Fraud detection and prevention

The term “fraud” has not been clearly defined. Fraud is more than a misstatement, an error or a misrepresentation. It typically consists of two distinct components:

- A misrepresentation of a material fact
- The intent to deceive another party

The circumstances of the claim appear suspicious

- The claim is sent early
- A high sum is insured
- The insured died abroad
- The documents look suspicious

A misrepresentation of a material fact

Fraud detection and prevention

When to be alert?

- The circumstances of the claim appear suspicious
- The word of fraud spreads quickly, like wild fire. If a company does not pursue the “small” frauds, the successful swindlers will spread the word. There follows a vicious circle where there is more and more small fraud which then leads to the confidence to perpetrate higher value frauds. In most cases, it will be worth pursuing because the police and courts may be involved. Once a fraud is found out, it can be turned over to the police who will investigate it, causing the insurance company does not pursue the “small” frauds, the successful swindlers will spread the word. There follows a vicious circle where there is more and more small fraud which then leads to the confidence to perpetrate higher value frauds. In most cases, it will be worth pursuing because the police and courts may be involved. Once a fraud is found out, it can be turned over to the police who will investigate it, causing the insurance company may require a waiting period, and make allowance for various insurance contract law

To ensure the validity of a claim:

- Is the claim fraudulent?
- Is the claim included in the effective insurance cover?
- Does the claim fulfill the contractual obligations?
- Is the claim included in the effective insurance cover?
- Has the event occurred within the covered period?
- Has the premium been paid?
- Does the claim fulfill the contractual obligations?

Fraud, the assessor has to

- Verify whether there could be misrepresentation or fraud, and be aware of existing requirements for medical expertise so that they can be of help in case of a lawsuit

Conclusion

In order to come to a justified and suitable claims decision, which should always be at the centre of everything a claims assessor sets out to achieve, the assessor will need to:

1. The legal area – in far greater detail than the court decisions, policy conditions and the insurance law but also with the contractual obligations and check the exclusions
2. The medical area – it is very important to calculate the degree of disability, to plan the medical progress, if it is presumably permanent, and of course to work out the remaining working abilities: the claimant is capable of
3. The occupational area – i.e. be familiar with the job profile, have occupational expertise as to what kind of work will be possible for the insured
4. The administrative area – i.e. check the contractual obligations and check the exclusions for the insurance contract amount. Additionally, the insurance claim process may require a waiting period, and make allowance for various insurance contract riders and sublimits.
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7. The administrative area – i.e. check the contractual obligations and check the exclusions for the insurance contract amount. Additionally, the insurance claim process may require a waiting period, and make allowance for various insurance contract riders and sublimits.

Claims management incorporates all the functions performed in handling claims across all product lines from life or Accident business through to Critical Illness or Disability.

Is your company ready to deal with claims management?

Is the insurance cover effective?

- Has the premium been paid?
- Has the event occurred within the covered period?
- Does the claim fulfills the contractual obligations?
- Is the policy definition met (accident, critical illness…)

With worldwide expertise, SCOR Global Life is well positioned to help your company develop a tailor-made solution for claims management. For further information please speak to your usual SCOR Global Life contact.

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The role of the claims assessor

The primary function of the claims assessor is to pay eligible claims correctly and promptly, and act as an ambassador to prevent the ineligible claims. The challenges are to confirm the accuracy of the answers on the insurance application and to ensure that the insured condition has been met, or the challenge is to verify whether the answers on the insurance application are accurate. It is the claims assessor’s job to determine whether the information is complete and accurate.

Focus of claims assessment is dependent on insurance cover

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High value claims are likely to deserve more attention, particularly if they are made early in the life of the policy. They often require someone who has medical qualifications to be involved. There is no doubt that it significantly reduces the response time and makes the claims assessment process more effective.

We have discussed hereafter some of the new techniques insurers carry out in order to achieve these benefits.

- **Tele-claims**
  - They are becoming more and more common and are able to build rapport with the person dealing with their claim.
  - They are being used by the insured, as well as a tool to avoid postal costs and reduce the cost of claims assessment.
  - Insurers can obtain an excellent insight into their customers by listening to their claims.
  - It is surprising the amount of information people know about their medical situation. For example, claimants suffering from cancer tend to know the grade and stage of their disease, what their treatment is going to be and what their prognosis is. Another positive aspect is the possibility for the claims assessor to get a feel for whether somebody is telling the truth and answering questions correctly or stumbling and answer incorrectly. A good option because the customers like speaking to somebody who has medical qualification.

- **Training in conversation management or techniques for dealing with customers**
  - There is no doubt that it significantly reduces the response time and makes the claims assessment process more effective.
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  - They are being treated like individuals and are able to appreciate the calls.

In conclusion, the tele-claims service provides considerable benefits to both insurers and claimants alike. There is no doubt that it significantly reduces the response time and makes the claims assessment process more effective.

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**Reduced costs**

- The claims assessor may also have to determine whether they could perform an occupation for which their professional work experience or training renders them suitable. Against different rules apply in different countries. For example, in Germany, the assessor would have to ensure any occupation for which they determined the claimant was suited follows the insurance contract.

- The policyholder should be able to qualify for entry into the labour market.

- The insured should maintain his social status and his income.

**Time-savings**

- Key to the assessment of disability insurance is the information which the claimant collects from the claimant.

- To summarise, the main task of a claims assessor is to check for any non-disclosure or misrepresentation before determining whether the claimant meets the claims criteria. The assessor will make a range of investigations using a blend of written and verbal communication. The philosophy of any insurer should be to pay all valid claims promptly and to avoid payment for any invalid or fraudulent claims.

- It is important that an insurer has an efficient and well-run claims department to ensure that this is achieved.

**Accurate identification of valid/invalid claims**

- The quality of information allows the assessor to approach the claim in a much more tailored way considering only the medical attendants who will have the best access to medical records and allowing the assessor to ask more targeted questions. Ideally, insurers in the UK who have adapted tele-claims report a substantial reduction in their medical budget and have even saved thousands of pounds in postal costs.

**Reduced complaints**

- Besides, the customers really appreciate the calls. They are being treated like individuals and are able to appreciate the calls. Overall, it improves the profitability of the portfolio by increasing the assessor’s ability to spot fraudulent or invalid claims and reducing the cost of claims assessment. The insurer’s image is also improved through positive customer service.