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FRAUD PREVENTION IN INSURANCE COMPANIES

We know that insurance is based on contractual terms under which the insurer gives and the insurer assumes the insurance risk for a fee (premium) to implement the insurance indemnity in favor of the insured (beneficiary or a third party) if the insured event. But the main thing in this case, must necessarily realized one of the principles of insurance - the most trusted party that assumes that each participant agreement shall notify each other complete and accurate information about the subject of the contract, but on the other hand, the failure of this principle is not required 'necessarily means the possibility of fraudulent practices in the insurance sector. Fraudulent activity implies the existence of at least one of the following elements: - misrepresentation regarding significant circumstances within the subject matter of the insurance contract (for example, withholding information, forgery or fraud); - the intention to mislead; - the intention of obtaining illegal revenue. The absence of even one element of this illegal activity refers to the category of abuse in the insurance sector, which should be understood by any activity that uses the insurance law opposite way. Thus, the abuse of insurance is part of insurance fraud that unlike him, has no legal consequences.

Focus on the types of insurance fraud: 1. Depending on sources: internal and external fraud. Internal fraud committed by agents of the insurance market, including: insurance companies, insurance agents, brokers and other representatives of the insurance industry (such as the sale of insurance policies without a license for a particular type of insurance theft of insurance reserves; obstructing an investigation related public authorities). External fraud is a form of abuse in the insurance sector by policy holders, beneficiaries or third parties, sometimes through participation in collusion with insurance agents, brokers and other intermediaries and assisting organizations (eg, providing false information and initiating an insurance case to obtain insurance compensation, billing mediation organizations for non-existent or unnecessary services to meet the insurance company or providing the same score for opla and several times). 2. Depending on the stage of committing fraudulent activities, insurance fraud (from underwriting to payment of insurance). Fraud underwriting stage includes illegal activities related to the concealment of information on the stage of submission of application for insurance for the policyholder. Also include fraud committed at the stage of renewal of the contract; coverage determination or smaller insurance premium; willful default of existence has concluded an insurance contract covering the same property risk and the risk of an accident; and obtaining insurance coverage for fictitious (imaginary) risks. It should be borne in mind that the policyholder must necessarily inform the insurance company any information on changes of the object of insurance. 3. Depending on the nature of insurance fraud, "spontane" fraud and planned fraud. The socalled "spontane" fraud associated with undesirable opportunistic behavior and policyholders is to use the possibility of overstating the size of the loss on real insurance claims. The planned fraud involves clearly thought out and implemented fraud for the purpose of augmenting their income or income third parties through insurance companies (examples are intended fraud include submission of an accident on fictitious injuries, accidents, theft, abuse involving doctors, lawyers and other professionals , embezzlement of premiums by insurance agents; fraud by insurance companies when entering into and performance of the insurance contract). Therefore, the term "planned fraud" directly linked to a criminal offense, namely Art. 190 of the Criminal Code of Ukraine.

Common deceptive practices in the insurance industry are: - injuries due to staged accidents, including injuries rigged confirmed diagnosis doctor; - manipulation of the repair of vehicles, including overstating the cost of repairs; - fraud on the part of property owners, which involves burning building or other immovable object ownership to obtain insurance, fictitious organization burglary; - fraud on disability, including staging injury / illness or exaggerating the extent of damage the body.

But the fight against insurance fraud is complicated by many factors: - Insurance fraud is a dynamic phenomenon that evolves together with the environment and the operation progresses due to increased complexity of operations; - Insurance fraud is difficult to detect. To this end it is necessary to implement an appropriate system of monitoring and control of the insurance company or supervisors sector; - legal proof of fraudulent practices in the insurance sector is complicated and depends on the professionalism of the security of the insurance company. In this regard, the company has to invest significant financial resources to the training of relevant personnel and complex software that helps detect cases of insurance fraud; - the need to perform multifaceted functions of service control for insurance fraud and the main task of monitoring the structural unit of insurance fraud is to prevent, detect, monitor and investigate various abuses in the insurance industry; - For maximum effectiveness of the control system of insurance fraud should consider the following: - control of insurance fraud must be dynamic, not static in nature. Static control tools that underlies appropriate automated software systems, helping to ensure procedural consistency, but is unable to verify the authenticity of the transaction; - monitoring the level of transactions is insufficient to effectively combat abuses in the insurance sector. Successful detection of complex fraudulent schemes should be based on the results of horizontal analysis and cross-context information about the transaction and clearly regulated procedures for external authentication of the data; - responsibility in the control of insurance fraud within the structural units of the insurer disappear with the establishment of appropriate automated systems prevent abuse, because not provide the expertise for the operation of the model. Therefore, it is important to determine those responsible for the supervision of insurance fraud on various types of insurance specialization, establishing their relationship with the Security and regulation stages within automated monitoring software, which involve these employees; accurate assessment of the costs of measures to prevent and counter insurance fraud is a difficult task, since the relevant control procedures are

potentially significant in terms of cost, duration and degree of fragmentation in different types of insurance; - conflict strategic development tasks of the insurer and control of insurance fraud, namely the nature of the warning control of fraud is seen as a threat to the formation and maintenance of image insurer aimed at increasing the loyalty of policyholders; efficient service insurance contracts recently become synonymous with efficiency of business processes, in this sense means a reduction in the length of time identifying fraudulent activities during the underwriting or the decision to pay the insurance indemnity; - the fight against insurance fraud should not be a separate initiative. In theory, the insurance company that uses technology to control the insurance fraud, receives the appropriate competitive advantage.

Summarizing the foregoing, it should be noted that currently effective element of control over insurance fraud is to organize and maintain a database of abuses in the insurance sector, but the initiative on the creation of such a database is owned by the insurance companies and their associations, self-regulatory organizations together with the competent supervisory authorities of the financial sector. And most importantly, a mandatory element of the current legislation should be the definition of insurance fraud and its types, methods of identifying elements of administrative and criminal liability.