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Addressing insurance fraud: Aviva's response and industry-wide implications

01 May 2025 Felicity Pallas

On 8 April 2025 Aviva published a report detailing a 14% increase in the number of claims declined due to fraud in 2024.

The insurer identified over 12,700 suspect claims valued at £127 million and flagged more than 98,000 fraudulent insurance applications. Additionally, Aviva is currently investigating another 14,600 claims for suspected fraud.

Key insights from the report include:

- **Motor claims fraud:** This category represents 75% of all fraudulent activities, with a notable shift from crash-for-cash schemes to exaggerated injury claims and inflated repair and credit hire costs.
- **Spoof ads:** There are ongoing issues with misleading advertisements from claims and accident management companies that inflate costs and complicate the claims process.
- **Liability and household fraud:** Public liability fraud saw a 12% increase, while household insurance fraud now represents one in ten detected cases, often involving inflated or fabricated claims for items such as mobile phones and laptops.
- **Commercial insurance fraud:** There has been a significant increase in fraudulent property claims (up 89%) and commercial motor fraud (up 14%), primarily driven by exaggerated costs.
- **Application fraud and ghost broking:** The incidence of these frauds has nearly doubled, with a marked rise in ghost-brokered policies and ongoing investigations into ghost broking.

To combat this rise in insurance fraud, Aviva continues to invest heavily in analytics, machine learning and staff training. The company also collaborates with the Insurance Fraud Enforcement Department and employs legal measures, such as Serious Crime Prevention Orders to tackle fraud. Aviva has also restated its commitment to settling legitimate claims swiftly and safeguarding customers from the adverse effects of insurance fraud.

What does this mean for insurers?

The surge in insurance fraud, as detailed by Aviva, underscores the pressing challenges facing insurers, highlighting the essential need for more sophisticated fraud detection systems and substantial investments in cutting-edge technologies such as analytics and machine learning. These technologies can help with the detection and prevention of fraudulent activities. In this context, many insurers are investing in AI technologies to assist in identifying and mitigating fraudulent patterns and behaviours. This is particularly important in the fight against fraud, as fraudsters are themselves increasingly using AI to facilitate the creation of fraudulent claims, as discussed in our previous article (AI is creating fraudulent claims).

However, AI is not the only solution. Insurers are also advised to prioritise continuous training and development for their staff. This commitment is vital to equip employees with the necessary skills to identify and combat fraud effectively. Claims investigators need to be proficient in using the latest technological tools and analytical techniques, which are critical in detecting fraudulent claims.

Maintaining customer trust and confidence is paramount. Insurers must meticulously balance robust fraud prevention measures with the efficient and fair handling of legitimate claims. This balance is crucial to prevent alienating honest customers, ensuring they feel valued and fairly treated, which in turn fosters long-term customer loyalty.

Overall, the increase in fraudulent claims and applications necessitates a proactive and dynamic approach from insurers. It is imperative insurers protect their interests and those of their honest customers by staying ahead of fraudsters through continuous innovation in fraud detection and prevention strategies. This proactive stance not only safeguards insurers' assets, but also upholds the integrity of the insurance industry, ensuring its sustainability and trustworthiness in the eyes of consumers. This comprehensive approach will be instrumental in navigating the evolving landscape of insurance fraud.

Previous

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Next

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Contents

Author

Felicity Pallas

Paralegal

felicity.pallas@brownejacobson.com

+44 (0)330 045 1173

Tim Johnson

Partner

tim.johnson@brownejacobson.com

+44 (0)115 976 6557

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