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Who pays the bill for sharply increasing insurance fraud? You

Insurance fraud is increasing sharply and South African consumers are footing the bill.

In 2023 alone, South African life insurers and investment companies detected 13 074 cases of fraud and dishonesty, a staggering 46% increase from the previous year's 8 931 cases.

Losses linked to these activities jumped by 128%, increasing from R77.2 million in 2022 to R175.9 million in 2023, according to the Association for Savings and Investment South Africa.

Liezel van der Schyff, manager of the private division at GIB Insurance, says this increase is not just due to more people trying their luck.

"We are seeing a definite shift in how fraud is perpetrated. It is more organised, more deliberate and often coordinated," she says.

"It is no longer just individuals inflating a claim. There are syndicates, fake brokers and even inside help in some cases."

From seemingly harmless exaggerations to fully fabricated claims, the spectrum of insurance fraud is wide and damaging.

Van der Schyff says a growing trend involves customers manipulating electronic device claims, often with help from repair shops or friendly IT contacts.

"For example, clients will claim their phones or laptops are irreparably damaged, supported by a manufactured damage report, to secure a brand-new replacement. If the device is discontinued, insurers are often forced to replace it with the closest equivalent – usually a better, newer model."

Other common claims include lightning or power surge damage to electronics and roof leak claims, where many are maintenance-related and excluded from insurance policies.

To counter these tactics, insurers rely more heavily on technology to vet claims, including requiring proof like IMEI numbers and blacklist references for mobile phones, or deploying assessors to physically inspect damage before approving payouts.

Van der Schyff says fraudulent claims like these also have a ripple effect on the entire pool of policyholders, where insurers are forced to increase premiums across categories that are considered high risk, including jewellery, electronics and portable tech.

Insurers are tackling these challenges by increasingly implementing fraud prevention strategies that leverage technology such as predictive analytics and AI-powered systems that flag inconsistencies across multiple data points, making it harder for fraudulent claims to slip through.

Van der Schyff says insurers are also working together towards the common goal of stamping out fraud by sharing data to identify repeat offenders and syndicate activity, while internal forensic departments conduct investigations, sometimes even scanning social media to verify the details of a claim.

"If fraud is detected, the consequences are serious. The policy would be cancelled and the client is flagged across insurance industry records. If they try to take out a new policy elsewhere, they are legally required to disclose this history and many insurers will decline to cover them," she says.

What can you do as a policy holder? Van der Schyff says for consumers who try to stay on the right side of the claims process, the rules are simple: be honest, submit accurate information and notify your insurer of any material changes to your risk profile.