INDIAN JOURNAL OF LEGAL REVIEW

VOLUME 4 AND ISSUE 2 OF 2024

INSTITUTE OF LEGAL EDUCATION

INDIAN JOURNAL OF LEGAL REVIEW

APIS – 3920 – 0001 | ISSN - 2583-2344

(Free and Open Access Journal)

Journal's Home Page – https://ijlr.iledu.in/

Journal's Editorial Page - https://ijlr.iledu.in/editorial-board/

Volume 4 and Issue 2 of 2024 (Access Full Issue on - https://ijlr.iledu.in/volume-4-and-issue-2-of-2024/)

Publisher

Prasanna S,

Chairman of Institute of Legal Education (Established by I.L.E. Educational Trust)

No. 08, Arul Nagar, Seera Thoppu,

Maudhanda Kurichi, Srirangam,

Tiruchirappalli – 620102

Phone : +91 94896 71437 - info@iledu.in / Chairman@iledu.in

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INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 4 AND ISSUE 2 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

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UNMASKING DECEPTIVE SCHEMES: AN IN-DEPTH ANALYSIS OF INSURANCE FRAUD CASE STUDIES IN INDIA

AUTHOR - KARANDEEP SINGH, STUDENT AT CHANDIGARH UNIVERSITY

BEST CITATION - KARANDEEP SINGH, UNMASKING DECEPTIVE SCHEMES: AN IN-DEPTH ANALYSIS OF INSURANCE FRAUD CASE STUDIES IN INDIA, *INDIAN JOURNAL OF LEGAL REVIEW (IJLR)*, 4 (2) OF 2024, PG. 1519-1528, APIS – 3920 – 0001 & ISSN - 2583-2344

ABSTRACT

Insurance fraud poses a significant challenge to the Indian insurance industry, affecting the insurers and policyholders alike as well as the economy by adding large sums of economic debt on the nation. This research paper presents a comprehensive examination of big billion dollars insurance fraud in India through a detailed analysis of very recent case studies. By scrutinizing real-world examples of insurance fraud, this study seeks to unveil the intricacies of deceptive schemes, the underlying motivations, and the modus operandi employed by fraudsters. The study leverages a diverse set of case studies encompassing various insurance domains, including life, health, property, and motor insurance, to provide a holistic perspective on the issue. Through a qualitative approach, the paper delves into the multifaceted nature of insurance fraud, identifying common patterns and distinctive characteristics that enable a better understanding of fraudulent activities. In conclusion, this study underscores the urgency of addressing insurance fraud penal mechanism and separate and specific legislation to combat insurance fraud in India and the need for collaborative efforts among insurers, regulators, and law enforcement agencies to develop proactive strategies for detection and prevention. By dissecting real-world case studies, this research aims to provide valuable insights that can contribute to the formulation of more robust anti-fraud measures and the safeguarding of the Indian insurance sector.

Keywords: Insurance, Fraud, Insurance Fraud Control Act, Case Studies, Multi crore scam, business, law

I. INTRODUCTION

As per the Insurance Regulatory and Development Authority of India (IRDAI), Bharat will be the sixth-largest insurance market within a decade, leapfrogging Germany, Canada, Italy and South Korea[1]. The regulatory developments would furthermore contribute to the growth. The recent pandemic has emphasized the importance of healthcare on the economy, and health insurance would play a critical role in the effort to strengthen the healthcare ecosystem. Insurance market in India is expected reach US$ 222 billion by 2026[2]. Robotic Process Automation (RPA) and AI will occupy center stage in insurance, driven by newer data channels, better data processing capabilities and advancements in AI algorithms. Bots will become mainstream in both the front and back-office to automate policy servicing and claims management for faster and more personalized customer service. The

[1] Tnn, 'India to be 6th largest insurance market' (*The Times of India*, 23 December 2022) <https://timesofindia.indiatimes.com/business/india-business/india-to-be-6th-largest-insurance-market/articleshow/96439612.cms> accessed 5 October 2023.

[2] IRDAI, 'COMMITTEE'S REPORT ON STUDY OF THE FEASIBILITY OF ALLOWING LIFE INSURERS TO OFFER INDEMNITY BASED HEALTH POLICIES' (*Insurance Regulatory and Development Authority of India*, 28 September 2020) <https://irdai.gov.in/documents/37343/366723/Report+on+the+Feasibility+of+allowing+Life+Insurers+to+offer+Indemnity+base.pdf/d19f2513-9e22-f681-7462-2a5ab7ed1044?version=1.1&t=1665242038288&download=true> accessed 29 September 2023.

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]
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government's flagship initiative for crop insurance, Pradhan Mantri Fasal Bima Yojana (PMFBY), has led to significant growth in the premium income for crop insurance. Ayushman Bharat (Pradhan Mantri Jan Arogya Yojana) (AB PMJAY) aims at providing a health cover of 5 lakh per family per year for secondary and tertiary care hospitalization. Insurance cover for 44.6 crore persons under PM Suraksha Bima and PM Jeevan Jyoti Yojana was provided during the FY 22-23. The IPO of Life Insurance Corporation (LIC) of India was the largest IPO ever in India and the sixth biggest IPO globally of 2022. As of November 2022, listing of LIC accounted for more than a third of resources mobilized in the primary equity market until November 2022.

India's Insurance industry is one of the premium sectors experiencing upward growth. This upward growth of the insurance industry can be attributed to growing incomes and increasing awareness in the industry. India is the fifth largest life insurance market in the world's emerging insurance markets, growing at a rate of 32-34% each year[3]. In recent years the industry has been experiencing fierce competition among its peers which has led to new and innovative products within the industry. Foreign Direct Investment (FDI) in the industry under the automatic method is allowed up to 26% and licensing of the industry is monitored by the insurance regulator the Insurance Regulatory and Development Authority of India (IRDAI). The insurance industry of India has 57 insurance companies - 24 are in the life insurance business, while 34 are non-life insurers. Among the life insurers, Life Insurance Corporation (LIC) is the sole public sector company. There are six public sector insurers in the non-life insurance segment. In addition to these, there is a sole national re-insurer, namely General Insurance Corporation of India (GIC Re). Other stakeholders in the Indian Insurance market include agents (individual and corporate), brokers, surveyors and third-party administrators servicing health insurance claims. The insurance industry has undergone numerous transformations in terms of new developments, modified regulations, proposals for amendments and growth in 2022. These developments have opened new avenues of growth for the industry while ensuring that insurers stay relevant with changing times and the latest digital disruptions. The Insurance Regulatory and Development Authority is vigilant and progressive and is determined to achieve its mission of 'Insurance for all by 2047', with aggressive plans to address the industry's challenges. The growth of the insurance market is being supported by important government initiatives, strong democratic factors, conducive regulatory environment, increased partnerships, product innovations, and vibrant distribution channels. Insurance Industry was largely dominated by offline channels like corporate agents, offline brokers or banks. Today, rapid digitization, product innovation and progressive regulation policies have made it possible for consumers to buy insurance through multiple distribution channels with the click of a button. The instability of the covid-19 pandemic highlighted the necessity for consumers to invest in products that would increase financial security, one of them being life insurance.

The rapid growth of the insurance industry in India has indeed brought numerous opportunities, but it has also created an environment conducive to various types of fraud. This growth can be attributed to factors such as rising disposable incomes, increased awareness of insurance products, regulatory reforms, and a burgeoning middle class. However, the very factors driving the industry's growth also attract fraudsters seeking to exploit vulnerabilities. After considering these growth statistics and figures, it's quite clear that Indian Insurance Industry is one of the biggest markets for nurturing huge monetary profits alongside mainstreaming the actual insurance need i.e., to reduce financial uncertainty and make loss

[3] Daily News Analysis, 'LIC and Insurance Sector in India' (*IAS Gyan*, 29 April 2023) <https://www.iasgyan.in/daily-current-affairs/lic-and-insurance-sector-in-india#:~:text=India%20is%20the%20fifth%20largest,34%20are%20non%2Dlife%20insurers.> accessed 5 October 2023.

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manageable in the hard times. In India, the insurance business suffered a loss of Rs. 45,000 crore due to insurance scams in 2019[4]. But About 60 per cent of Indian insurance companies are seeing a rapid increase in insurance fraud, especially in the life and health insurance space, according to Deloitte's Insurance Fraud Survey 2023[5]. The popularity and rapid growth of this industry is the main reason for increasing frauds as such big numbers can easily make one trustworthy of deceptive techniques which one is offered and trapped. No doubt that these statistics indicate growth but one should not forget that frauds here usually amounts to lakhs if not crores, and all related scams initially contribute to these growing numbers. The rapid digitalization too has for 34% been the fraud causing factor.

Before going into deep further, it is must to understand what an insurance fraud actually is and how its done and does its effect really matters? The word 'fraud' finds its roots in the word 'fraus-fraudis', which means the commission of an act of bad faith done in order to obtain a profit[6]. And it is worth noting that Indian Insurance Act of 1938[7] does not define the term 'Insurance Fraud'. So, according to California Department of Insurance, Fraud occurs when someone knowingly lies to obtain a benefit or advantage to which they are not otherwise entitled or someone knowingly denies a benefit that is due and to which someone is entitled. According to the law, the crime of insurance fraud can be prosecuted when:

- The suspect had the intent to defraud. Insurance fraud is a "specific" intent crime. This means a prosecutor must prove that the person involved knowingly committed an act to defraud.
- An act is completed. Simply making a misrepresentation (written or oral) to an insurer with knowledge that is untrue is sufficient.
- The act and intent must come together. One without the other is not a crime.
- Actual monetary loss is not necessary as long as the suspect has committed an act and had the intent to commit the crime.

Insurance fraud carries substantial ramifications, both in terms of financial and ethical implications. It erodes the confidence placed in the insurance sector, escalates expenses for every policyholder, and redirects valuable resources from legitimate purposes. The vital task of identifying and thwarting insurance fraud is essential for upholding the integrity of the insurance system and ensuring its ability to offer essential protection to individuals who truly require it. The importance of insurance fraud stems from its effects on different parties involved, such as insurance firms, policyholders, and society in general. Here are key aspects that underscore the importance of insurance fraud:

1. Financial Consequences for Insurance Companies:

Insurance fraud leads to significant financial losses for insurance companies. When fraudulent claims are paid out, legitimate policyholders may face higher premiums to cover the losses, leading to increased costs for everyone[8].

2. Increased Costs for Policyholders:

As insurance companies pass on the cost of fraud to their policyholders through higher premiums, honest policyholders are burdened

[4] SK Sethi , 'Insurance Frauds Control Act; an urgent need in India' (*Business Today*, 28 September 2020) <https://www.businesstoday.in/opinion/columns/story/insurance-frauds-control-act-an-urgent-need-in-india-fraudulent-claims-indian-penal-code-253947-2020-04-05#:~:text> accessed 29 September 2023.

[5] Deloitte, 'Navigating the insurance sector through a fraud risk lens and Survey 2023' (*Deloitte*, February 2023) <https://www2.deloitte.com/in/en/pages/financial-services/articles/Insurance-fraud-survey-2023.html> accessed 29 September 2023.

[6] Elena Popa, Insurance Fraud, 2008 AGORA INT'L J. JURID. SCI. 225 (2008).

[7] Indian Insurance Act 1938.

[8] FBI, 'Insurance Fraud' (*Federal Bureau of Investigation*) <https://www.fbi.gov/stats-services/publications/insurance-fraud> accessed 9 October 2023.

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APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

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with increased costs. This can make insurance less affordable for individuals and businesses[9].

3. Undermining Trust:

Insurance fraud erodes trust in the insurance industry. When fraud becomes widespread, it can lead to skepticism among policyholders, making it more difficult for insurers to provide the necessary financial protection.

4. Legal and Ethical Implications:

Engaging in insurance fraud is a criminal offense in many jurisdictions, leading to serious legal consequences such as fines, imprisonment, and a criminal record. It also carries significant ethical implications[10].

5. Strain on Resources:

Insurance companies must allocate resources to investigate and combat fraud, diverting funds and personnel away from other critical functions such as underwriting and claims processing.

6. Impact on Legitimate Claimants:

When resources are focused on investigating fraudulent claims, it can lead to delays in processing legitimate claims. This can be especially burdensome for individuals or businesses in need of timely financial assistance.

7. Economic Costs to Society:

Insurance fraud contributes to higher overall insurance premiums and costs, which can affect the economic well-being of a society. It may also lead to job losses in the insurance industry due to financial strain on companies.

8. Resource Allocation in Law Enforcement:

Law enforcement agencies must allocate resources to investigate and prosecute insurance fraud cases, diverting resources away from other important areas of law enforcement.

9. Cybersecurity Concerns:

In the modern era, insurance fraud has expanded to include cyber insurance fraud, where criminals exploit vulnerabilities in cybersecurity to make fraudulent claims. This raises concerns about data security and privacy[11].

10. Reputation Damage:

Insurance fraud can damage the reputation of individuals or businesses involved in fraudulent activities, leading to long-term consequences in personal and professional life.

II. RESEARCH QUESTIONS

The aim of this research is twofold:

- To examine recent incidents of Insurance fraud occurring in India in order to identify the level, intent, motive, prominent area, techniques used, and similarity in cases of such frauds.
- To create a generalization statistics of pattern of Insurance Fraud happenings in the country.
- To learn whether the provisions of Indian Criminal Justice system being adequate or is there a need for a specific legislation?

III. RESEARCH METHODOLOGY

This research paper is prepared following the doctrinal methodology. Secondary sources are used for research paper which include but not limited to latest decided cases, newspaper headings, newspaper articles, blogs, published articles are researched and are taken into consideration to reach the generalization.

[9] Centre for insurance policy and research, 'Insurance Fraud' (*National Association of Insurance Commissioners*, 12 June 2023) <https://content.naic.org/cipr-topics/insurance-fraud> accessed 9 October 2023.

[10] Ricardo Lara, 'Insurance Fraud is a Felony' (*California Department of Insurance*) <https://www.insurance.ca.gov/01-consumers/105-type/95-guides/15-gen/insur-fraud-is-felony.cfm> accessed 9 October 2023.

[11] Cremer, F., Sheehan, B., Fortmann, M. *et al.* Cyber risk and cybersecurity: a systematic review of data availability. *Geneva Pap Risk Insur Issues Pract* 47, 698–736 (2022). https://doi.org/10.1057/s41288-022-00266-6.

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IV. CASE STUDIES

1. *Multi crore Insurance Scam detected in Sangrur, Punjab*

Case Analysis: A notable breakthrough was the discovery of a multi-crore insurance scam by the Sangrur police in Punjab, which was carried out by an interstate ring of con artists. The gang's strategy entailed gathering information from insurance providers and tricking policyholders into investing their money in Ponzi schemes by promising to waive their insurance premiums.

Key specifics: The crime was discovered as a result of a complaint delivered to the Dhuri police station. A specialized police unit was established to look into the situation. The gang had 14 members in total, one of whom was a woman. They had operations in Punjab and Haryana.

Modus Operandi: The gang obtained policyholder information from insurance firms and located people who had neglected to pay their yearly premiums. They induced these people to invest in Ponzi schemes by pretending to be investment advisors and promising them not only advantageous returns but also the exclusion from paying annual premiums. Seven gang members were detained, including the suspected leader Arun Kumar and Dushyant, who are both from Manipmajra near Panchkula. Ekta Sharma, Jugraj Singh, Shagunpreet Singh, Gagandeep Singh, and Jagraj Singh were among the other members who were detained.

Investigations Still Underway: Police teams were actively looking for the seven other gang members who were still at large. The gang had been successful in obtaining roughly Rs 2.68 crores from gullible policyholders, including cheating a businessman from Ludhiana out of Rs 4 crore and another businessman from Haryana out of Rs 1.5 crore.

Assets Recovered: During the inquiry, police found 113 grams of gold, a car, many cell phones, and Rs 13.76 lakh in cash on the arrested people.

Increasing Complaints: After the group was exposed, new complaints from victims in Punjab and Haryana surfaced; they were being investigated.

The case serves as a reminder of the value of caution and in-depth due diligence when considering investing options, particularly in the context of insurance coverage. The remaining gang members are being vigorously sought after by law enforcement, and as new allegations are looked into, more developments in the case are anticipated.

2. *In Delhi, gang makes off with Rs 2.4 crore unclaimed insurance money*

Analysis and Complaints Made: Five individuals in India's capital fraudulently withdrew money from unclaimed insurance policies of deceased policyholders. Among those apprehended are an Aadhaar center employee and former/current employees of Max Life Insurance, who had filed the initial complaint.

Modus Operandi: The group siphoned off nearly Rs 2.4 crore from 37 policies belonging to 22 people. They used data from policyholders whose maturity amounts were unclaimed and substituted the details with those of individuals from impoverished communities. The gang then applied for PAN and voter cards for these individuals and digitally opened bank accounts using e-Aadhaar authentication.

Key details: Indian Penal Provisions of Section 421[12] and 465[13] are involved which caused the arrests to be made.

Arrests Made: Five individuals in this case have been so far arrested by the Cyber Cell, Delhi for allegedly fraudulently withdrawing money from unclaimed insurance policies of deceased policyholders[14].

[12] Indian Penal Code 1860, s 421.
[13] Indian Penal Code 1860, s 465.
[14] PTI, 'Gang withdrew unclaimed money from insurance firm by forging documents; 5 held' (*Press Trust of India*, 26 April 2023) <https://www.ptinews.com/news/north/gang-withdrew-unclaimed-money-from-insurance-firm-by-forging-documents-5-held/558491.html> accessed 9 October 2023.

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Assets recovered: Law enforcement seized 55 PAN cards, 33 Aadhaar cards, 32 voter ID cards, 46 debit cards, 73 checkbooks, and six swipe machines. The fraudulent activity came to light when Max Life Insurance reported the misappropriation of about Rs 51 lakhs, pertaining to surrendered or matured policies. An investigation revealed that the money was received by unidentified individuals whose refund requests were processed through ex-employees of the insurance company. The fraudsters had opened multiple accounts in different banks under the policyholders' names. The investigation led to the arrest of the accused, including those with access to policyholder data, an Aadhaar center employee, and others involved in the scheme[15].

Ongoing Investigations: Max Life Insurance took immediate action against the involved employees, terminated their employment, and supported the ongoing investigations. The company emphasized its commitment to conducting business with high ethical standards and zero tolerance for unethical and fraudulent practices that could harm its reputation or customers' interests[16].

3. Mumbai man claims money for lapsed life insurance policy online, ends up losing Rs 2.24 crore in scam

Case summary: An alarming case of fraud was discovered by Navi Mumbai Cyber Crime cell team and arrested old cybercriminal along with his aides who defrauded a resident of Kamothe worth Rs. 2.24 crores by using fake identity as IGMS employee. The accused fraudulently took Rs. 2.24 crore on pretext of helping the complainant to get maturity sum on his insurance policy that had lapsed during covid-19.

Key details: The fraud was ascertained when the complainant lodged a complaint at Kamothe police station and an FIR of cheating under section 420[17] of IPC was registered against the accused.

Modus operandi: The accused used fake identity and pretend to be Deepak Bansal as the IGMS employee (integrated grievance management system). The data was leaked and the accused targeted the complainant by helping him to get the maturity amount of his lapsed insurance policy and gradually demanding him to transfer money with assurance of its reimbursement but complainant did not receive payment for 3 years and ended up by losing Rs. 2.24 crores.

Ongoing investigation: The accused include Prashant Chamoli (aged 32) key accused, Parvez Sharif (aged 41) and Ranjit Tiwari (aged 32) {both who aided by providing 5 sim cards and several bank accounts for transferring payment}. It was found that 1.80 crore was transferred to Gurugram bank account of accused. The team of cyber cell reached there and arrested the accused. All the accused were under police custody and it was found out that the key accused has also committed similar crimes before.

Assets recovered: During investigation, the police found and seized 5 mobile phones, 5 sim cards, a visa debit and passport from him[18].

4. 30 year Old Man and 2 others held in Rs. 2 crore insurance fraud case in Maharashtra

Case Analysis: One more incident of insurance fraud was detected and registered by Shivaji park police where accused named Dinesh Taksal fraudulently claims insurance amount by faking his own death. Dinesh along with his friends arrested for attempting to dupe a life insurance firm for make an insurance claim of

[15] Raj Shekhar, 'In Delhi, gang makes off with Rs. 24 crore unclaimed insurance money' (*Times of India*, 27 April 2023) <https://timesofindia.indiatimes.com/city/delhi/gang-makes-off-with-rs-2-4cr-unclaimed-insurance-money/articleshow/99796543.cms?from=mdr> accessed 9 October 2023.

[16] Press Trust of India, 'Gang withdrew unclaimed money from insurance firm by forging documents; 5 held' (*ZEE Business*, 26 April 2023) <https://www.zeebiz.com/india/news-gang-withdrew-unclaimed-money-from-insurance-firm-by-forging-documents-5-held-232390> accessed 9 October 2023.

[17] Indian Penal Code 1860, s 420.

[18] Diya Bhati, 'Mumbai man claims money for lapsed life insurance policy online, ends up losing Rs 224 crore in scam' (*India Today*, 7 September 2023) <https://www.indiatoday.in/amp/technology/news/story/mumbai-man-claims-money-for-lapsed-life-insurance-policy-online-ends-up-losing-224-crore-in-scam-2432401-2023-09-07> accessed 9 October 2023.

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Rs. 2 crore by declaring an alive person to be dead.

Modus operandi: The accused while purchasing the life insurance policy submitted bogus documents, income tax papers, property papers etc. and LIC issued him a 2 crore policy after scrutinizing all the documents. After one and a half year, a claim was made that Dinesh had died in road accident. A couple appeared before the court claiming to be parents of accused. But the insurance company in their internal probe found that all the property of accused was sold and his father was died in 2012.

Key details: The matter was discovered on the complaint of LIC officer Omprakash Sahu, a case was registered under section 465, 467[19], 479[20], 420, 120(b)[21] of IPC against the accused.

Ongoing investigation: The accused have been identified as Dinesh Taksal who is the key accused, Anil Latke, Viyay Malvade. The insurance company officials had suspected that how within one and half year of purchasing of policy a death has been made and started their own investigation. It was found that all the documents, PAN card etc. were bogus and on complaint of LIC officer the case was registered and investigation was initiated.

5. The multi-million insurance fraud of Haryana, the biggest and gravest of the decade

Case Analysis: This case revolves around an elaborate insurance fraud scheme that specifically targeted individuals afflicted by disease, poverty, and desperation. The perpetrators exploited the vulnerabilities of their victims to enroll them in insurance policies and subsequently filed fraudulent claims to receive multi-million rupee payouts from insurance companies. The case highlights the audacity and sophistication of the criminal operation and underscores the importance of ethical conduct and transparency in the insurance industry[22].

Modus Operandi: The criminal gang headed by Pawan Bhoria and his 8 other members which are his cousins, nephew and friends identified individuals suffering from serious illnesses, primarily cancer, and those living in impoverished or desperate conditions. The computer operator at Rohtak's public hospital sold the names of cancer patients for Rs. 10,000 – 15,000 per name. They coerced or manipulated these vulnerable individuals into becoming beneficiaries of insurance policies, often without their informed consent. Once the insurance policies were established, the gang members filed fraudulent claims, exaggerating medical expenses and misrepresenting the nature and severity of illnesses. They used fake medical records, forged signatures, and multiple identities to perpetrate the fraud.

Key Details:

- The scheme targeted vulnerable individuals facing serious illnesses or living in poverty.

- Victims were manipulated into enrolling in insurance policies worth Rs. 8 to 20 lakhs.

- Fraudulent claims were filed, involving inflated medical expenses and misrepresented illnesses.

- The doctors in the autopsises reports looked away obvious signs of cancer on the bodies of decreased and mentioned only accident injuries, making easy for fraudsters to claim insurance.

- The gang even bribed investigation agents of private insurance companies after the families pressed for claims and asked to submit report in their favour.

- The fraud resulted in multi-million rupee payouts from insurance companies.

[19] Indian Penal Code 1860, s 467.
[20] Indian Penal Code 1860, s 479.
[21] Indian Penal Code 1860, s 120(b).

[22] Snigdha Poonam and Leena Dhankhar, 'A multi-million insurance fraud that preyed on disease, poverty, desperation' (*Hindustan Times*, 31 December 2019) <https://www.hindustantimes.com/india-news/haryana-scam-cashes-in-on-the-terminally-ill/story-Nr5HHN4jsWC5gUwA6sqGMK.html> accessed 9 October 2023.

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- Suspicion arose due to repetitive and excessive claims linked to disease, poverty, and desperation.

Ongoing Investigation: Following the discovery of the fraudulent scheme, an extensive investigation was launched by law enforcement agencies of Haryana which is Special Task Force (STF) of Haryana Police, operated from Panchkula and insurance investigators. The investigation aims to uncover the full extent of the fraud, identify all individuals involved in the criminal operation, and gather evidence to bring them to justice. At least 100 people have been accused of being complicit in the scam which was carried for almost a time span of 2 years, which case execution of nearly 100 similar cases and cheating done with more than 25 insurance companies of over Rs. 100 Crore. This includes scrutinizing insurance records, medical documents, and financial transactions linked to the case.

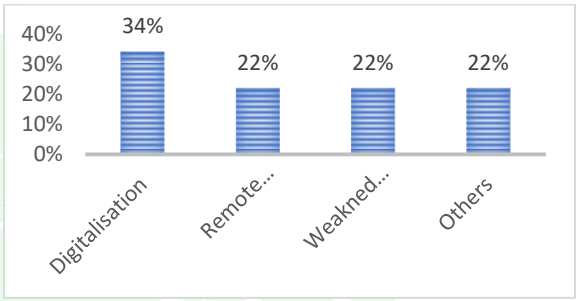
Arrests Made: Several arrests have been made in connection with this case starting from April 2019 till April 2023. The arrested individuals likely include members of the criminal gang responsible for orchestrating the fraud, forgery as well as destruction of evidence. STF Haryana arrested the mastermind, and his 2 close aids from Sonipat. These arrests mark an important step in dismantling the operation and holding those responsible accountable for their actions. The investigation is ongoing, and more arrests may occur as additional evidence is gathered[23].

Overall, this case highlights the importance of ethical conduct and vigilance within the insurance industry and serves as a reminder of the vulnerabilities faced by individuals in desperate circumstances. It also underscores the commitment of law enforcement and insurance authorities to bring those responsible for the fraud to justice.

[23] Snigdha Poonam and Leena Dhankhar, 'How a Haryana gang used cancer & poverty to 'steal' crores of rupees from insurance firms' (*The Print*, 15 May 2019) <https://theprint.in/india/a-multi-crore-insurance-fraud-that-fed-on-poor-cancer-patients-in-haryana/235771/> accessed 9 October 2023.

V. REASONS ATTRIBUTED FOR SUCH INSURANCE FRAUD

After the comprehensive study and examination of above mentioned case studies and also keeping into consideration the Deloitte's survey on Insurance Fraud 2023, the approximate reasons can be deciphered as follows:



- **Increase in Digitalization –**

The increase in digitalization in India has undoubtedly brought about numerous benefits, such as greater convenience and accessibility to financial services. However, it has also created new avenues for insurance fraud. As more insurance transactions and claims processes have moved online, fraudsters have adapted to exploit vulnerabilities in these digital systems. One of the primary ways digitalization contributes to insurance fraud is through identity theft and fake documentation. With personal information readily available online, criminals can easily impersonate policyholders, submit false claims, or create fictitious policies. Moreover, the automation of claims processing can make it challenging to detect irregularities, as fraudulent claims may appear genuine at first glance. As it was seen in the case no. 2, that fraudsters generated fake aadhar cards and used e-aadhar authorization to fake identity. In case no. 3 also, the fraudster defrauded the insurance amount of Rs. 2.24 crores by using fake identity as IGMS employee. Additionally, the prevalence of online communication and transactions has enabled fraudsters to use phishing attacks and social engineering to manipulate policyholders into revealing sensitive information. To combat this rise in digital insurance fraud, insurers need to invest in advanced fraud detection technologies and employ stringent verification processes while

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also educating customers about the risks associated with sharing personal information online.

- **Remote Working –**

The concept of remote working is made possible only by way of increased digitalization and technological advancement. However the concept gets separated as there is involvement of physical movement in order to commit fraud. Remote working has significantly aided insurance fraud in India by creating a more conducive environment for fraudulent activities. The shift to remote work has led to increased reliance on digital platforms and communication tools, making it easier for fraudsters to manipulate and exploit vulnerabilities in insurance processes. For instance, remote work has led to a surge in health insurance fraud[24], where individuals submit fake medical bills or false claims for treatments that never occurred. With less oversight and in-person verification, it becomes challenging for insurance companies to detect these fraudulent activities. Additionally, the lack of physical presence in the office has given rise to identity theft and document forgery, as criminals can easily obtain and manipulate personal information online. Furthermore, remote working can also blur the lines between personal and professional activities, making it more challenging for insurers to distinguish between legitimate and fraudulent claims. To combat the rise of insurance fraud in the era of remote work, insurers must implement robust digital verification processes, invest in fraud detection technology, and provide training to their employees to remain vigilant and adapt to these evolving threats.

- **Weakened controls –**

Weakened controls refer to lack of strict, stringent and up-to-date penal provisions to prevent, control and combat the problem. The lack of proper legislation and weakened controls in India have had a significant impact on the increase in insurance fraud cases. Insufficient and outdated legal frameworks create loopholes that fraudsters can exploit with relative ease. In many cases, there is a lack of specific regulations and penalties related to insurance fraud, which leads to a perception of low risk among potential fraudsters. Without stringent legal consequences, fraudsters are emboldened to engage in fraudulent activities such as submitting fake claims, staging accidents, or misrepresenting information on insurance applications.

Moreover, the absence of robust regulatory oversight and enforcement mechanisms allows unscrupulous individuals and organized groups to operate with impunity. Inadequate supervision of insurance companies and intermediaries can result in lax compliance and internal controls, making it easier for fraudulent practices to go undetected. This lack of oversight can also hinder the industry's ability to invest in advanced fraud detection technologies and training programs for employees.

To address this issue and curb the rise of insurance fraud in India, there is a pressing need for comprehensive and up-to-date legislation that defines various forms of insurance fraud and prescribes strict penalties for offenders. Additionally, regulatory bodies should be empowered with the authority and resources to monitor and enforce compliance within the insurance sector. Strengthened legal controls and effective enforcement will serve as a deterrent and contribute to a more transparent and trustworthy insurance industry in India, ultimately benefiting both insurers and policyholders.

VI. AUTHORS CONTENTION: THE NEED FOR INSURANCE FRAUD CONTROL ACT FOR INDIA

It is important to note that India's 1938 Insurance Act does not even define the phrase "insurance fraud." The generalization drawn from

[24] Xiaoqian Zhu and others, 'Intelligent financial fraud detection practices in post-pandemic era' [2021] 2(4) The Innovation <https://doi.org/10.1016/j.xinn.2021.100176> accessed 9 October 2023.

INDIAN JOURNAL OF LEGAL REVIEW [IJLR – IF SCORE – 7.58]

VOLUME 4 AND ISSUE 2 OF 2024

APIS – 3920 - 0001 *(and)* ISSN - 2583-2344

Published by

Institute of Legal Education

https://iledu.in

examining the aforementioned case studies demonstrates that there has been a notable rise in the motivations of con artists when committing scams that result in insurance fraud, and trends show that this is due to the absence of strict and effective penal mechanisms. The pattern of such fraud cases also points towards an increase in the amounts of fraud committed, whether measured year by year or decade wise. Our legal system has laws that deal with things like forgery, fraudulent acts, and cheating, etc., like the Indian Penal Code, 1860. But none of these rules are really focused on reducing insurance fraud, and they are ineffective at acting as a disincentive to slow down the spread of the same.

Though their exists the Insurance Regulatory and Development Authority (IRDA) which has been taking steps to address the fraud risks being faced by the insurance industry[25] but the pattern exhibited by study of above mentioned recent cases of insurance shows that IDRA had a played a very least to no role in such cases, these recent cases also point out to the declining efficiency of IDRA in fulfilling its objective. Furthermore, as IDRA requires every insurance company to put up and maintain a Fraud Monitoring Network. Such a network's structure must include procedures to minimize, detect, prevent, and safeguard insurance company workers, intermediaries, and policyholders against fraud threats. And such policies are ineffective unless there are adequate criminal consequences for persons who break the former. And such prosecution can only be sanctioned by a statutory body, which in this case is a prospective Insurance Fraud Control Act[26].

Taking an international look denotes that the requirement of such specific statutory enactment was felt by other nations too. Taking an example of Canada, the Insurance Crime Prevention Bureau was formed in 1973 to fight insurance frauds, collect information on insurance frauds and carry out investigations.

Insurance fraud is a felony in the United Kingdom, according to the Fraud Act of 2006. In the United Kingdom, the Insurance Fraud Bureau focuses on discovering and combating organised and cross-industry insurance fraud.

In Denmark, the Danish pensions and insurance association, Forsikring & Pension (F&P), runs exercises at the Danish Police Academy on how to prevent insurance fraud.

Due to the growing backlog of ongoing judicial cases in our courts, initiating legal action against insurance frauds is uncommon, and frauds of small enough sums are dismissed rather than investing time and energy in pursuing them.

As India's insurance market grows, insurers and business executives will be concerned about fraud risk management. To control and limit the risk of fraud, insurers will need to constantly examine their procedures and policies.

Insurance fraud is a huge problem that affects the lives of innocent people, both directly via unintentional or purposeful injury or damage and indirectly by causing insurance premiums to grow year after year. Even Head-Fraud Control of a leading life insurance company in India also points out "Neither do we have any specific laws connected to insurance frauds which are spelled out in the Indian Penal Code, 1860. The Indian Contract Act, 1872 also does not have any specific laws pertaining to insurance frauds. Even though the sections related to forgery or fraudulent acts can be applied in the IPC, it does not succeed in deterring the commission of insurance frauds[27]."

[25] Deloitte, Insurance Fraud Framework, (Deloitte, July 2013) <https://www2.deloitte.com/content/dam/Deloitte/in/Documents/financial-services/in-fs-insurance-fraud-framework-noexp.pdf> accessed 9 October 2023.

[26] Abhijith Christopher and Aditi Dubey, 'The Exigency for An Insurance Frauds Control Act in India: Challenges to Be Addressed' [2020] 10(1) Nirma University Law Journal.

[27] *Ibid.*