INSURANCE FRAUD

Junior Lecturer **Elena Popa**
„Dunărea de Jos" University, Galaţi
neculaelena2003@yahoo.com

Abstract:

The present article aims at proving that the Insurance fraud has a significant number of facts antisocial of economic and financial nature that have been little discussed although they the cause of serious damages to the insurance companies.

Insurance fraud is a phenomenon extremely harmful that is to be met in the Romanian insurance companies as well as in other countries in the European Community, Canada or USA. The real problem with this issue is that it does not get enough attention, being a very serious one, although not as frequent as other forms of economic and financial criminal acts.

In the fight against insurance fraud, the insurance companies have to conjugate their efforts into detection and neutralization of policyholders of bad faith in their attempt to frame or to produce, intentionally, insured events, as well as into actions of removing the causes generating fraud, more precisely into drafting and adoption of control methodologies specific to each insurance company, creating new departments specialized in combating fraud in the insurance.

Keywords: insurance, fraud, injury, precedent

The word comes from the Latin fraus-fraudis, being seen as the act of bad faith committed to obtain a profit. In the legislation in force in the insurance, fraud is not defined, and the specific facts of insurance that constitute the crime of fraud are not described.

With the U.S. and the European Union this activity is regulated nationally by specific laws and structures specialized in investigations and control, in Romania, currently, there is no legal regulation on the concept of insurance fraud, a definition of facts constituting crimes in this area, no database on people who intentionally produce damage insurance, nor bodies and institutions specialized in combating this phenomenon.

A large proportion of the payment of compensation for the risks insured is represented by events produced intentionally or by staging, known among general practice insurers as the insurance fraud.

Insurance fraud encompasses all crimes committed in a period in the security system on the national territory. The offense is "the fact that is assumed to be a social peril guilty as provided for criminal law". It also implies committing any of the facts that the law punishes as crime consumed or as an attempt and participation in the commission as author, instigator or accomplice.

In the concept of fraud insurance covered all human behaviors prohibited by criminal law which affect the security system.

Typically, the stages of an insurance fraud are:

- preparation of fraud to obtain insurance
- claiming the insurance for a fake injury
- Exploiting illegal insured damage
- committing them deliberately.

In the area of specialty is known more criteria for the classification of fraud, among which we mention:

A). After the number of people involved in committing the fraud:

1. Individual simple fraud - in which case the derogatory claims more than his due[248]

2. complex fraud, which may be:

- Internal fraud - in which case the derogatory cooperate with representatives of insurer

- External fraud - in which case the derogatory collaborate with individuals or with representatives or officials of institutions, this collaboration can be direct and indirect[249]

3. influence through fraud - in which case representatives of the various organs of the state
intervene, directly or indirectly.

B). After the type of insurance:

1. Fraud produced in the optional insurance, among which are mentioned: damages of accidents, auto thefts and fraud insurance products in the maritime transport.

2. Fraud produced in the motor vehicle liability insurance mandatory

Another classification can be:

1. actual fraud - are all criminal acts committed on the territory within a specified period of time
2. apparent fraud - include all offenses in the security system signaled by the criminal justice system and registered as such
3. fraud laws - are all criminal acts for which they pronounced judgments, condemning remaining final.

In the case of voluntary insurance and liability, the insurance contract is a contract of indemnity (of compensation). Under this contract, the insured or injured person (in case of liability insurance) is compensated for an injury resulting from insured events unfolded. Under these circumstances, the insured person is not supposed to obtain a benefit from this event.

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[248] For example, somebody claims the total painting of the vehicle although the findings should be part of a painting of elements of the property damage, or claims the replacement of a bench in a situation when the findings that should be repaired are located respectively ş.a.

[249] Improper framing of facts, made intentionally or in ignorance.

According to this principle (to repair the injury), the policyholder/derogatory is reinstated in the accounts which he had an advance of damage. So the basic concept of insurance is to compensate for losses incurred, not obtaining a profit.

In practice, however, following profit-making, fraud is frequently done in insurance.

The facts on the intentional production of the risks insured or staging of events which is insured risks (fire, theft, traffic accidents, etc.) are covered generic and sanctioned by the Criminal Code.

Thus, the deed of making incorrect statements on the conditions, the conclusion of the insurance and real production claims, to present data on the unreal insured risk, to provide undue compensation, over compensation, to submit false documents on the purchase of parts needed to repair, to prepare estimates for repairs inconsistent with reality, etc. often take forms of crimes by deception, forgery, use of false or abuse in the service when they are perpetrated by employees of an insurance company or by the finding bodies.

Insurance fraud are generated and favored by numerous factors such as economic and financial, legal and psychosocial factors including: the forms of organization and regulation of the legal business, insufficient funds, external and internal controls, business, public opinion, insufficient legal regulation etc. At the same time, insurance frauds are amplified and diversified by the abuses, shortcomings and negligence which are manifested in the work of insurance companies in determining damages and payment of damages.

In the insurance companies in Romania are recorded cases of complicity in acts of deception committed by the insured persons, preparation of bogus documents (invoices, contracts, arrangements for payment) and appropriating the money for these, committing abuses, corruption and negligence in handling records of injury and payment of damages.

In many cases, insurance fraud is favored by employees of insurance companies, in breach of willfully, by negligently laws and regulations relating to contract administration and insurance, or by mistreatment records of damage.

At the conclusion of insurance contracts and policies either they do not comply with the conditions of the insurance, or inspections of risk on the integrity and value of properties insured, and capacity payment are not carried out, or the insurance company carries out inspections of risk to other goods (bearing the identification of properties insured) than goods insured.

In many cases the insurance risk is concluded only after the damage is done, or the value of goods insured is over-exaggerated without analyzing the effectiveness of contracts to be concluded.

At the same time, payments of undue compensation and insurance fraud are favored by complicity and failure by the inspectors of damage insurance, rules and methods for handling files of damage, through the adoption of technological solutions without complying with the instructions in force, such as: replacing damaged parts that can be easily repaired; payment of compensation for uninsured

risks; the misuse of wear coefficients; payment of equipment not included in insurance; risks insured or committed before the conclusion of assurance.

The most common frauds are those related to the intentional production of risks insured, such as: staging of thefts; overestimated damage; preparation of findings and technical expertise inconsistent with reality; presenting unreal estimates of repair and labor; optional insurance to a value greater than the real value of the property; insuring additional equipment at a very high value; insuring a vehicle without informing the insurer about the existence of problems on the property, etc.

There are frequent attempts to fraud insurance companies by inflating the damage and making the required compensation for the risks insured higher than they really are (risks being caused by fires, floods, landslides and other phenomena that affect the construction and other goods).

In these forms of insurance there are numerous cases of presentation, by insurance policyholders or beneficiaries, of invoices and false accounting documents on the purchase of goods and spare parts. Sometimes it even happens that these false documents are issued by "ghost" companies. Usually, for the cast are presented invoices and receipts without valid tax, issued by companies not validated to the Office of National Trade Register or firms that do not have such activities as object of their activity.

It is also of common practice the conclusion, using fraudulent means, of optional insurance contracts for cars brought from abroad that, for various reasons, can not be registered in circulation and are then intentionally ignited and burned completely to seek civil damages from the insurance risks.

For the preparation of insurance contracts are given to inspection of risk, cars registered in circulation, having the same color, type and brand with unregistered cars. In statements and insurance contracts, with the complicity or negligence of employees of insurance companies, identification data (series chassis and engine) of unregistered vehicle in movement are recorded, after which they are involved in the events insured.

Other times, cars that can not be registered, which are in an advanced state of wear and risks covered by insurance products intentionally, for which contracts have been concluded by insurance, are repaired, sold and put into circulation in place of legally registered cars.

Met in practice the presentation of another vehicle to the insurer, the real car (to be insured) is already damaged or stolen, but unreported to the police or already received compensation from another insurance company. Another common practice is insuring a vehicle (for usually with high value) that will then be sold by the owner of a wreck (similar vehicle damaged already) at a price much lower, without documents, after which follows the declaration of the insured vehicle theft; or insurance for failure or damage existing (hard to view at the inspection of risk) for the benefit of future repairs.

Some frauds, with particular consequences for insurers, are committed by business partners of insurance, service sites and auto insurance intermediaries.

Abuses are often committed in car services such as: deception or other criminal acts related to reality and fairness of repairs made to damaged vehicles of insured risks; production of bogus documents for the replacement and repair of auto parts and subassemblies; estimates of labor inconsistent with reality; higher prices than those under laws, etc. Higher prices than those agreed by the conventions concluded with insurance companies, supply lines and added undue commercial for auto parts used to repair vehicles, etc. are pretended to be charged by these units.

In recent years, cars thefts have an upward course, many of which are committed by organized groups of criminals through skills and methods difficult to detect. In Romania gangs of criminals have begun to organize, based on the model of mafia criminal groups, with the main concern in marketing abroad the stolen cars. Each member of the organization is specialized in a particular activity: tracking and stealing of the car, preparing false documents or false registration numbers, transporting and exploiting the vehicles. At present, to protect the car, there is no alarm system that can not be disabled by gangs of criminals. There is a preference in stealing either luxury cars, which are sold abroad, or domestic origin cars, which are dismantled and sold piece by piece.

Often, stolen cars are returned to the market after the successful amendment of the chassis or by changing benches, windshields, engines, etc.

There are frequent cases when cars are sold by owners either to the criminals or to persons of good faith, after which they are reported to the police and insurance companies as stolen by unknown authors. Most times, cars sold are removed from the country with the complicity of policyholders, by networks of traffickers, specialized in this area and they are recovered in other European countries.

Many luxury cars, stolen abroad, introduced in the country, are assured CASCO and then destroyed to make the staging of events provided. In general, they destroy vehicles under international tracking or fold under seizure.

Many thefts of cars are registered in police records with unknown authors. For stealing cars, criminals used ingenious modes of operation, special instruments made particularly for the appropriate types of vehicles to be stolen.

In the insurance of motor vehicles there are frequently committed thefts by dismantling and selling of motor vehicles. These are cases of intentional production of road accidents followed by partial or total ignition of vehicles, preparation of the minutes of finding inconsistent with reality, and the presentation of fictitious documents for procurement of parts or overstated repair estimates.

Important damages are paid by insurance companies on the basis of the minutes drawn up by employees of the police, inconsistent with reality (i.e. changing the date of production of the accident or changing the guilt of individuals involved) and on the basis of prior agreements, between those involved the events, on the task of determining guilt of the person who holds the insurance policy of compulsory auto liability. Sometimes, the guilt of persons involved in such events is determined or suggested, contrary to the dynamics of road accidents, even by police workers or even by the employees of the insurance company.

Insurance losses generated by such practices will be even higher by the introduction of constant settlement on the insurance market, when guilty persons involved in light traffic accidents is to be established by policyholders and insurance companies.

Another widespread method of committing fraud in auto insurance is the approval and opening of several cases of damage with several insurance companies to the same car accident. Thus, concluding such policies of insurance liability requires more than one insurance policy for the same vehicle, followed by the declaration of the event to the police departments of different localities, thereby achieving multiple damages from several insurance companies. Typically, in these cases, direct repair of damaged car is requested.

In the case of insurance of goods during transport, the most encountered fraud is represented by acts of deception in connection with the reality of the risk insured and the damage caused, or committing intentional road accidents followed by total or partial destruction of goods transported, as well as cases of presentation of bogus documents on the amount of transported goods, etc.

In the work of insurance intermediaries (agents, legal persons and brokers) violations of rules concerning the conclusion of insurance contracts are recorded. Such violations are: no insurance risk inspections, after the claims (antedating the insurance document), non-submitting the insurance premiums within limits (the intermediary must comply with a deadline of reporting and filing documents, insurance) or appropriating them, without justifying documents received from branches, as well as fake delivering of the slips from branches, and receiving undue commissions, etc.

One of the most dangerous and serious fraud committed in the insurance constitutes an intentional distortion of financial reporting and misappropriation of assets.

Fraudulent financial reporting is performed by distortion, falsification or deliberate omission of values or presentation of false information in the financial statements. It consists of manipulating or altering accounting records and documents, their erroneous interpretation, intentional omission of events, transactions, and technical reserves of injury or other significant information, or by intentionally applying the wrong accounting policies related to assessment, recognition, presentation or description of information.

Most of the time, reporting and distortions of economic and financial situations are evaluated by factors leading to conceal actual results and performance indicators, to obtaining undue advantage materials, to complying requirements of the insurance market, maximizing revenue as a result of performance management, influencing perceptions of performance and company profitability, etc.

Embezzlement of assets entails acquiring company assets by employees (alone or in collusion with others inside and outside the company), through a variety of ways. The most common ways of committing crime is the issuance of receipts and other bogus documents, the acquisition of physical assets or intangible assets, payments for fake goods and services, the use of assets for personal purposes, etc.

In practice, to prevent and combat fraud in the insurance involves, in addition to knowledge favored causes and ways of manifestation of fraud, investigation and verification of claims on the reality of their production, the extent and size of the damage and the legality of the payment of compensation required.

Investigation of the main events is provided in analyzing the contents of damage files, checking facts and dynamics production risks insured, reality and the authenticity of documents presented for determining the correct compensation and the guilty persons, measurement and research on the spot, consultation documents and carrying out technical surveys or otherwise, collections of information, making pictures and hearing of witnesses, etc. All these run, preferably, on the spot, as soon possible after the commission claims.

In analyzing the content of files and damage assessment data contained in papers and documents are prepared to respect the methodologies of finding claims of products, rules of organization and to resolve the damage files and regulations specific to each type of insurance issued by insurance companies. At the same time, it aims to checking if those recorded in printed documents were made without changes and erasures, if they crossed the minutes of finding in the boxes that have not been completed (in order to avoid further additions), if these entries are signed by people involved in events, etc.

When checking for the reality of damage, for the fairness of acts and legality of the prepared damages, there will be particularly analyzed the cases of damage to be found that the notices of injury were made late, records of finding are made superficial or incomplete, there are contradictions between the acts in the dossier on the date the damage occurred, the date of approval, the dynamics of the event, and any other suspicions.

It will be checked whether parts bought for cars of foreign origin repair were purchased from the companies mentioned in the bill and the prices recorded in the documents will be identified with the Trade Registry firm designated in the bill, aiming to prove whether the repair bills submitted by policyholders or harm were not issued by "ghost" companies or by ones to have changed the activity meanwhile.

Insurance fraud, a phenomenon particularly harmful, is not to be evident only at insurance companies in Romania, but in all the countries of the European Community, Canada, USA etc. It registers remarkable growth in terms of frauds, thefts and trafficking of insured cars.

Studies of these countries shows that policyholders believe that it is immoral to be overstated a claim that is acceptable and to obtain a profit from a claim, even if it is legal. Over 50% of interviewed people in studies in Britain have not found anything wrong with a coin fraud to obtain compensation from insurance.

In the U.S. and some Western countries of the European Community it is considered normal for the policyholders to receive undue compensation for the reason that they have paid for years to fund insurance. This moral concept is known in the literature as "compensation culture". In fact, most citizens of these countries

do not consider a fraud that tries their peers and sometimes succeed in obtaining the insurance compensation unwarranted.

Sometimes, in situations in which policyholders have received "satisfactory" compensation by fraud, they constitute opinion formers, and give directions to colleagues, friends, neighbors who record damages for insured risks, how to proceed for redress bigger. Moreover, once they committed fraud and they have not been discovered and punished, since a precedent was created, people who have received overpayments persist in the commission of other cases of fraud.

It often happens to lose sight of the fact that insurers are financially affected by the amounts paid without a real cause and that the financial effect, caused by fraud, is to be recovered, in the following years, by increasing the premium of insurance that will be paid by all the policyholders.

Therefore, here it is a picture of how harmful the insurance fraud can be, how big is the impact of the insurance risk factor on economic and financial losses and how important is knowing the problem in order to organize the necessary self protection and the fight against insurance fraud.

Awareness and combating fraud will heavily depend on the solutions adopted at the insurance companies, the accuracy of the concept determined by control structures created, on the methods and means used and the financial resources allocated for this purpose.

In Romania, the work to combat insurance fraud is left (unlike other countries) only on account of insurance companies.

In the U.S., the fight against insurance fraud is a federal issue, it is led and coordinated by the Directorate of the investigations into insurance in the FBI and the Division for the Prevention of Fraud in Insurance, founded by the insurance companies. The European Union operates with the European Committee Insurance to develop strategies and laws to prevent fraud.

In the absence of comprehensive regulations and specific security measures, combating fraud does not deliver the results that the insurance market would like. Most cases asked to the prosecution of persons who have committed crimes in insurance have been removed from the track due to the lack of knowledge of the scope and forms of crime manifestation, lack of specific regulations on insurance fraud and gaps in existing legislation and in some rules of insurance.

On the legislative, the basic concern of the insurance companies should be the development of standards to define and incriminate distinctively the activities within the scope of insurance fraud and the creation of bodies to coordinate activities to combat fraud at the national level. In the absence of specialists, however, frauds are hard to detect even if they are a common practice.

Uncovering fraud implies joint efforts of removing the causes generating fraud of all insurance companies (in the country and abroad) in the detection and neutralization of bad faith policyholders who are trying to frame or to produce, intentionally, events and assured action. It requires the elaboration and adoption of control methodologies specific to every one of the insurances, the creation of specialized departments in combating fraud at insurance companies. Meanwhile,

the fight against insurance fraud requires adoption in Romania, a suitable law for the insurance market after accession in the EU.

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