INSURANCE FRAUD – THE GREATEST MORAL, ECONOMIC AND SOCIAL CHALLENGE FACING THE INSURANCE INDUSTRY TODAY?

12 AUGUST 2013 | PUBLIC & PRODUCT LIABILITY

In 2012 the highest reported global insured loss event was Hurricane Sandy at around US$25 billion (Munich Re – 2012 Natural Catastrophe Year In Review). At the beginning of 2012, the FBI released a report on investigating insurance fraud which, on figures provided to it by Insurance Information Institute, cost the US insurance industry US $30 billion per year. So in 2012 it may in fact be more accurate to say that the highest insured loss event was the collective dishonesty of policyholders, insurance industry insiders and organised criminal networks ripping off insurance companies. To borrow a phrase, it is certainly arguable that insurance fraud is the greatest moral, economic and social challenge facing the insurance industry today.

Most people if they drove past an insurance company’s business premises and saw a brand new set of golf clubs in the car park would not stop, get out, put the golf clubs in their boot and drive away. However, a number of those same people may when making a burglary claim include golf clubs on the insurance claim form when they may not have had a set to start with, or the old set remain hidden in the back of the garage. This may be good for the golfing equipment supplies industry but not so good for the insurance industry. Why is it that normally law abiding people are prepared to pad a claim or outright lie on their insurance claim forms?

In October last year we published an article on insurance fraud and suggested a way to reduce it may be to require policy holders to deliberately and separately declare on their claim form that all information, including items and values claimed is true and correct, and specifically acknowledge that false and misleading information and fraud may expose them to criminal penalties.

Recently research was undertaken by a UK consultancy, Consumer Intelligence, part of which revealed that dishonesty dropped by around 9.5% when people were asked to be honest before they supplied information. Based on UK figures, Consumer Intelligence estimated that by asking people to be honest up front rather than near the end of the claim form, the industry could cut nearly £100 million off the £1 billion a year estimated annual cost of fraudulent claims in the UK.
A “pre-emptive strike” to the problem of insurance fraud, such as redesigning the claim form, is much easier than dealing with insurance fraud (or suspected fraud) after the claim has been made. In Australia the onus of proof on the insurer to establish fraud is very high. Added to this is the inherent difficulty in most fraud cases requiring an insurer to prove its case based on circumstantial evidence i.e. evidence of circumstances which can be relied upon not as proving a fact directly, but instead as pointing to its existence. Knowing or suspecting a claim to be fraudulent is one thing, proving it is an entirely different matter.

On 14 June, 2013 the Victorian Court of Appeal handed down its decision in the case of Mutual Community General Insurance Pty Ltd v Khatchmanian [2013] VCSA144. The case involved a house fire and a claim made by the insured that was resisted by the insurer alleging that the insured had connived in the fire. The insurer was unsuccessful, and not only had to pay the claim but also interest back dated to the day on which it was held to have been unreasonable for it to withhold payment.

In the Khatchmanian case the insured and his family were away on the weekend that the fire occurred. The fire had been deliberately lit. In dismissing the appeal of the insurance company the court held, amongst other things, that the claimant was not financially motivated to destroy the house by fire, notwithstanding that the insured had a credit card debt of approximately $65,000 on an income of $55,000 per annum plus repayments on a $600,000 mortgage. One reason the court gave in dismissing the insurers submission on motive, was that while the insurer relied on a raft of financial calculations to support its contention that the insured must have realised that he was in parlous financial circumstances, there was no evidence that the insured himself had undertaken such calculations, nor that he personally considered that his borrowings had increased to such an extent that he was in financial trouble.

The insurer also relied upon there being no evidence of forced entry to the house as evidence that whoever started the fire (which started inside the home) had gained accessed using a key or with the assistance of the insured. Expert evidence was led by the insurer on this point. The backdoor being forcibly opened was said by the expert to have been the way in which the fire brigade gained access to the home (but no evidence was called from the fire brigade). The insured’s expert could not however rule out entirely that the position of glass fragments from the front window were consistent with the application of external force, and an argument was raised by the plaintiff that a laundry window may have been opened by the arsonist to gain access and then closed by the arsonist after leaving the building. The Court of Appeal rejected the insured’s expert evidence on access.

The insurer in this case made a call that it had sufficient information to prove its case, but both the trial judge and Victorian Court of Appeal disagreed.

One final word. As frustrating as defending insurance fraud claims and the extent of fraud generally might be, insurers ought to guard against complaining too loudly or too publicly. The Consumer Intelligence research warned against insurers issuing reports with claims such as
“Britain is whiplash capital of Europe” even if they are true. The reason for this is that if people think fraud is widespread or difficult to prove, they are more likely to think it acceptable to put forward fraudulent claims. This, for insurers, is what you might call being between a big rock and a very hard place.

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