

# Combating Insurance Abuses: A Comparative Analysis between Turkey and United Kingdom

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## Abstract

Insurance fraud may be defined as intentional deceit of an insurance company by a beneficiary with goal of earning financial gains before or after issuing of the policy. It may occur in many types. One of the insurance fraud types is self-cutting of the insured for insurance claim. However it sounds unbelievable, it is a fact which is getting more prevalent day by day. In this study it is aimed to provide an overview of the type, scale and impact of insurance fraud in Turkey, and particularly self-cutting for the insurance claim over a case study. Insurance fraud has an impact not only on insurers but also on the insureds. Therefore reducing and deterring the insurance fraud is significant, and it is also aimed to offer the actions to reduce insurance fraud in this study. Insurance fraud has an impact not only on insurance companies but also on the insured. Therefore reducing and deterring the insurance is significant. In this study it is aimed to provide an overview of the type, scale and impact of insurance abuses in Turkey and the UK. It is also aimed to specify the measures and the institutions on fighting against insurance abuse in Turkey and in the UK as well.

## Keywords

Insurance Abuse, Insurance fraud, Combating Insurance Fraud in Turkey, Turkish Law, Combating Insurance Fraud in the UK

## 1. Introduction

Insurance abuse is the intentionally deliberate deception of the insurer by the insured person through an unrealistic declaration or concealment of an important truth that would change the insurer's judgment in order to gain unfair profits.

The first well-known fact is the attempt of a merchant named Hegestratos in

300 BC to transport corn on ship by borrowing, to sell the corn, and to get out of debt by intentionally sinking the ship and declaring that the corn sank with the ship. But he could not succeed and the fact was noticed.<sup>1,2</sup>

Abuse is carried out by knowingly giving false information to the insurance company or hiding important information, when the policy is drafted, to ensure that the insurance company draws up a contract not to be made under normal conditions. Abuse is carried out by causing intentional damage within the insurance period or by showing the degree of the damage more than the actual or by showing the form of damage differently.<sup>3</sup> When we approach from the point of view of the policyholders, insurance abuse is the main reason of the unfair and unjust insurance premium.

## 2. Effects and Types of Insurance Abuse

There are many different adverse effects of insurance abuse:<sup>4</sup>

- Reductions occur in the profits of insurance companies.
- Increases in losses may occur and financial problems may arise in insurance companies.
- As the costs increase, insurance premiums also increase and the financial structures of the insurance companies may weaken due to decreasing insurance because of premium increase.
- There may be a liquidity shortage.
- Declines in credit ratings of insurance companies financially weakened may occur.

The most common abuses are gathered under five main groups;

Life Insurances: If the declaration obligation is intentionally violated in order to use the insurer as a financier, there is a high likelihood of insurance abuse.

The facts such as showing a person who is alive deceased, for example, by burning a corpse obtained from a grave and tumbled down a cliff in a car may be seen. The first action to be taken in such cases is identification. In cases where the insured or beneficiary cause difficulty providing information and documentation, it shall be useful to evaluate the suspicion of abuse.

It is also observed in life insurances that while credited person is the actively working young individual of the family, insurance is made for the old or even sick individual of the family as if he/she gets the credit.

In life insurances, insurance abuses may be carried out to obtain indemnity through the persons who deceased in the past or lost or who is of unsound mind.

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<sup>1</sup>Çilingir A. (2014). "Sigortacıların Yumuşak Karnı: Sigorta Suistimalleri", Akıllı Yaşam Dergisi, p. 38.

<sup>2</sup>Duramaz S. (2017). "Sigorta Suistimalleri, Türkiye ve Dünyadaki Boyutları, Alınan Önlemler, İstanbul, p. 24-25.

<sup>3</sup>Insurance Europe (2013). "The European Insurance and Reinsurance Federation), The Impact of Insurance Fraud booklet", p. 9.

<sup>4</sup>Pešout P, Andrlé M. (2011). "Insurance Fraud Management as an Integrated Part of Business Intelligence Framework", World Academy of Science, Engineering and Technology, 2011.

<http://waset.org/publications/10950/insurance-fraud-management-as-an-integrated-part-of-business-intelligence-framework> (Accessed on: 19.12.2017).

In facts that a person having a low income determines high indemnity, financial risk assessment (underwriting) is required.

*Health Insurances:* The most common abuse in private health insurance is the misstatement of the insured in relation with the health status during the insurance period and the desire to ensure that the current diseases are covered by insurance such as the newly emerging disease. Even persons who want to get insured in order to have a financier after getting appointment for surgery may be faced.

It is one of the most commonly seen abuses that diseases not covered by the insurance in private health insurances are tried to be covered by different diagnostics. The cases such as operations under different gynecologic diagnosis in infertility treatments, financing rhinoplasty operations under the name septum deviation, buying sunglasses under the name of prescription glasses, and getting checked-up as if the person is sick are frequently seen. Such facts are realized in cooperation with the relevant health institutions or without their knowledge.

Insurance abuses that may be encountered in health insurances include that the relative of the insured use the insurance instead of him/her.

Another insurance abuse which may be frequently seen in health insurances may be unnecessary examinations and treatments by health institutions. Unnecessary examination and treatment may be demanded for commercial purposes as well as defensive medicine purposes.

*Disability Insurances:* In order to pay indemnity for disability insurances, it is first necessary to determine whether there is a causal link between the accident or disease covered by the insurance and the disability realized.

The facts such as drafting disability report in a way which shall contain disability rate higher than it is for lower invalidities and disability existing before the accident is shown to have been caused by the accident with fraud disability report are the frequently seen abuses. Even the insured who took out a disability policy from multiple insurance companies and causes disability by intentionally cutting his/her fingers and/or toes and demands indemnity is seen in Turkey as well as in the world.

*Fire Insurances:* Fire is one of the oldest risks, and it has an important place in the history of insurance. Just like the prominence of the Great Fire of London<sup>5</sup> on the world insurance history, the Beyoglu Fire is a milestone for Turkish insurance history. Beyoglu fire has been an important milestone in terms of the history of the insurance industry in Turkey and in recognition of the necessity of insurance industry.<sup>6</sup>

Fire insurance is seen as a branch required to be especially inspected in terms of judicial insuring with the suspicion of insurance abuse in order to detect whether the fire broke out of accident or arson.

Arson has been one of the major abuses in insurance both in many European

<sup>5</sup>Çilingir A. Insurance Eurpoe. p.9.

<sup>6</sup><http://www.sigortacigazetesi.com.tr/buyuk-beyoglu-yangini-padisahin-sigorta-policesi>. (Accessed on: 05.12.2017).

countries and in the U.S. since the 1980s. The day-by-day increase in arson of a place has caused insurance companies to open fire investigation units as a separate unit. This has led to significant developments in the reduction of fires from unknown causes in Europe.<sup>7</sup>

*Motor Insurances:* It may be counted in motor damages that damage having occurred on the car is exaggerated, the car is hidden and notified to have been stolen, invoice is drafted for original spare parts although the car has been repaired with second-hand parts, a planned accident is organized to get indemnity from the insurance company (crash for cash)<sup>8</sup>, it is attempted to show someone else as the driver in case that driver without license or alcoholic driver has caused the accident, stretch film is stuck on the glass of the car to show it as if it is broken and indemnity is requested in terms of glass indemnity, and damaged car is insured.

After the Accident Report started in 2008 in Turkey and allowing car owners to draw up accident report without waiting for police officers to arrive, motor damages loss of the insurers have increased and it is alleged that car owners write their own scenarios.<sup>9</sup>

Very recently, the mobile accident report application has been initiated in order to prevent auto insurance abuses in the Turkish insurance sector. With the application downloaded to the smart phones, the QR-code on the policy is read and the policy and insured information are automatically provided and the accident report can be drafted in electronic environment. Even accident photographs and camera images can be added to the electronic report. This practice is applicable firstly and only in Turkey in the international arena. One of the main purposes of this application is to prevent and detect insurance abuses that occur. At the same time, accident statistics in Turkey shall be obtained. It is stated that it is thought that this application would considerably reduce the possibility of fake accident damages.<sup>10,11</sup>

### 3. Legal Approach to Insurance Abuses in Terms of Turkish Legislation

*In terms of Turkish Penal Code (TCK):* The persons having tried to obtain in-

<sup>7</sup>Çilingir Clarke M. (1989). "Insurance Fraud", The British Journal of Criminology, Vol. 29, No.1 1989, (Winter), pp. 1-20. <https://doi.org/10.1093/oxfordjournals.bjc.a047785>. (Accessed on: 19.01.2018).

<sup>8</sup>[https://www.insurancefraudbureau.org/media/1036/ifb\\_crash\\_for\\_cash\\_report\\_online.pdf](https://www.insurancefraudbureau.org/media/1036/ifb_crash_for_cash_report_online.pdf). (Accessed on: 15.01.2018).

<sup>9</sup>Technology Journal of Insurance Information and Monitoring Centre (2016). "Fraud in Bodily Injuries", page. 44-47. <https://www.sbm.org.tr/dergi/7/index.html#46> (Accessed on: 05.12.2017).

<sup>10</sup>Yıldırım İ. (2015). "Sigortacılıkta Suistimler ve Ahlaki Tehlike Sorunu: Türk Sigorta Sektörüne Yönelik Bir Değerlendirme", International Journal of Social Science, Number: 36, p. 203-213, Summer II, 2015.

[https://www.researchgate.net/publication/283179232\\_SIGORTACILIKTA\\_SUISTIMALLER\\_VE\\_A\\_HLAKI\\_TEHLIKE\\_SORUNU\\_TURK\\_SIGORTA\\_SEKTORUNE\\_YO](https://www.researchgate.net/publication/283179232_SIGORTACILIKTA_SUISTIMALLER_VE_A_HLAKI_TEHLIKE_SORUNU_TURK_SIGORTA_SEKTORUNE_YO) (Accessed on: 05.12.2017).

<sup>11</sup><https://www.sbm.org.tr/en/News/Pages/Mobile-Accident-Report-Era-Just-Started.aspx> (Accessed on: 19.01.2018).

insurance indemnity with fraudulent actions and documents shall have committed the aggravated fraud pursuant to the Article 158/1-k of TCK. The offender of the aggravated fraud in order to obtain insurance sum is not only “the insured” but also everyone trying to obtain unearned gain from the insurance company. For example, the optic firm selling sunglasses as if they sold prescription glasses to the person who has insurance of prescription glasses shall have committed the aggravated fraud in order to obtain insurance indemnity or a third person who tries to get indemnified for his/her financial damages from the insurance company by drafting traffic accident report although there is no actual accident shall have committed this crime.

*In terms of Wrongful Insurance Practices:* In order to effectively fight against wrongful insurance practices containing insurance abuses as well and to regulate the procedures and principles related to detection, notification, assessment, and reporting of the wrongful insurance practices and principles and procedures regarding the obligations of all the parties related to the insurance relationship, “Regulation on Procedures and Principles of Detection, Notification, and Recording of Wrongful Insurance Practices and Fighting Against Them” (Regulation on Wrongful Insurance Practices) has been enacted.<sup>12</sup>

The term of “wrongful insurance practices” has been defined as every kind of action of one or more of parties within the insurance relationship or persons having a role in this relationship to obtain unearned gain.<sup>13</sup>

Regulation of Wrongful Insurance Practices has defined the types of wrongful insurance practices and this definition is tabulated in the following way (*see Table 1*),<sup>14</sup>

Regulation of Wrongful Insurance Practices regulates how insurance companies and insurance agencies shall provide efficient procedures for prevention, detection, recording, removal, and notification to the relevant bodies of wrongful insurance practices and they shall facilitate the required source for this purpose.<sup>15</sup>

Insurance companies are able to take required actions in order to detect the potential risks against the wrongful insurance practices and to control the processes in which wrongful insurance practices may be made<sup>16</sup>. When the insurance companies reject the indemnity claim due to the suspicion of wrongful insurance practice, they are obliged to make notification in written and to process it to the database generated for this purpose in SBM.<sup>17</sup>

Where insurance companies as the result of the systematic controls of SBM or notifications made to it that wrongful insurance practices constitute a crime, they are obliged to notify the relevant judicial bodies and Under secretariat of

<sup>12</sup>Çilingir See: Official Journal-date: 30.04.2011, number: 26552.

<sup>13</sup>See: Article 4/1-d of Regulation of Wrongful Insurance Practices.

<sup>14</sup>See: Article 5 of Regulation of Wrongful Insurance Practices.

<sup>15</sup>See: Article 7 of Regulation of Wrongful Insurance Practices.

<sup>16</sup>See: Article 8 of Regulation of Wrongful Insurance Practices.

<sup>17</sup>See: Article 11 of Regulation of Wrongful Insurance Practices.

**Table 1.** Types of wrongful insurance practices.

Type	Definition
Wrongful insurance practices in the Company	They are the wrongful insurance practices carried out by the staff member at every level of the company alone or with third parties from the company and/or out of the company on the detriment of the company.
Wrongful insurance practices of the insured	They are the wrongful insurance practices carried out by the insured against the company.
Wrongful insurance practices in the course of indemnity	They are the wrongful insurance practices against the company carried out by the persons in the course of indemnity such as the beneficiary, indemnity tracking agents, and insurance experts.
Wrongful insurance practices of the agency	They are the wrongful insurance practices carried out by the insurance intermediaries such as agency, broker etc. against the companies, insured persons or other persons within the insurance relationship.
Other wrongful insurance practices	They are the wrongful insurance practices out of the cases listed above.

Treasury.<sup>18</sup>

In case that the insured or other beneficiaries act to obtain unearned gain, it may be possible that they fails to obtain insurance indemnity or obtain it in an incomplete form as well as criminal liability may arise.<sup>19</sup>

## 4. The Scale and Impact of Insurance Abuse

### 4.1. In Turkey

Statistics on abuse reports made are provided for public access through the Insurance Abuses Information System Database (SISBIS) initiated by the Insurance Information and Surveillance Centre (SBM) and Damage Monitoring Centre (HATMER) on the website. These statistics include even subdivisions such as method, branch, year and month.

When annual statistics provided by the insurance companies regarding the abusing methods (*see Table 2*), in case that the item “other” is ignored, while the abusing method having the highest rate is “planned (organized damages) abuse” for the years of 2012, 2013, 2014, and 2015, the highest rate for the year of 2016 is “abuses with the statement of hit & run” and the highest rate for the year 2017 is “abuse related to driver change/driver runaway”.

When distribution of abuse notifications by years (*see Figure 1*), it is seen that the highest number of abuse notification was made in 2012 in which abuse notification system was first established, generally the same number of notifications have been made in the following 3 years, a decline was experienced in number of notifications in the year of 2016, and the number increased again in 2017. Awareness on notification of insurance abuse is highly important. When the awareness increases, it is thought that the number of the notifications will in-

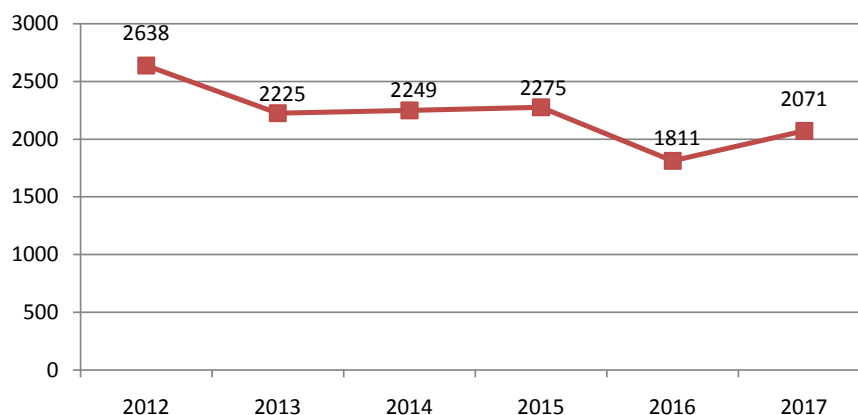
<sup>18</sup>Çilingir See: Article 14 of Regulation of Wrongful Insurance Practices.

<sup>19</sup>See: Circular of Undersecretariat of Treasury dated 01.17.2011 and numbered 2017/12.

crease accordingly.

When abuse statistics are examined by insurance branches (*see Table 3*), it is seen that the highest number of abuse notification for all years belongs to motor insurance damages. Raising awareness on motor insurance abuses is one of the significant factors on this result. While motor insurance damages were followed by personal accident insurance in the years of 2012, 2014, 2015, and 2016, fire insurances followed it in the years of 2013 and 2017.

When insurance abuse statistics are examined, it is seen that the first three



**Figure 1.** Distribution of abuse notifications by years. Source: SBM (20).

**Table 2.** Abuse method in the notification of insurance companies.

Abuse Method	2012		2013		2014		2015		2016		2017	
	#	%	#	%	#	%	#	%	#	%	#	%
Insurance Abuses after the Damage	590	22.4%	522	23.5%	424	18.9%	377	16.6%	303	16.7%	314	15.2%
False KTT	0	0.0%	0	0.0%	411	18.3%	384	16.9%	225	12.4%	220	10.6%
(Accident Report) Abuses												
Planned Damage	853	32.3%	740	33.3%	486	21.6%	448	19.7%	273	15.1%	0	0.0%
(Organized Damage) Abuses												
Abuses of Statement "Hit & Run"	0	0.0%	0	0.0%	291	12.9%	381	16.7%	308	17.0%	325	15.7%
Abuses Made through												
Counterfeit Policy	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	247	11.9%
In case that it is proven that unfair												
advantage has been obtained	0	0.0%	0	0.0%	0	0.0%	0	0.0%	149	8.2%	0	0.0%
Abuse by False Invoices	379	14.4%	423	19.0%	206	9.2%	0	0.0%	0	0.0%	0	0.0%
Abuse of Fake Injury	0	0.0%	0	0.0%	0	0.0%	206	9.1%	0	0.0%	0	0.0%
Abuse of Damaging Own Property	195	7.4%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Abuses of Driver Change/Driver												
Runaways	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	340	16.4%
Premium Abuses	0	0.0%	146	6.6%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
Other	621	23.5%	394	17.7%	431	19.2%	479	21.1%	553	30.5%	625	30.2%
<b>TOTAL</b>	<b>2638</b>	<b>100.0%</b>	<b>2225</b>	<b>100.0%</b>	<b>2249</b>	<b>100.0%</b>	<b>2275</b>	<b>100.0%</b>	<b>1811</b>	<b>100.0%</b>	<b>2071</b>	<b>100.0%</b>

Source: SBM.

<sup>20</sup><https://www.sbm.org.tr/tr/Sayfalar/HasarTakipMerkezi.aspx> (Accessed on: 15.01.2018).

**Table 3.** Abuses by insurance branches.

BY BRANCH ABUSE	2012		2013		2014		2015		2016		2017	
	Branch	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number	Ratio	Number
Motor	4219	96.6%	3775	97.1%	2525	95.3%	2636	96.0%	2507	95.0%	2426	87.8%
Other	21	0.5%	14	0.4%	22	0.8%	22	0.8%	42	1.6%	31	1.1%
Personal Accident	58	1.3%	10	0.3%	13	1.3%	35	1.3%	27	1.0%	6	0.2%
Medical	7	0.2%	29	0.7%	20	0.4%	11	0.4%	19	0.7%	18	0.7%
Fire	34	0.8%	39	1.0%	12	0.8%	23	0.8%	18	0.7%	267	9.7%
Unemployment	0	0.0%	3	0.1%	41	0.1%	3	0.1%	13	0.5%	2	0.1%
Transportation	5	0.1%	1	0.0%	2	0.0%	0	0.0%	7	0.3%	0	0.0%
Individual Pension	0	0.0%	5	0.1%	3	0.2%	5	0.2%	3	0.1%	9	0.3%
Engineering	9	0.2%	4	0.1%	0	0.1%	2	0.1%	2	0.1%	2	0.1%
Life	16	0.4%	6	0.2%	11	0.3%	8	0.3%	0	0.0%	3	0.1%
Agriculture	0	0.0%	0	0.0%	1	0.0%	0	0.0%	0	0.0%	0	0.0%

Source: SBM (20).

notifications are motor insurances, fire insurances, and health insurances.

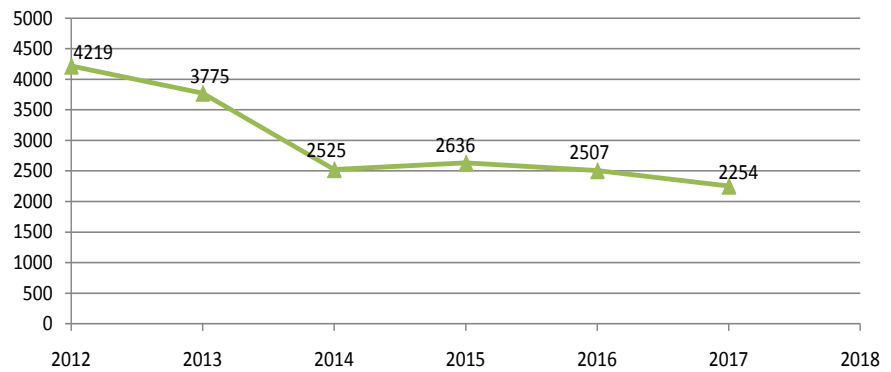
It is observed that the highest number of abuse notification was made in 2012 in the motor insurances branch which is at the top of the list of abuse notifications number, a significant decrease occurred in the year of 2014, and the number of notifications close to each other was made in the following years (see **Figure 2**).

An important increase is observed in 2017 in the fire insurances branch which is the runner-up in the number of abuse notifications (see **Figure 3**). In Turkey, per year average 100 thousand fire accidents occur, and this number is increasing 10% every year<sup>21</sup>. This table may be assessed as increase in awareness for fire insurance abuses since there has been an increase over 10% in the number of fire in the country for the year 2017.

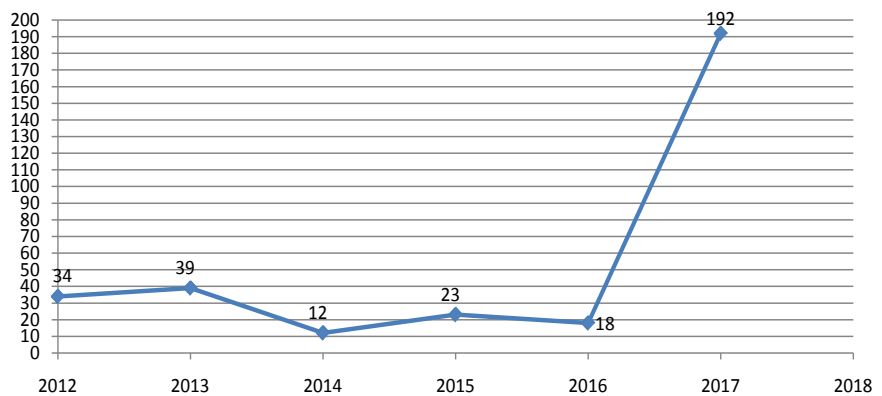
It is observed that the lowest number of abuse notification was made in 2012 in the health insurances branch which ranks third in the list of number of abuse notifications, a considerable increase occurred in the year of 2013, and number of notifications close to each other was made after the year of 2016 (see **Figure 4**). It is thought that the number of abuse is high since it is common that the existing disease is tried to be hidden and covered by the insurance. It suggests that there is a lack of awareness and information about the cases, despite the fact that it is an abuse but are not referred so. In addition, it is thought that it is also beneficial to make a more certain and detailed classification of types of health insurance abuse in the abuse entrance screens.

<sup>21</sup><http://kobitek.com/yapilarda-yangin-orani-her-yil-yuzde-10-artiyor> (Accessed on: 30.04.2018).

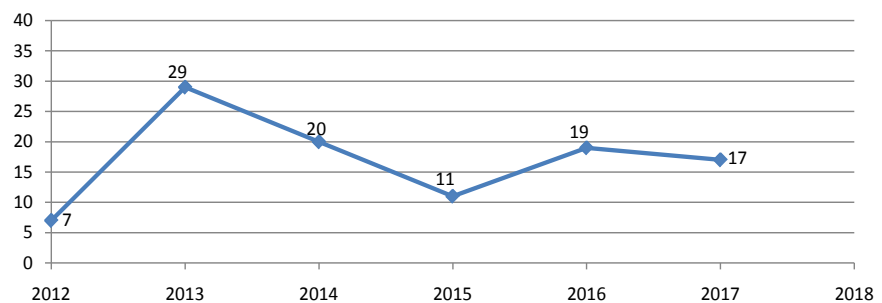




**Figure 2.** Distribution of abuse notifications by years in the branch of motor insurances. Source: SBM (20).



**Figure 3.** Distribution of abuse notifications by years in the branch of fire insurances. Source: SBM (20).



**Figure 4.** Distribution of abuse notifications by years in the branch of health insurances. Source: SBM (20).

#### 4.2. In the UK

The extent of insurance fraud varies between countries. Detected and undetected fraud is estimated to represent up to 10% of all claims expenditure in Europe. This figure varies between countries and classes of insurance due to a number of factors, such as how the market functions or the local prevalence of one type of insurance. In the UK, the Association of British Insurers (ABI) estimates that fraud adds, on average, an extra £50 (€58) a year to the annual insurance bill for

every policyholder.<sup>22</sup>

The latest ABI detected fraud statistics for 2012 include:<sup>23</sup>

- The total value of detected fraud for non-life insurance in 2012 exceeded £1bn for the first time, while for life insurance it dropped below £30 mio.
- Overall, the average fraud saving for non-life was £8750, but this varied between £30,000 for liability insurance and £391 for pet insurance.

## 5. Combating Insurance Abuses

### 5.1. In Turkey

Insurance companies form defence mechanisms by evaluating data. However, this fight is very limited. It is important to take a holistic approach to the issue of insurance abuse and to look at it from the perspective of all actors involved in the insurance relationship, such as insurance companies, insured, insurance agencies, and contracted suppliers. It is crucial to be able to detect the abuse and analyse the relationship between them that all the insurance companies' policies, indemnity claims, agencies and experts can be seen.

*The Institutions Involved in Fighting Against Insurance Abuses in Turkey*

*Insurance Information and Monitoring Centre (SBM)*: SBM is an organization where all the policies of all the insurance companies in the sector, the damages, the agencies and the experts data are kept and the relations between them are analysed<sup>24</sup>. It ensures that the organized abuses involving more than one insurance company is brought to light.

There are some studies by SBM to prevent abuse and some services offered to insurance companies. For example, in 2014, a system has been established that makes a risk scoring to prevent and track down the abuse and this smart system has some analytic models. A risk score is drawn by blending all existing data and capturing the relationships of insurance stakeholders. The risk score can be based on the vehicle, policy or damage file. It is a picture that all this network of relationships made up and a network under the name of social network analysis has been initiated and all these relations are displayed on that application. This system also brings similar abuse files to the screen and increases their risk scores.<sup>25</sup>

When the sum of the outstanding loss and the losses paid is taken into account, it is stated that the insurance companies pay 5.5 billion TRY (approximately 1.4 billion USD) for only the traffic to the insured persons and that there is also the possibility of abuse here. It is stated according to the benchmarks in Europe that there is abuse with the rate of 10-30 percent, it corresponds to approximately 1.7 billion TRY (approximately USD 452 million), and it means it is

<sup>22</sup>Insurance Europe, p. 11.

<sup>23</sup>Association of British Insurance (2013). "Detected fraud statistics update, 26.07.2013". <https://www.abi.org.uk/news/industry-data-updates/2013/07/detected-fraud-statistics-update/> (Accessed on 21.04.2018).

<sup>24</sup>Article 31/B of Insurance Law numbered 5684.

<sup>25</sup><https://sbm.org.tr/BasindaSBM/Sayfalar/AydinSatici-Turkiyede-sigorta-suistimallerini-azaltacag-iz.aspx> (Accessed on: 15.01.2018).

abuse possibility of TRY 1.7 billion in 11 billion. It is stated that insurance companies can catch up to 5 percent of these abuses with their own work, and SBM, which is a joint surveillance centre, can capture an average of 25 percent of the abuses. The main focus of SBM is not individual abuses but organize criminal organizations that have turned abuse into work. It is asserted that those involved in organized insurance abuse use the gaps in the system, in case that some of them are detected, persons intending to do such work may avoid abuse by being aware of the existence of such system and the penal process which they shall face. (25)

*Sub-Information Centres:* SBM collects the information in the branches of life, disease/health, traffic and compulsory insurances in a single centre, enabling the insurance activities to be carried out in a more comprehensive and effective manner. Sub-information centres have been established on some insurance branches to enable more effective and deep analyses. These sub-information centres are designated as Traffic Insurance Information and Surveillance Centre (TRAMER), Life Insurance Information and Monitoring Centre (HAYMER), Health Insurance Information and Monitoring Centre (SAGMER), Insurance Damage Tracking and Monitoring Centre (HATMER).<sup>26</sup>

*Insurance Fraud Prevention Bureau (SİSEB):* Established in September 2015, the Insurance Fraud Prevention Bureau (SİSEB) was established to support insurance companies in the fight against insurance abuse and to prevent financial losses in this area.<sup>27</sup>

SİSEB, established under Insurance Association of Turkey, examines social network analysis screens. For example, there are 25 million files of damage and the number of traffic policies in just 1 year is about 16 million. In this context, all of these data are related to each other and a picture is revealed, the relationship of insurance stakeholders are caught and risk scores for insurance holders are given and shared with insurance companies.<sup>28</sup>

Especially the prevention of organized abuse and the development of analytical models and early warning systems and creation of the perception of “insurance abuse is a crime” constitute the main missions of the SİSEB (16). For the time being, SİSEB is analysing motor insurances and it is aimed to make similar analyses in health insurances and other insurances which have a high risk of abuse.

*Insurance Fraud Database System (SİSBİS):* Insurance abuses are followed and reported over a system called SİSBİS in Turkey. SİSBİS is a central database in which data regarding “wrongful insurance practices and insurance abuse provided by third parties and insurance companies are kept and abuse notifications are made in an electronic environment.

SİSBİS covers motor, health, life and all other insurance branches. With

<sup>26</sup>Regulation Insurance Information and Monitoring Centre. Articles 9-16. See: Official Journal, 09.08.2008 dated 26962 numbered.

<sup>27</sup><https://siseb.sbm.org.tr/Hakkimizda> (Accessed on: 04.12.2017).

<sup>28</sup>[https://www.sas.com/tr\\_tr/customers/sigorta-bilgi-merkezi.html](https://www.sas.com/tr_tr/customers/sigorta-bilgi-merkezi.html) (Accessed on: 20.01.2018).

SİSBİS, the rights of both insurance companies and insured persons are protected. In terms of insurance companies, it is aimed to reduce the additional cost of fraud by using SISBIS and to ensure that more correct decisions are taken on whether the risks are covered and pricing of risks. In terms of insured persons, SİSBİS aims to protect the rightful interests of honest insured persons and reduce premium costs.<sup>29</sup>

Examples of insurance abuse cases that insurance companies may report include; (29)

- Abuse cases finalized in the court,
- The cases of claim applicants subject to the prosecution investigation,
- Cases in which waiver is taken from the insured where there is abuse cases revealed by the company,
- The cases rejected with the suspicion of false damage and the cases where the insured files a claim against the company,
- The cases regarding drunk driving,
- The cases regarding driver details (such as the cases rejected due to insufficient driving license),

The cases which the companies needs additional examination with the suspicion of fraud.

## 5.2. In the UK

In the UK, ABI estimates that fraud adds, on average, an extra £50 (€58) a year to the annual insurance bill for every policyholder. The Insurance Fraud Bureau (IFB) focuses on detecting and preventing organised and cross-industry insurance fraud. IFB is a not-for-profit company established in 2006 to lead the insurance industry's collective fight against insurance fraud. IFB act as a central hub for sharing insurance fraud data and intelligence, using the unique position at the heart of the industry and unrivalled access to data to detect and disrupt organised fraud networks. IFB uses a wide range of data and intelligence to achieve two primary objectives:<sup>30</sup>

- Help insurers identify fraud and avoid the financial consequences;
- Support police, regulators and other law enforcement agencies in finding fraudsters and bringing them to justice.

One of the aims of IFB is to raise public awareness of insurance fraud scams: how they work and how to spot them, so that the chances of being caught out are reduced. IFB works closely with the police and other law enforcement agencies. It encourages and helps people to report suspected or known frauds anonymously through an insurance cheat-line. The impact of the IFB has been hugely positive since its launch in July 2006, with numerous arrests and tens of millions of pounds of savings for insurers and ultimately their customers. In the

<sup>29</sup><https://www.sbm.org.tr/tr/Sayfalar/Yanlis-Sigorta-Uygulamalari.aspx> (Accessed on: 15.01.2018).

<sup>30</sup>Insurance Europe. p.9.

UK, social media is being followed. A claim for alleged back injuries was rejected when Facebook images showed the claimant performing gymnastics and training for a charity run.

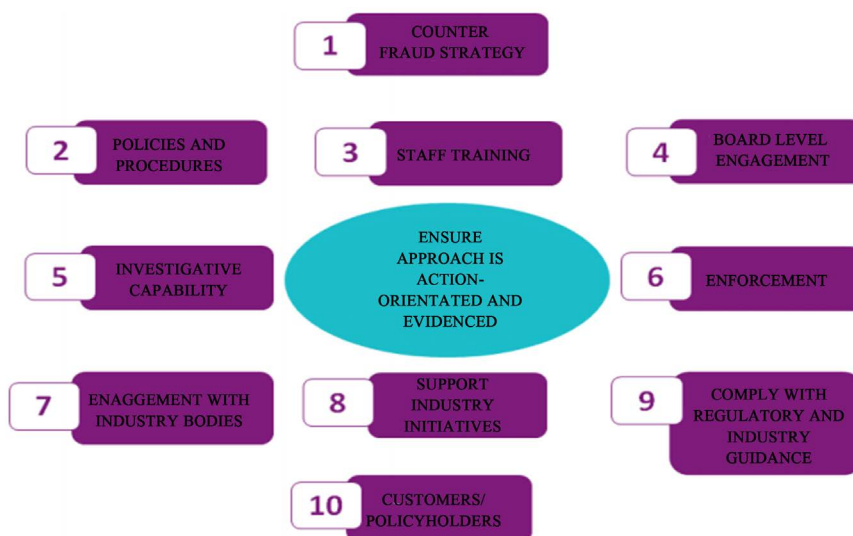
In the UK, bodies like the IFB and IFED run specialist workshops for counter-fraud staff, and many insurance companies additionally run training schemes at induction and throughout employees' careers and appoint "fraud champions" who emphasise and remind colleagues of the possibility of fraud in all areas of the business.

Combating insurance fraud remains an industry strategic priority. In 2016, insurers detected 125,000 dishonest insurance claims valued at £1.3 billion. It is estimated that a similar amount of fraud goes undetected each year. Therefore insurers invest at least £200 million each year to identify fraud.<sup>31</sup>

In the UK, ABI has designed a checklist to assist insurers, particularly smaller insurers with a limited counter fraud function, and their corporate partners, in putting in place strong fraud defences. The checklist also sets out how firms can contribute to the UK insurance sector's counter fraud strategy, to ensure that the UK remains an attractive place to do business (see **Figure 5**).<sup>32</sup>

## 6. Conclusion and Recommendations

Violations of the declaration obligation in the insurance system are very common. It is one of the most common problems that insurance companies all over the world face. For example, it is seen in a survey study on phone with 602



**Figure 5.** Effective counter fraud practices—checklist for insurers and partners.

<sup>31</sup>Association of British Insurance, <https://www.abi.org.uk/products-and-issues/topics-and-issues/fraud/> (Accessed on 21.04.2018).

<sup>32</sup>Association of British Insurance, "Effective Counter Fraud Practices—Checklist for insurers and partners" <https://www.abi.org.uk/globalassets/sitecore/files/documents/publications/public/2016/fraud/effective-counter-fraud-practices-checklist-for-insurers-and-partners.pdf> (Accessed on 21.04.2018).

households in United States of America that insurance abuse is common as well as insurance abuse is a fact which is regarded more acceptable and tolerant compared to the other financial crimes.<sup>33</sup>

The first step in preventing abuse is to make sure that the action taken is an abuse. For example, even if the misstatement (violation of statement obligation) on the subjects which affect the insurance of the insurer and the conditions of the insurance when drawing up an insurance contract is regarded as soft abuse<sup>34</sup>, it is still an abuse and shall be subjected to the judicial sanctions to be applied due to abuse. Raising awareness for the people who are not aware of the fact that the statement obligation is insurance fraud on this subject and legal sanctions of the abuse shall be the first and the most important step of the fighting against the abuse.

It is important to arrange trainings to raise awareness regarding the insurance abuse. That is because these abuses arising out of that people tell lie or hide some facts for their benefit and regarded as soft abuse (2, 34) are abuses and must not be permitted. Even the definition made under the name of soft fraud may cause wrongful perception. That is because calling some abuses “soft” may lead to the belief that such abuses may not be that bad. More importantly, softening such abuses may encourage the abusers and normalize the abuses. In this respect, whatever its effect, classification softening the abuses shall provide no benefit as well as it may cause damages.

It is considered that persons which can see the insurance from the criminal point of view and have the training and notion of judicial insuring shall have an efficient role to fight against and minimize the abuses.<sup>35,36</sup>

It shall be of importance to ensure that actors of the insurance sector, with insurance company employees who carry out risk and indemnity assessment, insurance marketing employees, insurance agencies, and legal department employees of insurance companies being in the lead, are trained to see the facts from the criminal point of view and judicial insuring and insurance abuses are noticed and prevented.

Taking measures and establishing systems to prevent insurance abuses by observing international good practices are another important step.

In conclusion, it is of utmost importance that data analyses are made by looking at the picture through a common database in fighting, a better cooperation with law enforcers, the Ministry of Health and the other regulators is ensured, and the most importantly, public awareness that fighting against the abuse is

<sup>33</sup>Polat O. (2015). “Tibbi Uygulama Hataları/Medical Malpractice”, 2. Baskı, Seçkin Yayıncılık, February 2015.

<sup>34</sup>Ernest & Young (2012). “Fraud in Insurance on Rise”, 2010-2011 Survey Report. p.16. [http://www.ey.com/Publication/vwLUAssets/Fraud\\_in\\_insurance\\_on\\_rise/\\$FILE/Fraud\\_in\\_insurance.pdf](http://www.ey.com/Publication/vwLUAssets/Fraud_in_insurance_on_rise/$FILE/Fraud_in_insurance.pdf) (Accessed on: 05.12.2017).

<sup>35</sup>Polat O. (2017). “Klinik Adli Tıp / Clinical Forensic Medicine”, 8. Baskı, Seçkin Yayıncılık, January 2017.

<sup>36</sup>Polat O. (2013). “Forensic Expertise in Forensic Medicine”, 1. Baskı, Seçkin Yayıncılık, November 2013.

their benefit is raised.

Finally, The UK may be a good practice for Turkey on combating insurance abuse. As in the UK, a checklist may be designed in Turkey for insurers and partners to combat insurance abuse.

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