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***Miloš M. Petrović, PhD*[1]**

NECESSITY OF CLOSER INTERNATIONAL COOPERATION OF VARIOUS INSTITUTIONS IN FIGHTING AGAINST INSURANCE FRAUD

PROFESSIONAL PAPER

Abstract

In this paper, the author analyses a few examples of fraud in life and accident insurance. The cases that are the subject of this Article can be classified as "heavy frauds" according to the seriousness of the crime committed and as "external" according to the source type. The course and epilogue of the trials show how important it is to have the closest possible coordination between the judicial, police and insurance institutions and that the character of insurance frauds is becoming increasingly international, requiring stronger cross-border inter-institutional cooperation. Also, experts from a growing number of disciplines (from medicine, through mechanical engineering to technological sciences) do have a particularly notable role in discovering false insurance claims. Their expertise findings can make a decisive contribution to clarifying the circumstances of each and every case. The examples presented in this Article illustrate that closer cooperation between all the named participants and the use of advanced methods and technologies are the indispensable tool of a good and a more efficient fight against the insurance fraud.

Key words: *insurance fraud, false claim, life insurance, international cooperation*

I. Introduction

The insurance fraud is present in all parts of this industry - from traffic, through health, to property and other (false or exaggerated) claims. This is an act of illegal

[1] Miloš M. Petrović is a doctor of political sciences and author of papers in the field of European law and political sciences. E-mail: petrovic1milos@gmail.com.
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request for payment addressed to the Insurer on the basis of a false claim under an insurance policy.[2] The insurance fraud also relates to the situations like filling in the insurance forms with false and lacking information at the insurance application as well as submitting claims for indemnity upon false or misleading circumstances including the exaggeration of the insured occurrence.[3] Another term that is closely related to this phenomenon is that of a moral hazard, i.e. the risk that a person's behaviour will differ depending on whether such a person is covered or not by an insurance policy, which is a challenge in all domains of insurance business.[4] This phenomenon will be analysed in more detail in several cases that are the subject-matter of this Article

One of the standard insurance fraud classifications is the division into "heavy fraud", which occurs when a loss is planned or conspired in advance and the "soft fraud", based on legitimate claims but with an element of greed, e.g. exaggerated insured occurrence.[5] There is a relevant case to this effect in the Slovenian practice that included a claim filed under accident insurance. This type of insurance can cover sudden events and circumstances resulting in death, complete, partial, temporary or permanent disability or impaired health that requires treatment.[6] The mentioned claim was based on an accident resulting in a degree of disability, that became doubtful on the basis of evidence related to the accident of the insured person. This text will also briefly present a case of an American insured person, on whose behalf a request for premium payment was filed following his death.

In addition to the classification into „heavy" and „soft" fraud, according to the gravity of a case, we use an additional classification according to the source of fraud – to internal and/or the external, outside fraud.[7] The internal frauds are colloquially called "insider" and refer to situations when an insurance employee cooperates with the insured person in order to file a false or exaggerated claim with a view to exercising their right to the sum insured.[8] The eternal fraud, on the other hand, is the fraud where the insured person or a third party requires indemnity under a false or exaggerated claim.[9] Hereinafter, the author will present several examples of "heavy" insurance fraud of external nature.

The insurance fraud refers to an object and/or insurance subject-matter that is deliberately destroyed, damaged or hidden with the aim to collect the sum

[2] Slobodan Petrović, Milosav Stojanović, Insurance Fraud, *Insurance Trends* no. 1/2012, pp. 61.
[3] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 4.
[4] Đorđe Ćuzović, Fraud and moral hazard in insurance, *European Review of Insurance Law*, ISSN 2334-833X, 1/2020, p. 3.
[5] Slobodan Petrović, Milosav Stojanović, Insurance Fraud, *Insurance Trends* no. 1/2012, p. 64.
[6] Dunav Insurance Company, Accident insurance, https://www.dunav.com/proizvodi/nezgode/, visited on September 10, 2020.
[7] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 5.
[8] Ibid.
[9] Ibid.

insured.[10] In Serbian and European legislation, this concept is classified as a criminal act, manifested in two forms: hiding, inflicting damage to or destroying the object insured, on the one hand and inflicting harm, bodily injury and health impairment to oneself.[11] Experts and professionals from various fields (from judiciary, through police, to the employees in the insurance industry) have a very important role in evidencing such abuses, by mutual cooperation in such situations. Moreover, in an increasingly globalized world, there is a growing need for closer cooperation between institutions at the international level in combating such crimes. The cases that we will hereinafter analyse are examples of close inter-institutional and inter-state cooperation that have contributed to clarifying the circumstances necessary for making adequate decisions on insurance claims. Basic information on the cases that are the subject of this paper are mostly taken from foreign media papers, listed in the schedule of literature used. The fact that the media followed up with great agility on such criminal proceedings is particularly favourable for insurance companies, given that reporting on such cases contributed to the development and improving of public awareness on the abuses in the field of insurance.

1. Request for Payment of Sum Insured Upon Occurrence of Accident

In January 2019, a 21-year-old woman from Ljubljana arrived at the hospital escorted by a few people. The injury was serious: the woman lost her left hand, as she claimed, while cutting branches with a circular saw on her property.[12] Already in the hospital, it was noticed that neither the patient nor the accompanying persons brought the severed hand of this twenty-one-year-old with them to the hospital, for the doctors to try and save it, which in itself was weird.[13] However, in spite of this fact and upon initiative of doctors, it was organized that the hand be brought from her home in order to be timely sewn.[14]

A case investigation was initiated and it included, in addition to the mentioned girl, her partner and his parents.[15] The police have officially filed an indictment against all the named persons, alleging that this case did not represent an accident but

[10] Joko Dragojlović, Krivično delo prevare u osiguranju, Kultura polisa, Novi Sad, str. 674.
[11] Ibid, 676.
[12] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 08. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on 15. 9. 2020.
[13] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957,* visited on: 16.9.2020.
[14] Ibid.
[15] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on: 15. 9. 2020.

a pre-designed act in order to collect indemnity from several insurance companies.[16] In that sense, the prosecution stated that the severed hand was intentionally left at the location where the accident had occurred in order to increase the degree of injury and thus cause disability.[17] As part of the trial that began in 2019, these persons were taken into custody whereas the media speculated that if a verdict was brought against them, the prison sentence for such a crime could be up to eight years.[18]

During 2020, the trial started against the above persons, suspects for the attempted fraud of over one million euros.[19] During the trial, evidence was presented that in the year preceding the occurrence, the first accused, with the help of her partner, took out as many as five insurance policies covering an accident under life coverage.[20] The plaintiff presented the evidence that the woman's partner searched various models of prosthetic arms on the Internet in the days before the accident, which was one of the key arguments in proving the mischievious cause of the accident.[21] The accused persisted in claiming that the occurrence was accidental, while the prosecution maintained the attitude that it was a deliberate attempt to collect a huge amount of money from the insurance companies.[22] Also, the prosecution stated that the girl committed this act at the urging of her partner, his parents included, and the court decided that all these persons should be prosecuted.[23]

The prosecutor also stated that the opinions of medical and mechanical experts showed that the accused had been intentionally injured, proposing that she be sentenced to four years and six months in prison, her partner to five years in prison, his mother to four years, and her husband to one year in prison. [24] The Slovenian court agreed with the prosecutor's allegations and ruled that the mentioned persons were responsible for the criminal offense of attempted insurance fraud. The first accused was sentenced by a court decision to two years in prison, her partner to three years, while his father was sentenced to a suspended sentence of one year.[25]

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[16] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957*, visited on: 16.9.2020.

[17] Ibid.

[18] Ibid.

[19] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on: 15. 9. 2020.

[20] BBC News, Woman who sawed off own hand found guilty of fraud, 12. 9. 2020, *https://www.bbc.com/news/world-europe-54125770,* visited on: 15. 9. 2020.

[21] Ibid.

[22] *Politika online*, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* accessed on: 15. 9. 2020.

[23] Ibid.

[24] Ibid.

[25] Russell Hope, Julija Adlesic: Woman who deliberately cut off own hand in insurance scam jailed for two years, SkyNews, 12.09.2020**,** *https://news.sky.com/story/julija-adlesic-woman-who-deliberately-cut-off-own-hand-in-insurance-scam-jailed-for-two-years-12069121,* visited on: 15. 9. 2020.

There is an interesting example from the Dutch insurance practices. A miner, who maintained an insurance policy against disability at work, had to stop working due to a shoulder injury, which was a significant problem for his type of work.[26] For the next six years, this insured person received a monthly allowance until the insurance company got an anonymous notification that the insured (despite his alleged disability) not only practiced surfing but was also internationally known in the discipline.[27] An investigation was initiated and the insurance company came into possession of photos showing the insured surfing in strong winds, which was one of the key grounds to annul the decision on the payment of the sum insured, request a refund and include him in the national register of insurance fraudsters.[28]

2. Fake Death in Context of Insurance Fraud

This section will present two separate cases of faking death in order to exercise the right to a sum insured. Both cases involved cross-border embezzlement, discovered thanks to a cooperation between institutions and turned out to be an unfounded and illegal claim against insurers.

At the end of the first decade of the 21st century, a Moldovan citizen residing in the United States took out life insurance with the Mutual Omaha Insurance Company in the US state of Minnesota, with coverage of two million dollars and named his wife the primary beneficiary.[29] In October 2011, the body of a man who died of a heart attack was found in the interior of Moldova; the personal documents and inspections carried out by competent institutions indicated that the person was the insured in question.[30] According to the investigation of judicial authorities, during the next month, his wife submitted a claim for payment of the sum insured upon death of her husband, and the sum of two million dollars which was paid to her bank account.

Through the cooperation between the Federal Bureau of Investigation and the National Tax Agency in the following years, it was established that this was a false request and several key facts were revealed. Namely, the insured did not die, but lived under a different name for years in Pridnjestrovlje, a breakaway Moldovan territory.[31] Moreover, as the investigation showed, the financial transfers included his immediate family's transactions with banks in Moldova, the United States and

[26] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p.10.
[27] Ibid.
[28] Ibid.
[29] United States Department of Justice, Moldovan National Sentenced To 41 Months In Prison For Faking His Death For $2 Million Insurance Payout, 29. 7. 2019, *https://www.justice.gov/usao-mn/pr/moldovan-national-sentenced-41-months-prison-faking-his-death-2-million-insurance-payout,* visited on: 2. 9. 2020.
[30] Ibid.
[31] Ibid.

Switzerland.[32] Additionally, one of the main elements on the investigation was in 2013, when during border checks, recent photos of the father were found in the computer of the insured's son, who was returning from a trip from Moldova, even though he had allegedly died several years earlier.

Like the case from Slovenia, this case represents a "heavy fraud", planned in advance and with premeditation in order to illegally collect the funds payable in case of death of the insured person. The investigation showed, as in the Slovenian case, that other family members were instructed to commit the crime. The accused Moldovan citizen was extradicted to the United States in 2018 for trial and by the decision of the competent court in Minnesota, sentenced to 41 months in prison for insurance fraud committed by faking death.

There is a case similar to this, of a Pakistani citizen residing in the UK, who faked his death in Pakistan in an effort to obtain indemnity from a British insurer to the amount of one million British pounds.[33] Namely, the Insurer was contacted by a person who claimed that she was a partner of the Insured and that the Insured had died of a heart attack during his visit to the Pakistan at the age of thirty-nine.[34] The investigation showed that the person who contacted the Insurer was in fact the Insured himself, who pretended to be his own partner, sending the notification to the Insurer by e-mails and telephone calls.[35] The proof of this came through the expertise of a voice expert, who determined by comparing his and the other voice that it most probably belonged to one and the same person.[36]

In the process initiated by the Insurer, a partner company was engaged in Pakistan and they established that there was no burial of persons under the accused's name in the cemetery where he was allegedly buried at the time.[37] They also made an analysis of the documentation he submitted in an effort to collect indemnity from the Insurer. On that occasion, among other documents, the Insurer also examined a death certificate and a medical certificate of the cause of death and found them to have been false, i.e. that the Insured's health record was empty and the medical institution that issued the certificate did not appear to have officially existed.[38]

Despite the numerous pieces of evidence that indicated that it was a case of fraud for the purpose of exercising the right to payment of the sum insured, the

[32] Ibid.

[33] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20.01.2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Owain Thomas, Serial fraudster jailed for five years after £1m fake life insurance claim, Mortgage Solutions United Kingdom, 17. 1. 2020, *https://www.mortgagesolutions.co.uk/news/2020/01/17/serial-fraudster-jailed-for-five-years-after-1m-fake-life-insurance-claim/,* visited on: 11. 9. 2020.

[38] Ibid.

Insured maintained the attitude that in fact his partner was the one who filed a false death claim for financial gain.[39] As in the Moldovan case, this case has been successfully clarified thanks to the close inter-institutional cooperation necessary to collect and verify all information related to claim for indemnity. In this case, the procedure was done by the London Police Insurance Fraud Department, which was contacted by an unnamed Insurer when they noticed suspicious matters related to the case.[40] The accused was sentenced to five years and seven months in prison.

3. OLAF – Encouraging European Cooperation in Combating Financial Fraud

Closer interstate and international cooperation is one of the ways to combat financial fraud as much as possible, including those in the insurance industry. A few decades ago, in the years leading up to the creation of the single market (1993), the European Community recognized the need for its member states to become more closely involved in the fight against financial fraud.[41]

Upon an initiative of the European Commission, UCLAF (Coordination Unit for the Suppression of Financial Fraud) was established first, with their scope of activities gradually expanding supported by the European Parliament.[42] Ten years later, in 1999, a decision was made to establish a body with stronger supervision and performance capabilities.[43]

The OLAF Institution (*Office Europeen de Lutte Antifraude*, in Serbian: *Evropska kancelarija za borbu protiv prevara*, hereinafter: Office), was established to research problematic aspects of financial management within various areas and institutions in the European Union.[44] Unlike their predecessor, whose scope of activity was primarily linked to the European Commission, the OLAF has a wider scope of activities that includes other European bodies, especially targeting the investigation of fraud linked to the budget of the European Union, corruption and other offenses, as well as with the development of the European Commission's anti-fraud strategy.[45] Some authors also interpret the expansion of the activities of the Office for the Fight against

[39] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[40] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[41] European Commission, OLAF – History, 2020, *https://ec.europa.eu/anti-fraud/about-us/history_en,* visited on: 6. 10. 2020.

[42] Ibid.

[43] Ibid.

[44] European Commission, OLAF – European Anti-Fraud Office, 2020, *https://ec.europa.eu/anti-fraud/home_en*, visited on: 6. 10. 2020.

[45] Ibid.

Fraud as the strengthening of the supranational legal system of the European Union compared to that of the member states, upon which the fight against financial fraud crucially relies.[46] In addition, the Office has competencies that enable it to deepen the cooperation with bodies outside the European Union, which is especially important given the increasingly globalized financial flows.[47] The main activities of the Office additionally include the development of a comprehensive strategy and legal acts for combating fraud, investigation and risk identification, proposing measures against financial fraud to European institutions and the creation and maintenance of relevant databases.[48]

As early as 2006, the number of investigations launched independently by the European Anti-Fraud Office exceeded the number of those where they supported the member states and since 2013, each country has been obliged to establish an office that would coordinate activities with OLAF, in terms of financial fraud.[49] The strengthening of this authority was supported by the need to protect the single market as well as the cash in possession of the European citizens. To this end, the Office has created an electronic service *Fraud Reporting*, through which citizens can independently submit a request for investigation of fraud or other irregularities that could potentially harm European funds, as well as gross omissions in the conduct of European institutions or officials.[50] While OLAF has achieved more notable results in areas such as customs violations and tobacco smuggling, its development path suggests that its competencies and scope will lead to further expansion to protect EU funds and European taxpayers' funds. Anyway, the European Anti-Fraud Office is already a contact point for providing support to member states in the field of finances, including insurance, which represents a good starting point for the development of interstate cooperation in this area.

II. Conclusion

The epilogues of a few analysed lawsuits show that the mentioned persons deliberately tried to create a reason for the occurrence of an insured event (e.g. by causing partial disability due to loss of the left hand), in order to subsequently claim indemnity from several insurance companies. These are the cases of a "heavy fraud", with a high degree of premeditation of the persons involved in causing the accident, which is classified as a more serious crimes in the category of insurance

[46] See: Véronique Pujas, The European Anti-Fraud Office (OLAF): A European policy to fight against economic and financial fraud? Journal of European Public Policy 10(5), 2003, pp.778-797.

[47] European Commission, OLAF - Policies to prevent and deter fraud, 2020, *https://ec.europa.eu/anti-fraud/policy/preventing-fraud_en,* visited on: 6. 10. 2020.

[48] Ibid.

[49] Ibid.

[50] European Commission, Fraud Reporting, 2020, *https://fns.olaf.europa.eu/*, visited on: 5. 10. 2020.

fraud. Experts in the field of medicine and mechanical engineering also played a significant role in passing the verdicts, since they, each from their own perspective, testified that this was a false claim. The analysed situations illustrate the importance of cooperation among various institutions for a more successful combat against the insurance fraud.

In the cases related to the falsification of death, fraud has also shown to often involve an international component, making the job difficult for experts investigating such claims due to the need for cross-border cooperation, which is not always fully effective. However, the epilogue of such cases shows that the internationalization of cooperation in this field is a must for a most successful fight against false claims and that, in the context of fighting against fraud with international connotations, international activities of the involved institutions are necessary to get a more complete picture of any one insurance application. The mentioned cases have been classified as the so-called "heavy frauds", where the illegal activities of reporting false claims for indemnity are designed in advance to collect the reported "damages" from the Insurer. In addition to external frauds, which were illustrated in this text, there are not rare examples of "insider" frauds which, unfortunately, include the employees of the insurance industry. In Europe alone, the monetary value of detected insurance fraud in 2017 amounted to over two billion euros, while, if we include the projections for undetected false claims, the amount would rise to as much as thirteen billion euros.[51]

In not so small part of the public, due to ignorance of legal and financial flows, there is a notion that in the case of insurance fraud, it is a "crime without victims".[52] Unfortunately, such attitudes contribute to pertaining phenomenon of moral hazard, as well as that of false claims.[53] On the other hand, cases like the above illustrate that these criminal activities not only illegally demand millions in payments from insurers, but also that they are acts punishable by imprisonment for several years. The high media coverage of these cases, combined with not at all lenient court fines, contribute to a higher level of awareness of the general public about this type of financial fraud, which is becoming common in an increasingly globalized world.

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[52] Consult the above source.
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