DEALING WITH INSURANCE FRAUD BY IMPLEMENTING TAKAFUL

Firdavs Uktamov
Student of International Islamic Academy of Uzbekistan
firdavsuktamov36@gmail.com

Abstract: *This article explores the best way to settle claims in liability insurance when claimants can falsify claims to misrepresent their losses. In such cases, linking insurance payouts to the claimed losses is more effective than relying on claims auditing, which does not prevent fraud. The article focuses on insurance fraud, starting with an overview of different types of insurance and their evolution. It then examines the nature and scale of insurance fraud, the challenges in controlling it, and proposes an alternative insurance method to tackle these issues.*

Key words. *insurance, takaful, fraud, moral hazard, insurance firms, risk, tabarru', ta'awun, insurance reserves, insurance policies.*

Introduction

The growing prevalence of insurance fraud presents significant challenges to the global financial sector, necessitating innovative solutions to mitigate its impact. This article explores the implementation of Takaful, an Islamic insurance system, as a viable alternative to traditional insurance frameworks. Rooted in principles of mutual cooperation and shared responsibility, Takaful circumvents issues associated with riba (interest), al-maisir (gambling), and al-gharar (uncertainty) that are often criticized in conventional insurance models. By addressing fraud and moral hazards through collective risk-sharing and transparent operations, Takaful offers a practical solution to the ethical and structural shortcomings in the insurance industry. The discussion highlights its historical development, operational mechanisms, and potential for addressing systemic abuse. This study emphasizes the critical role of Sharia-compliant

insurance in fostering financial equity and resilience, particularly in regions grappling with fraudulent practices in insurance systems.

Main part

The concept of insurance is not new. According to written documents, the first pure insurance contract was signed in 1347 for a pool backed by pledges on landed estates in Genoa, Italy. Insurance has changed since then. These days, they are found in many areas of economics, including the socioeconomic sector (such as unemployment insurance), the financial market (such as options and derivatives), and the health sector (such as life and health insurance, often known as health plans). The distinctive dynamic of insurance is what makes it so fascinating. The only product that a customer purchases but is unsure of using is insurance; in fact, it is likely that he will never use it. Given that insurance is both a crucial and transformative product and a financially unusual instrument, it would be interesting to learn more about its features. There are several meanings associated with the term insurance. First of all, it refers to insurance organizations, which come in a wide range of forms, organizational structures, and goals. These include mutualist societies, social security programs, and private businesses. These organizations can be divided into groups according to whether they provide coverage for people or property, whether they use a mutualist or premium-based system, or whether they have public vs private objectives. Every organization has a unique mission, clientele, and legal underpinnings. A crucial question is brought up by this diversity: why are such disparate activity categorized under one term? What ties them together? Additionally, the word “insurance” denotes a fundamental element that unites these disparate organizations.

Insurance refers to an abstract technology - a methodical approach to risk management - that extends beyond the enterprises themselves. Based on the terminology of economists and actuaries from the 19th century, this technology can be characterized as an “art of combinations”. Insurance is a tool for constructing different arrangements suited to particular purposes and objectives rather than a single combination. It creates various kinds of institutions by

integrating aspects of social and economic realities while adhering to certain regulations. In a third sense, the interaction between the institutions that are based on the abstract technology is reflected in insurance. Contrary to popular belief, not all insurance companies are simply variations on the same model. There are major differences between organizations such as social insurance, terrestrial insurance, and marine insurance. They are different uses of risk technology that are influenced by certain political, social, and economic circumstances. The cultural and societal framework that dictates how insurance technology is used and valued is known as the “insurance imaginary”, and it is responsible for the diversity in how insurance manifests itself. For instance, a new political and social imagination that viewed insurance as crucial for mitigating communal risks propelled the development of social insurance in the late 19th century. The goal of sociologists, historians, and analysts is to comprehend why insurance companies use risk technology in specific ways and adopt particular forms at particular times. These shapes offer both limitations and chances for innovation, reflecting the larger socioeconomic circumstances that give rise to markets for security. Instead of being a set formula, insurance technology developed over time as a result of real-world uses. It was influenced by preexisting behaviors, which it then justified. The practice of insurance continuously modifies its methods to accommodate new realities as the political, moral, and economic landscapes change. The idea of risk is fundamental to the insurance concept. In this sense, risk is a way of assessing and controlling occurrences that could have an impact on a population or group of assets, it is not the same as danger or peril. Risk is a framework for comprehending and classifying possible threats rather than an intrinsic reality. Insurance uses a reasonable framework to classify events as "accidents" and calculate the likelihood of losses or damages. This method, which is similar to the reasoning behind a game of chance, transforms chance into measurable hazards, turning gaming into a metaphor for the world's unpredictable nature. As a risk technology, insurance essentially turns chance and randomness into organized mechanisms for dealing with uncertainties, influencing how

society minimizes and controls possible losses. Risk management is at the heart of the insurance industry. Actuarial analysis is carried out to better understand the statistical likelihood of specific outcomes, and all written regulations are examined with a variety of risks in mind. Benefits are reassessed or policyholder premiums are modified in response to discrepancies between statistical data and projections. In the insurance industry, premium levels are often determined by the risk involved with the insured person, property, or thing. Insurance firms occasionally collaborate with banks to promote their goods to the bank's clientele. This practice, known as “bancassurance” is more common in Europe, but is finding a foothold in the United States.

In essence, this mechanism indicates that the cost of capital for insurance businesses is positive. This sets them apart from mutual funds, banks, and private equity funds. This implies the possibility of more steady, lower-risk profits for stock insurance company investors (or mutual company policyholders). The sector's main product is insurance plans. However, annuities for retirees and a variety of corporate pension programs for employers have emerged in recent decades. Because of this, insurance companies are directly competing with other providers of financial assets for these kinds of products. These days, a lot of insurance companies have their own broker-dealer, either directly or through a partnership. Not every insurance provider serves the same clientele or provides the same goods. Financial guarantors, property and casualty insurers, and accident and health insurers are some of the biggest types of insurance firms. Auto, health, homeowners, and life insurance are the most popular categories of personal insurance plans. Most individuals in the Uzbekistan have at least one of these types of insurance, and car insurance is required by law as well as here in Uzbekistan.

Accident and health companies are probably the most well-known. These include companies such as United Health Group, Anthem, Aetna and AFLAC, which are designed to help people who have been physically harmed. Life insurance companies mainly issue policies that pay a death benefit as a lump sum

upon the death of the insured to their beneficiaries. Life insurance policies may be sold as term life, which is less expensive and expires at the end of the term or permanent (typically whole life or universal life), which is more expensive but lasts a lifetime and carries a cash accumulation component. Life insurers may also sell long-term disability policies that replace the insured's income if they become sick or disabled. Well-known life insurers include Northwestern Mutual, Guardian, Prudential, and William Penn.

Property and casualty companies insure against accidents of non-physical harm. This can include lawsuits, damage to personal assets, car crashes and more. Large property and casualty insurers include State Farm, Nationwide and Allstate.

Businesses require special types of insurance policies that insure against specific types of risks faced by a particular business. A fast-food restaurant, for instance, need a coverage that covers harm or damage brought on by using a deep fryer for cooking. Although they are not exposed to this kind of danger, vehicle dealers nevertheless need insurance against potential harm or damage sustained during test drives. Depending on their ownership structure, insurance companies are categorized as either stock or mutual. Additionally, there are some exceptions, including fraternal organizations and Blue Cross Blue Shield, which have a different organizational structure. Nonetheless, the most common forms of insurance company organization are stock and mutual corporations. A corporation owned by its shareholders or stockholders; a stock insurance company’s goal is to turn a profit for them. Policyholders are not actively involved in the company's gains or losses. Before being approved by state regulators, an insurer must have a certain amount of capital and surplus on hand in order to function as a stock corporation. If the company’s stock is listed on a public exchange, further conditions must be fulfilled. Some well-known American stock insurers include Allstate, MetLife, and Prudential.

A mutual insurance company is a corporation owned exclusively by the policyholders who are "contractual creditors" with a right to vote on the board of directors. Generally, companies are managed and assets (insurance reserves,

surplus, contingency funds, dividends) are held for the benefit and protection of the policyholders and their beneficiaries. Management and the board of directors determine what amount of operating income is paid out each year as a dividend to the policyholders. While not guaranteed, there are companies that have paid a dividend every year, even in difficult economic times. Large mutual insurers in the Uzbekistan Uzbekinvest, Gross Insurance, Kapital Sugurta and Uzagrosugurta. Most of insurance companies were able to achieve significant positive results in terms of insurance premiums volume in 2017. Positive results in terms of insurance premiums volume were achieved by 23 of 27 companies. According to the information of the Ministry of Finance of the Republic of Uzbekistan, there was a change in the list of the first three leaders of the market under the results of 2017.

Gross Insurance LLC became one of the three leaders instead of Kafolat Insurance Company JSC. As a result, Uzagrosugurta JSC (14.5%) and Uzbekinvest NKEIS (14.1%) took the first and second positions in the market. The third position was taken by Gross Insurance LLC with a market share of 8.8%. The fourth and fifth positions were taken by Kafolat Insurance Company JSC (8.7%) and O'zbekinvest Hayot LLC (6.8%). The last company of the Top-10 leaders in terms of insurance premiums collected is Euroasia Insuranc IC JV LLC with a market share of 3.3%.

Even though we did have experienced growth, insurance fraud is a major problem in the world at the beginning of the 21st century. It has undoubtedly existed everywhere insurance policies are made, taking on various shapes according to the available coverage and economic time. People and organizations have always been able and willing to submit false claims, from the introduction of "railway spine" in the 19th century to "trip and falls" and "whiplash" in the 20th century. The word "fraud" implies that the behavior is unlawful, with penalties and punishment as possible repercussions. The reality of contemporary debate is a far broader definition of fraud, encompassing several undesired, opportunistic, and needless systemic manipulations that do not qualify as criminal activity.

Legislative reformers or civil adjudicators could be more equipped for those. Developing a system that effectively classifies claims into groups that necessitate the purchase of extra data is the main challenge facing insurers dealing with fraud and systemic abuse. The Journal of Risk and Insurance's five papers in this issue contribute to our understanding in a number of ways. Statistical models are used to measure, detect, and discourage fraud, intelligent technologies are applied to informative databases to facilitate efficient claim sorting, and strategic analysis is applied to health insurance and property-liability scenarios.

Ex-ante and expost moral hazard are the two types of moral hazard dilemmas. The distinction has to do with the time at which people act - either before or after the state of the world. Moral hazard occurs when insured persons act riskier just because they are covered. Additionally, deceptions or deliberate acts are linked to a moral hazard mindset. There is a vast amount of literature on this subject. An entire survey could be written on this subject. The principal-agent problem is introduced by Shavell (1979). When an agent does something that affects both the principal and himself, but the principle is unable to see what the agent is doing, this is known as a principal-agent issue. Insurance policies, in which insurers are the principal and insured the agents, are comparable to this scenario. In another study, Shavell (1979) offered a mode in which the insurer does not know the activities of individuals and the probabilities of the world's states depend on individual effort. In this case, partial coverage still holds to be optimal, but it varies as effort varies. The amount of effort is negatively related to partial coverage and if an individual care a lot, which means the cost of care for him is low, partial coverage is desirable. Shavell also showed that moral hazard doesn't completely eliminate insurance benefits – if an appropriate pricing rule is implemented – and that if insurer can partially know insured actions, moral hazard is reduced – as intuitively is understandable since information asymmetry is lower. Moral hazard was examined using a principal-agent problem framework by Grossman and Hart (1983). Authors have typically tackled this challenge by increasing the utility of the principal while limiting the agent's utility to a

particular, minimal level [see Shavell (1979)]. Since agents are the ones who act, it makes sense that they would consider his "first order" preferences. Instead of employing this strategy, Grossman and Hart (1983) employed a cost vs benefits analysis. Both costs and benefits are incurred by the primary as a result of the agent's action. As a result, he does not need to select the agent "first order." The findings indicate that maintaining a negative relationship between the principal and agent payoffs across the whole outcome range is never the best course of action for an incentive scheme. Additionally, criteria were discovered for a monotonic incentive scheme function. Ex-post moral hazard was initially studied by Spence and Zeckhauser (1971). The authors of the research suggested that an optimal contract depends on the principal's ability to observe the state of nature and the accident's nature, rather than knowing the accident's nature as happens in ex-ante moral hazard. Selecting the best contract will be a second-best activity when the principle has limited monitoring capacity, as demonstrated in one of the scenarios he presents. Frauds are another kind of ex-post moral hazard, as demonstrated by Derrig (2002). Provable beyond a reasonable doubt, fraud is defined by the author as "the deliberate act of obtaining money or value from an insurer under false pretenses or material misrepresentations". In the literature, fraud costs related to the insurer obtaining more information were described as expensive state verification by Bond and Crocker (1997). One illustration of that is the auditing process used by insurance firms. Costly state fabrication is another expense associated with fraud, as demonstrated by Picard (2013). This expense is related to insured charges in order to keep the insurer from realizing that the claim is fraudulent. One instance of that is collusion strategies. Picard (2013) offers intriguing findings. He first demonstrates how fraud affects the creation of ideal contracts. A deductibles contract may be the best option in some circumstances because it lowers audit expenses. Coinsurance contracts of some kind may also be the best option since they lessen the incentives for fraud. Second, insurer collaboration will prevent false claims. For instance, shared databases and common agencies assist insurance companies in reducing the risk of adverse

selection. Additionally, because their incentives are matched, contractual connections between insurers and third parties prevent collusion. Brokers are dissuaded from engaging in collusions if sales commission is tied to a loss-premium ratio.

Making money can be done in a variety of ways, such as investing in business concepts or saving money. Although it is possible to decide where to invest, some investors are not given this option because all of the work is done for them by qualified specialists. Investing effectively is impossible for anyone who is not an expert in the stock market. They invest whatever he can get his hands on because of this. For this reason, they invest their money in observable items and purchase everything. They also purchase stock in low-profit businesses in the new economy, which are currently making little money but are expected to generate significant profits in the future. Regardless, the majority of buyers deal with paper and figures rather than actual organizations. It is a common misperception that everyone may profit from crises and tragedies, with the exception of insurers. When there has been no occurrence, their revenue is regarded as gained. This does appear to be correct at first glance. because we frequently hear about insurance firms going bankrupt because of a catastrophe or disaster. First to advocate for stability are insurance firms! However, this is just as dumb as claiming that there is nothing for the police to gain from criminal activity. The more crimes committed, the more powerful, experienced, and other advantages the systems have. There wouldn't be an insurance industry if there were no unplanned catastrophes, floods, fires, or accidental deaths. Insurance firms already know how to handle payment and insurance-related problems, including when and where to begin. People who are obviously at risk or who seem to be at risk are not covered by their insurance. Even if it does, the cost of the insurance is really minimal. They “collect money from the public” in a manner similar to banks. This is the only place where the bank depositor wants to use riba to expand his funds. Additionally, the insurance provider makes threats about what you might lose. Essentially, you give them your money to spend, and they use it to fund other

ventures. Some insurance firms somehow go bankrupt after waiting for a calamity to occur. In reality, he starts paying the requisite sum of money without offering any justifications. It covers the owners' or their representatives' assets if sufficient funds are raised. They give the money they have collected from people to just one client, after which they declare themselves a bankrupt business. With that money, another pyramid of this type may be built.

Tragedies and accidents raise the topic of safety on the agenda. Advertising is not necessary. This "advertisement" is very successful despite being free. It never shows up in ad blocks but rather in texts. Given the prevalence of insurance industry scams, using an alternative is required.

An insurance program that conforms to Islamic law is called takaful is the best way to solve this problem. Health, life, and general insurance needs are covered by takaful policies. Members invest money in a pool system to insure one another against loss or harm in takaful, a form of Islamic insurance. The foundation of takaful-branded insurance is sharia, or Islamic religious law, which outlines how people have an obligation to work together and defend one another.

Since commercial insurance firms are thought to violate Islamic prohibitions on riba (interest), al-maisir (gambling), and al-gharar (uncertainty) principles - all of which are prohibited by sharia - takaful insurance businesses were established as an alternative. In a takaful arrangement, all policyholders or parties commit to guaranteeing one another and contribute to a mutual fund or pool in lieu of paying premiums. The takaful fund is created from the pool of contributions that have been gathered. The amount contributed by each participant is determined by their individual situation and the kind of coverage they need. Like a traditional insurance policy, a takaful contract outlines the type of risk and the duration of coverage. A takaful operator oversees the management and administration of the takaful fund on behalf of the participants, charging a predetermined fee to cover expenses. Costs include underwriting, claims handling, and sales and marketing, much like with a traditional insurance firm.

The concept of takaful or Islamic insurance was first introduced in Sudan in 1979, inspired by the growing needs of the Muslim consumers for an insurance protection that conforms to the Islamic law. Takaful is a system of Islamic insurance based on the principle of mutual cooperation (ta'awun) and donation (tabarru'), where the risk is shared collectively and voluntarily by the group of participants. It is derived from an Arabic word meaning 'joint guarantee' or 'guaranteeing each other' (Mahmood, 2008). It is an arrangement by a group of people with common interests to guarantee or protect each other from certain defined misfortunes such as premature death, disability and property damages (Obaidulllah, 2005). Under takaful schemes, participants mutually agree to guarantee and to protect each other against a defined loss or damage, by jointly providing financial assistance to any members suffering from a loss. Such financial assistance is made possible through the creation of a common pool contributed out of the participants' resources as donations. As a concept, insurance does not contradict the Islamic principles since it is essentially a system of mutual help. However, the operation of conventional insurance involves the elements of uncertainty (gharar) and gambling (maysir) in the contract of insurance, and usury (riba) in its investment activities, which do not conform to the requirements of Shariah. Gharar, may exist with regard to the scope of coverage, terms of the contract and source of the claim payments. Maysir, may arise from any speculative element present in a contract, such as an unequal exchange of the amount of money. Riba, or excessive profit, may arise from financial interest received from the investment of funds collected from the participants. Avoidance of these elements is essential in an insurance system acceptable by the Syariah, and this is where takaful differs with the conventional insurance. Takaful arrangement embraces the elements of mutual cooperation, shared responsibility, mutual protection, and joint indemnity (Central Bank of Malaysia, Takaful Industry Review, 2005). The majority viewpoint by many contemporary Islamic jurists and scholars is that, for an insurance system to be acceptable by Islamic tenets, it must be founded on the principles of mutual cooperation tabarru'

(donation). These are the essence of an Islamic insurance, which embraces the elements of mutual guarantee, mutual protection and shared responsibility. Tabarru' means donation, gifts or contribution. Participants in a takaful scheme mutually agree to relinquish as donation, a certain proportion of their contributions, into a takaful fund, to provide financial assistance to any members of the group suffering from a loss. Under takaful contracts, each participant contributes a certain proportion of the full amount of his contribution as tabarru'. The donations from all participants are accumulated into a common fund called tabarru' fund or risk fund, from which compensation or indemnification is paid to participants suffering a defined loss (Obaidullah, 2005). Takaful is also built on the principle of mutual cooperation where each participant participates in each other's loss, while takaful operator facilitates this cooperation using its expertise (Jching, 2008). The participants assume all the risk involved in the operation of takaful business. If the operation results in surplus, they would be entitled to the whole sum, or to a certain preagreed percentage (depending on the takaful model adopted). If the fund is insufficient, participants would not be asked to pay additional premium (Ahmad Nordin, 2007). Instead, takaful operator will provide interest-free loan, known as Qard Hassan, from the shareholders' fund, to meet the deficit. Essentially a cooperative risk-sharing plan, takaful system aims to provide insurance protection against risks such as premature death, illness, disability and property damages. It embraces the elements of mutual help, mutual protection and shared responsibility among participants, bolstered by the principle of tabarru'. Takaful is a type of joint-guaranteed insurance mechanism, based on the law of large number, in which members pool their financial resources together against certain loss exposures (Maysami and Kwon, 1999).

Conclusion

Members' claims are paid from the takaful fund, and any money left over after accounting for potential future claim costs and other reserves belongs to the fund's members rather than the takaful operator. The participants may get those money in the form of cash dividends or distributions, or they may receive a

decrease in their future contributions. Ultimately, the money you invested remains in your account, but traditional insurance uses it for their purposes, even though, insurance was developed in response to people's desire for security and stability and is a product that protects both individuals and businesses against specific unforeseen circumstances. Which means they are essentially allowed to use their customers' money to invest for themselves. As a result, they are comparable to banks, although investing takes place to a far higher degree. That is why implementing takaful insurance in those countries which are suffering from the scams are best option for countries.

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