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Fraud policy

General

Fraud tarnishes the image of the insurance sector and of our own underwriting business in particular. Fraud also has an undeniable impact on claim levels and thus the result of our underwriting portfolio.

In 2018, insurers proved 12,879 cases of insurance fraud. This is the highest that figures have been since they were first recorded by the Centre for Insurance Crime Prevention (*Centrum Bestrijding Verzekeringscriminaliteit*). By taking this successful approach to fraud, the sector realised a saving of 82 million euros in 2018. That means that over the past six years, more than half a billion euros have been saved through effective action against fraudsters. As a result, honest customers have not had to pay for the financial losses that these fraudsters tried to cause.

It is the fourth year in a row that there has been an increase in the number of fraud cases detected by insurers. In total, almost 45,000 indications of fraud were investigated in 2018. The increasing use of innovative fraud detection technologies such as artificial intelligence plays an important role in the detection of indications of fraud. This increases the chances of people who think they 'can give it a go once' being caught.

Apart from the direct losses caused by fraud, insurers also spend a lot of time investigating and settling such cases. Even simple fraudulent claims cause losses where ultimately the well-intentioned consumer is the victim. In order to prevent this and discourage potential fraudsters, insurers introduced a tit-for-tat approach in 2017. With this approach, a fraudster who is caught is presented with an invoice which 'starts at' 532 euros via SODA. The invoice is to compensate for the internal investigation costs that the insurer has incurred. Since this approach was introduced, more than two thousand cases have been handled in this way already. This summer, the total amount paid by fraudsters passed the milestone of one million euros.

Top five types of insurance most subject to fraud:

- Car insurance
- Building and contents insurance
- Liability insurance
- Package policies (combined insurance policies)
- Travel insurance

The definition of fraud

The misuse of an insurance product or service by the policyholder or insured or beneficiary in order to obtain a benefit (in cash or kind) to which they are not entitled.

Policy

It is the responsibility of the management to establish an effective fraud policy and to provide suitable measures. We will not tolerate any form of fraud.

It is important for everyone within our company to be familiar with the relevant aspects of fraud and for the awareness of fraud to be encouraged and supported by all employees.

Fraud prevention is a regular part of the daily acceptance and claims handling process. We focus on the detection and investigation of the aspects of fraud in our procedures and instructions. Employees have been informed regarding investigation indicators and how to apply them. In addition, every new insurance policy and any payment of compensation is checked based on the CIS database.

The Fraud Control Guide for authorised agents and the score lists for investigation indicators and risk points have been incorporated in our Knowledge Portal and are available to our employees. Employees are familiar with the content of these documents. A suspicion of fraud is checked against the investigation indicators and risk points. This check is demonstrably recorded.

The managing director is our designated fraud contact person. If (possible) fraud is detected, the managing director is notified directly by the employee who detected it. The fraud contact person records special registrations detected in the CIS database (including ERR registrations) and every suspicion of fraud in the fraud register. This is done even if there is eventually found to be no question of fraud or it cannot be proved.
The fraud contact person is responsible for the confidential handling of the fraud register.

If an ERR registration is detected or (a suspicion of) fraud is found in relation to an authorised agent insurance policy, the fraud contact person will inform the authorising party's fraud coordinator within 3 working days. The instructions of the authorising party will be followed.

Our fraud policy is laid out and explained on our website so that policyholders and other interested parties can take note of it.

In addition to the process controls that we carry out on a daily basis, we provide a number of management controls for detecting fraud retrospectively.

Any cases of internal fraud identified are handled as specified in the Incident Procedure. Fraud is always reported to the Ministry of Justice.