INSURANCE FRAUD IN SWEDEN 2024

Collaboration Against Fraud Creates Security for All

Risks are a part of everyday life. Traffic accidents, fires, theft, and prolonged illness are just a few examples of incidents that can have severe consequences for individuals. Insurance plays a crucial role in providing us with security and other protection by collectively distributing these risks. Everyone pays a premium in exchange for the insurance company compensating those affected when an accident occurs.

For the principle of insurance to function, however, it must not be abused. In recent years, organized crime has increasingly targeted compensation from both public welfare systems and insurance companies. At the same time, digitalization has revolutionized our society, creating new challenges. Technology, such as artificial intelligence (AI), offers new opportunities for insurance companies to detect and prevent fraud through advanced analytics and pattern recognition. However, the same technology can also be used by criminals to commit more sophisticated insurance fraud.

To identify suspected insurance fraud, and thereby prevent incorrect payouts, insurance companies conduct investigations to protect honest policyholders and to avoid premiums becoming unnecessarily high.

The insurance industry has intensified its efforts to combat insurance fraud. Since 2017, insurance companies have conducted annual control activities focused on common fraud schemes. In 2024, the industry carried out a review to follow up on all police reports related to insurance fraud and the Swedish Police Authority's decisions to deny or close a preliminary investigation. Since only a few police reports on insurance fraud led to prosecution, the industry wanted to examine whether these decisions were made on valid grounds. The results are discouraging. More than half of the Police Authority’s decisions last year were either incorrect or unreasonable.

It is not enough for insurance companies to investigate suspected fraud and stop incorrect payouts. To truly address the problem, law enforcement must take strong action. And cooperation between public authorities and insurance companies must be strengthened. By working together to combat fraud and organized crime, we do not only protect the insurance system but also contribute to a safer and better society for all.

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Insurance and Insurance Fraud

Insurance plays a vital role in society and is based on the principle of spreading risks across a larger group. This allows individuals and businesses to protect themselves from unforeseen events at a reasonable cost. However, this principle does not work in the long run if individuals or criminal networks exploit this model for personal gain.

The idea of insurance is simple: sharing risks. Those who insure themselves distribute their risk within a larger collective instead of carrying it on their own. Through insurance, individuals and businesses can protect themselves financially from unexpected events. Each policyholder pays a premium that reflects the risk they add to the collective. With more people choosing to insure themselves, the security within the collective becomes stronger.

Hidden Figures in Insurance Fraud

Each year, non-life insurance companies in Sweden handle more than 3 million claims and pay out approximately 70 billion SEK in compensation to their customers. A rough estimate suggests that insurance fraud accounts for 5–10% of these payouts, equating to around 3.5–7 billion SEK annually. Ultimately, the cost of fraud affects honest customers through increased premiums.

Profits from Fraud for Criminal Networks

Fraud is becoming an important source of income for organized crime. A substantial portion of the profits goes directly to criminal networks. According to the Police Authority, the profits from these crimes significantly exceed the estimated earnings from drug trafficking.

Insurance fraud is committed by both individuals and organized crime groups. Some individuals may not fully realize that insurance fraud is a serious crime, while professional criminals see fraud as a profitable source of income.

These fraudulent activities harm honest policyholders. Each year, the average Swedish household contributes nearly 500 SEK to fraud-related costs through increased premiums.

Lenient Sentences for Insurance Fraud

The risk of getting caught committing insurance fraud is perceived as low. Additionally, courts often apply lenient sentences. In most cases, a conviction results in a conditional sentence and a fine, even for large-scale and organized fraud schemes.

What is an Insurance Fraud?

Insurance fraud occurs when a policyholder, through their actions, receives compensation for a claim that never happened or deliberately secures a higher payout than they are entitled to.

Examples of Insurance Fraud:

- Exaggerating the value of stolen or damaged items.
- Providing false information when purchasing an insurance policy.
- Deliberately breaking a mobile phone to buy a newer model.
- Staging a car accident to receive compensation for a vehicle that is unsellable.
- Traveling abroad for cosmetic surgery and having the clinic falsify documents to claim the surgery as an emergency medical procedure.
- Misrepresenting insurance history or behavior to obtain a lower premium than warranted by actual risk.

Industry Efforts to Combat Insurance Fraud

The insurance industry is committed to protecting honest customers by preventing insurance fraud. This work is carried out through the investigative efforts of insurance companies and industry-wide initiatives.

Investigators in the industry's special investigation units (SIU) and elsewhere often have a background in law enforcement. Hence, they are experienced in conducting criminal investigations. Approximately 170 investigators at non-life insurance companies in Sweden are conducting nearly 10,000 fraud investigations annually. In recent years, insurance companies have increased the number of investigators to combat fraud more effectively.

In addition to investigations, insurance companies implement preventive measures such as raising awareness, restructuring policies to discourage fraud, and they are also exploring advanced technologies, such as AI, to detect fraudulent claims through pattern recognition and predictive analytics.

Industry-Wide Efforts

There are several industry-wide efforts that contribute to the prevention of insurance fraud. The industry organization Insurance Sweden works to influence public authorities to prioritize combating fraud and to change current legislation. Also, Insurance Sweden has published a recommendation for the SIUs and other investigators to ensure high ethical standards and professional competence in investigative work. Further, the recommendation guarantees that investigations meet the requirements for integrity and data protection.

Insurance Sweden's two subsidiaries, Larmtjänst and Gemensamma Skadeanmälningsregistret (GSR), also play important roles in the industry's efforts to prevent insurance fraud. Larmtjänst provides industry-wide services to support the SIUs and individual investigators. Larmtjänst has also created a hotline where it receives tips from the public and serves as an important liaison to law enforcement agencies both nationally and internationally. For example, Larmtjänst is active in the International Association of Special Investigation Units (IASIU), in the Global Insurance Fraud Summit and in anti-fraud initiatives at the European industry organization Insurance Europe. GSR provides an industry claims register, which serves as an important tool in preventing improper payments and to identify cases that merit further investigation.

Control Activities

The insurance industry has intensified its collective efforts to combat insurance fraud. Since 2017, the industry has conducted yearly control activities aimed at making it more difficult to commit insurance fraud. The following activities have been conducted so far:

- 2017: Vehicle Fires – An initiative to review claims of car fires (arson) to determine whether it also was insurance fraud.

- 2018: Staged Traffic Accidents – An initiative to investigate whether staged accidents posed a significant problem.
- 2019: Stolen and Lost Watches – A review of claims regarding stolen and lost watches to assess the prevalence of fraud.
- 2020: Vehicle Fires (Follow-up) – A follow-up to the 2017 initiative focusing again on reviewing car fires.
- 2022: Commercial Claims – An effort to examine claims related to commercial insurances.
- 2023: Manipulated Documentation – An initiative to detect manipulated documents, receipts, and images being used to obtain fraudulent compensation.
- 2024: Police Authority's Decisions – A examination of decisions to deny or close a preliminary investigation to assess whether these decisions were made on incorrect grounds, given the low prosecution rates.

For 2025 the industry conducts a review of Travel Insurance Claims to prevent insurance fraud.

Larmtjänst on Social Media

Larmtjänst is active on various social media platforms to raise awareness about insurance-related crimes and to receive tips from the public regarding insurance fraud and stolen property. Larmtjänst can be found on Facebook, LinkedIn, and Instagram under the names Larmtjänst and Stöldtipset. Stöldtipset is the industry's centralized tip-off service. The public can also provide tips by calling the hotline at 020-325 325, which is staffed 24/7.

Insurance Fraud in Sweden

During 2024, insurance companies in Sweden investigated more than 11,000 suspected frauds and unclear insurance claims. These investigations resulted in the denial of claims totaling more than SEK 800 million.

Non-life Insurance Statistics:

- Approximately SEK 70 billion paid out in compensation
- Around 3 million reported claims
- 11,208 investigations conducted
- SEK 820 million in denied compensation

Denied Compensation (in million SEK):

	2024	2023	2022	2021	2020
Total Amount of Denied Compensation	820	682	578	505	517
Of which:					
• Home / Property / Travel Claims	228	231	197	209	163
• Motor Claims	289	216	187	168	161
• Commercial Claims	195	144	106	86	106
• Personal Injury Claims	76	51	58	26	64
• Other Claims	32	40	31	17	23
Investigations	11 208	9 979	8 875	10 588	8 198

Source: Larmtjänst. Based on statistics reported by the following non-life insurance companies: Dina, Folksam, Gjensidige, ICA Försäkringar, If Skadeförsäkring, Länsförsäkringar, Trygg Hansa and Svedea.

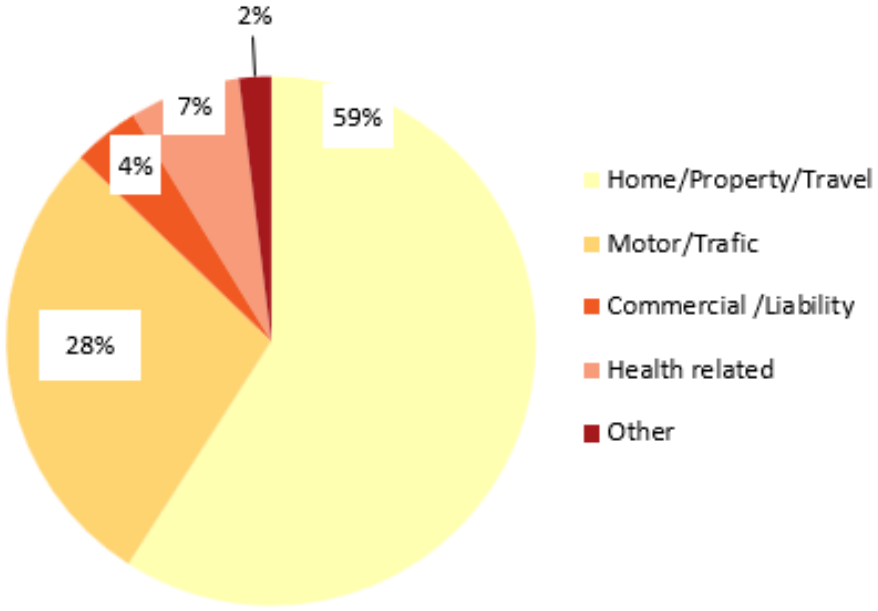
Reasons for Denying Claims

The most common reason for an insurance company to deny a claim is that the alleged incident either did not occur or could not be substantiated. In 2024, 39 percent of suspected fraud cases were denied on this basis. The second most common reason was the submission of false or inaccurate information (19%), followed by the policyholder's refusal to cooperate with the investigation.

Exaggerated claims—so-called *"claim inflation"*—accounted for only 2 percent of suspected fraud cases. In reality, exaggerated claims are significantly more common, but this kind of inaccurate information is often addressed earlier in the process. As a result, such investigations are underrepresented in this set of statistics.

Share of Suspected Insurance Fraud by Insurance Category

Fraud attempts are primarily detected within the insurance category of home/property/travel (59%) and motor (28%). Commercial/liability insurance together with health-related insurance account for only 11 percent of the total number of suspected fraud cases, although the associated amounts are often substantial. The category *Other* includes, among others, pet and boat insurance.



The following statistics on pages 7-9 come from background variables of 5,603 insurance claims where insurance companies declined compensation following a fraud investigation. The statistics were reported to Larmtjänst in 2024 by the following non-life insurance companies: Dina, Folksam, Gjensidige, ICA Försäkring, If Skadeförsäkring, Länsförsäkringar, Svedea, and Trygg Hansa.

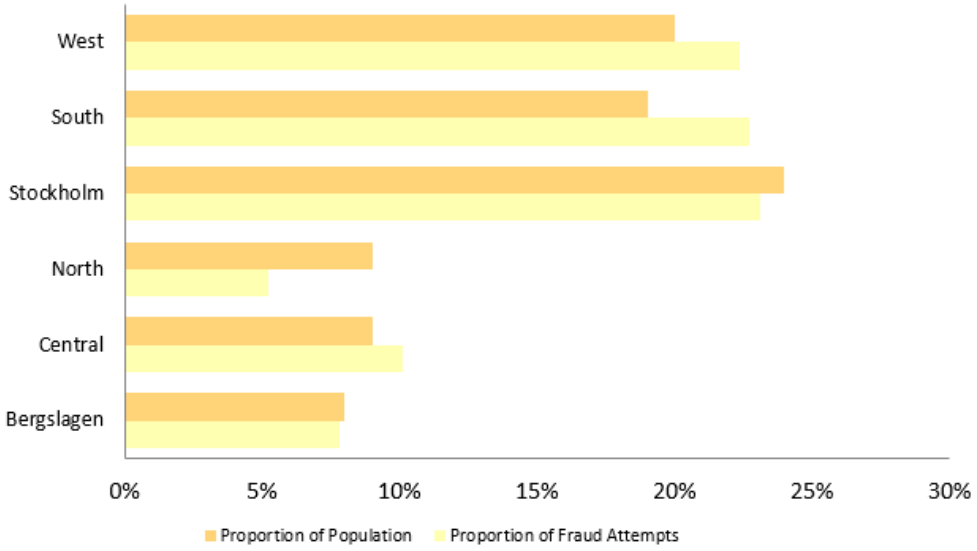
Who Commits Insurance Fraud?

An analysis of background variables related to insurance fraud cases reveals significant differences based on gender, age, and geographic location when it comes to the likelihood of committing insurance fraud.

An analysis of background variables in suspected insurance fraud cases shows that men (61%) are clearly overrepresented compared to women (39%), even when accounting for the fact that there are more male policyholders in certain insurance categories—such as motor insurance.

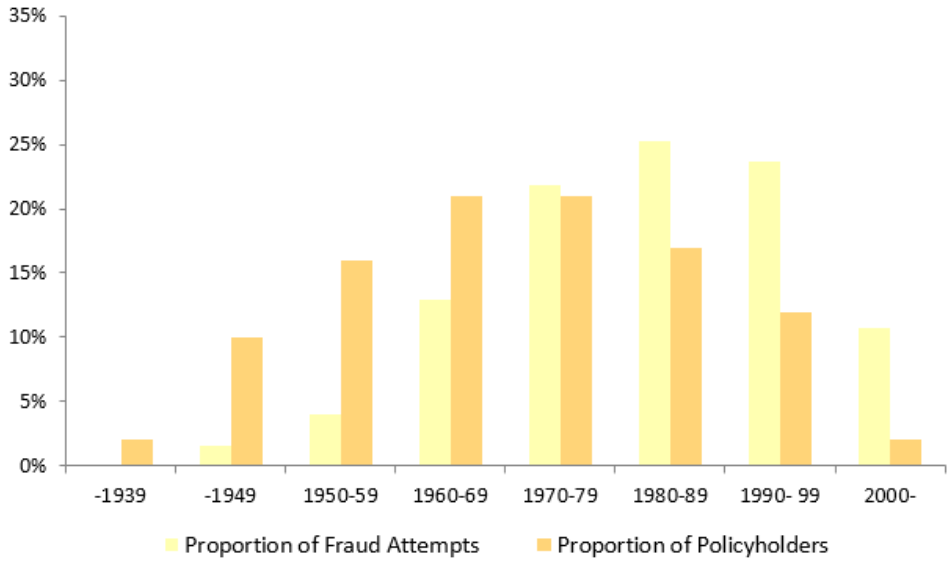
Geographic Distribution by Police Region

An analysis of the geographic distribution by Police Region shows that the West and South are somewhat overrepresented in relation to their share of the population. In contrast, the number of attempts detected in the North Police Region is lower than the region's population share. These differences may partly be explained by how insurance companies allocate their investigative resources to different parts of the country.



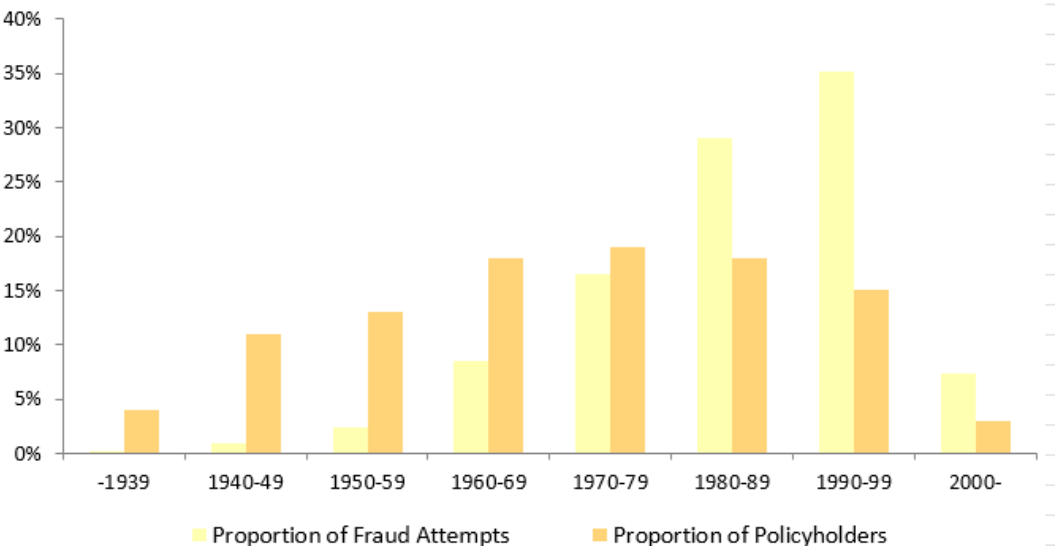
Year of Birth – Motor Insurance

Policyholders born in the years between 1980 and 1999 are overrepresented in this set of statistics relative to their share of motor insurance policyholders. This age group accounts for just over half of the attempted fraud cases within this insurance category. Those born in the 2000s also show a higher share of fraud attempts compared to their proportion among policyholders.



Year of Birth – Home, Property, and Travel Insurance

Policyholders born in the years between 1980 and 1999 are clearly overrepresented relative to their share of policyholders within the insurance category of home, property, and travel. Altogether, this age group accounts for one-third of the fraud attempts.



Attitudes Toward Insurance Fraud

Capturing the attitudes of the public can be challenging, but a survey can still offer some insight into various views and behaviors. The statistics on the following pages are based on a survey conducted by Novus during the period of January 11–17, 2024. It was carried out on a nationally representative sample of individuals aged 18 to 84. A total of 1,016 interviews were conducted.

Key Findings:

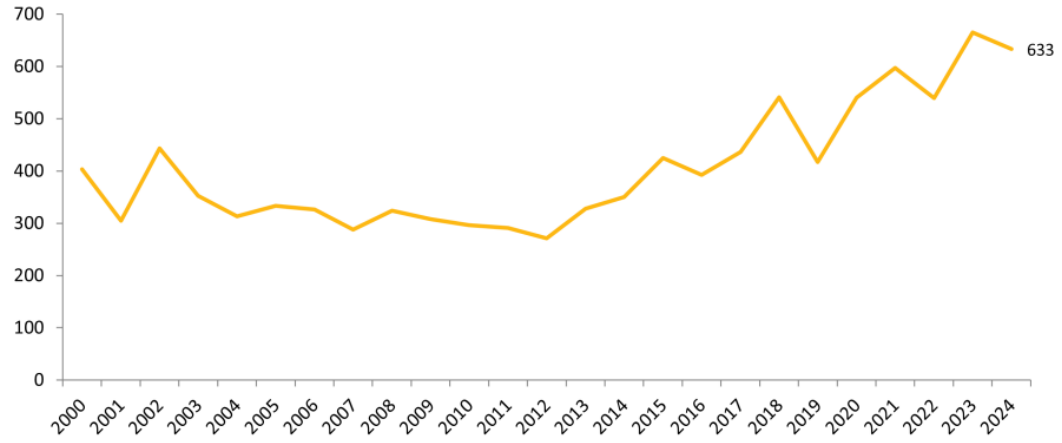
- Just over four in ten (41%) consider insurance fraud to be a very serious crime.
- More than six in ten (65%) say they would never knowingly inflate the value of insured items to receive higher compensation.
- Over one in ten (13%) know someone who has committed insurance fraud.
- Over one in three (34%) would report suspected insurance fraud to the police if they could do so anonymously.
- More than seven in ten (75%) believe it is important for insurance companies to conduct investigations to prevent insurance fraud.
- Just under two in ten (19%) believe that the risk of getting caught is high.

Police Reports, Prosecutions, and Convictions

Insurance fraud is a crime with a high level of undetected cases. In 2024, 633 insurance fraud cases were reported to the police, of which 523 by insurance companies. However, far from all crimes are being reported. Further, only around 15 percent of all police reports over the past five years have resulted in prosecution. Due to the low prosecution rate, insurance companies sometimes choose not to report suspected fraud. Instead, these matters are handled solely through civil proceedings.

In recent years, fraud-related crimes have increased significantly in Sweden. Technological developments have introduced new methods and opportunities to commit fraud. The profits from these crimes are growing—and substantial amounts end up in the hands of organized crime networks.

The insurance industry special investigation units (SIUs) mainly consist of investigators with a law enforcement background. Their investigative work is carried out high ethical and quality standards, guided by a recommendation from Insurance Sweden on investigations of questionable insurance claims.



The chart above shows insurance fraud cases reported to the Swedish Police Authority. Source: The Swedish National Council for Crime Prevention (Brå).

Investigations of Suspected Fraud

In 2024, non-life insurance companies in Sweden conducted over 11,000 investigations, accounting approximately for 0.4 percent of all insurance claims. An investigation may be initiated when there are inconsistencies in the documentation or information provided by the policyholder. Insurance fraud reports to the police are mostly done by insurance companies, although in some instances frauds schemes are discovered in connection with other criminal investigations.

Police-Reported Insurance Fraud Cases

The statistics show a slight increase in the number of insurance fraud cases being reported to the Police Authority in recent years. Nonetheless, a significant number of suspected cases are never reported. One reason for this may be the declining interest to investigate these types of crimes by the police and prosecutors.

In 2024, 633 insurance fraud cases were reported to the police – a slight decrease compared to 2023, when 665 cases were reported.

Few Cases Lead to Prosecution

Over the past five years, only 15 percent of all police reports on insurance fraud have resulted in prosecution, even though insurance companies only report cases that have undergone thorough investigations and where suspects have been clearly identified. Due to the low prosecution rate, insurance companies sometimes handle these matters solely through civil proceedings.

To examine the issue more closely, the insurance industry decided to follow up in 2024 on how the Policy Authority handled the industry's fraud reports. The results were troubling: more than half of all decisions were found to be either incorrect or unreasonable.

Of all insurance fraud cases reported to the Police Authority over the past five years, 84 percent led to a preliminary investigation, 15 percent resulted in prosecution, and 2 percent ended with a summary imposition of a penalty.

Police Reports, Investigations and Prosecutions

Year	Police Reports	Preliminary Investigation	Prosecutions Initiated	Summary Imposition of a Penalty	Waiver of prosecution
2023	665	571	48	13	0
2022	539	625	125	22	0
2021	597	585	135	14	0
2020	540	369	79	4	0
2019	417	166	14	2	0

Regional Differences

In 2015, the Swedish National Council for Crime Prevention (Brå) conducted a study to investigate why so few reports of insurance fraud led to prosecution. The study found notable geographic differences in the likelihood of prosecutors deciding to prosecute.

There are also regional differences in the number of police reports of insurance fraud across police regions. Of the 633 reports filed in 2024, the majority were made in metropolitan areas. A total of 169 reports were registered in Stockholm.

Examination of the Industry's Police Reports

In 2024, the insurance industry decided to follow up on how the Policy Authority handled the industry's police reports and the Police Authority's decisions to deny or close a preliminary investigation. The purpose of this initiative was to assess whether these decisions were being made on valid grounds, as few reports resulted in prosecution or other legal actions.

Over the past five years, only 15 percent of all insurance fraud reports to the police have led to prosecution, and just 2 percent have resulted in summary impositions of a penalty. The insurance industry considers these figures remarkably low, especially given that insurance companies only report cases that have undergone thorough investigations and always involve clearly identified suspects.

To understand the reasons behind these low numbers and to ensure that decisions to deny or close preliminary investigations were being made on valid and legally sound grounds, the industry carried out an in-depth examination of these decisions in 2024. The goal was to follow up on reports of insurance fraud where preliminary investigations were denied or closed.

How the Examination was done

Throughout 2024, insurance companies submitted decisions to deny or close a preliminary investigation. These decisions from the Police Authority were then reviewed by Larmtjänst together with the corresponding police reports. Larmtjänst categorized these decisions as follows:

- Reasonable: There were valid grounds to not proceed with a preliminary investigation.
- Unreasonable: There were valid grounds to proceed with a preliminary investigation.
- Incorrect: There was no legal basis for the decision.

Results of the Examination

The examination was conducted between January 1 and December 31, 2024. Of the 126 decisions reviewed, Larmtjänst found that 46 percent were incorrect, and 27 percent were unreasonable. Only 27 percent were deemed reasonable. This meant that 73 percent of the reviewed decisions were either incorrect or unreasonable.

Grounds for Closure

While Larmtjänst did find some justifiable decisions—such as those motivated by the statute of limitations —a large proportion of the decisions were unreasonable or

incorrect. The *unreasonable* category included decisions where the Police Authority stated that there were no suspects, even though the policyholder had been clearly identified.

Larmtjänst also observed that several decisions were justified by claiming that the attempted fraud case was deemed not a punishable crime. The reasoning was that the insurance company's investigation had already prevented the crime, commonly referred to as "unserviceable attempts." This is considered an unreasonable basis for a decision to deny or close a preliminary investigation, as only a small fraction of all claims is subject to an investigation, and further, an estimated 5–10 percent of all payouts are linked to insurance fraud.

The *incorrect* category included decisions in which the Police Authority cited the possibility to use a waiver of prosecution according to the Swedish Code of Judicial Procedure even though it was an assessment that could only be made by a prosecutor.