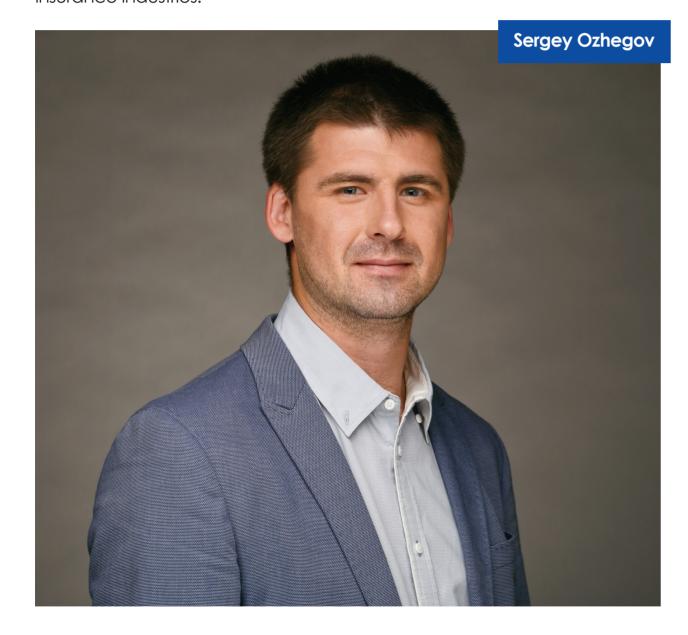# Occupational fraud
an insurance time bomb

How to detect and prove
occupational fraud in
insurance industries.

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O ccupational fraud makes a home in each and every industry, financial and business services, insurance, healthcare, hospitality, retail and more. However, to control rapidly increasing fraud cases, we need to work on certain strategies. In this article, we'll discuss how to change the situation in insurance companies.

What it takes to become an insider

In South Africa, a third of all insurance claims were considered fraudulent by the SAICB and cost the industry R15 billion (GBP 700 million) and these are the cases that were announced. The experts say that it is possible to radically change the situation for the better by active interaction with anti-fraud organisations such as the Insurance Crime Bureau (South Africa), the European Anti-Fraud Office (OLAF), etc., since they help with investigations and provide training to organisations. Then a full-fledged exchange of information between law enforcement and insurers will be provided as well as between insurance companies themselves.

However, if fraud involves accomplices within a company, then these measures will not be effective for a long time. KPMG calculated that it takes an average of 18 months from the source of the fraud to the violation discovery. Imagine how much can be done within a year and a half of intensive work. A coalition between a client and employee has virtually unlimited possibilities to harm a company: first at the contract signing stage, then at the stage of settlement of losses. Fraudsters inside can

- help insure non-existent property;
- backdate a policy;
- overestimate the real value of the insured property;
- hide a fraud, for example, that a healthy person is insured as a person with incurable diseases; and
- hide insured event fraud, for example, the fact of the staged property theft;
- and much more.

Let's consider a couple of examples from our clients. The branch of an insurance company, in which there were 11 agents, had been unprofitable for a long time until the risk management department found the reason. The backdating sale of insurance policies was a common thing in this branch.

The employees of another company actively faked photos of the condition of insurance objects. With the help of Photoshop and average design skills, the employees made completely wrecked cars out of simply scratched cars. Moreover, the employee of the insurance company at the stages of coordination with the service station and the settlement of losses for remuneration accepted this photo evidence.

Copying current customer databases is a different event. However, it is impossible not to mention it in the context of the conversation. In case of leaking a database to competitors, the damage can be more significant. In addition, in order to assess the magnitude of problems, you don't even have to appeal to the experience of clients, it is enough to google "sale proposals for database of insured persons" on the Internet.

Fraud-fighting strategies

Abuse of functions is often hidden, according to our study, 49% of companies do not report incidents related to employee actions. The conspiracy of fraudsters inside and outside the company are difficult to detect and difficult to prove. Nevertheless, this does not mean that insurers have nothing to do with this situation.

A set of effective measures – to adopt in a company to fight against corporate fraud – may look like this:

1. Use employee screening while hiring

A fraudster is often a chronic diagnosis. If you use screening tests, malintent will come to the surface at the stage of the interview. From the first days of employee screening, the number of security incidents involving newcomers is half decreased. You can check a potential employee using different methods: lie detector, databases, interview, etc. Depending on the concept and characteristics of business, employee screening will be different.

2. Apply anti-fraud programmes not only to customers, but also to your employees

Antifraud programmes are a set of measures that can significantly reduce the risk of fraud. These programmes are actively used in banks, less frequently in insurance. Measures usually include:

- Staff training;
- Identification and control of competing interests;
- Internal audit;
- Physical and logical access control; and
- Coordination and authorisation procedures.

These programmes can be deployed both manually and automatically using special software.

3. Monitor employee activity

The first option is to detect risk groups. This approach assumes that an investigation is being conducted against those who somehow attracted the attention of a security department. The primary interest is to detect the employees whose level of expenses is much higher than the level of income. Thanks to this approach, the risk of disrupting working atmosphere is mitigated, but there is a great chance to miss an important incident.

In the cases described above, the violations were detected with the help of data loss prevention software (DLP). It allows you to control the entire team in automatic mode and find information about dubious negotiations both written and oral, changes in documents and images. This is the second approach. With the amount of information that gets accumulated in companies, automated systems are becoming more widespread.

In my opinion, a comprehensive approach is needed and this kind of approach can be implemented by installing modern employee monitoring systems, as they help to monitor online and anticipate malicious activities of employees, thereby preventing fraud and, if necessary, conducting a retrospective investigation and collecting evidence. ∎

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