

Fraud & Crime Prevention Task force

Reference: NLI-FRD-09-023

Subject: Fraud & Crime Prevention – State of play

1. Definition

There are many different definitions of “fraud” and “crime”.

These concepts vary across countries and, within a specific country, depending on the angle from which they are considered (eg civil versus penal).

For the purpose of our work, fraud is defined as

“Act or omission, related to the conclusion of an insurance contract or to a claim, which is meant to gain “unjustified enrichment” for the fraudster or other party, or to cause a loss to another party.

This might be for example to gain otherwise not obtainable insurance cover or to pay a premium that is not related to the risk level or to present an unjustified claim under law or in terms of its amount.”

According to the above definition, driving uninsured is not a fraud case since there is no insurance contract. This is a crime (though not in all countries) or at least a non civic behaviour.

Uninsured driving is part of the scope of our work when a fraud case as defined above has been made possible by the system put in place to compensate the victims of a road accident caused by an uninsured vehicle.

The theft of a vehicle is similarly out of scope, except when this event was staged to get money from insurer of the vehicle.

1.1 Timing

Fraud can be committed at any step of the insurance process at which it is committed

- Underwriting: the insurer is induced either to issue an insurance policy that it would not otherwise have issued or to issue an insurance policy on terms which are based on false information.
(eg staged underwriting)
- Claims: the insurer is induced to pay an unjustified claim or an exaggerated amount

1.2 Fraudster

For the purpose of our work, a fraudster can be anyone who is making use of an insurance contract to commit fraud.

- Policyholder
- Insured
- Beneficiary
- Intermediary (broker)
- Staff member (agent and others)
- Service providers (coachbuilders, carpenters, health professionals, etc)
- Third parties
- etc

This includes for example the internal fraud, ie the fraud committed by the staff or with the complicity of the staff, provided that the act is in relation with an insurance contract.

This excludes other crime committed by the staff, eg embezzlement by payment of the claims compensation due to a client on his own bank account, as it does not make use of an insurance contract, though this is considered as fraud in some countries (such as The Netherlands).

Note: There is no typical fraudsters' profile.

1.3 Modus operandi

There is almost an unlimited number of different modus operandi of pledging fraud.

- According to the IAIS¹, There are three basic components that contribute to the occurrence of fraud, which are often known as the fraud triangle:
 - motive/incentive (eg financial problems, pressure of unrealistic business objectives)
 - opportunity
 - rationalization (ie the mental process of justifying the fraud)
- Modus operandi can be differentiated according to:
 - **The way the fraud is initiated:** opportunistic or aforethought (criminal). The former constitutes the main part of the fraud cases and tends to aggravate in times of economic crisis. The related two general profiles of fraudsters can be defined as followed²
 - The "opportunity" fraudster is normally a law-abiding person who sees an opportunity to commit fraud. For example, this type of fraudster might imagine that insurers have limitless funds and might find it acceptable to make up claims in order to recover the costs of premiums paid in previous years when there have been no claims.
 - The repeated opportunistic fraudster, each time he/she has a claim (first experience "positive")
 - The "professional" fraudster earns or complements his/her income by committing fraud. He or she may continue committing fraud until detected and may target a number of insurers. An extension of the professional fraudster profile is organised crime involving a group of persons capable of committing complex and extensive frauds. The fraudulently obtained funds may be used to finance other criminal acts.
 - The **object to which the fraud relates:** the existence of the insured event or the compensation amount which is claimed.

Below some examples

- The event that triggers a claim
 - Did not happen (false claims)
 - was caused intentionally (staged claims, such as car accident or work accident involving foreign workers)
 - took place before the underwriting of the insurance cover (but declared to be subsequent to it)
 - is misreported to make it look like an event covered by the insurance policy.
- The severity of the consequences of an insured event (compensation)
 - Fake injury/loss/damage
(eg insured pretends pain or other symptoms and misleads the doctor to prescribe sick leave, the insured is working despite the injury but is still claiming compensation for loss of income).
 - Pre-existing damage/injury, already compensated or uninsured, is added to the claim.
 - Exaggeration of the injury, loss or damage (eg Property values, insured's income, etc are inflated)
 - people who try not to recover quickly

¹ IAIS Guidance paper on preventing, detecting and remedying fraud in insurance, 2006
http://www.iaisweb.org/_temp/Guidance_paper_on_preventing_detecting_and_remedying_fraud_in_insurance.pdf

² IAIS Guidance paper on preventing, detecting and remedying fraud in insurance, 2006

2. Consequences for the consumers/society

2.1 Qualitative description

■ Costs of fraud

The costs of fraud are, in order of decreasing importance to the insurance industry:

- 1°) The relationship between the policyholder and the insurance company is less trustful than it should ideally be.
Reputation of the insurance company: the fighting against fraud requires some investigation and might also (slightly) delay in the claims compensation. This is sometimes misinterpreted as a reluctance of the insurance company to paying the amount that it is due to pay to the insured for a legitimate claim.
- 2°) Higher insurance premiums: fraud induces higher costs for the insurance companies, which need to incorporate them in the premium charged to the policyholders.
 - On the one hand the total amount of claims paid is higher than it should normally be (undue or exaggerated claims).
 - On the other hand, additional administrative (underwriting and claims) costs are required to combat fraud:
 - The time spent per file increases as a result of a more detailed examination of the risk (underwriting) or the claims
 - Use of experts (own staff or external) for complex and doubtful cases (object at risk, fraudulent claim, etc)
- 3°) Financing of big criminal organization: fraud to insurance is an easy and non-violent way, for criminal organization to collect money in order to finance their criminal activities (see terrorism financing). Insurance fraud is a low risk, high profits criminal activity.
- 4°) Risk of downward spiral: premiums increase as a consequence of fraud, the policyholder who was honest might no longer wish to pay for someone else's fraud and commits fraud in turn.
- 5°) Risk of injury to the public (e.g. staged motor accidents)
- 6°) Cost of fraud to public authorities, police and courts investigating / prosecuting the claim, tax

■ Benefit of fighting fraud

- The detection of fraud enables the insurance company to reduce costs. This impacts favorably the premium that is charged on average on the policyholders.
- It also has an "educational" effect as it limits the risk of repeated opportunistic fraud
- The identification of fraudsters to insurance can result in the arrest of one or several criminal(s) in other areas.
 - Either the insurance fraudster has pledged other crimes that are discovered at that occasion (criminal inclination of the fraudster),
 - or the insurance fraud was aimed at financing other criminal activities.

2.2 Quantitative (rough) estimate of the economic relevance

Many studies are available, which provide rough estimates of the cost of fraud to insurance.

Most of them however have a very limited scope: they are often restricted to a specific insurance cover (often bodily injury in motor and health insurance) or to a specific country.

The collection of sound statistical data in this area is particularly difficult as there is not a common Fraud definition validated, as not all detected fraud cases are reported and the level of undetected fraud is unknown. The former is particularly true for the fraud cases which are detected at the underwriting stage.

Though we cannot get an accurate picture of the overall problem of fraud our best estimate is that, in most European countries fraud detected at the stage of the claims settlement has been roughly estimated at 5 to 10% of the yearly pay-out in Non-life compensations.

There is no estimate available on pure underwriting risk.

- **In the Netherlands**, the Dutch association of insurers³ reported that:
 - 12% of the consumers confessed having committed insurance fraud
 - consumers estimate that 44% of Dutch population has committed insurance fraud.
 - assessed that, in the Netherlands, fraud represents an increase in insurance premium of about 150 €/family.

- **In Finland**, half of the investigated cases related to Motor while half of the €52 millions claimed reimbursements in investigated cases related to property cover for companies. A survey conducted in 1996 and 2003, informed about people's approach to insurance fraud, how common fraud was according to their experience and what they thought about fraud prevention. Both questionnaires were circulated to a random sample of 2 000 Finns obtained from the population register and response rates were about 40% in both cases. The main outcomes of this survey are:
 - the views on the seriousness of insurance fraud vary with the age: the older the person, the more serious he or she considered the fraud.
 - More than 80% of respondents accept the claims database in which Finnish insurers register all new claims (slight increase)
 - 79% of the respondents considered prevention the best way (slight increase), rather than punishment
 - Interview studies made 2006 and 2008; from 1 000 personally interviewed person approximately every fifth know person who have committed insurance fraud

- **In France**, 40% of the €80 millions economies realized by insurers in 2008 thanks to fraud fighting related to Motor⁴. The report also provides detailed information on :
 - The distribution (in number and amount) of fraud by product branch and hazard (eg TPL bodily injuries)
 - The ones who detected and who evidenced fraud cases (expert, staff member, etc), by product branch and hazard
 - The prosecution rate
 - Features of fraud cases investigated by ALFA⁵

- **In Germany**, it was assessed that insurance fraud costs 4 billion / year, ie 10% of the claims expenditures. A 2002 GfK study, commissioned by the German Insurance Association (GDV), polled the attitude of consumers in respect of insurance in general and of insurance fraud in particular. This study is expected to be updated within a few months. According to the survey, 28% considers that insurance fraud is not a crime.

³ Alex H. Westerman, « Dutch approach in tackling insurance fraud », GenRe, Köln, December 2007

⁴ ALFA – Recueil Statistiques 2008

⁵ Agence pour la lutte contre la fraude à l'assurance; see <http://www.alfa.asso.fr/webalfa/alfaeditpublicanglais.nsf/accueil?Openpage>

- **In Italy**, some indications on the entity of the phenomenon in Italy are offered by the specific inquiry that ISVAP (the supervisory body for private insurance) has been leading on criminal activity in the insurance sector. Official data, processed by ISVAP on the basis of reports by undertakings, provide a partial and largely underestimated result of the phenomenon. In these official surveys Italy results as one of the countries that are less exposed to the phenomenon of insurance fraud, with a national average which of about 3% of the total MTPL claims and 0.53 % of the total claims in fire and natural disasters (representing 1.70 % of the total claims expenditures).

With regard to MTPL, a relevant figure is the positive correlation existing, in each province, between fraud incidence on the claims total and the claims frequency.

- **In Sweden**, a 1982 report from the Swedish National Council for Crime Prevention (Brå) claims that least 10% of all payment of insurance claims were fraudulent which means with today's figures that we have a cost of fraud of 4 – 5 billion SEK (about 0.4 – 0.5 billion eur).

A 1998 report from the Police Academy claiming that the number of committed Insurance Frauds is about 100 000 crimes each year till a total cost of 1,5 billion SEK (0.15 billion eur).

A 2002 a report from Lunds University regarding personal injury claims saying that 80 persons in the investigation were reported for Insurance Fraud which causes the insurance companies a cost of 8 million SEK (0.8 million eur) but only 25% of the reported was convicted.

There is no more recent data available since, similarly to Denmark and Norway, there is a general consensus of the need to fight fraudulent claims.

- **In the UK**, the ABI recently assessed⁶ that

 - undetected general insurance claims fraud totals £1.9 billion a year.
 - This adds £44 to the annual costs individual policyholders face, on average, each year.
 - The detection of general insurance fraud has improved significantly over the last five years. Over £730 million worth of fraudulent claims were detected and prevented in 2008. This represents a 30% increase in detection since 2007.
 - The insurance industry is detecting more of the fraud that is being attempted. Improved data sharing through the Insurance Fraud Bureau and a more focused approach to detecting fraud across insurers have contributed to this improvement.
 - The indications are that the recession is having an impact on fraud, but it is too early to say for certain that this is happening.
 - 4% of all claims by value (excluding life insurance) were fraudulent in 2008 (3% in 2007).
 - Dishonest claims on home insurance were the most common, with 55,000 false or exaggerated claims detected. By value, fraudulent motor insurance claims were the highest, with £360 million saved.
 - Fraud detected in 2008:

Class of Insurance	Number of frauds detected (estimated)	Value of frauds detected (estimated)
Motor	35,300	£360 million
Household buildings and contents	55,400	£110 million
Travel	4,300	£ 5 million
Creditor	2,500	£19 million
Commercial	9,800	£ 240 million
Total	107,200	£ 730 million

⁶ ABI – General Insurance claims fraud - Research Brief – July 2009

3. Context

The legal and cultural context as well as the relationship with stakeholders may either facilitate fraud prevention and fighting or contribute to an increase of the phenomenon.

3.1 Relevant legislation/regulation

■ Data protection:

The legislation on data protection often limits the possibilities of comparing the cases and drawing common patterns in order to identify *modus operandi* and hence fighting fraud on an efficient/targeted way (eg with automatic access to external databases, IT expert systems, etc).

Despite the existence of an EU directive⁷ to that respect, the situation varies widely across countries within the EU. The problems posed by this lack of consistency across the EU in respect to the transposition of the Directive and by legal uncertainty resulting from unclear definitions has been reported by stakeholders participating at the conference organized by the Commission on the today's challenges for the data protection legal framework, in particular in respect to new technologies.

In Spain for example, it is expressly permitted to have common files in order to specifically prevent fraud (swindle) in insurance, without having to be given the consent of the affected party. Nevertheless, in these cases the affected party must be notified when his/her data is first introduced by the Controller and how to exercise the rights of access, rectification and cancellation.

In Sweden the EU Data Protection Directive has been implemented without exceptions, which results in difficulties to create registers and also to co-operate with the Authorities especially from their point of view. On the other hand there is no law of secrecy regarding the insurance business, which means that the exchange of information is possible between companies and to Authorities from the claims.

The Commission launched a stakeholders' consultation in preparation of the review process of the legal framework for data protection (deadline 31.12.2009).

An overview of the accessible information is available in annex (see enclosed document with reference NLI-FRD-09-024).

■ Investigators

The conditions to which investigators have to comply in order to legally investigate differ from country to country.

- **In some countries (such as France and Belgium)** private investigators (such as those working in/for the insurance companies) need to be accredited by the relevant public authorities.
- **In Finland**, the insurance contract act requires the policyholders to provide the information to companies but also to investigators. The Finnish association published good practice guidelines for insurance investigation.
- **In Italy**, investigators must have a license granted by the relevant public authorities. In those cases which fall under a criminal procedure, the judge in charge of that specific case, can authorize the investigator to proceed with the investigation.
- **In the Netherlands**, the rules are more restricted for commercial investigators than for insurance investigators.
- **In Norway**, insurance companies work with own and external private investigators, where the latter are used for difficult cases (on a regional basis).
- **In Spain**, the services of surveillance and security of people or property are regulated by law, as activities complementary and subordinated to public security. These activities may be rendered by security companies and by private security staff, including private detectives. In the security field, the services of private detectives only involve gathering information and evidence on private

⁷ Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:31995L0046:EN:HTML>

activities and events, without being authorized to investigate frauds (as this offence is prosecutable by law). If any such event comes to their knowledge they must immediately report it to the competent authorities and submit all the information and instruments that they have obtained.

- **In Sweden**, the investigation is done mainly by insurance investigators, who are often former police officers (there are about 140 investigators, among which about 130 are employed by the insurance company). Independent private detectives do usually not deal with insurance fraud cases. It is estimated that each and every one does approx. 100 investigations per year (at least 13 000 per year) out of which 60% was rejected, out of which 300 – 400 cases each year went to civil court and 300 was reported to the Police. There is no specific authorization or condition required. The Swedish association issued guidelines for investigation of suspected cases of insurance fraud (October 2002).
- **In the United Kingdom**, the vast majority of insurance claims are not subject to investigation. Of the few that are, most are conducted by in-house investigators, covered by FSA regulation, or chartered loss adjusters who are subject to their own (voluntary) professional standards. Private Investigators fall within the scope of the Private Security Industry Act 2001 which makes provision for the regulation of the private security industry. However a commencement order for the PI part has not yet been enabled. The ABI supported the Act as a way of helping to raise the ethical and professional standards of investigators and to help drive out rogue investigators. It was intended that licensing of private investigators would start in 2008 by the Security Industry Authority (SIA), which is an independent body reporting to the Home Secretary but has been postponed until “at least” 2012 as private Investigators are not perceived as a threat to the public. The ABI published Guidelines on the instruction and use of private investigators and tracing agents in July 2007⁸.

■ **Anti-Money Laundering (AML)**

- directive 2005/60/EC of the European Parliament and of the Council of 26 October 2005 on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing⁹
- FATF guidance for AML and terrorism financing: the CEA is contributing to the drafting of an insurance sector guidance on the risk-based approach (RBA) to combating money laundering and terrorist financing.

■ **Insurance contract**

- EU directives¹⁰
 - Solvency II: Fraud is part of the operational risks (OpRisk), which need to be modeled in the frame of Solvency II.
- National legislations
 - As mentioned above, the Finnish insurance contract act requires the policyholders to provide the information to companies but also to investigators.
 - In the Nordic countries, the legislation does not offer insurers the possibility to refuse an insurance policy for retail consumers and retail insurers are prevented by law to investigate potential fraud cases at the application stage. As a consequence, retail insurers scrutinize claims and do not hesitate to deny compensation in case of fraud.
 - For the industrial risks in Nordic countries and all lines of business in most other countries (except IT for MTPL), insurers are free to accept a risk (or not) and have the opportunity to detect fraud during the underwriting process but experience difficulties to reduce/deny a claims compensation on the basis of fraud.

■ others

⁸ http://www.abi.org.uk/Bookshop/default.asp#Fraud_Prevention

⁹ <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2005:309:0015:0036:EN:PDF>

¹⁰ http://ec.europa.eu/internal_market/insurance/legis-inforce_en.htm

3.2 Cultural aspects

■ **Image of the insurance sector**

Insurers are often perceived by people as financial institutions that are happy to collect their money (insurance premium) but are reluctant to pay due claims compensation and make their best to minimize the compensation paid, in due case below the level that the insured is entitled to get. Also:

- consumers may think that they have been paying premiums for a long time and are, therefore, 'entitled' to get some money back by making a fraudulent claim; they do not feel guilty when finding a way to get (undue) compensation from an insurer.
- many consumers see insurance fraud as a victimless crime (the only loser is the big, well-funded insurance company).

■ **Position of the consumer associations**

The perception mentioned above can be reinforced by consumers' associations, for example when they lobby to limit the sanction of the consumer who made a false declaration (in view of getting a lower premium).

■ **Insurers' policy**

- Some insurers might not have effective fraud risk management framework (policies, procedures and controls to both prevent or detect and fight fraud) as a result of:
 - A lack of awareness
 - Their beliefs that their portfolios cannot be affected by the Fraud phenomenon for some good reasons
 - A deliberate decision, driven by commercial considerations and/or economic reasons (cost & benefit analysis), which might for example privilege a fast service (underwriting or claims settlement) delivery.
- The insurance sector is sometimes reluctant to be vocal in the press, as they fear that it might
 - inspire fraudsters or
 - worsen their image.

■ **The litigation culture** (eg prosecution versus Alternative Dispute Resolution/ADR) also plays a role in the extent of fraud.

The situation to that respect varies from country to country but also within a specific country. In Italy for example, the litigation culture is much more present in the Southern than in the Northern parts of the country.

■ **Lack of deterrent**

Police and courts are often not particularly interested in insurance fraud, so fraudsters are unlikely to get to court.

■ **Public-private partnership: Cooperation with the relevant authorities**

- The cooperation with the police officers might be dictated by act of competences that would specify the rules applicable to the exchange of information with the private sector. In addition, fighting insurance fraud will mostly not be their top priority but rather considered as an issue for insurance companies to deal with on their own.
- **In the Netherlands**, the Dutch National Platform for Crime Control (NPC) aims at facilitating the cooperation between the government and the business community for the fighting against crime harming trade and industry. Members are the ministers of Justice and of Home Affairs, Secretary of State of Economic Affairs, Presidents of the Dutch Associations of Banks and of Insurers as well as representatives of trade unions, local government, prosecution service and police).
- **In the UK**, a Memorandum of Understanding (MoU) has been signed in February 2008 between the ABI and the Association of Chief Police officers (ACPO), providing guidelines on the exchange of information between the police and insurance companies and loss adjusters. This MoU only applies to issues arising from an insurance claim (and not arising from the proposal). Policyholders need to be advised of this potential exchange of information with the police, at the proposal and claim stage.

Further details are available in the enclosed overview (document with reference NLI-FRD-09-025).

- **Relationship with the media**
In Finland for example, insurance fraud is not a taboo in the media; it is possible to communicate directly on the importance of fraud prevention.
- **Lawyers**
When the lawyers' remuneration is proportional to the compensation paid to the victim, they are very much interested in claims litigation, especially for personal injuries (eg whiplash), and some pay less attention to the legitimacy of the claim. This situation is very specific to the United Kingdom and Italy; it appears not to be experienced in other member states.
- **Service providers**
When the insurance company has established a network of repairers (such as coachbuilders for Motor insurance, carpenters for Home insurance, doctors and hospitals for Health insurance), these are key players to trigger the claims.
- **Claims management companies (CMCs)**
Some – CMCs pursue people to make claims who might not otherwise have considered it.

3.3 Stakeholders: identification of key organisations/institutions, public and private

- In general
 - Media (press, etc)
 - Policymakers
 - Supervisors
 - Associations of consumers
 - Associations of brokers
 - Associations of lawyers
 - Associations of loss adjusters
 - Claims management companies
 - Service providers (e.g. doctors)
 - ...
- national:
 - public authorities
 - police officers
 - ...
- European:
 - European Commission
DG JLS F1 Expert meeting on policy needs of data on crime & criminal justice)
 - Europol (The European Police Office)
 - BEUC(The European Consumers' Organisation)
 - BIPAR (The European Federation of Insurance Intermediaries)
 - CEIOPS (The Committee of European Insurance and Occupational Pensions Supervisors)
 - ...
- International:
 - Interpol (The International Police Organisation)
 - FATF (Financial Action Task force)
 - IAIFA (International Association of Insurance Fraud Agencies)
 - IASIU (International Association of Special Investigation Units)
 - ACFE (Association of Certified Fraud Examiners)
 - IAATI (International Association of Auto Theft Investigators)
 - IAMI (International Association of Marine Investigators)
 - TAPA (Transported Assets Protection Association)

4. Communication

4.1 Pre-requisites

To make the issue convincing **we need a sound basis of materials and statistical figures**. The latter is one of the most crucial points since the insurance companies either do not gather statistical materials or - if they do - the figures are not comparable from company to company.

4.2 Approach

The set-up of a communication requires the definition of

1. the purpose,
2. The audience,
3. The message,
4. The media

We should learn from existing good and bad communication experiences, also:

- outside the insurance sector (eg illegal copy of DVD)
- on other issues than fraud (eg drink driving or seat belts in Motor¹¹)

4.3 Purpose

The objective of effective communication in the field of crime/insurance fraud should be a substantial and sustainable preventive effect. The purpose of an internal communication might for example aim to awareness raising, information sharing on best practices, etc. The purpose of an external communication might for example be to change the social perception of fraud, the police forces' and courts' attitude towards insurance fraud (greater law enforcement, stricter penalties, etc).

The scope of the communication should be specified on the basis of the expected return (most expensive and/or fraud cases):

- type of insurance fraud (opportunistic versus professional)
- insurance product (eg motor is a significant issue in the UK because of whiplash, which constitutes a huge proportion of both opportunistic and professional frauds. This is not the case in many other European states)
- modus operandi (eg front-end fraud (at application stage) is a big issue for the UK, not least because of comparison websites). Damage caused by insurance fraud is essentially the result of "minor" fraudulent behaviour and not as much of organized crime or serial criminal behaviour.

4.4 Audience

- Internal communication: national insurance associations, insurance companies, tied agents, etc
- External communication: consumers, public authorities, other stakeholders (brokers' associations, etc)

The main target group for the external communication is the average citizen.

In order to avoid the usual criticisms on the lack of involvement by insurers when communicating externally, we should start with the internal communication in order to get first the appropriate awareness and approach within the insurance sector, before requiring actions from third parties.

4.5 Message

The arguments to be used are for example:

- insurance fraud is a crime
- if you commit fraud you will get caught and get penalties
- honest policyholders pay for fraudsters (pay attention not put all our clients under a general suspicion, which could have a counterproductive effect)
- An insurance fraudster regularly commits also other offences
- Fighting fraud benefits the society; this is not an insurance problem but a society problem.

4.6 Media

The most appropriate media will be chosen depending on the targeted audience: press (specialized, mass, etc), posters, radio, TV, etc

¹¹ see CEA Road Safety Compendium 2009; http://www.cea.eu/uploads/DocumentsLibrary/documents/1237474647_road-safety-compendium.pdf

5. Further actions

- **Surveys and studies**
 - Collection of statistics (in cooperation with the Statistical Committee)
 - Analysis of the use (benefits & constraints) of insurance specific and external data bases across Europe and of the possibility to widely share them at UE level
 - Analysis of other existing fraud prevention and detection tools (softwares, voice recognition systems, etc), their scope of application, the legal framework, their effectiveness etc.
 -
 - 'Analysis of the prosecution landscape in different member states in order to get a far more detailed understanding of different member states' approaches to fraud - i.e. police interest, court action etc.
 - Survey on the perception towards insurance and insurance fraud across Europe (nice to have)
- **Communication:** Compendium of good anti-fraud practices across CEA members
- **Lobbying**
 - Contribution to the consultation on data protection, which aims to obtain views on the new challenges for personal data protection in order to maintain an effective and comprehensive legal framework to protect individual's personal data within the EU. Stakeholders are invited to reply to the 3 questions below by 31.12.2009
 1. new challenges for personal data protection, in particular in the light of new technologies and globalisation
 2. whether the current legal framework meets these challenges
 3. What future action would be needed to address the identified challenges
- **Cooperation with international bodies**
 - Short term: Contribution to the review of the IAIS guidance, which is due to be published in October 2010, as from the earliest stage (ie internal process which will start end 2009 while the public consultation over the summer 2010)
 - Longer term: Cooperation with third parties
 - with private organisations such as IASIU, IAIFA, IAATI, IAMI and TAPA to start with, in order to learn about new modus operandi, tools, etc
 - with public authorities such as Interpol/Europol at a second stage
- **Set up of a specific fraud & crime prevention network**

The set-up of a permanent group, which would meet regularly (eg once a year) in order to:

 - share information on the most frequent and emerging modus operandi
 - spread early warnings on changing trends (eg impact of the economic crisis)
 - exchange experience on the public relations and press work in terms of crime prevention
 - identify future issues to be addressed
 - identify improvements to be managed and their priorities & benefits
 - facilitate the settlement of cross-border insurance fraud cases (eg list contact people in the CEA, together with a specification of the countries where he/she can provide useful information).