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[Celebrating International Fraud Awareness Week 2024: Combating Insurance Fraud Together](#)



As we enter the International Fraud Awareness Week 2024, it's an opportune moment to reflect on the critical issue of insurance fraud along with the collective efforts required to combat it. The general insurance sector is intricately linked to most of the industries, such as infrastructure, automotive, healthcare, agriculture, and society as a whole. It is pivotal in strengthening the economy by providing essential financial security to individuals and businesses. Understanding why people hesitate to buy insurance despite its advantages is crucial. Why does the industry, despite a combined ratio exceeding 100%—indicating it pays out more in claims than the premium it earns—still face scepticism about its willingness to pay claims?

One primary reason for this paradox is the prevalence of insurance fraud, costing the Indian insurance industry crores of rupees annually. Fraudulent claims push claim ratios higher, resulting in increased premium costs and a trust deficit. Such deceitful practices stifle industry growth and adversely affect society.

At the heart of every insurance contract is the principle of “utmost good faith,” requiring all parties to act honestly and disclose relevant information. Quick claims processing and efficient payments help claimants recover from financial setbacks without delays, improving public perception and motivating more individuals to consider insurance.

However, fraud undermines this trust and hampers insurers' ability to handle genuine claims efficiently. With past experiences of fraud, insurance companies have developed systems to track and mitigate fraudulent activities. Nevertheless, fraud consumes valuable operational resources, such as workforce and financial reserves.

Some of Common types of insurance fraud which affect good relations include:

Staged Accidents: Fraudsters deliberately cause accidents to file false claims for vehicle damage and personal injuries. For example, some may stage a fire accident at their factory when revenue declines. They aim to recover losses and benefit from insurance claims by staging such an accident.

Phantom Billing: A fraudulent practice where healthcare providers inflate or create charges for services that were never provided to the patient. This is often used to exploit insurance benefits, resulting in unjust financial gains for the provider while driving up costs for insurers and patients alike.

Fake Policies: Perpetrators pose as authentic insurance entities to sell fake policies, collecting premiums for non-existent or invalid policies. exploiting the trust of individuals seeking genuine coverage. Since these policies are fraudulent, they hold no legal validity, leaving victims without actual coverage and often unaware until they attempt to make a claim.

Non-existent Damage: Insured individuals exaggerate claim amounts by intentionally damaging or misrepresenting the condition of insured property to receive higher pay out.

To avoid becoming victims of fraud, customer should follow these protocols:

Verify Policy Authenticity: Ask for the insurance intermediary's valid license and confirm their authorization. Visit the official website and contact the company to verify the policy's authenticity.

Check the Channel: Purchase policies from reliable sources. If buying online, verify the insurer's official website domain, as fraudsters often create fake websites to deceive customers. Verify the insurer's official website domain and use secure 'https' websites.

Use Empanelled Services: Avail services from empanelled hospitals and motor garages for quality care and discounted rates.

Opt for Safe Payment Methods: Pay the insurer directly via cheque, debit/credit card, or online modes to create a clear transaction trail.

While vigilant customers can prevent many instances of fraud, insurers also leverage forensic science, data analytics, and advanced technology to detect and prevent fraudulent activities. In collaboration with the government, regulators and institutions like Insurance Information Bureau (IIB), VAHAN, UIDAI, RTO, CCTNS, court records, and the Medical Council the industry is actively working to address this issue to enhance fraud detection, risk identification and prevention. This integration would allow insurers to receive early claim notifications, leading to faster settlements and reduced litigation.

By staying informed and cautious, customers can protect themselves from fraud. Together with the industry's efforts, we can create a more secure and trustworthy insurance environment. Bajaj Allianz General Insurance is committed to fighting fraud and ensuring that genuine customers receive the protection and benefits they deserve. We strive to build a robust and transparent insurance ecosystem through continuous innovation and collaboration with stakeholders.

As we mark International Fraud Awareness Week 2024, let's pledge to stay vigilant and work together to combat fraud, ensuring a safer and more reliable insurance landscape for everyone.

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