



Article

The impact of insurance fraud on the global economy

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Insurance fraud is one of the most pressing socio-economic issues of this era. Insurance is an arrangement to provide financial compensation to individuals and businesses for the effects of misfortune, but fraudsters make a fortune in the process. This paper aims to investigate the causes of insurance fraud and suggest ways to fight against dishonest behaviour. A qualitative research methodology was adopted to collect data. The paper concludes that the major causes of insurance fraud are financial stress, greed, a sense of entitlement, poor remuneration, weak internal control, and lack of awareness and training. Due diligence to recruit staff, regular staff training, rotation of duties, effective internal control, and stringent claims handling procedures are some of the key factors to maintain orderly functioning of the industry and fight against insurance fraud. Unless insurance fraudsters are severely punished under the criminal justice system, the innocent consumers will continue to suffer, and the economy, at large.

A lie has speed, but the truth has endurance.¹

— E J Mohn

I Introduction

Insurance fraud has never been more complex and challenging than with evolving technology. Insurance fraudsters are exploiting new techniques to commit insurance fraud. A study in the United States showed that the total losses due to insurance fraud across the country were \$308 billion.² However, this figure may not reflect the actual amount of insurance fraud because some insurers may not know they have been defrauded. Insurance frauds detected in the United Kingdom in 2019 increased by 5% from £1.2 billion in 2018, but 2020, mainly due to COVID-19 restrictions, saw a decrease in detected frauds.³ However, insurance fraud increased in the United Kingdom by 61% between March 2022 and April 2023.⁴ This also may have been

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1 Pinterest, R G Montillana, *Wise Quotes* <<https://it.pinterest.com/renzgabrielm/wise-quotes/>> (accessed 19 June 2025).

2 Conroy Simberg, *Detected Insurance Fraud Costs the US \$308 Billion Annually* (News & Events, 17 March 2023) 1 <<https://www.conroysimberg.com/blog/insurance-fraud-costs-the-u-s-308-billion-annually>> (accessed 5 January 2025).

3 The ABI, *Detected Insurance Fraud — new data shows that every five minutes a fraudulent claim is discovered* (Media Release, 7 September 2020) 1 <<https://www.abi.org.uk/news/news-articles/2020/09/detected-insurance-fraud/>> (accessed 11 January 2025).

4 Fintech Global, *Rise in insurance fraud linked to the cost of living squeeze* (Media Release, 28 June 2023) 1 <<https://fintech.global/2023/06/28/rise-in-insurance-fraud-linked-to-cost->

underestimated given the undetected fraudulent claims. The cost of insurance fraud in Canada is approximately \$3–5 billion annually.⁵

The detected and undetected fraudulent activities combined account for approximately 10% of total claims paid in Europe.⁶ In Australia, insurance fraud cases total \$560 million for motor and property insurance alone, and undetected cases total around \$400 million.⁷ The number of financial complaints in Australia last year increased by 9%.⁸ In New Zealand, fraudulent claims cost insurers up to 10% of their gross written premiums each year.⁹ According to New Zealand's Insurance Fraud Bureau (IFB), in 2020, fraudulent claims cost insurers around \$739 million.¹⁰ Insurance companies in China, India, and Singapore have also experienced a rise in fraudulent claims and, as a result, are taking steps to combat insurance fraud. In China, the financial regulatory authority and the police have mounted a joint crackdown on insurance fraud.¹¹

In October 2024, the Insurance Regulatory and Development Authority of India launched an Insurance Fraud Monitoring Framework to strengthen fraud prevention, transparency, and cyber security in the insurance sector.¹² In Singapore, all insurers are required by the Monetary Authority of Singapore (MAS) 'to adhere to sound risk management practices to effectively prevent, detect, report, and remedy insurance fraud'.¹³ In September 2019, the IFB was launched by the Insurance Council of New Zealand (ICNZ) to combat

of-living-squeeze/> (accessed 10 January 2025).

5 T O'Brien, 2024: *The Future of Combating Insurance Crime is Here* (Media Release, 25 January 2024) <<https://www.equiteassociation.com/executive-corner/2024-the-future-of-combatting-insurance-crime-is-here>> (accessed 1 January 2025).

6 Insurance Crime Platform, *Breaking Boundaries, A European approach to countering insurance fraud* (2023–2024) Annual Report, p 1, available at: <<https://www.insuranceeurope.eu/downloads/ar-2024-fraud/Fraud.pdf>> (accessed 16 January 2025).

7 Insurance Council of Australia, *Insurance industry boosts fight against fraud and scams* (News Release, 21 May 2024) 1 <<https://insurancecouncil.com.au/resource/insurance-industry-boosts-fight-against-fraud-and-scams/>> (accessed 8 January 2025).

8 Australian Financial Complaints Authority, *Financial complaints rise further 9% to record 105,000 in 2023-24* (Media Release, 1 August 2024) 1 <<https://www.afca.org.au/news/media-releases/financial-complaints-rise-further-9-to-record-105000-in-2023-24>> (accessed 8 January 2025).

9 Insurance Fraud Bureau New Zealand, *Insurance Fraud Bureau Whitepaper* (2019) p 8 <https://ifb.org.nz/wp-content/uploads/2019/08/Insurance-Fraud-Bureau_White-Paper.pdf> (accessed 20 February 2025).

10 G Olano, *Insurance fraud is far from a 'victimless crime'* (Media Release, 26 February 2021) 1 <<https://www.insurancebusinessmag.com/nz/news/breaking-news/insurance-fraud-is-far-from-a-victimless-crime-247654.aspx>> (accessed 20 February 2025).

11 L Shangyi and C Yin, 'Crackdown on insurance fraud crimes yield a result', *China Daily* (Online, 4 April 2025) 1 <<https://www.chinadaily.com.cn/a/202501/04/WS677873cea310f1265a1d8ee3.html>> (accessed 8 January 2025).

12 'IRDAI Launches Insurance Fraud Monitoring Framework', *Banking Frontiers* (Online, 28 October 2024) <<https://bankingfrontiers.com/43261-2/>> (accessed 10 January 2025).

13 Monetary Authority of Singapore, *Guidelines on Risk Management Practices for Insurance Business — Insurance Fraud Risk* (Guidelines, 10 January 2024) 1 <<https://www.mas.gov.sg/regulation/guidelines/guidelines-on-risk-management-practices-for-insurance-business—insurance-fraud-risk>> (accessed 10 January 2025).

insurance fraud through detection and education.¹⁴ The IFB is New Zealand's first (all 128 members of the ICNZ) integrated enterprise to be launched to fight against increasing insurance fraud.¹⁵

Insurance fraud is rapidly increasing, making it difficult for insurance companies to survive in this risk-filled ecosystem. Insurance fraud is a global issue that has far-reaching consequences for insurers, who bear the costs of fraudulent claims, and consumers, to whom these costs are ultimately passed on in the form of higher premiums, and the economy at large. Insurance fraud undermines the rights of genuine claimants. Several studies have been undertaken on insurance fraud, but this study is unique.

The objective of this paper is to investigate the causes of insurance fraud and suggest ways to fight against deceitful behaviour so that innocent consumers are not affected as they are because of the fraud. The concept of insurance fraud, types of insurance fraud, and causes of insurance fraud, and finally, ways to combat insurance fraud are discussed as follows.

II The concept of insurance fraud

What constitutes fraud? In the ordinary sense of the term, fraud implies that the activity is illegal and capable of being prosecuted because of the vulnerability of the result. In *Baden Delvaux and Lecuit v Société Generale pour Favoriser le Développement du Commerce et de l'Industrie en France SA (Baden Scale)*,¹⁶ Gibson J classified five different levels of culpable cognisance upon which a person could be imputed with liability.¹⁷ The Baden Scale consists of five categories: actual knowledge; wilfully ignoring the obvious; wilfully and recklessly failing to make inquiries; knowledge of circumstances which would indicate the facts to an honest and reasonable man; and knowledge of circumstances which would put an honest and reasonable man on inquiry.¹⁸

However, the classic definition was formulated by the House of Lords in *Derry v Peek*,¹⁹ as making 'a material statement knowing it is false, or without belief in its truth, or recklessly, not caring if it is true or false'.²⁰ In this case, the defendant company issued a prospectus that they would have the right to use steam or mechanical power. The plaintiff bought shares in the company believing that the company had the absolute right to use steam or mechanical power.

However, the Board of Trade refused the use of steam or mechanical power, and the company wound up. The plaintiff sued the defendant for fraudulent misrepresentation. The trial judge dismissed the action because the use of steam or mechanical power was subject to the Board of Trade's approval, and

14 Insurance Fraud Bureau New Zealand <<https://www.facebook.com/InsuranceFraudBureauNZ/>> (accessed 20 February 2025).

15 Above.

16 *Baden Delvaux and Lecuit v Société Generale pour Favoriser le Développement du Commerce et de l'Industrie en France SA* [1983] BCLC 325.

17 Above.

18 Above.

19 *Derry v Peek* (1889) 14 App Cas 337 (House of Lords).

20 Above.

as such, it was not unreasonable for them to rely on the Board of Trade. The Court of Appeal reversed the decision of the trial court and held that ‘in an action for “deceit”, it would be necessary to prove not only the existence of a bona fide belief but also the grounds on which it was arrived at and in their reasonableness’.²¹ The House of Lords reinstated the judgment of the lower court on the basis that an action for deceit requires actual fraud, not merely the absence of a reasonable basis for the erroneous belief.²²

The defendant in *Thomas Witter Ltd v TBP Industries Ltd*²³ negotiated a contract to sell a carpet company to the plaintiff, and during the negotiation, the defendant made a negligent representation regarding the accounts. However, the contract included a clause that stated that the plaintiff had not agreed based on any representation or warranty made by the defendant.²⁴ The defendant’s statement regarding the accounts was incorrect. As a result, the plaintiff brought this action against the defendant for negligent misrepresentation. The defendant denied any liability based on the limitation clause in the contract between the parties.²⁵ The court held that the clause only applied to contractual breaches between the parties and not to inducing the plaintiff into the agreement.²⁶ In essence, this case stressed that while parties can contractually limit liability for negligent or innocent misrepresentation, they cannot exclude liability for fraudulent misrepresentation.

However, in *Yeganeh v Zurich Plc*,²⁷ the plaintiff insured his building and contents with the defendant insurer. The building and contents were destroyed in a fire, and the plaintiff sought indemnity from the insurer.²⁸ The insurer, Zurich, declined the claim on the basis that the plaintiff deliberately caused the fire, and hence, the claim was fraudulent. The England and Wales High Court (Queen’s Bench Division) held that the insurer failed to establish that the plaintiff deliberately set fire to the house.²⁹ However, the insurer established that the plaintiff’s claim for the contents was partly fabricated. Therefore, it followed that the entire claim failed.³⁰

In *KBC Bank v Industrial Steels (UK) Ltd*,³¹ the Queen’s Bench Division held that ‘... there is no need to show an intention to cause harm’.³² In this case, the beneficiary knowingly supplied an unstamped and undated Certificate of Origin simply because this was administratively convenient. The Court held the beneficiary was liable to the nominated bank as the issuing bank’s obligation was only to pay against genuine documents.³³ The beneficiary was obliged to look into the accuracy of the documents. But since

21 Above.

22 Above.

23 *Thomas Witter Ltd v TBP Industries Ltd* [1996] 2 All ER 573 at 577.

24 Above.

25 Above.

26 Above.

27 *Yeganeh v Zurich Plc* [2010] EWHC 1185 (QB); [2011] Lloyd’s Rep IR 540 at [4].

28 Above.

29 Above.

30 Above.

31 *KBC Bank v Industrial Steels (UK) Ltd* [2001] 1 Lloyd’s Rep 370 at 374.

32 Above.

33 Above.

he acted 'recklessly, as regards the content of the documents, the beneficiary was liable in deceit'.³⁴

The meaning of fraud as set out in *Derry v Peek* was the basis of the analysis in *Aviva Insurance Ltd v Brown*.³⁵ In this case, the claimant (Aviva) insurer brought an action to recover the sums that it paid to the defendant (Mr Brown) under the policy covering alternative accommodation, which Aviva asserted was fraudulent.³⁶ The court dismissed the insured's claim for alternative accommodation and allowed the insurer to recover £58,500, and also recover the cost of repairs.³⁷ The court applied the standards of reasonable and honest person, and concluded that the fraudulent conduct was more than 'immaterial'.³⁸

This case appears to diverge from the traditional test established in *Derry v Peek*, but the judge stressed that a person who makes an untrue statement recklessly, careless of whether it is true or false, is dishonest; the motive behind the fraud is immaterial. Once it is established that the insured acted fraudulently, the court takes a harsh approach to deter people from doing it.

In *Lek v Mathews*,³⁹ Lord Viscount Summer's view on the meaning of fraudulent claims, about an express clause, depended on 'the seriousness of any fraud in the making of a claim unless it could be treated as de minimis'.⁴⁰ In this case, the plaintiff insured his stock (stamps) against loss or damage by theft for £44,000. A theft occurred, and the insured submitted an exaggerated claim to the insurer. The question before the House of Lords was whether the statement made by the insured about the valuation of the stamps was true or false. The House of Lords held that the meaning of insurance fraud, in an express clause, stresses the seriousness of fraud in claiming unless it could be treated as de minimis.⁴¹ The false claim clause provided that, if one part fell, all claims fell. The burden of proof fell on the insurer, but a higher degree of probability was required for the more serious allegations than the normal civil standard of 'on the balance of probabilities'.⁴²

The courts have defined insurance fraud in many cases, but the most detailed definition is the case of *Agapitos v Agnew*.⁴³ This is a case of hull insurance in which the policy contained a warranty that there would be no hot work on the vessel. But if hot work were required, it should be approved by the insurer's surveyors — and a warranty to that effect was in the policy. When the hot work began, the insurer was informed via a facsimile. The vessel caught fire during the hot work, and since no approval was obtained from the surveyor, the insurer denied the claim based on a breach of the

³⁴ Above.

³⁵ *Aviva Insurance Ltd v Brown* [2011] EWHC 362 (QB).

³⁶ Above.

³⁷ Above.

³⁸ Above.

³⁹ *Lek v Mathews* (1927) 29 LI L Rep 141.

⁴⁰ Above.

⁴¹ Above.

⁴² *Hornal v Newberger Products Ltd* [1957] 1 QB 247.

⁴³ *Agapitos v Agnew* [2002] 2 Lloyd's Rep 42.

warranty. The insured denied breaching the warranty as the surveyor failed to inspect.⁴⁴

The House of Lords arrived at five categories of fraudulent insurance claims, namely:

- (1) a claim where the insured knows that they have not suffered any loss;
- (2) a claim where the insured has claimed a higher sum than the loss suffered;
- (3) a claim to which the insurer has a valid defence, but the insured purposely concealed it;
- (4) a claim where fraudulent devices or means are used; and
- (5) a claim the insured initially and honestly believed to be true but subsequently found out that they had not suffered any loss or that the loss was less than that claimed for and yet decided to pursue without rectifying his or her mistake.⁴⁵

An overstated claim by an insured may be a fraud but is not a breach of the insured's duty of utmost good faith that could give rise to insurers avoiding the contract *ab initio*.⁴⁶

However, this raises an important question: that the duty of disclosure and the duty to avoid making fraudulent claims are two separate duties. The failure to disclose in the claims process becomes a fraudulent claim when there is the deliberate suppression of a defence.⁴⁷ However, under the common law rule, if the fraud is willful, the insured loses all claims.⁴⁸

The court is less concerned about the size of the claim and instead looks at whether the alleged fraud involves 'innocent and minimal exaggeration'. This was the view of the Court of Appeal in *Versloot Dredging BV v HDI Gerling Industrie Versicherung AG (The DC Merwestone)*.⁴⁹ In this case, a flood near the bow of the vessel resulted in major damage to the main engine. The insured sought an indemnity of 3.2 million euros on its hull and machinery policy for replacing the engine.⁵⁰ An investigation into the mishap revealed that the insured's general manager was aware of the ingress of water but, in a letter, falsely claimed that 'the alarm had gone off on the day of the incident'.⁵¹ The High Court found in favour of the insurer because the letter was a fraudulent device to promote the claim.⁵² The Court of Appeal held that the question is not the relative size of the fraudulent claim but whether the

44 Above.

45 *Baden Scale* (n 16).

46 Above.

47 Above.

48 *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The 'Star Sea')* [2001] 1 Lloyd's Rep 1 (*The Star Sea*); *K/S Merc-Scandia XXXXII v Lloyd's Underwriters (The 'Mercandian Continent')* [2001] 2 Lloyd's Rep 563 *Britton v Royal Insurance Co* (1866) 4 F & F 905; (1866) 176 ER 843.

49 *Versloot Dredging BV v HDI Gerling Industrie Versicherung AG (The DC Merwestone)* [2014] EWCA Civ 1349 at [109].

50 Above.

51 Above.

52 Note: the fraudulent device rule originated in *Agapitos v Agnew* (n 43) as Popplewell J's dicta.

alleged fraud involves ‘innocent and minimal exaggeration and upheld the insurers’ refusal of the claim’.⁵³

Although the fraudulent claim/device⁵⁴ rule has been approved in many cases,⁵⁵ the effect of the all-or-nothing rule is terrible. For instance, depriving the insured of a valid claim worth more than 3.2 million euros is disproportionately harsh and shocking. Given the low culpability of the fraudulent conduct (false letter), insensible planned deceit (alarm had gone off), only one incident of fraud, and fraudulent conduct by an employee to promptly get paid, it is even more disgraceful. Perhaps the court should have made a provision in the fraudulent claim rule to take into account:

- (1) the circumstances in which the fraudulent conduct was committed;
- (2) the gravity of the consequences of the fraudulent conduct; and
- (3) the frequency of the fraudulent conduct.

However, for public policy interests, the strictness of the fraudulent claim rule is not compromised, but the law of natural justice should also not be compromised.

Thus, Popplewell J said:

[t]he law does not provide in this context that the end always justifies the means; but nor should it say that any dishonest means which are more than de minimis should deprive a litigant of his just ends. What will be just and proportionate will depend upon the circumstances of each case, which may vary considerably.⁵⁶

A landmark judgment by the Supreme Court declared that the court has the power under the *Civil Procedure Rules* and the inherent jurisdiction to strike out a case for abuse of process at any stage of the proceedings.⁵⁷ In this case, the insured exaggerated his injury claim, which the insurer sought to strike out on the basis that this is a substantially dishonest claim.⁵⁸ The Supreme Court declined to strike out the claim in its entirety but awarded damages for the genuine part of the claim.⁵⁹ The court added that it is the policy of the law that a person cannot be deprived on the grounds of abuse of process for damages to which he is otherwise entitled.⁶⁰

The various types of insurance fraud are discussed as follows.

III Types of insurance fraud

Insurance fraud can run from a petty exaggerated motor vehicle claim to a large-scale corporate fraud or arson involving a multimillion-dollar loss.

53 Above.

54 *Wisenthal v World Auxilliary Insurance Corp Ltd* (1930) 38 Ll L Rep 54.

55 For instance, applied by the Supreme Court in *Summers v Fairclough Homes Ltd* [2012] 1 WLR 2004 and the Privy Council in *Stemson v AMP General Insurance (NZ) Ltd* [2006] UKPC 30.

56 *Versloot Dredging BV v HDI Gerling Industrie Versicherung AG (The DC Merwestone)* [2013] EWHC 1666 (Comm) at [133].

57 *Summers v Fairclough Homes Ltd* (n 55).

58 Above.

59 Above.

60 *Ul-Haq v Shah* [2010] 1 WLR 616.

Lord Justice Millett in *Galloway v Royal Exchange (UK) Ltd*,⁶¹ said:

[t]here seems to be a widespread belief that insurance companies are fair game and that defrauding them is not morally reprehensible.⁶²

Just as the industry is cursed by nature, in terms of natural disasters, so are the truthful consumers by legislators for failing to enact laws to protect them.

A False or wilful misconduct

As the word suggests, wilful misconduct is where the insured knows that he has not suffered any loss but still claims.⁶³ It could be that the insured is the author of the loss himself or engaged a third party to cause the loss on his behalf, for example, arson. It could also be that the subject matter was never in his possession, or he had no legal interest in the subject matter. For instance, with a fire claim, the insured claimed for jewelry under his All Risk policy when the jewelry was stolen before the fire. However, such a claim can also be regarded as an ‘exaggerated’ claim because the insured’s loss is less than the sum claimed.

In any event, the insurer is not liable for a false claim of the insured. Still, unless the policy otherwise provides, the insurer is liable for any loss proximately caused by an insured peril, ie on the happening of an uncertain event. In *Prudential Insurance Co v Inland Revenue Cmrs*,⁶⁴ Channell J said: ‘The essence of insurance is contingency’ that is, the event should involve some amount of uncertainty. If the insured has control over the event, for example, arson, then it is no longer uncertain and subject to insurance.

Moreover, in *Graham v Belfast and Northern Counties Railway Co*, the court had to define the phrase ‘wilful misconduct’. The court defined ‘wilful misconduct’ as a person knowingly doing the wrongful act, or failing to omit to do it, regardless of the consequences.⁶⁵ The purpose of committing the misconduct is to cause a loss and then claim from his insurer.⁶⁶

This case is different from the case of *Papadimitriou v Henderson*⁶⁷ where the insured vessel was seized during a voyage, and a total loss was claimed from its insurers. The insurer rejected the claim because the insured’s wilful misconduct caused the loss as he deliberately allowed the vessel to continue the voyage when he knew that it was likely that the naval forces would capture the vessel, and he failed to take reasonable steps to avert the risk.⁶⁸

Another classic case involving ‘wilful conduct’ is the Australian case of *Wood v Associated National Insurance Co Ltd*.⁶⁹ In this case, the owners of the vessel abandoned the vessel with a few inexperienced crews on board and

61 *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyd’s Rep IR 209.

62 Above.

63 R Zheng, *Fraudulent Claims in Commercial Insurance Law: A Legal and Economic Analysis* (Thesis, School of Law, Swansea University, 2012) <<https://cronfa.swan.ac.uk/Record/cronfa42644>> (accessed 7 January 2025).

64 *Prudential Insurance Co v Inland Revenue Commissioners* [1904] 2 KB 658 at 663.

65 *Graham v Belfast & Northern Counties Railway Co* [1901] 2 IR 13.

66 Above.

67 *Papadimitriou v Henderson* (1939) 64 Ll L Rep 345.

68 Above.

69 *Wood v Associated National Insurance Co Ltd* [1985] 1 Qd R 297.

increased the sum insured on the vessel. Within a few days, the weather changed, and the news reported that cyclone-force winds were expected in the vicinity; the owners did nothing, assuming that the unskilled crew would have abandoned the vessel, and they would claim from the insurers. The crew abandoned the vessel, which broke its anchor, was stranded, and became a constructive total loss. The underwriters denied liability based on the owners' wilful misconduct as per the terms of the *Australian Marine Insurance Act 1909*.⁷⁰ But surprisingly, the Supreme Court of Queensland, after analysing English, American, and Canadian authorities, found that the loss to the vessel resulted as a likely consequence of the plaintiffs' conduct in leaving her with inexperienced crews in the circumstances she was in during that period. The vessel was exposed to the perils of the seas; the owners knew that she was not capable of withstanding such conditions and were indifferent to the risk that she would not survive those perils.⁷¹

B An exaggerated claim

An exaggerated or opportunistic claim is the most common type of insurance fraud. Here, the policyholder knowingly claims for more than the value of the loss. It is difficult to discern an exaggerated claim as the claim arises from a genuine loss. If the loss is sizable, then assessors or loss adjusters are engaged to investigate, assess, and report back to the insurer. The motive of a policyholder to inflate his claim is simple: for financial gain, that is, to make a profit from his loss.

Thus, the question arises as to what degree of exaggeration will make a claim fraudulent. A fraudulent claim is one that is willfully false in any substantial respect⁷² or anything not so insubstantial as to make the maxim *de minimis* applicable⁷³ and is not a limited claim that as to the whole is false.⁷⁴ A fraud is a fraud; regardless of the exaggerated sum, it is against the principle of utmost good faith, the foundation of insurance. Some policyholders see this as an opportunity to recover premiums when, in essence, insurance is about indemnity.

C A claim concealing evidence

While there may be a genuine claim, to promote the claim, the insured intentionally misrepresents the facts or suppresses evidence helpful to the

⁷⁰ *Marine Insurance Act 1909* (Cth) s 61(2)(a), which is identical to s 55(2) of the *Marine Insurance Act 1906* (UK).

⁷¹ *Wood v Associated National Insurance Co Ltd* (n 69).

⁷² *Goulstone v Royal Insurance Co* (1858) 1 F & F 276; (1858) 175 ER 725.

⁷³ *Lek v Mathews* (n 39) at 141.

⁷⁴ See also, *Orakpo v Barclays Insurance Services Co Ltd* [1995] LRLR 443; *Galloway v Guardian Royal Exchange (UK) Ltd* [1999] Lloyd's Rep IR 209. In this case, the insured had a genuine burglary claim for £16,000 but he deliberately exaggerated his claim by £2000 for the loss of a computer that he never possessed. In the first place, Lord Woolf MR considered the question as a mathematical one in the sense that 'one must look at the whole of the claim ... the fraudulent part is 10% of the whole claim. Millet LJ rejected the test by reference to the proportion of the entire claim as this would lead to' the absurd conclusion that the greater the genuine loss, the larger the fraudulent claim. Cf *Entwells Pty Ltd v National & General Insurance Co Ltd* (1991) 6 WAR 68.

defence for the insurer, such as an exclusion or breach of a policy condition or warranty.⁷⁵ For instance, the insured was driving under the influence of alcohol when had an accident but concealed this fact from the insurer. Another example of a claim concealing evidence would be an unlicensed driver who ended up in an accident. This is also a breach of the policy condition.

However, if there is no misrepresentation or concealment, it could be construed as the insured merely putting forward a starting figure for negotiation.⁷⁶ In such cases, it would be even more difficult to apprehend that the insured is concealing some information that may give the right to an insurer to repudiate the claim. The onus is on the insurer to establish fraud, ie evidence of lies, inconsistent statements, or deception. Concealment or suppression means the act of preventing or concealing vital information from people who have a right to know, for instance, the insurer.

D A claim involving the use of fraudulent devices

This category is unique because the insured has suffered a genuine loss, but to expedite payout, he submits a fraudulent document. Because of the distortion, the insurer has the right to repudiate the claim as fraud. This type of fraud is typical in fire, burglary, and marine cargo as the insured may submit a false stock declaration or a bill of lading. However, this type of fraudulent claim is not limited to documents only; it can extend to deliberate concealment of material documents, as in the case of *Wisenthal v World Auxilliary Insurance Corp Ltd*.⁷⁷ In this case, the insurer alleged that the insured had not only exaggerated her claim but also concealed relevant documents and facts relating to the claim.

While directing the jury, Roche J said:

Fraud was not mere lying. It sought to obtain an advantage, generally monetary, or to put someone else at a disadvantage by lies and deceit. It would be sufficient to come within the definition of fraud if the jury thought that in the investigation deceit had been used to secure easier or quicker payment of the money than would have been obtained if the truth had been told.⁷⁸

In *Black King Shipping Corp and Wayang (Panama) SA v Massie (Litsion Pride)*,⁷⁹ the court rejected the argument that the fraudulent claim principle was limited to claims only and extended to include any supporting documents about the fraudulent claim, such as the backdated letter as in this case.⁸⁰

⁷⁵ *Continental Illinois National Bank & Trust Co of Chicago v Alliance Assurance Co Ltd (The Captain Panagos DP)* [1986] 2 Lloyd's Rep 470 at 511.

⁷⁶ *Orakpo v Barclays Insurance Services Co Ltd* (n 74).

⁷⁷ *Wisenthal v World Auxilliary Insurance Corp Ltd* (1930) 38 Ll L Rep 54.

⁷⁸ Above at 62.

⁷⁹ *Black King Shipping Corp and Wayang (Panama) SA v Massie (The Litsion Pride)* [1985] 1 Lloyd's Rep 437.

⁸⁰ *Agapitos v Agnew* (n 43) at [7].

This proposition was later taken up by Mance LJ in *Agapitos v Agnew*,⁸¹ as to what constitutes a fraudulent device and accordingly concluded by saying that:

A fraudulent device is used if the insured believes that he has suffered the loss claimed, but seeks to improve or embellish the facts surrounding the claim, by some lie ... My tentative view of an acceptable solution would be ... (c) To treat as relevant for this purpose any lie, directly related to the claim to which the fraudulent device relates, which is intended to improve the insured's prospects of obtaining a settlement or winning the case, and which would, if believed, tend, objectively, before any final determination at the trial of the parties' rights, to yield a not insignificant improvement in the insured's prospects, whether they be prospects of obtaining a settlement or a better settlement, or of winning at trial.⁸²

This established the principle that the use of a fraudulent device to promote an otherwise valid claim would be treated as a fraudulent claim, which entitles the insurer to terminate the contract of insurance *ab initio*.⁸³ In other words, the fraudulent act of the insured to promote an otherwise valid claim made the entire claim void.

However, Mance LJ's decision in *Agapitos v Agnew*⁸⁴ was short-lived, as in *Interpart Comercio e Gestao SA v Lexington Insurance*,⁸⁵ the court accepted the underwriter's argument that the insured used a fraudulent certificate to advance his claim but still declined to grant judgment in favour of the underwriter, saying:

the law on the promotion of claims by fraudulent means, was 'uncertain' and in a state of development, in particular, the degree of nexus that there has to be between the fraudulent conduct and the promotion of the claim against the insurer was unclear ... It is not yet established how close must be the relationship between the fraud relied upon and the claim.⁸⁶

Similarly, in *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV*,⁸⁷ Cooke J rejected the insurer's plea that the insured had deliberately concealed material facts to promote his claim by saying that it is 'undoubtedly a difficult, contentious, and developing area of law'.⁸⁸

Nevertheless, Mance LJ's decision in *Agapitos v Agnew*⁸⁹ was followed in *The Game Boy*.⁹⁰ In this case, the vessel was insured under a marine hull policy for a sum of \$1.8 million. After the loss, the insured submitted his claim, but the insurer rejected the claim on the basis that the insured had deliberately misrepresented the condition and value of the vessel. The vessel was over-insured, and to support that value, the insured submitted several

81 Above.

82 Above.

83 Note: this is not the case in Australia due to s 56 of the *Insurance Contract Act 1984* (Cth).

84 Above.

85 *Interpart Comercio e Gestao SA v Lexington Insurance* [2004] Lloyd's Rep IR 690.

86 Above.

87 *Marc Rich Agriculture Trading SA v Fortis Corporate Insurance NV* [2005] Lloyd's Rep IR 396.

88 Above.

89 *Agapitos v Agnew* (n 43) at [7].

90 *Interpart Comercio e Gestao SA v Lexington Insurance* (n 85) at [238].

false documents. The insurer contended that even if the insured had a valid claim, the claim had to fail because the insured used fraudulent devices to advance his claim. The court found in favour of the insurer as the insured had used fraudulent devices to advance their claim and obtain an indemnity.⁹¹

If we take the plain literal meaning of the word 'fraud' then fraud is a fraud irrespective of 'how close the relationship between the fraud relied upon and the claim is'. The Australian Court in *Tiep Thi To v Australian Associated Motor Insurer Ltd*⁹² seems to incline to the plain literal meaning of the word 'fraud'. In this case, the insured's car was involved in an accident while being driven by her son, who was only 15 years old, without her approval. The insured realised that the policy would not cover the damages because the car was being driven by an unlicensed person. Therefore, after three days, she reported to the police that her car had been stolen and damaged. She claimed against her insurance policy and repeated the same false story that her car was stolen and damaged. When the claim was being processed, it turned out that the insured misunderstood the terms and conditions of the policy. The court ruled in favour of the insurer.⁹³

Buchanan JA said that:

The existence of an underlying valid claim does not render fraud irrelevant; the dishonest intention required for fraud is at least one to induce a false belief in the insurer to obtain payment or some other benefit under the policy, with or without belief or knowledge of a lack of entitlement; and fraud which relates to the claim made with the requisite intent will disentitle the claimant even if made after the first presentation of the claim.⁹⁴

On the other hand, in *Ewer v National Employers Mutual General Insurance Association Ltd*,⁹⁵ McKinnon J thought that there was nothing wrong if the claimant submitted a claim for the cost of new furniture to replace second-hand furniture that had been destroyed. He added that perhaps this is the beginning of negotiations between the insurer and the insured as to an appropriate settlement.⁹⁶ Thus, a fraudulent device is used when 'the insured believes that he has suffered the loss claimed but seeks to improve or embellish the facts surrounding the claim by some lie'.⁹⁷

91 Above. See also *Stemson v AMP General Insurance (NZ) Ltd* [2006] Lloyd's Rep IR 852; *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 3 VR 279; [2001] 161 FLR 61; [2001] VSCA 48.

92 *Tiep Thi To v Australian Associated Motor Insurers Ltd* (n 91).

93 Above.

94 Above.

95 *Ewer v National Employers Mutual General Insurance Assoc Ltd* [1937] 2 All ER 193.

96 Above.

97 Per Mance LJ in *The Aegeon* [2002] EWCA Civ 247, and *Aviva Insurance Ltd v Brown* [2011] EWHC 362.

E A reckless claim

In *The Glamorganshire Iron and Coal Company v Irvine*,⁹⁸ Willes J said that:

[i]t is equally fraudulent if the statements are made in the knowledge that they are false or with a reckless disregard of whether they are true or not, or not knowing whether they are true or false, and careless whether they are true or not.

The above proposition was further clarified in *Medd v Cox*⁹⁹ where the plaintiff bought a motor cruiser from the defendant, who was a professional launch vendor. The defendant described the launch as having a 'new Morris Navigator engine', 'exceptional condition', and 'original cost over £1000'.¹⁰⁰ Upon inspection, the vessel was found to be in very bad condition. The plaintiff claimed damages for fraudulent misrepresentation. The trial judge held that the statement was false but based on the fact that 'she was not in excellent condition'.¹⁰¹ This decision of the trial judge was appealed, and after considering the relevant evidence, Sir Wilfrid Greene MR held that there was no evidence to establish 'that the defendant knew that those statements, when he made them, were untrue'.¹⁰²

Thus, Sir Wilfrid Greene MR stated,

It is to be remembered that to sustain a case of fraud, it is quite insufficient to prove that the untrue statement was made carelessly. What it is necessary to prove is a guilty state of mind in the person making the statement. He must either know that his statement is untrue or he must make it recklessly not caring whether it is true or false. That guilty mind must exist, and unless one or other of those two facts is established about the state of mind of the defendant, no finding of fraud can be supported in law.¹⁰³

Thus, recklessness means that the person making the misrepresentation does not know the true state but takes steps either to inquire, or chooses not to enquire, and turns a blind eye.

IV Why do people commit insurance fraud?

This is a million, perhaps a billion-dollar question, because not only is insurance premised on good faith, but so is social security. In the event of a loss, subject to the terms and conditions of the policy, the insurer indemnifies the insured for the loss. That is, put the insured back in the same financial position, or as near as possible, as he/she enjoyed before the loss. And yet some, or perhaps most, people interfere with insurance. This is like slaughtering the 'golden' hen. Some insurance frauds are committed

98 *Glamorganshire Iron & Coal Co v Irvine* (1866) 4 F & F 947 at 955–956; (1866) 176 ER 861. See also *Derry v Peek* (n 19).

99 *Medd v Cox* (1940) 67 LI L Rep 5.

100 Above.

101 Above.

102 Above.

103 It is interesting to note the decision of the court in *Blackburn, Low & Co v Vigors* (1887) 12 App Cas 531 at 536–537, where Lord Halsbury LC considering a scenario of a person proposing hull insurance is expected to know both the condition and the history of the ship. If he failed to enquire and proposes for insurance, this might be construed as fraud. This might be illustrated as turning a blind eye.

knowingly based on opening room for negotiation; others are committed out of greed. Some of the most notable motivations for insurance fraud are discussed as follows:

A Lack of criminal responsibility

The greatest influence on the decision to commit insurance fraud is the lack of criminal responsibility. In most cases, criminal responsibility is evaded. The fraudster knows that if he is successful, then he will gain; and if he is unsuccessful, there is nothing to lose.¹⁰⁴ If insurance fraud is criminalised, people will not only refrain from committing it but also ensure they only claim legitimate losses. In any event, some habitual wrongdoers will continue to fake their claims; the number of fraudulent claims will drastically decrease, and the chances of detecting fraudulent claims will be high. This may result in lower premiums, better coverage, and more consumer protection.

B To generate revenue and/or make a profit

Generally, people commit insurance fraud to generate revenue or make a profit. Conversely, some people suffer losses but deliberately exaggerate their claims not essentially to open discussion or to begin negotiations but to defraud the insurers.

C Low chances of discovery

The chances of discovery of a fraudulent claim are drastically low because of collusion among the employees of the insurer, the insured, and other people in the system. This simultaneously increases the opportunity and incentive to commit insurance fraud. The greater the network of defaulters, the bigger the scam; hence, the greater the harm to the insurers. This is ultimately passed on to the consumers by insurers' increased premiums and excesses/deductibles and offering reduced or restricted coverage. Because of some unscrupulous and unethical policyholders, all other policyholders suffer whether they are frauds or not.

D Recover premiums paid

Most insurance fraudsters are not habitual criminals but commit fraud to, at least, get back what they paid.¹⁰⁵ However, some policyholders exaggerate their claims because they know that ultimately their claims will be adjusted. Some commit insurance fraud because they believe that there is nothing wrong with defrauding. Others see that it is morally wrong to submit a fraudulent claim but vindicate their actions as justified by the situation. Some people think that insurance companies are charitable organisations that would

¹⁰⁴ *The Star Sea* (n 48) at 1. See also *Sharon's Bakery (Europe) Ltd v AXA Insurance UK Plc* [2011] EWHC 210 (Comm).

¹⁰⁵ Insurance Europe, *The Impact of Insurance Fraud* (Booklet) p 1 <<https://www.insuranceeurope.eu/publications/492/the-impact-of-insurance-fraud/?inline=1>> (accessed 12 January 2025).

keep paying whenever the policyholder requires funds. Similarly, some people perceive committing insurance fraud as equivalent to drawing funds from the bank.¹⁰⁶

E The nature of the contract

The nature of the insurance contract *per se* plays a role in sponsoring fraud. This is because insurance is premised on the good faith of the insurer and the insured, this can also encourage the policyholder to take advantage of the insurer's reliance and abuse it. As much as the insured, insurers are abused if they fail to fully explain the proposal and policies to consumers and prospective consumers. When a business depends on the honesty of customers, the business has an inherent risk of fraud because it is impossible to determine the level of sincerity and good behaviour of customers as people constantly change. Customers know that if they are caught committing fraud, the consequence is the termination of the contract of insurance *ab initio*,¹⁰⁷ and all benefits under the policy will be forfeited; that's all.

V What is the industry doing to combat fraud?

The insurance industry, together with other law enforcement agencies, is using increasingly sophisticated techniques to detect fraud, but at the same time, the fraudsters are capitalising on the blind spots in the technology and strategy to perpetrate criminal acts. In the fight against fraud, Croatia, Estonia, Finland, Germany, Ireland, Malta, the Netherlands, Norway, Portugal, Slovenia, Spain, Sweden and the United Kingdom exchange information to help them identify potential frauds.¹⁰⁸ The network is committed to dealing with common challenges in the industry.

In addition, insurance companies in France, Sweden, and the United Kingdom have set up separate national bodies or groups to investigate insurance fraud. The insurance companies in France set up a national body known as 'Agence pour la lutte contre la fraude à l'assurance' (ALFA),¹⁰⁹ in Sweden, insurance companies have created special investigation units;¹¹⁰ and in the United Kingdom, the IFB.¹¹¹ These bodies or units are charged with detecting insurance fraud and reporting detected or suspected fraud to police.

In addition, underwriters in Croatia, Denmark, Estonia, Germany, Ireland, the Netherlands, Portugal, Spain, Sweden, and the United Kingdom increased solidarity with international law enforcement agencies such as Europol, Interpol, and national insurance associations to combat fraud. In 2012, the Insurance Fraud Enforcement Department (IFED) (part of the City of London Police) was formed in the United Kingdom and funded by insurers. In the first

106 Above.

107 Note: This is not the case in Australia due to s 56 of the *Insurance Contract Act 1984* (Cth).

108 *The Impact of Insurance Fraud* (n 105) p 13.

109 Above.

110 Above.

111 Above.

year of their operation, over 200 arrests were made with £12 million (€14 million) of suspected insurance fraud.¹¹²

Furthermore, in Sweden, service providers use technology, such as key readers, to confirm that car keys belong to the car allegedly stolen.¹¹³ A claim for alleged back injuries was rejected when Facebook images showed the claimant performing gymnastics and training for a charity run.¹¹⁴ Like any crime, insurance fraud can be minimised, but it cannot be entirely eradicated. The consequence of insurance fraud is the termination of the insurance contract *ab initio*.¹¹⁵ The policyholder loses all premiums paid.

VI Conclusion

Insurance fraud is a crime we all pay for, whether through higher premiums, restricted cover, law enforcement, and court costs, or higher medical bills. The cost of insurance fraud has more far-reaching consequences than one can imagine. Thus, insurance fraud should not be taken lightly because it is not only a crime against innocent victims, but it also undermines the rights of genuine claimants.

Insurance companies around the world are vigorously fighting against fraud, but impostors are swiftly swindling millions of dollars each year. Many people regard insurance fraud as a low-risk but high-return investment. Because of the lack of attention from some insurance companies, corrupt practices, and the lack of monitoring systems, wrongdoers are attracted to insurance as a source of revenue, less detrimental than committing armed robbery, killing, trafficking, or drug dealing. Fraud, such as opportunistic manipulation, capitalising on loopholes in the system, or criminal behaviour (other than arson), in most places, is hardly prosecuted. While it is envisaged that insurance fraud is ceaselessly taking its toll, the actual extent and cost of fraudulent claim is difficult to quantify with precision because of there are several obstacles such as, the nature of the fraud (conceal), fraud is not static as fraudsters/unscrupulous business tycoons, individuals, and employees capitalise on the opportunities with latest technology and reap millions of dollars.

This paper recommends that:

- (1) every insurance policy incorporates a fraudulent claims clause that in the event of fraud, the contract will be automatically terminated *ab initio* (subject to legislative overrides such as s 56 of the *Insurance Contracts Act 1984* (Cth));
- (2) if it is established that an insured has submitted a fraudulent claim, the insurer has the right to recover all previous claims paid under the policy (with interest), even if the previous claims were legitimate;
- (3) vital information on fraudsters should be shared on a public database;

112 Above.

113 Above.

114 Above.

115 Note: This is not the case in Australia due to s 56 of the *Insurance Contract Act 1984* (Cth).

- (4) insurance fraud should be criminalised and the fraudster severely punished; and
- (5) the fraudsters should never be permitted to join the insurance circle again.

This will send a clear message to fraudsters that the building block of insurance, the 'principle of utmost good faith', should be truly observed by all participants — which is legally justifiable and economically efficient in the best interests of all, including the fraudster.