

Insurance Claims Fraud · Priimal Claim

USD 80 to 100 billion per year: estimated annual global cost of property and casualty insurance claims fraud and leakage (Insurance Information Institute; FBI; Accenture P&C survey)

What is insurance claims fraud?

Insurance claims fraud and leakage spans the full spectrum from hard fraud, entirely fabricated claims including staged accidents and phantom vehicles, to soft fraud, where a legitimate claim is inflated through exaggerated injuries or added damage unrelated to the incident. Provider fraud, where workshops, medical practitioners, or legal representatives bill systematically for services not rendered or inflated, often involves network-level coordination across many claims. The core detection challenge is not identifying these fraud types in principle: it is finding the network patterns across claims that connect participants, providers, and incidents in ways no single claims file or individual system was designed to see.

The financial reality

Industry association data places claims fraud and leakage at between 5% and 10% of total non-life claims paid across European markets, with the FBI placing the US figure alone at over USD 40 billion annually. Accenture's survey of European P&C claims executives found 39% believed 5 to 10% of claims paid at their organisation were fraudulent but undetected, with estimated annual losses for European P&C insurers of EUR 8 to 12 billion. For a motor and health insurer with EUR 200 million in annual non-life gross written premium, applying a 65% loss ratio and a conservative 7% fraud rate implies an annual claims fraud exposure of approximately EUR 9.1 million. At an illustrative 50% recovery rate, the recoverable annual value would be approximately EUR 4.5 million. These losses are structurally difficult to detect because the signals that identify a fraud ring are distributed across dozens of individual claim files in systems never designed to be analysed together.

Dominant loss typologies

- **Staged accidents:** Organised groups deliberately cause or fabricate road traffic incidents, generating coordinated claims for vehicle damage, personal injury, and associated costs across multiple participants.
- **Personal injury exaggeration:** Legitimate accidents are used as the basis for inflated or extended injury claims, particularly for soft-tissue injuries that are difficult to clinically refute.
- **Repair workshop fraud:** Garages in collusion with claimants invoice for unnecessary work, non-existent parts, or replacements where repairs would have sufficed.
- **Medical provider fraud:** Physiotherapy clinics and medical providers submit inflated or fictitious invoices for claimants who were never treated or whose treatment was significantly less than billed.
- **Ghost claimants and identity fraud:** Claims are submitted using stolen, synthetic, or deceased identities, or in the names of individuals not present at the incident.
- **Legal representative involvement:** Solicitors and claims management companies acting outside professional duties become coordinators of fraud rings, generating referral fees and directing claimants to colluding providers.

Regional context

The UK's ABI detected £1.16 billion in fraudulent general insurance claims in 2024, a 2% increase on the prior year, representing detected fraud only. The FBI estimates total US insurance fraud losses exceed USD 40 billion annually across property and casualty lines. In Central and Eastern Europe, documented fraud rates in motor lines range from 6% to 12% of claims paid in markets including Poland, Romania, and Hungary, according to national insurance bureau statistics. Across Southeast Asia and sub-Saharan Africa, organised staged accident networks and medical provider collusion are increasingly documented in regulatory enforcement publications from markets including Nigeria, Kenya, and the Philippines.

Priimal Claim: A Vantage product

Priimal Claim is an AI-scoring and case management platform for motor and health insurance claims integrity. Insurers upload their existing claims data, including free-text adjuster notes and unstructured documents. Vantage scores every claim across six fraud flag categories and returns a prioritised investigation queue for SIU teams. Available under Core Value: pay a share of documented recovered value only, capped at the equivalent flat-rate subscription price. Nothing recovered, nothing owed. To learn more, visit priimal.com or contact connect@priimal.com.