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NEOPHODNOST BLIŽE MEĐUNARODNE SARADNJE RAZLIČITIH USTANOVA U BORBI PROTIV PREVARA U OSIGURANJU

STRUČNI RAD

Apstrakt

U ovom radu biće analizirano nekoliko primera prevara u domenu osiguranja života i osiguranja od nesrećnog slučaja (nezgode). Slučajevi koji su predmet članka prema ozbiljnosti počinjenog krivičnog dela mogu se svrstati u red „tvrdih prevara", a prema tipu izvora u „eksterne" prevare. Tok i epilog tih sudskih procesa pokazuje značaj što bliže koordinacije pravosudnih, policijskih i osiguravajućih ustanova, kao i sve zastupljeniji međunarodni predznak u prevarama u osiguranju, koji zahteva i jačanje prekogranične interinstitucionalne saradnje. Takođe, naročito zapaženu ulogu u razotkrivanju lažnih zahteva u osiguravajućoj delatnosti imaju i veštaci iz sve većeg broja disciplina, od medicine, preko mašinstva, do tehnoloških nauka. Njihove ekspertize mogu odlučujuće doprineti rasvetljavanju okolnosti svakog pojedinačnog slučaja. Primeri prikazani u ovom članku ilustruju da bliža saradnja između svih spomenutih aktera i upotreba naprednih metoda i tehnologija predstavljaju nezamenljiv alat u valjanoj i efikasnijoj borbi protiv prevara u domenu osiguranja.

Ključne reči: *prevare u osiguranju, lažni odštetni zahtev, osiguranje života, međunarodna saradnja*

I. Uvod

Prevare u osiguranju zastupljene su u svim oblastima koje pokriva ta delatnost; od saobraćajnih, preko zdravstvenih, do imovinskih i drugih (lažnih ili preuveličanih)

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odštetnih zahteva. Radi se o činu protivpravnog zahtevanja isplate od osiguravača na osnovu lažne tvrdnje po polisi osiguranja.[2] Prevare u osiguranju takođe se povezuju i sa situacijama poput davanja neistinitih ili nepotpunih informacija u prijavama za osiguranje ili osiguravajućim obrascima, kao i iznošenje zahteva o gubitku zasnovanog na neistinitim ili obmanjujućim okolnostima, uključujući i preterivanje u pogledu nastalog slučaja.[3] Kao još jedan od pojmova koji se blisko povezuje s tim fenomenom jeste moralni hazard, odnosno rizik da će se ponašanje osobe razlikovati u slučaju da ima ugovorenu polisu osiguranja u odnosu na situaciju kada je nema, što predstavlja izazov u svim domenima osiguravajuće delatnosti.[4] Taj fenomen biće bliže analiziran u okviru nekoliko slučajeva koji su predmet ovog članka.

Jedna od osnovnih klasifikacija prevara u osiguranju jeste podela na „tvrde prevare", koje se dešavaju kada se s predumišljajem planira ili izmišlja gubitak, i „meke prevare", koje se zasnivaju na legitimnim zahtevima, ali gde postoji element koristoljublja, npr. putem preuveličavanja nastale štete.[5] U slučaju iz slovenačke prakse radilo se o zahtevu za osiguranje od posledica nesrećnog slučaja (nezgode). Taj vid osiguranja može pokriti iznenadne događaje i okolnosti koji kao posledicu imaju smrt, potpuni, delimični, privremeni ili trajni invaliditet ili narušeno zdravlje koje zahteva lečenje.[6] U pomenutom slučaju radi se o zahtevu po osnovu nesrećnog slučaja koji je ishodovao određenim stepenom invaliditeta, a koji je doveden u pitanje na osnovu dokaza u vezi s nezgodom osiguranice. U ovom tekstu biće ukratko prikazan i predmet jednog američkog osiguranika, u čije je ime pokrenut zahtev za isplatu premije po osnovu smrtnog ishoda.

Pored podele na „tvrde" i „meke" prevare, koja se povezuje s ozbiljnošću slučaja, u upotrebi je i dodatna klasifikacija prema izvoru prevare – na interne tj. unutrašnje prevare, i na eksterne tj. prevare što dolaze spolja.[7] Interne prevare se kolokvijalno nazivaju i „insajderskim", i one se odnose na situacije kada zaposleni u osiguranju sarađuje s osiguranikom u cilju prikazivanja lažne ili preuveličane štete, a zarad ostvarivanja prava na osiguranu sumu.[8] S druge strane, eksterne prevare su one gde osiguranici ili neko treće lice zahteva naknadu štete koja je izmišljena ili preuveličana.[9] Dalje u tekstu biće prikazano nekoliko primera „tvrdih" prevara u osiguranju koje su eksternog karaktera.

[2] Slobodan Petrović, Milosav Stojanović, Prevare u osiguranju, *Tokovi osiguranja* br. 1/2012, str. 61.
[3] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 4.
[4] Đorđe Ćuzović, Prevare i moralni hazard u osiguranju, *Evropska revija za pravo osiguranja*, ISSN 2334-833X, 1/2020, p. 3.
[5] Slobodan Petrović, Milosav Stojanović, Prevare u osiguranju, *Tokovi osiguranja* br. 1/2012, str. 64.
[6] Kompanija „Dunav osiguranje", Osiguranje od posledica nesrećnog slučaja (nezgode), *https://www.dunav.com/proizvodi/nezgode/* , pristupljeno: 10. 9. 2020.
[7] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 5.
[8] Ibid.
[9] Ibid.

Prevara u osiguranju odnosi se na objekat ili subjekat osiguranja koji se s namerom uništava, oštećuje ili sakriva, u nastojanju da se naplati osigurana suma.[10] U domaćem, kao i u drugim evropskim zakonodavstvima, ta pojava klasifikuje se kao krivično delo, koje se manifestuje u dva oblika: sakrivanje, oštećenje ili uništenje osigurane stvari, s jedne strane, i samopovređivanje, telesno oštećenje i narušavanje zdravlja samom sebi.[11] Veoma značajnu ulogu u dokazivanju takvih zloupotreba imaju stručnjaci i profesionalci iz različitih oblasti, od onih u pravosuđu, preko policijskih službenika, do samih zaposlenih u delatnosti osiguranja, koji međusobno sarađuju u takvim situacijama. Takođe, u sve globalizovanijem svetu, postoji i sve snažnija potreba za bližom saradnjom institucija na međunarodnom nivou u suzbijanju takvih krivičnih dela. Slučajevi koji će biti analizirani predstavljaju primere bliske interinstitucionalne, ali i međudržavne saradnje, koji su doprineli rasvetljavanju okolnosti neophodnih za donošenje odgovarajućih odluka u vezi s osiguravajućim zahtevima. Osnovne informacije o slučajevima koji su predmet ovog teksta najvećim delom preuzete su iz inostranih medijskih tekstova koji su navedeni u spisku korišćene literature. Činjenica da su mediji prilično ažurno pratili te krivične procese predstavlja donekle povoljnu okolnost za osiguravače, imajući u vidu da je izveštavanje o slučajevima doprinelo upoznavanju i podizanju nivoa svesti javnosti o zloupotrebama u oblasti osiguravajuće delatnosti.

1. Zahtev za isplatu osigurane sume po osnovu nesrećnog slučaja

Dvadesetjednogodišnjakinja iz Ljubljane u januaru 2019. godine stigla je u bolnicu u pratnji nekoliko osoba. Povreda je bila ozbiljna: devojka je ostala bez leve šake tokom, kako je tvrdila, sečenja grana kružnom testerom (cirkularom) na svom imanju.[12] Već u bolnici uočena je činjenica da ni pacijentkinja ni njeni pratioci nisu sa sobom u bolnicu poneli odsečenu šaku ove dvadesetjednogodišnjakinje, kako bi doktori pokušali da je spasu, što je samo po sebi bilo donekle čudno.[13] Međutim, uprkos tome, uz inicijativu doktora, organizovano je dopremanje šake iz njenog doma kako bi bila blagovremeno prišivena.[14]

Uskoro je pokrenuta istraga oko ovog slučaja koja je, pored spomenute devojke, obuhvatila i njenog partnera, kao i njegove roditelje.[15] Policija je zvanično

[10] Joko Dragojlović, Krivično delo prevare u osiguranju, Kultura polisa, Novi Sad, str. 674.
[11] Ibid, 676.
[12] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 08. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* pristupljeno: 15. 9. 2020.
[13] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957*, pristupljeno: 16.9.2020.
[14] Ibid.
[15] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* pristupljeno: 15. 9. 2020.

podigla optužnicu protiv svih navedenih lica pod navodima da spomenuti slučaj nije predstavljao nesreću već unapred osmišljen akt u cilju naplate odštetnog zahteva od nekoliko osiguravajućih kuća.[16] U tom smislu, optužba je glasila da je odsečena šaka namerno ostavljena na mestu gde se situacija desila kako bi se uvećao stepen povrede i tako izazvao invaliditet.[17] U okviru procesa koji je započet 2019. godine, spomenuta lica sprovedena su u pritvor, a mediji su spekulisali da bi u slučaju presude protiv njih zatvorska kazna za takvo krivično delo mogla da iznosi i do osam godina.[18]

U toku 2020. godine počelo je i suđenje spomenutim licima, osumnjičenim za pokušaj prevare u osiguranju teške preko milion evra.[19] Naime, u toku suđenja izneti su dokazi da je u godini što je prethodila situaciji prvooptužena uz pomoć partnera ugovorila čak pet osiguravajućih polisa koje pokrivaju nesrećan slučaj u domenu životnog osiguranja.[20] Tužilac je izneo dokaze da je njen partner u danima pre nesreće preko interneta pretraživao različite modele protetičkih ruku, što je predstavljalo jedan od ključnih argumenata u dokazivanju namernog izazivanja nesreće.[21] Optužena je istrajala na tvrdnji da je do situacije došlo nesrećnim slučajem, dok je tužilaštvo ostalo pri oceni da se radilo o namernom pokušaju kako bi se naplatio visok novčani iznos od osiguravajućih kuća.[22] Takođe, optužba je glasila i da je devojka to uradila na nagovor partnera, u šta su bili uključeni i njegovi roditelji, te je sud odlučio da sva lica treba krivično goniti.[23]

Tužilac je naveo i da su mišljenja medicinskih i veštaka mašinske struke pokazala da se optužena povredila namerno, predloživši da ona bude osuđena na četiri godine i šest meseci zatvora, njen partner na pet godina zatvora, njegova majka na četiri godine, a njen suprug na godinu dana zatvora.[24] Slovenački sud složio se s navodima tužioca i presudio da su spomenuta lica odgovorna za krivično delo pokušaja prevare u osiguranju. Prvooptužena je odlukom suda osuđena na dve godine zatvora, njen partner na tri godine, dok je njegov otac osuđen na uslovnu kaznu od godinu dana.[25]

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[16] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957,* pristupljeno: 16.9.2020.

[17] Ibid.

[18] Ibid.

[19] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* pristupljeno: 15. 9. 2020.

[20] BBC News, Woman who sawed off own hand found guilty of fraud, 12. 9. 2020, *https://www.bbc.com/news/world-europe-54125770,* pristupljeno: 15. 9. 2020.

[21] Ibid.

[22] *Politika online*, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* pristupljeno: 15. 9. 2020.

[23] Ibid.

[24] Ibid.

[25] Russell Hope, Julija Adlesic: Woman who deliberately cut off own hand in insurance scam jailed for two years, SkyNews, 12.09.2020, *https://news.sky.com/story/julija-adlesic-woman-who-deliberately-cut-off-own-hand-in-insurance-scam-jailed-for-two-years-12069121,* pristupljeno: 15. 9. 2020.

Zanimljiv je i jedan primer iz holandske osiguravajuće prakse. Rudar, koji je posedovao polisu što se odnosila na zaštitu od onesposobljenosti na radu, morao je prestati da radi usled povrede ramena, koja je za njegovu vrstu posla predstavljala značajan problem.[26] Narednih šest godina osiguranik je primao mesečnu naknadu, sve dok osiguravajuća kuća nije dobila anonimnu dojavu da osiguranik (uprkos navodnoj onesposobljenosti za rad) ne samo da praktikuje surfovanje već je u toj disciplini i međunarodno poznat.[27] Pokrenuta je istraga, a osiguravajuća kuća došla je u posed fotografija koje pokazuju osiguranika kako surfuje pri snažnom vetru, što je bio jedan od ključnih osnova da odluku o isplati osigurane sume poništi, traži povraćaj novca i uvrsti ga u nacionalni registar prestupnika na polju prevara u osiguranju.[28]

2. Lažiranje smrtnog ishoda u kontekstu prevare u osiguranju

U ovom delu biće prikazana dva odvojena slučaja lažiranja smrti radi ostvarivanja prava na osiguranu sumu. Oba slučaja podrazumevala su prekogranične malverzacije koje su, zahvaljujući saradnji između institucija, razotkrivene, i tako se ispostavilo da se radi o neosnovanom i protivpravnom zahtevu prema osiguravačima.

Jedan moldavski građanin s prebivalištem u Sjedinjenim Američkim Državama krajem prve decenije XXI veka ugovorio je osiguranje života kod osiguravača „Mutual of Omaha Insurance Company" u američkoj saveznoj državi Minesota s pokrićem u vrednosti od dva miliona dolara, a kao prvog korisnika odredio je svoju suprugu.[29] U oktobru 2011. godine u unutrašnjosti Moldavije pronađeno je telo muškarca preminulog od srčanog udara, a lična dokumenta i uviđaji nadležnih ustanova upućivali su na to da se radi o osiguraniku.[30] Prema istrazi pravosudnih organa, njegova supruga narednog meseca podnela je zahtev za isplatu osigurane sume na osnovu smrti bračnog partnera, koja joj je u narednih nekoliko meseci uplaćena na bankovni račun u dvomilionskom dolarskom iznosu.

Saradnjom između Federalnog istražnog biroa i nacionalne poreske agencije u narednim godinama utvrđeno je da se radilo o lažnom zahtevu, pri čemu je otkriveno nekoliko ključnih činjenica. Naime, osiguranik nije preminuo već je pod drugim imenom godinama živeo u Pridnjestrovlju, otcepljenoj moldavskoj teritoriji.[31] Takođe, kako je istraga pokazala, finansijski prenosi uključivali su i transakcije njegove

[26] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p.10.
[27] Ibid.
[28] Ibid.
[29] United States Department of Justice, Moldovan National Sentenced To 41 Months In Prison For Faking His Death For $2 Million Insurance Payout, 29. 7. 2019, *https://www.justice.gov/usao-mn/pr/moldovan-national-sentenced-41-months-prison-faking-his-death-2-million-insurance-payout,* pristupljeno: 2. 9. 2020.
[30] Ibid.
[31] Ibid.

uže porodice prema bankama u Moldaviji, SAD i Švajcarskoj.[32] Pored toga, jedan od glavnih momenata u istrazi nastupio je 2013. godine, kada su prilikom pograničnih provera u kompjuteru osiguranikovog sina, koji se vraćao s putovanja iz Moldavije, pronađene skorašnje fotografije oca, iako je on navodno preminuo više godina ranije.

Poput slučaja iz Slovenije, i u ovom predmetu radi se o „tvrdoj prevari", koja je unapred i s predumišljajem isplanirana kako bi se na protivpravan način preuzela sredstva koja su predviđena u slučaju nastupanja smrtnog slučaja osiguranika. Istraga je pokazala, kao i u slovenačkom slučaju, da su i drugi članovi porodice bili upućeni u to da se odvija krivično delo. Optuženi moldavski državljanin izručen je Sjedinjenim Američkim Državama 2018. godine radi suđenja, a odlukom nadležnog suda u Minesoti osuđen je na 41 mesec zatvora za prevaru u osiguranju zbog lažiranja smrtnog ishoda.

Sličan je slučaj pakistanskog građanina s boravištem u Velikoj Britaniji, koji je lažirao svoju smrt u Pakistanu u nastojanju da od britanskog osiguravača dobije naknadu štete u visini od milion britanskih funti.[33] Naime, osiguravaču se obratila jedna osoba tvrdeći da je osiguranikova partnerka, koja je rekla da je osiguranik preminuo od srčanog udara tokom posete Pakistanu u trideset devetoj godini.[34] Istraga je pokazala da je osoba koja se obratila osiguravaču zapravo sam osiguranik, koji se pretvarao da je sopstvena partnerka, a obaveštenje osiguravaču uputio je elektronskim porukama i u telefonskim pozivima.[35] Taj deo je dokazan zahvaljujući veštačenju stručnjaka za glas, koji je poređenjem njegovog i drugog glasa utvrdio da postoji visoka verovatnoća da se radi o istoj osobi.[36]

U okviru procesa koji je pokrenuo osiguravač, angažovana je partnerska firma u Pakistanu koja je utvrdila da na groblju gde je navodno sahranjen optuženi u tom periodu nije bilo pogreba osoba pod tim imenom.[37] Takođe je izvršena i analiza dokumentacije koju je on predao u nastojanju da naplati štetu od osiguravača. Pored ostalih dokumenata, tom prilikom pregledani su izvod iz matične knjige umrlih i medicinska potvrda o uzroku smrti, za koje je utvrđeno da su lažni, to jest da je njegov zdravstveni karton prazan, a da medicinska ustanova koja je izdala potvrdu deluje da nije zvanično ni postojala.[38]

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[32] Ibid.

[33] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20.01.2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* pristupljeno: 10. 9. 2020.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Owain Thomas, Serial fraudster jailed for five years after £1m fake life insurance claim, Mortgage Solutions United Kingdom, 17. 1. 2020, *https://www.mortgagesolutions.co.uk/news/2020/01/17/serial-fraudster-jailed-for-five-years-after-1m-fake-life-insurance-claim/,* pristupljeno: 11. 9. 2020.

[38] Ibid.

I pored brojnih dokaza koji su upućivali da se radi o prevari zarad ostvarivanja prava na isplatu osigurane sume, osiguranik je ostao pri stavu da je zapravo njegova partnerka bila ta koja je podnela lažnu prijavu smrti zarad ostvarivanja finansijske koristi.[39] Kao i u moldavskom slučaju, taj predmet je uspešno razjašnjen zahvaljujući bliskoj interinstitucionalnoj saradnji koja je nužna radi prikupljanja i provere svih informacija koje se odnose na zahtev za isplatu sredstava. U ovom slučaju, proces je vodilo Odeljenje za prevare u osiguranju londonske policije, kojoj se neimenovani osiguravač obratio kada je uočio sumnjive stavke što su se povezivale s tim slučajem.[40] Optuženi je osuđen na pet godina i sedam meseci zatvorske kazne.

3. OLAF – podsticanje evropske saradnje u suzbijanju finansijskih prevara

Bliža međudržavna i međunarodna saradnja predstavlja jedan od načina da se u što znatnijoj meri suzbiju finansijske prevare, uključujući i one u osiguravajućoj delatnosti. Evropska zajednica je još pre nekoliko decenija, u godinama koje su prethodile stvaranju jedinstvenog tržišta (1993) uvidela potrebu da se njene države članice bliže povežu u borbi protiv finansijskih prevara.[41]

Najpre je na inicijativu Evropske komisije uspostavljen UCLAF (jedinica za koordinaciju u suzbijanju finansijskih prevara), čiji je delokrug postepeno proširivan, uz podršku Evropskog parlamenta.[42] Nakon desetak godina, 1999. godine, donesena je odluka da se uspostavi telo s jačim mogućnostima nadzora i delovanja.[43]

Institucija OLAF (*Office Europeen de Lutte Antifraude*, na srpskom jeziku: Evropska kancelarija za borbu protiv prevara, dalje u tekstu: Kancelarija), osnovana je radi istraživanja problematičnih aspekata finansijskog upravljanja u okviru različitih oblasti i institucija u Evropskoj uniji.[44] Za razliku od njene prethodnice čiji je domen delovanja bio prvenstveno povezan s Evropskom komisijom, OLAF ima širi opseg rada koji uključuje i ostala evropska tela, pri čemu se naročito usmerava na istraživanje prevara povezanih s budžetom Evropske unije, korupcijom i drugim prekršajima, kao i s razvojem strategije Evropske komisije za borbu protiv prevara.[45]

[39] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* pristupljeno: 10. 9. 2020.

[40] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* pristupljeno: 10. 9. 2020.

[41] European Commission, OLAF – History, 2020, *https://ec.europa.eu/anti-fraud/about-us/history_en,* pristupljeno: 6. 10. 2020.

[42] Ibid.

[43] Ibid.

[44] European Commission, OLAF – European Anti-Fraud Office, 2020, *https://ec.europa.eu/anti-fraud/home_en,* pristupljeno: 6. 10. 2020.

[45] Ibid.

Širenje aktivnosti Kancelarije za borbu protiv prevara pojedini autori tumače i kao jačanje nadnacionalnog pravnog sistema Evropske unije u odnosu na države članice, od kojih borba protiv finansijskih prevara presudno zavisi.[46] Pored toga, Kancelarija poseduje i nadležnosti koje joj omogućavaju produbljivanje saradnje i s telima izvan Evropske unije, što je naročito važno imajući u vidu sve globalizovanije finansijske tokove.[47] Osnovne aktivnosti Kancelarije dodatno obuhvataju razvijanje sveobuhvatne strategije i pravnih akata za suzbijanje prevara, istraživanje i prepoznavanje rizika, predlaganje mera protiv finansijskih prevara evropskim institucijama i stvaranje i održavanje relevantnih baza podataka.[48]

Već 2006. broj istraga koje je Evropska kancelarija za borbu protiv prevara samostalno pokrenula prevazišao je broj onih u kojima je služio kao podrška državama članicama, dok je od 2013. godine svaka zemlja u obavezi da uspostavi službu koja se bavi koordinacijom aktivnosti sa OLAF-om u pogledu finansijskih prevara.[49] Jačanje tog tela argumentuje se potrebom da se zaštiti jedinstveno tržište, kao i novac evropskih građana. U tu svrhu, Kancelarija je napravila i elektronski servis *Fraud Reporting* („prijavljivanje prevara"), putem kojeg građani mogu i samostalno da podnesu zahtev za ispitivanje prevara ili drugih neregularnosti koje potencijalno mogu naštetiti evropskim fondovima, kao i da prijave ozbiljne propuste u postupanju evropskih institucija ili službenika.[50] Dok je OLAF u dosadašnjoj praksi zapaženije rezultate postigao u domenima poput kršenja carinskih propisa i šverca duvanskih proizvoda, putanja njegovog razvoja sugeriše da će njegove nadležnosti i opseg delovanja voditi daljoj ekspanziji u cilju zaštite fondova u Evropskoj uniji i novca evropskih obveznika. U svakom slučaju, Evropska kancelarija za borbu protiv prevara već predstavlja kontaktnu tačku za podršku državama članicama u finansijskoj oblasti, uključujući i oblast osiguranja, što predstavlja dobar osnov za razvoj međudržavne saradnje i u toj delatnosti.

II. Zaključak

Epilozi nekoliko analiziranih sudskih procesa pokazuju da su navedena lica nastojala da s namerom stvore povod za nastanak osiguranog slučaja (npr. izazivanjem delimičnog invaliditeta usled gubitka leve šake), kako bi nakon toga zahtevala isplatu odštete od nekoliko osiguravajućih kuća. U tim slučajevima radilo se o „tvrdoj prevari", gde je postojao visok stepen predumišljaja uključenih lica u pogledu izazivanja nezgode, što spada u ozbiljnija krivična dela u kategoriji prevare

[46] Videti: Véronique Pujas, The European Anti-Fraud Office (OLAF): A European policy to fight against economic and financial fraud?, *Journal of European Public Policy* 10(5), 2003, pp. 778-797.

[47] European Commission, OLAF - Policies to prevent and deter fraud, 2020, *https://ec.europa.eu/anti-fraud/policy/preventing-fraud_en,* pristupljeno: 6. 10. 2020.

[48] Ibid.

[49] Ibid.

[50] European Commission, Fraud Reporting, 2020, *https://fns.olaf.europa.eu/*, pristupljeno: 5. 10. 2020.

u osiguranju. Značajnu ulogu u donošenju presuda imali su i veštaci iz oblasti medicine i mašinstva, koji su, svako iz svoje perspektive, posvedočili da se radi o lažnom zahtevu. Analizirane situacije ilustrativne su za prikazivanje značaja saradnje između različitih ustanova u cilju uspešnije borbe protiv prevara u osiguranju.

I u predmetima koji se odnose na lažiranje smrti takođe se pokazalo da prevare neretko uključuju i međunarodnu komponentu, što otežava posao stručnjacima koji istražuju takve zahteve usled neophodnosti prekogranične saradnje koja nije uvek u potpunosti efikasna. Ipak, epilog tih slučajeva govori da je internacionalizacija saradnje na tom polju nužan element za što uspešniju borbu protiv lažnih zahteva, te da su u borbi protiv prevara s međunarodnim predznakom neophodne i međunarodne aktivnosti uključenih ustanova, kako bi se dobila što celovitija slika o svakom pojedinačnom zahtevu za osiguranje. I u tim slučajevima radi se o takozvanim „tvrdim prevarama", gde su protivpravne aktivnosti lažnog prijavljivanja odštetnih zahteva unapred smišljane radi isplate prijavljene „štete" od osiguravača. Pored eksternih prevara, koje su bile ilustrovane u ovom tekstu, nisu retki ni primeri „insajderskih" prevara u kojima nažalost učestvuju i zaposleni u delatnosti osiguranja. Samo u Evropi novčana vrednost detektovanih prevara u osiguranju u 2017. godini iznosila je preko dve milijarde evra, dok se, ukoliko se uračunaju i projekcije za nedetektovane lažne zahteve, iznos penje do čak trinaest milijardi evra.[51]

U nemalom delu javnosti, usled neupućenosti u pravne i finansijske tokove, postoji i predstava da se u slučaju prevara u osiguranju radi o „zločinu bez žrtava".[52] Takve predstave nažalost doprinose održavanju fenomena moralnog hazarda, kao i lažnih potraživanja.[53] S druge strane, slučajevi poput gorenavedenih ilustruju da se tim krivičnim aktivnostima ne samo protivpravno zahtevaju milionske isplate od osiguravača, već i da se radi o delima koja su kažnjiva zatvorom u trajanju od nekoliko godina. Visoka medijska propraćenost tih slučajeva, u kombinaciji s nimalo blagim sudskim kaznama, doprinose višem stepenu svesti šire javnosti o ovoj vrsti finansijske prevare, koja postaje česta pojava u sve globalizovanijem svetu.

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[51] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 6.
[52] Konsultovati prethodno navedeni izvor.
[53] Konsultovati: Đorđe Ćuzović, Prevare i moralni hazard u osiguranju, *Evropska revija za pravo osiguranja*, ISSN 2334-833X, 1/2020.

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UDK:368.183:368.3:368.98:327.32.3:35.08:355.85:343.53
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NECESSITY OF CLOSER INTERNATIONAL COOPERATION OF VARIOUS INSTITUTIONS IN FIGHTING AGAINST INSURANCE FRAUD

PROFESSIONAL PAPER

Abstract

In this paper, the author analyses a few examples of fraud in life and accident insurance. The cases that are the subject of this Article can be classified as "heavy frauds" according to the seriousness of the crime committed and as "external" according to the source type. The course and epilogue of the trials show how important it is to have the closest possible coordination between the judicial, police and insurance institutions and that the character of insurance frauds is becoming increasingly international, requiring stronger cross-border inter-institutional cooperation. Also, experts from a growing number of disciplines (from medicine, through mechanical engineering to technological sciences) do have a particularly notable role in discovering false insurance claims. Their expertise findings can make a decisive contribution to clarifying the circumstances of each and every case. The examples presented in this Article illustrate that closer cooperation between all the named participants and the use of advanced methods and technologies are the indispensable tool of a good and a more efficient fight against the insurance fraud.

Key words: *insurance fraud, false claim, life insurance, international cooperation*

I. Introduction

The insurance fraud is present in all parts of this industry - from traffic, through health, to property and other (false or exaggerated) claims. This is an act of illegal

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request for payment addressed to the Insurer on the basis of a false claim under an insurance policy.[2] The insurance fraud also relates to the situations like filling in the insurance forms with false and lacking information at the insurance application as well as submitting claims for indemnity upon false or misleading circumstances including the exaggeration of the insured occurrence.[3] Another term that is closely related to this phenomenon is that of a moral hazard, i.e. the risk that a person's behaviour will differ depending on whether such a person is covered or not by an insurance policy, which is a challenge in all domains of insurance business.[4] This phenomenon will be analysed in more detail in several cases that are the subject-matter of this Article

One of the standard insurance fraud classifications is the division into "heavy fraud", which occurs when a loss is planned or conspired in advance and the "soft fraud", based on legitimate claims but with an element of greed, e.g. exaggerated insured occurrence.[5] There is a relevant case to this effect in the Slovenian practice that included a claim filed under accident insurance. This type of insurance can cover sudden events and circumstances resulting in death, complete, partial, temporary or permanent disability or impaired health that requires treatment.[6] The mentioned claim was based on an accident resulting in a degree of disability, that became doubtful on the basis of evidence related to the accident of the insured person. This text will also briefly present a case of an American insured person, on whose behalf a request for premium payment was filed following his death.

In addition to the classification into „heavy" and „soft" fraud, according to the gravity of a case, we use an additional classification according to the source of fraud – to internal and/or the external, outside fraud.[7] The internal frauds are colloquially called "insider" and refer to situations when an insurance employee cooperates with the insured person in order to file a false or exaggerated claim with a view to exercising their right to the sum insured.[8] The eternal fraud, on the other hand, is the fraud where the insured person or a third party requires indemnity under a false or exaggerated claim.[9] Hereinafter, the author will present several examples of "heavy" insurance fraud of external nature.

The insurance fraud refers to an object and/or insurance subject-matter that is deliberately destroyed, damaged or hidden with the aim to collect the sum

[2] Slobodan Petrović, Milosav Stojanović, Insurance Fraud, *Insurance Trends* no. 1/2012, pp. 61.
[3] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 4.
[4] Đorđe Ćuzović, Fraud and moral hazard in insurance, *European Review of Insurance Law*, ISSN 2334-833X, 1/2020, p. 3.
[5] Slobodan Petrović, Milosav Stojanović, Insurance Fraud, *Insurance Trends* no. 1/2012, p. 64.
[6] Dunav Insurance Company, Accident insurance, https://www.dunav.com/proizvodi/nezgode/, visited on September 10, 2020.
[7] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p. 5.
[8] Ibid.
[9] Ibid.

insured.[10] In Serbian and European legislation, this concept is classified as a criminal act, manifested in two forms: hiding, inflicting damage to or destroying the object insured, on the one hand and inflicting harm, bodily injury and health impairment to oneself.[11] Experts and professionals from various fields (from judiciary, through police, to the employees in the insurance industry) have a very important role in evidencing such abuses, by mutual cooperation in such situations. Moreover, in an increasingly globalized world, there is a growing need for closer cooperation between institutions at the international level in combating such crimes. The cases that we will hereinafter analyse are examples of close inter-institutional and inter-state cooperation that have contributed to clarifying the circumstances necessary for making adequate decisions on insurance claims. Basic information on the cases that are the subject of this paper are mostly taken from foreign media papers, listed in the schedule of literature used. The fact that the media followed up with great agility on such criminal proceedings is particularly favourable for insurance companies, given that reporting on such cases contributed to the development and improving of public awareness on the abuses in the field of insurance.

1. Request for Payment of Sum Insured Upon Occurrence of Accident

In January 2019, a 21-year-old woman from Ljubljana arrived at the hospital escorted by a few people. The injury was serious: the woman lost her left hand, as she claimed, while cutting branches with a circular saw on her property.[12] Already in the hospital, it was noticed that neither the patient nor the accompanying persons brought the severed hand of this twenty-one-year-old with them to the hospital, for the doctors to try and save it, which in itself was weird.[13] However, in spite of this fact and upon initiative of doctors, it was organized that the hand be brought from her home in order to be timely sewn.[14]

A case investigation was initiated and it included, in addition to the mentioned girl, her partner and his parents.[15] The police have officially filed an indictment against all the named persons, alleging that this case did not represent an accident but

[10] Joko Dragojlović, Krivično delo prevare u osiguranju, Kultura polisa, Novi Sad, str. 674.
[11] Ibid, 676.
[12] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 08. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on 15. 9. 2020.
[13] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957,* visited on: 16.9.2020.
[14] Ibid.
[15] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on: 15. 9. 2020.

a pre-designed act in order to collect indemnity from several insurance companies.[16] In that sense, the prosecution stated that the severed hand was intentionally left at the location where the accident had occurred in order to increase the degree of injury and thus cause disability.[17] As part of the trial that began in 2019, these persons were taken into custody whereas the media speculated that if a verdict was brought against them, the prison sentence for such a crime could be up to eight years.[18]

During 2020, the trial started against the above persons, suspects for the attempted fraud of over one million euros.[19] During the trial, evidence was presented that in the year preceding the occurrence, the first accused, with the help of her partner, took out as many as five insurance policies covering an accident under life coverage.[20] The plaintiff presented the evidence that the woman's partner searched various models of prosthetic arms on the Internet in the days before the accident, which was one of the key arguments in proving the mischievious cause of the accident.[21] The accused persisted in claiming that the occurrence was accidental, while the prosecution maintained the attitude that it was a deliberate attempt to collect a huge amount of money from the insurance companies.[22] Also, the prosecution stated that the girl committed this act at the urging of her partner, his parents included, and the court decided that all these persons should be prosecuted.[23]

The prosecutor also stated that the opinions of medical and mechanical experts showed that the accused had been intentionally injured, proposing that she be sentenced to four years and six months in prison, her partner to five years in prison, his mother to four years, and her husband to one year in prison. [24] The Slovenian court agreed with the prosecutor's allegations and ruled that the mentioned persons were responsible for the criminal offense of attempted insurance fraud. The first accused was sentenced by a court decision to two years in prison, her partner to three years, while his father was sentenced to a suspended sentence of one year.[25]

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[16] BBC News, Slovenian woman's hand sawn off 'in insurance fraud', 11. 3. 2019, *https://www.bbc.com/news/world-europe-47531957*, visited on: 16.9.2020.

[17] Ibid.

[18] Ibid.

[19] Politika online, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* visited on: 15. 9. 2020.

[20] BBC News, Woman who sawed off own hand found guilty of fraud, 12. 9. 2020, *https://www.bbc.com/news/world-europe-54125770,* visited on: 15. 9. 2020.

[21] Ibid.

[22] *Politika online*, Žena optužena da je namerno odsekla šaku zbog osiguranja, 8. 9. 2020, *http://www.politika.rs/sr/clanak/461999/Zena-optuzena-da-je-namerno-odsekla-saku-zbog-osiguranja,* accessed on: 15. 9. 2020.

[23] Ibid.

[24] Ibid.

[25] Russell Hope, Julija Adlesic: Woman who deliberately cut off own hand in insurance scam jailed for two years, SkyNews, 12.09.2020**,** *https://news.sky.com/story/julija-adlesic-woman-who-deliberately-cut-off-own-hand-in-insurance-scam-jailed-for-two-years-12069121,* visited on: 15. 9. 2020.

There is an interesting example from the Dutch insurance practices. A miner, who maintained an insurance policy against disability at work, had to stop working due to a shoulder injury, which was a significant problem for his type of work.[26] For the next six years, this insured person received a monthly allowance until the insurance company got an anonymous notification that the insured (despite his alleged disability) not only practiced surfing but was also internationally known in the discipline.[27] An investigation was initiated and the insurance company came into possession of photos showing the insured surfing in strong winds, which was one of the key grounds to annul the decision on the payment of the sum insured, request a refund and include him in the national register of insurance fraudsters.[28]

2. Fake Death in Context of Insurance Fraud

This section will present two separate cases of faking death in order to exercise the right to a sum insured. Both cases involved cross-border embezzlement, discovered thanks to a cooperation between institutions and turned out to be an unfounded and illegal claim against insurers.

At the end of the first decade of the 21st century, a Moldovan citizen residing in the United States took out life insurance with the Mutual Omaha Insurance Company in the US state of Minnesota, with coverage of two million dollars and named his wife the primary beneficiary.[29] In October 2011, the body of a man who died of a heart attack was found in the interior of Moldova; the personal documents and inspections carried out by competent institutions indicated that the person was the insured in question.[30] According to the investigation of judicial authorities, during the next month, his wife submitted a claim for payment of the sum insured upon death of her husband, and the sum of two million dollars which was paid to her bank account.

Through the cooperation between the Federal Bureau of Investigation and the National Tax Agency in the following years, it was established that this was a false request and several key facts were revealed. Namely, the insured did not die, but lived under a different name for years in Pridnjestrovlje, a breakaway Moldovan territory.[31] Moreover, as the investigation showed, the financial transfers included his immediate family's transactions with banks in Moldova, the United States and

[26] Insurance Europe, Insurance fraud: not a victimless crime, IE report, Brussels, 2019, p.10.
[27] Ibid.
[28] Ibid.
[29] United States Department of Justice, Moldovan National Sentenced To 41 Months In Prison For Faking His Death For $2 Million Insurance Payout, 29. 7. 2019, *https://www.justice.gov/usao-mn/pr/moldovan-national-sentenced-41-months-prison-faking-his-death-2-million-insurance-payout,* visited on: 2. 9. 2020.
[30] Ibid.
[31] Ibid.

Switzerland.[32] Additionally, one of the main elements on the investigation was in 2013, when during border checks, recent photos of the father were found in the computer of the insured's son, who was returning from a trip from Moldova, even though he had allegedly died several years earlier.

Like the case from Slovenia, this case represents a "heavy fraud", planned in advance and with premeditation in order to illegally collect the funds payable in case of death of the insured person. The investigation showed, as in the Slovenian case, that other family members were instructed to commit the crime. The accused Moldovan citizen was extradicted to the United States in 2018 for trial and by the decision of the competent court in Minnesota, sentenced to 41 months in prison for insurance fraud committed by faking death.

There is a case similar to this, of a Pakistani citizen residing in the UK, who faked his death in Pakistan in an effort to obtain indemnity from a British insurer to the amount of one million British pounds.[33] Namely, the Insurer was contacted by a person who claimed that she was a partner of the Insured and that the Insured had died of a heart attack during his visit to the Pakistan at the age of thirty-nine.[34] The investigation showed that the person who contacted the Insurer was in fact the Insured himself, who pretended to be his own partner, sending the notification to the Insurer by e-mails and telephone calls.[35] The proof of this came through the expertise of a voice expert, who determined by comparing his and the other voice that it most probably belonged to one and the same person.[36]

In the process initiated by the Insurer, a partner company was engaged in Pakistan and they established that there was no burial of persons under the accused's name in the cemetery where he was allegedly buried at the time.[37] They also made an analysis of the documentation he submitted in an effort to collect indemnity from the Insurer. On that occasion, among other documents, the Insurer also examined a death certificate and a medical certificate of the cause of death and found them to have been false, i.e. that the Insured's health record was empty and the medical institution that issued the certificate did not appear to have officially existed.[38]

Despite the numerous pieces of evidence that indicated that it was a case of fraud for the purpose of exercising the right to payment of the sum insured, the

[32] Ibid.

[33] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20.01.2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[34] Ibid.

[35] Ibid.

[36] Ibid.

[37] Owain Thomas, Serial fraudster jailed for five years after £1m fake life insurance claim, Mortgage Solutions United Kingdom, 17. 1. 2020, *https://www.mortgagesolutions.co.uk/news/2020/01/17/serial-fraudster-jailed-for-five-years-after-1m-fake-life-insurance-claim/,* visited on: 11. 9. 2020.

[38] Ibid.

Insured maintained the attitude that in fact his partner was the one who filed a false death claim for financial gain.[39] As in the Moldovan case, this case has been successfully clarified thanks to the close inter-institutional cooperation necessary to collect and verify all information related to claim for indemnity. In this case, the procedure was done by the London Police Insurance Fraud Department, which was contacted by an unnamed Insurer when they noticed suspicious matters related to the case.[40] The accused was sentenced to five years and seven months in prison.

3. OLAF – Encouraging European Cooperation in Combating Financial Fraud

Closer interstate and international cooperation is one of the ways to combat financial fraud as much as possible, including those in the insurance industry. A few decades ago, in the years leading up to the creation of the single market (1993), the European Community recognized the need for its member states to become more closely involved in the fight against financial fraud.[41]

Upon an initiative of the European Commission, UCLAF (Coordination Unit for the Suppression of Financial Fraud) was established first, with their scope of activities gradually expanding supported by the European Parliament.[42] Ten years later, in 1999, a decision was made to establish a body with stronger supervision and performance capabilities.[43]

The OLAF Institution (*Office Europeen de Lutte Antifraude*, in Serbian: *Evropska kancelarija za borbu protiv prevara*, hereinafter: Office), was established to research problematic aspects of financial management within various areas and institutions in the European Union.[44] Unlike their predecessor, whose scope of activity was primarily linked to the European Commission, the OLAF has a wider scope of activities that includes other European bodies, especially targeting the investigation of fraud linked to the budget of the European Union, corruption and other offenses, as well as with the development of the European Commission's anti-fraud strategy.[45] Some authors also interpret the expansion of the activities of the Office for the Fight against

[39] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[40] Terry Gangcuangco, Fraudster in fake death claim gets jail sentence, Insurance Business United Kingdom, 20. 1. 2020, *https://www.insurancebusinessmag.com/uk/news/breaking-news/fraudster-in-fake-death-claim-gets-jail-sentence-210753.aspx,* visited on: 10. 9. 2020.

[41] European Commission, OLAF – History, 2020, *https://ec.europa.eu/anti-fraud/about-us/history_en,* visited on: 6. 10. 2020.

[42] Ibid.

[43] Ibid.

[44] European Commission, OLAF – European Anti-Fraud Office, 2020, *https://ec.europa.eu/anti-fraud/home_en*, visited on: 6. 10. 2020.

[45] Ibid.

Fraud as the strengthening of the supranational legal system of the European Union compared to that of the member states, upon which the fight against financial fraud crucially relies.[46] In addition, the Office has competencies that enable it to deepen the cooperation with bodies outside the European Union, which is especially important given the increasingly globalized financial flows.[47] The main activities of the Office additionally include the development of a comprehensive strategy and legal acts for combating fraud, investigation and risk identification, proposing measures against financial fraud to European institutions and the creation and maintenance of relevant databases.[48]

As early as 2006, the number of investigations launched independently by the European Anti-Fraud Office exceeded the number of those where they supported the member states and since 2013, each country has been obliged to establish an office that would coordinate activities with OLAF, in terms of financial fraud.[49] The strengthening of this authority was supported by the need to protect the single market as well as the cash in possession of the European citizens. To this end, the Office has created an electronic service *Fraud Reporting*, through which citizens can independently submit a request for investigation of fraud or other irregularities that could potentially harm European funds, as well as gross omissions in the conduct of European institutions or officials.[50] While OLAF has achieved more notable results in areas such as customs violations and tobacco smuggling, its development path suggests that its competencies and scope will lead to further expansion to protect EU funds and European taxpayers' funds. Anyway, the European Anti-Fraud Office is already a contact point for providing support to member states in the field of finances, including insurance, which represents a good starting point for the development of interstate cooperation in this area.

II. Conclusion

The epilogues of a few analysed lawsuits show that the mentioned persons deliberately tried to create a reason for the occurrence of an insured event (e.g. by causing partial disability due to loss of the left hand), in order to subsequently claim indemnity from several insurance companies. These are the cases of a "heavy fraud", with a high degree of premeditation of the persons involved in causing the accident, which is classified as a more serious crimes in the category of insurance

[46] See: Véronique Pujas, The European Anti-Fraud Office (OLAF): A European policy to fight against economic and financial fraud? Journal of European Public Policy 10(5), 2003, pp.778-797.

[47] European Commission, OLAF - Policies to prevent and deter fraud, 2020, *https://ec.europa.eu/anti-fraud/policy/preventing-fraud_en,* visited on: 6. 10. 2020.

[48] Ibid.

[49] Ibid.

[50] European Commission, Fraud Reporting, 2020, *https://fns.olaf.europa.eu/*, visited on: 5. 10. 2020.

fraud. Experts in the field of medicine and mechanical engineering also played a significant role in passing the verdicts, since they, each from their own perspective, testified that this was a false claim. The analysed situations illustrate the importance of cooperation among various institutions for a more successful combat against the insurance fraud.

In the cases related to the falsification of death, fraud has also shown to often involve an international component, making the job difficult for experts investigating such claims due to the need for cross-border cooperation, which is not always fully effective. However, the epilogue of such cases shows that the internationalization of cooperation in this field is a must for a most successful fight against false claims and that, in the context of fighting against fraud with international connotations, international activities of the involved institutions are necessary to get a more complete picture of any one insurance application. The mentioned cases have been classified as the so-called "heavy frauds", where the illegal activities of reporting false claims for indemnity are designed in advance to collect the reported "damages" from the Insurer. In addition to external frauds, which were illustrated in this text, there are not rare examples of "insider" frauds which, unfortunately, include the employees of the insurance industry. In Europe alone, the monetary value of detected insurance fraud in 2017 amounted to over two billion euros, while, if we include the projections for undetected false claims, the amount would rise to as much as thirteen billion euros.[51]

In not so small part of the public, due to ignorance of legal and financial flows, there is a notion that in the case of insurance fraud, it is a "crime without victims".[52] Unfortunately, such attitudes contribute to pertaining phenomenon of moral hazard, as well as that of false claims.[53] On the other hand, cases like the above illustrate that these criminal activities not only illegally demand millions in payments from insurers, but also that they are acts punishable by imprisonment for several years. The high media coverage of these cases, combined with not at all lenient court fines, contribute to a higher level of awareness of the general public about this type of financial fraud, which is becoming common in an increasingly globalized world.

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[52] Consult the above source.
[53] Consult: Đorđe Ćuzović, Fraud and moral hazard in insurance, *European Review of Insurance Law*, ISSN 2334-833X, 1/2020.

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