Insurance Fraud : “The Pandora’s Box” ?

written by Ritika Khatua | February 24, 2020

The “Pandora’s box” is a metaphor in our modern languages and the proverbial phrase which refers to a basis of interminable complications or trouble arising from a simple inaccuracy. In today’s world, mankind has broadened its perspective and pushed their limits in every aspect scheming the probability of growth. With this, often comes the oblivious evil. The insurance industry is a highly rated business at present which focuses on risk management with the anticipation of uncertain peril. The insurance sector is solely the balance between contingent gain and hopeful loss. Moving forward to an analysis of the basis, impact, and control of risks that insurance sectors face while providing risk management.

The Basis

‘Insurance’ is basically an arrangement by which a company or the state undertakes to provide a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a specified premium.[1]

The root cause of insurance fraud is financial enrichment. Insurance companies offer policies that are diverse starting from life Insurance, health insurance, marine insurance, fire insurance, car insurance, travel insurance and insurance on different insurable objects and properties. When a company insures an individual entity, there are certain fundamental legal regulations to be followed up initially and till the end. The contract of insurance between the insurer and the insured is based on 7 basic principles which are the principles of *uberrimae fidei* or utmost good faith,insurable interest, *proximate cause*, indemnity, subrogation, contribution, loss minimization. The insurance is technically

called as an *uberrimae fidei* contract. This principle demands the parties entering into the contract to conform with the utmost good faith.

In the cases of life insurance, the insurer proposes specific questions through the application form very initially and the assured is under a strict obligation to suffice all the 'material facts' that might impact the decision of the insurer. Any insurance contract runs under the notion that all the stated information is diligently disclosed and true to the best of the knowledge and information of the insured. But with this good faith, the insurers are often unaware of the Pandora's box which they might open up or give scope to. i.e., the miserable insurance frauds.

The term 'insurance fraud' basically means the exploitation of insurance contracts through illegal means for financial enrichment. The mere concept of insurance i.e., protection against eventual risks is exploited. Although many cases of insurance fraud by the insurers have been recorded, major cases of fraud reported are committed by the policyholders who malign the insurance contracts by attempting to make more money through exaggeration and disillusion of claims. In the cases of life insurance, the frauds are mostly defined at the initial stage by furnishing false pieces of information in the claim form deceiving the insurance company. Cases of presenting false identity cards, false birth certificates, and covering up of pre-existing medical history are very common ways of executing a life insurance policy which otherwise is *void ab initio*. Application fraud, exaggerated claims, post-dated insurance policy, fake and unnatural deaths, fraudulent house owners, workers compensation frauds, false injury are prevailing insurance scams. Local *panchayats* are reluctant enough and issue fake death certificates that come across during investigation. There are astonishing cases of car insurance where the owner makes false registration of car with regard to the place for avoiding localised heavy premiums. Often, homes are burnt down, vehicles are purposefully destroyed, sold to a third party or leftover for obtaining automobile insurance with the wrongful claim of damage or theft. The close gap between buying of policy and pressing of claim is an issue that ultimately turns out to be insurance fraud. A combination of poor due diligence in scripting policies by insurance companies and the organisational skills of the fraudsters in identifying the possible places of effectuating frauds is taking a big toll on the insurers. Insurance frauds are mostly taking place in rural and semi-rural areas and insurers have identified around 80 Districts across our country who are seriously invested and growing in this fraudulent domain.

The

Hon’ble National Consumer Disputes Redressal Commission, on October 8, 2018 through
Revision Petition No. 4461 of 2012 against the order dated 03/08/2012 in Appeal No.
109/2012[2] held
that “*It seems that the disease was not active at the time of filing of the proposal form. In addition, this disease of LL Hansen has no relationship with the actual cause of death i.e. "Cardio Respiratory Arrest" and in the light of judgement of the Hon'ble Supreme Court in Sulbha Prakash Motegaonkar And Ors. Vs. Life Insurance Corporation of India (supra), its suppression would not lead to total denial of the claim. So, I am of the view that even if any information was suppressed in the proposal form, it cannot be treated as material information.*”
Critically analysing, this controversial pronouncement talking about the nexus between the cause of death and suppressed medical issue catalysed the scope of frauds and turned out to be alarming for insurance companies.
Impact
The occurrence of fraud and illegal encounters impact the concerned industry by clogging the workflow. In recent years, significant growth in the number of these frauds are observed and they are being operated through innovatice techniques while the insurers are still struggling to identify the potential threats. Insurance fraud is untraceable unlike visible crimes such as theft or murder. In the meanwhile, the finance is getting affected. But an insurer and the currently insured are not the only one who are facing the impact of these rising numbers of insurance fraud. Consequences are also being faced by prospective policyholders. Genuine claims are getting delayed because of this evil faced by the insurance industry. Further, at times, criminal offence like property damage or a crime as heinous as murder of the insured takes place to fraudently claim an insurance amount.
Fronting and Control
Insurance companies do have a legal right and a moral obligation towards shareholders and policyholders of objecting to and repudiating fraudulent claims. Massive losses over time have alerted the insurance companies for taking measures to eradicate insurance frauds. Some companies are already in the process of setting up separate fraud investigation departments. Anti-fraud policies at insurance companies and internal resource training are helping in the early detection of fraud cases.
Insurance Regulatory and Development Authority of India (“IRDAI”) recently turned up with the ‘Insurance Fraud Monitoring Framework’ to help curb insurance frauds and to help companies to prepare

better for spotting frauds.
'The 190th report on the Revision of Insurance Act, 1938 ("Act") and the Insurance Regulatory And Development Authority Act, 1999' [3] made propositions basically on Section 38, 39, 45 of the Act.
The suggestion made was that there should be a specialized insurance fraud bureau and that immunity must be provided to any person sharing information about suspected fraud.
Discussions were also held regarding the reconsideration of insurance policy in question after the expiry of two years.
"*The Law Commission accordingly recommends that in case of repudiation of the policy on the ground of misstatement or suppression of a material fact, and not on the ground of fraud, the premiums collected on the policy till the date of repudiation will be liable to be returned to the insured or the legal representatives/ nominees/ assignees of the insured. Having said the above, by the Law Commission wishes to reiterate that in a case where the insurance company is able to conclusively prove that the suppression or misstatement of a material fact was fraudulent, i.e., where the claimants have failed to show that such suppression or misstatement was not with an intent to deceive, the insurance company would be entitled to deny the claimants even the premium amounts since fraud vitiates the entire contract*."
Some of the common diligence implemented by insurers to handle the peril are as below :

- Acknowledging the possibility of fraud.
- Enquiry and cross-checks of documents from the initial stage to detect the fraud.
- Ascertaining the potential of fraud which may help minimise the loss.
- Use of data analytics and statistical analysis to detect fraud.
- Strategizing and improvising software or technical skills.
- Apportioning investigators and keeping records updated.

Conclusion
Some few extra bucks squeezed out of an insurance company doesn't seem to be a concern which might leave much of an influence on any successful and reputed company. But, unfortunately squeezing-off those extra bucks, time and again, hits the finance of the company quite hard.
While insurance fraud directly hurts insurance companies, the indirect victims of this crime are the policyholders who mostly are oblivious of the impact. The best way for everyone to avoid being the victim is to create awareness regarding this issue and be vigilant. Maintaining the

very essence of an insurance contract i.e., utmost good faith by both the parties, can actually secure everyone from the grasp of loopholes
After all, the evils from
Pandora's box or say the miserable frauds in the insurance industry can very much arise from a simple miscalculation and affect wretchedly.

- [1] See : https://www.lexico.com/definition/insurance
- [2] http://lawcommissionofindia.nic.in/reports/InsuranceReport-2nddraft1.pdf

Contributed By - Ritika Khatua
Designation - Associate
King Stubb & Kasiva,
Advocates & Attorneys
Click Here to Get in Touch
New Delhi | Mumbai | Bangalore | Chennai | Hyderabad | Kochi
Tel: +91 11 41032969 | Email: info@ksandk.com