also tumbled down the stairs.



The couple alleged that they needed emergency medical treatment and supplied photographs of their injuries to support the claim. But the only injuries sustained by both parties were to their noses. We attended the medical clinic in person and confirmed it was not an accident and emergency facility, but a cosmetic surgery clinic specialising in rhinoplasty. Our investigation established that the couple had travelled to Iraq to have pre-booked ‘nose jobs’ and then tried to claim for the cost of surgery on their travel insurance policy.

We procured photographic, written and verbal evidence to confirm this was the case and the insurer declined the claim on the grounds of fraud. Undeterred, the policyholder took the claim to their domestic insurance ombudsman, who supported our decision. The couple began legal proceedings, but eventually backed down when they understood that their insurer would work with law enforcement and defend the claim in court. Without investigating this claim locally, most likely the claim would have been paid.

Summary

Overseas claims are rarely straightforward and investigating them effectively comes with a wide range of physical, technical, legal, cultural and logistical challenges.

The only way to create consistency and certainty in the quality of overseas claims investigations is to apply robust and well-resourced processes. In turn, this means having an international network that can provide expert intervention quickly, in person and at the point of need.

Close collaboration between the carrier, the investigation company and local investigation resources is imperative. And it is the quality of this collaboration and the strength of the framework on which it is built that creates transparency in the both the standard and cost of claims investigations.

Domestic insurers face many difficulties when investigating overseas claims. Yet, it is an area of operations in which it is possible to make swift improvements in results and to generate significant financial savings on the back of improved fraud detection rates.

While overseas claims investigations are complex, they can be simplified through access to appropriate local resources and a detailed understanding of country-by-country legislation and licensing, supported by the effective use of technologies such as AI, open-source intelligence and social media.

Bringing these components together enables a more consistent, transparent and effective approach to international investigations, supporting better outcomes across jurisdictions.