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Uncovering The Layers of Insurance Fraud in India: A Study of The Legal Landscape

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ABSTRACT

Insurance can be described as a contractual agreement in which a company commits to offering financial protection in the form of compensation for specific losses, damages, illnesses, or deaths to a person called the "insured". This assurance is provided in exchange for the payment of a predetermined premium. Insurance fraud takes place when an individual intentionally engages in activities with the aim of deceitfully obtaining an undeserved benefit or advantage, or knowingly denies a rightful benefit that someone is entitled to. India is a significant market for global insurance companies, however it's worth pointing out that conducting insurance operations in the country comes with its fair share of risks. This is due to the disproportionately high number of fraudulent cases faced by insurance companies in the country. Fraudulent claims are a prevalent issue across all types of insurance policies, with life insurance policies being six times more susceptible to false claims compared to other policy types. Insurance fraud is a growing problem in India, with fraudulent claims costing the industry billions of rupees each year. To combat this issue, it is essential to understand the legal landscape surrounding insurance fraud in the country. This article aims to provide an in-depth analysis of the layers of insurance fraud in India and the laws and regulations in place to tackle it. By examining the different types of frauds and the preventive measures, this study sheds light on the challenges faced by insurers and the legal system in detecting and preventing fraud, as well as the need for greater awareness and education on this issue.

Keywords*: Insurance policies, Insurance Fraud, Principles, Fraudulant Claims, Deception, Prevention, IRDAI.*

I. INTRODUCTION

The term 'fraud' originates from the Latin word 'fraus-fraudis,' denoting the perpetration of an act driven by dishonesty with the intention of gaining financial benefit. Insurance fraud can be defined as a deliberate act of deception carried against or by an insurance company or agent for financial gain. Fraud may be committed at different points by applicants, policyholders, third-party claimants, or professionals who provide services to claimants. Insurance agents and

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company employees may also commit insurance fraud. Common frauds include "padding" or inflating claims, misrepresenting facts on an insurance application, submitting claims for injuries or damage that never occurred, and staging accidents.[2] An important aspect to note is the inadequate emphasis placed on this significant problem, despite its severity, even though it may not occur as frequently as other types of financial and economic crimes. Moreover, it is worrisome that the Insurance Act of 1938 does not provide a precise definition for the term 'insurance fraud.' Although our legal system encompasses laws such as the Indian Penal Code, 1860 that address matters like forgery, fraudulent acts, and cheating, none of these laws are explicitly focused on addressing and deterring insurance fraud, thus lacking effectiveness in reducing its prevalence. Insurance fraud is not addressed explicitly in the Indian penal code. However, there are certain sections that can be applied to related offences. Section 205 deals with assuming a false identity for the purpose of an act or legal proceeding. Section 420 pertains to cheating and dishonestly inducing the transfer of property. Additionally, Section 464 covers the creation of false documents, including forged signatures and seals and Section 405 addresses criminal breach of trust.[3] Nevertheless, these existing legal provisions are insufficient to effectively prosecute individuals involved in organized insurance frauds in the present circumstances.

II. BREACH OF PRINCIPLES OF INSURANCE

Insurance frauds represent a violation of the principles of insurance particularly the principle of Uberrimae Fidei or utmost good faith and indemnity, which are fundamental to the insurance industry. Uberrimae Fidei is a principle that requires both the insurer and the insured to act in the utmost good faith, providing complete and honest information to each other during the insurance contract's formation. Insurance relies on the principle of Uberrimae Fidei to ensure transparency and trust between the parties involved. However, when an individual engages in insurance fraud, they intentionally deceive the insurer by providing false information or concealing relevant facts. This deceitful behavior undermines the principle of utmost good faith, compromising the integrity of the insurance contract.

The principle of indemnity is a fundamental concept in insurance, aiming to restore the insured to the same financial position they were in before the occurrence of a covered loss. Insurance contracts are designed to compensate for actual losses suffered, without allowing the insured to make a profit from the insurance claim. However, fraudulent activities such as inflating the

[2] Christopher, Abhijith and Dubey, Aditi, *The Exigency for An Insurance Frauds Control Act in India: Challenges to Be Addressed* (2020). Volume-10, Issue-1, Nirma University Law Journal:, December 2020.
[3] Indian Penal Code, 1860

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value of a loss, submitting fake claims, or staging accidents are clear breaches of the principle of indemnity. These fraudulent actions distort the purpose of insurance, as they seek unjust enrichment at the expense of the insurer.

Insurance frauds not only compromise the financial stability of insurance companies but also affect the entire insurance system. They lead to increased premiums for honest policyholders, as insurers must cover the costs associated with fraudulent claims. Furthermore, insurance frauds undermine public trust in the insurance industry and can have legal consequences for those involved in such activities.

III. TYPES OF INSURANCE FRAUDS

In India, various types of insurance frauds have been observed. Here are some prevalent ones:

1. **Fabricated or Deceptive Claims**: One of the common forms of insurance fraud involves policyholders or beneficiaries generating exaggerated or deceptive claims to obtain larger reimbursements from the insurance company. This practice is widely observed and can be seen in instances where health insurance policyholders submit fictitious medical bills, invoices, and receipts to inflate the number of claims. Similarly, individuals with vehicle insurance may contrive accidents or manipulate evidence to make false claims.
2. **Manufactured Accidents**: This type of fraud involves the deliberate creation of an accident or the fabrication of its occurrence to fraudulently file a claim. In such cases, policyholders engage in various methods to simulate accidents, such as staging a rear-end collision, intentionally colliding with a stationary object, or falsely claiming involvement in a non-existent event. Subsequently, the policyholder may proceed to submit false or inflated claims for vehicle damages or injuries supposedly sustained in the collision.
3. **Misleading Documentation**: This form of fraud occurs when policyholders supply misleading details on their insurance applications or claims, which can involve fabricated invoices, counterfeit bills, and falsified medical records. In these instances, policyholders or claimants knowingly submit deceptive or incorrect statements on their insurance applications or claim forms, including falsified invoices, receipts, fictitious bills, and manipulated medical documents. The health insurance sector is particularly susceptible to fraudulent documentation. For instance, policyholders may artificially create medical records or receipts to inflate the cost of their claims.

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4. **Multiple Claims**: This type of fraud occurs when policyholders file numerous claims, often with different policies or insurers, for the same loss or damage. This fraudulent practice is prevalent in the realm of property insurance. Policyholders may submit multiple claims with the intention of inflating the compensation provided by their insurance company or to seek reimbursement for items that were not genuinely lost or damaged. Additionally, they may submit multiple claims to multiple insurance providers for the same loss or damage, aiming to obtain multiple payouts.

5. **Premium Diversion**: This type of fraud takes place when a broker or agent accepts premium payments from policyholders but fails to remit them to the insurance provider, resulting in the policy lapsing. The practice of diverting premiums is prevalent in the life insurance and health insurance sectors. Brokers may redirect premiums for personal gain or to offset their own losses. They might also utilize the diverted funds to cover other insurance premiums or maintain the appearance of a thriving company.

6. **Bogus Policies**: This type of fraud is prevalent in the life insurance and health insurance sectors. It involves brokers or agents offering fabricated insurance policies to customers, collecting premiums without actually providing the coverage promised. Agents or brokers may issue these phantom policies to divert premium payments for personal gain or to maintain the financial stability of their company. Additionally, these fraudulent companies may offer coverage to individuals who are ineligible, including those with pre-existing medical conditions.

7. **Identity Theft**: Identity theft significantly impacts the health insurance and vehicle insurance sectors. This type of fraud involves criminals utilizing the stolen identities of victims to purchase insurance policies or submit fraudulent claims under the victim's name. These individuals may file fictitious claims using the stolen identities, seeking reimbursement for medical treatments or procedures they never received or making false claims for accidents or injuries they did not experience. Further, they may fraudulently obtain insurance coverage for which they are ineligible by exploiting stolen identities.

IV. FRAUD PREVENTION & CONTROL

According to a recent survey conducted by Deloitte[4], insurance companies in India have witnessed a surge in fraudulent activities specifically in the areas of life and health insurance. This increase can be attributed to various factors such as the accelerated digitization, the

[4] Deloitte's Insurance Fraud Survey 2023. https://www2.deloitte.com/content/dam/Deloitte/in/Documents/financial-services/in-insurance-fraud-survey-2023-noexp.pdf.

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widespread adoption of remote working arrangements following the pandemic, and weakened controls within the industry. The survey reveals that approximately 60 percent of Indian private insurers acknowledge a substantial escalation in fraud cases related to insurance. In light of these risks, it is imperative for insurers to prioritize the establishment of a proactive fraud risk management framework in order to effectively combat fraudulent activities and protect the interests of policyholders and shareholders.

Fraud Monitoring Framework[5]

As per the guidelines set by the Insurance Regulatory and Development Authority of India (IRDAI), every insurance company is required to establish a Fraud Monitoring Framework. This framework must consist of measures aimed at safeguarding, deterring, detecting, and reducing the risk of fraud involving policyholders/claimants, intermediaries, and employees of the insurance company.

Fraud Prevention Policies

Insurers are required to adopt a holistic approach to precisely define, evaluate, monitor, and track the risks associated with fraud, and subsequently establish robust policies and procedures for risk management. According to the guidelines set by the Insurance Regulatory and Development Authority of India (IRDAI), the board of directors of insurance companies must conduct an annual review of their respective anti-fraud policies, with additional reviews conducted as deemed necessary.[6] These policies should offer comprehensive guidance on protocols for fraud detection, identification of potential fraud avenues, recommendations for collaboration with state and local enforcement authorities to identify instances of fraud, and apprehend the individuals involved in fraudulent activities. These policies also mandate the establishment of a mechanism enabling insurance providers to exchange information regarding accidents and instances of fraud, in order to identify and flag such incidents within the insurance ecosystem.

Insurers have the responsibility to provide education and awareness to both potential and existing customers regarding their policies in order to prevent fraud. They must incorporate necessary warnings in insurance contracts and associated documents, clearly highlighting the consequences of providing false or inaccurate information. This is done to ensure the well-being of policyholders, claimants, and their beneficiaries.[7]

[5] IRDAI Guidelines (2016) https://irdai.gov.in/hi/document-detail?documentId=382140.
[6] Umang Dudeja, *Insurance Fraud Control Act : the need of the hour*, Ipleaders Blog (Sep 10, 2020), https://blog.ipleaders.in/insurance-fraud-control-act-need-hour
[7] Swati Sonal, *Insurance Fraud Prevention Laws, A Need Of Time: A Critical Analysis*, Volume IV Issue IV,

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Over the years, insurance companies have adopted several diligent measures to effectively manage the risks associated with fraud.[8] These measures include:

i) Recognizing the existence and likelihood of fraudulent activities, thereby maintaining a vigilant approach towards potential fraud cases.

ii) Conducting thorough inquiries and cross-checking documents right from the initial stages of claims processing, aiming to promptly identify any suspicious or fraudulent claims.

iii) Assessing the potential for fraud in order to minimize potential losses, enabling insurers to take proactive steps to mitigate risks and protect the interests of shareholders and policyholders.

iv) Employing advanced techniques such as data analytics and statistical analysis to detect patterns and anomalies that may indicate fraudulent behavior, enhancing the effectiveness of fraud detection efforts.

v) Developing and refining software systems or leveraging technical expertise to create robust fraud detection and prevention mechanisms, ensuring continuous improvements in fraud management capabilities.

vi) Allocating dedicated investigators who specialize in fraud detection and maintaining up-to-date records, ensuring a streamlined process of investigating suspicious claims and facilitating efficient documentation for future reference.

By implementing these diligent practices, insurance companies aim to strengthen their defenses against fraud, safeguarding the integrity of their operations and providing greater confidence to shareholders and policyholders.

V. CONCLUSION

Notwithstanding the efforts taken by insurers in combating insurance frauds, a comprehensive approach is required that involves both legislative and judicial measures. While the existing provisions of the Indian Penal Code offer some assistance to combat fraud, they are insufficient to effectively prosecute organized insurance fraudsters in the current scenario. Therefore, it becomes imperative for the government to introduce provisions that enable insurers to access an individual's insurance history and claims records, similar to the creditworthiness assessment

Indian Journal of Law and Legal Research (IJLLR) 1967, 1986, October 2022.

[8] Ritika Khatua, *Insurance Fraud : "The Pandora's Box" ?,* Lexology (Feb 24, 2020), https://www.lexology.com/library/detail.aspx?g=bcd71546-06cc-4a02-b1b4-663bbf76f9ad

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process used by banks through the Credit Information Bureau of India (CIBIL). Furthermore, the judiciary should adopt a more serious and proactive approach towards handling such cases ensuring the fair and just prosecution of fraudsters. By setting stringent precedents and delivering deterrent punishments, the judiciary can contribute to creating a deterrent effect and building a safer insurance ecosystem. Ultimately, by combining legislative measures that empower insurers with access to relevant information and a dedicated judiciary that demonstrates a zero-tolerance policy towards insurance frauds, India can pave the way for a more robust and efficient system that safeguards the interests of both insurers and policyholders. Such comprehensive efforts are vital in deterring fraudulent activities, instilling public trust, and promoting a fair and transparent insurance industry in the country.

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