

## **“Red Flags” of Insurance Fraud**

*Editor’s note: the following is an excerpt from the 2008 Fraud Examiners Manual - US Edition, published by the Association of Certified Fraud Examiners.*

Red flags of insurance fraud may include any of the following:

- The claim is made a short time after inception of the policy, or after an increase or change in the coverage under which the claim is made. This could include the purchase of a scheduled property or jewelry floater policy, or more than one during the time before the loss.
- The insured has a history of many insurance claims and losses.
- The insured earlier asked his insurance agent hypothetical questions about coverage in the event of a loss similar to the actual claim.
- The insured is very pushy and insistent about a fast settlement, and exhibits more than the usual amount of knowledge about insurance coverage and claims procedures, particularly if the claim is not well documented.
- In a burglary loss, the claim includes large, bulky property which is unusual for a burglary.
- In a theft or fire loss claim, the claim includes a lot of recently purchased, expensive property, or the insured insists that everything was the best or the most expensive model, especially if the insured cannot provide receipts, owner’s manuals, or other documentary proof of purchase.
- In a fire loss claim, property which would be personal or sentimental to the insured and which you would expect to see among the lost property—photographs, family heirlooms, or pets—is conspicuous by its absence.
- A large amount of the property was purchased at garage and yard sales and flea markets, or otherwise for cash, and there are no receipts (the insured usually will be unable to recall exactly where these sales took place or by whom).
- The insured cannot remember, or does not know, where he or she acquired the claimed property, especially unusual items, and/or he cannot provide adequate descriptions.
- On the other hand, the insured already has receipts and other documentation, witnesses, and duplicate photographs for everything; the claim is too perfect.
- Documentation provided by the insured is irregular or questionable, such as:
  - Numbered receipts are from the same store and dated differently or sequentially.
  - Documents show signs of alteration such as dates, descriptions, or amounts.

- Photocopies of documents are provided and the insured cannot produce the originals.
  - Similar handwriting or signatures—or the insured’s apparent handwriting—on different receipts, invoices, gift verifications, appraisals, etc.
  - The amount of tax is wrong, either for the price of the property or for the date appearing on the receipt.
  - Receipts, invoices, or shipping documents do not have “paid,” “received,” or other shipping stamps.
  - In a theft or loss away from home, the insured waits an unusually long time before reporting the theft to the police.
  - The insured is able to give the police a complete list of lost property on the day of the burglary or shortly after.
  - The amount of the claim differs from the value given by the insured to the police.
  - In a business inventory or income loss claim, the insured does not keep complete books, or the books do not follow accepted accounting principles.
  - The physical evidence is inconsistent with the loss claimed by the insured.
  - In a burglary loss, there is no physical evidence of breaking and entering, or a burglary could not have occurred unnoticed under the circumstances.
  - In a fire loss:
    - The apparent cause and origin of the fire is inconsistent with an accidental cause and origin, or there is evidence of the use of an accelerant.
    - The remains of the property do not match the claimed property.
  - The premises do not show signs of having contained the claimed property, or the amount of property will not fit into the space where the insured says it was.
  - Physical damage to the insured’s car is inconsistent with its having been in a collision with an uninsured car.
  - The insured has discarded the claimed damaged property before the adjuster can examine it.
  - The cost of the claimed property, over the period of time it allegedly was acquired, seems to exceed the insured’s financial ability to purchase it.
  - The insured refuses or is unable to answer routine questions.
  - The insured provides supporting evidence and documentation which cannot be corroborated.
- Information on a life application is very vague or ambiguous as to the details of health history: dates, places of treatment, names of physicians or hospitals, or specific diagnosis.
  - Applicant fails to sign and date the application.

- Pertinent questions on the application are not answered, such as income, other insurance carried, hazardous duties, or aviation or flying activity, etc.
- The insured has “excess insurance,” either shown at the time of application or developed through an underwriting report of database information.
- Earned income does not warrant amount of insurance being applied for.
- The applicant’s date of birth as shown on the application is much earlier than shown with other carriers or in previous applications or policies.
- The agent is putting on a great deal of pressure to have the policy issued because of the large amount applied for, but is going over the underwriter’s head in order to do so (working out of the system).
- The physician’s report is very vague on details of past medical history and does not coincide with the information shown on the application.
- A death claim is presented in which the death has taken place outside of the country.
- The signature on the application for insurance does not appear to be the same signature as shown on an authorization at the time of claim.
- A claimant or claimant’s attorney attempts to limit the type of information to be related by a signed authorization which is a standard authorization used by the company.
- An attorney is immediately brought into a contestable death claim, attempting to interfere with the investigation and to withhold information required by the company.
- The contestable death claim which is reported as an accidental death could possibly be a suicide (fatal accident involving only one vehicle, a hunting accident, an accidental shooting while cleaning a weapon or repairing same, etc.).
- An autopsy report discloses a different height and weight than what is shown on the recent application (auto or house fire death). Dental records do not coincide with those dental findings as shown by an autopsy report.
- Records are missing on a patient who was confined to a hospital, or records are missing on a patient from a physician’s office.
- The death claim package sent to the insurance company is too well packaged and complete in every detail with supportive documents. Documentation which was not initially asked for or required by the insurance company was voluntarily sent, such as newspaper reports, burial certificates, shipment of the body from one country to the home country.
- The routine audit of a designated insured group shows a significant increase of added employees whose names do not show up on the payroll.
- Gunshot wounds or stabbings were inflicted by the insured as the aggressor or were self-inflicted.

- Police accident reports were submitted by the claimant.
- Pressure for speed of handling—claimant wants to stop by the office to pick up his check “as we’re leaving for vacation in the morning.”
- Series of prescription numbers from the same drug store don’t coincide chronologically with the dates of the prescriptions.
- Automobile fire in a very remote rural area with no witness, but the driver claims an electrical shortage in the engine compartment caused the entire car to be gutted by flames.
- Preliminary information for a business fire loss or home fire loss indicates considerable financial difficulties and financial pressures being brought upon the owner and the fire is suspicious in nature and/or origin.
- An employee within the claims operations of an insurance company is known to be having a drinking problem, drug problem, financial pressures, or is having serious marital difficulties or having a known affair with another and irregularities start to appear.
- On burglary losses from a business or especially a home, the investigator observes that the remaining contents at the scene are of much inferior quality than that which is being reported stolen. There is no indication of indentation in the piling of the carpet where heavy items of furniture or equipment were to have been placed. There are no hooks or nails on the walls where valuable pictures might have been hung. Entrances or exits are too small to take a large item through without laboriously disassembling it.
- Any information on a claim that has been filed if it is determined that there is deliberate cover-up or false statements contained therein.
- A disability income protection claim is filed and it is determined that the claimant had recently purchased numerous expensive items on credit and had them all covered by credit A&H insurance coverage.
- Public transportation accidents in which there are more passenger claims filed than there were passengers at the time of the accident.
- A witness to an accident or incident deliberately tries to hide from investigators rather than come forth and tell the truth.
- An official document of findings is in complete conflict with the facts in the case and there is no explanation for this conflict of facts. Photographs or other documents do not substantiate the reported findings.

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