

Insurance Fraud Offense in the Algerian and American Systems: Between Theory and Application in Determining Criminal Liability Rules

Zian Mohamed Amine¹; PhD. Bouamra Okba²

¹Lecturer, Department A, Laboratory of Governance and Sustainable Development Faculty of Law and Political Science, University of Blida 02-Algeria

²Laboratory of Globalization and National Law, Faculty of Law and Political Science, Mouloud Mammeri University of Tizi Ouzou, Algeria

Email : ¹Ma.zian@univ-blida2.dz; ²Okba.bouamra@ummtto.dz

ORCID: ¹<https://orcid.org/0009-0000-5116-4695>; ²<https://orcid.org/0009-0006-5446-2149>

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Abstract :

The crime of fraud and deceit in the field of insurance is among the most dangerous newly emerging offenses that threaten both the public and private sectors. This is because it does not affect only insurance companies ; rather, its harmful consequences spread to policyholders and to society as a whole. Fraud in insurance, in both the Algerian and American systems, revolves around the idea of resorting to fraudulent methods and techniques in order to exploit insurance contracts, with the aim of obtaining an unjust, unlawful profit, and it is given a criminal description.

When discussing the rules for implementing and establishing criminal liability for the crime of insurance fraud and deceit in these two pieces of legislation, we find that there is a divergence between them in terms of the legislative approach. Thus, whereas the Algerian legislator limits itself to the general rules for classifying the act as fraud and deceit, the American system has devoted an independent and stringent legal arsenal to distinguish between civil and criminal fraud concerning these undesired behaviors in the insurance field. This is what will be studied in this article between theory and practice, in determining the provisions governing criminal liability.

Keywords : Fraud and deceit ; insurance fraud ; insurance companies ; criminal liability ; the Algerian legal system ; the American legal system.

Introduction

Insurance contracts are among contracts based on utmost good faith, as they are fundamentally founded on mutual trust between the insured person or thing and the insurance company, and on the distribution of risks between them. However, under changes in society and developments in the current situation at the level of criminality, this protective system has become a direct target of fraud and deception operations of various forms. These have evolved alongside advancements in media and communication technology, in parallel with the criminal's increasing sophistication. Moreover, the reality of criminal policy makes insurance fraud not merely a material act involving deceptive methods and tricks; rather, it constitutes an intelligent, cross-sector, transnational

criminal offense. It drains billions of dollars annually, intersects with cyberspace, money laundering, and has a direct impact on the national economy.

This scientific paper is of great importance both practically and theoretically, because it addresses a pressing issue at the national and international level: an “enhanced and evolving” criminal phenomenon, namely insurance fraud. It seeks to provide a comparative legal approach between two different legal systems: the Algerian system, which has Latin origins, and the American system, which has Anglo-Saxon origins. The aim is to examine the theory of legal treatment and the extent to which insurance fraud is covered, while also shedding light on supervisory and technological mechanisms between prevention policy and punishment policy.

This article aims to achieve a set of objectives, including the title of the scientific paper. Among the most important objectives is to identify the different patterns of insurance fraud, particularly in sensitive areas of major practical importance, including marine insurance and insurance of persons. It also entails analyzing the substantive and procedural rules governing criminal liability without civil liability in both Algerian and American legislation as two models. Furthermore, it highlights and clarifies the role of modern technology as a preventive tool to strengthen insurance security.

This topic raises many questions with legal, judicial, digital, and economic dimensions, revolving around a central problem: to what extent have the Algerian and American legislative systems succeeded in establishing effective rules and provisions to confront the risks of insurance fraud and deception by defining criminal liability, and how can modern preventive mechanisms contribute to closing the loopholes and gaps resulting from increasingly sophisticated fraudulent practices in insurance fields.

In general, addressing insurance fraud and deception in detail requires a comprehensive methodological pluralism encompassing description, analysis, comparison, and conclusion. This is done by identifying and describing the practical reality of insurance fraud and deception, particularly in the marine field and the scope of persons, by defining its concept and the most important methods upon which it is based. It is also accompanied by an analysis of the prevention and punishment policy pursued in determining criminal liability, by comparing the orientations of the Algerian legislator with those of the American legislator. This enables us to rely on the deductive approach in identifying the most important proposals that contribute to closing loopholes for manipulation in the field of insurance.

Therefore, the plan adopted in analyzing this article will be structured around two main axes: the first addresses legal applications concerning fraud and deception within the scope of insurance, while the second examines fraud in the insurance field between prevention and punishment.

First: Legal provisions on fraud and deception within the insurance sector

The insurance sector is one of the fundamental pillars of the modern economy on which all countries rely. At its core, it is based on the idea of “absolute good faith” and collective solidarity in order to confront individual risks. However, this latter has not been spared from the manipulations of criminals—people of bad intent who seek to obtain as large a compensation amount as possible. Thus, the phenomenon of insurance fraud, which used to be no more than simple misrepresentations, has become an organized crime targeting insurance companies. It is a modern and intelligent offense that relies on falsifying facts and events; moreover, it involves

staging accidents in order to obtain compensation to which one is not entitled. This has placed the legislator and the judiciary before the necessity of addressing the matter from the standpoint of its legal application, particularly in the maritime field and insurance companies.

01_ Insurance fraud in the maritime field

This will be studied by addressing the definition of this act, identifying its elements, and also presenting its most important manifestations.

a_ Definition of the act of insurance fraud

The crime of insurance fraud is defined as any alteration or distortion that affects the essence or composition of a good or item prepared for sale, which results in depriving it of its essential characteristics, concealing its defects, or giving it an appearance that suggests it is another item different from the truth. This is done with the aim of profiting from the lost characteristics or from the price difference. The act of fraud occurs by any means that brings about a material change in the goods, removes their essence, or presents them in an incorrect manner—thereby affecting the rights and interests of the contracting parties¹.

Insurance fraud is considered a deliberate fraudulent act that relies on providing misleading information in order to obtain an unlawful profit. It is classified as one of the most dangerous crimes because it is grounded in the offender's intelligence and the use of means that induce the victim to hand over their money without suspicion. The Algerian Supreme Court (Chamber of Criminal Offences and Misdemeanors) defined fraud from a legal standpoint as the appropriation of something belonging to another through fraudulent methods and maneuvers, without which that purpose would not have been achieved².

As for insurance fraud, its origins date back to the Middle Ages. The Insurance Fraud Prevention Agency (ALFA) defines it as an intentional act committed by a natural or legal person in order to obtain an unlawful profit from an insurance contract. This crime consists of the insured person's taking possession of the compensation amount through maneuvers that affect the insurer and push it to deliver. It is a crime of circumstances whose criminal activity ends as soon as the compensation is received. This crime is based on three elements, just like another offense³:

- **The legal (statutory) element:** which criminalizes the act and determines it, and which differs from one country to another according to its own penal law.
- **The material element:** which includes the criminal activity (fraud), the result (delivery of money), and the causal relationship between them. Most countries usually agree on its elements: criminal conduct, a result, and a causal relationship.
- **The moral (intentional) element:** which represents the criminal intent of the offender, and includes the intention to commit "fraud and insurance deceit" and the will to commit it.

¹ Muhammad Ben Moussa Nasr, *The Crime of Deceit/Ghish : Its Provisions, Forms, and Devastating Effects*, Al-Farqan Library, Dubai 2008, p. 215

² Alouane Iman, Leila Krache, *Marine insurance fraud*, Algerian Journal of Law and Political Science, Volume 07, Issue 01, 2022, p. 353

³ Insurance fraud is defined as an intentional act carried out by a natural or legal person, in order to obtain, without right, a profit from an insurance contract. Insurance fraud, the Insurance Fraud Prevention Agency ALFA, www.alfa.asso.fr

b_ The most important manifestations of fraud in maritime insurance

Maritime activity is one of the most important activities within the field of insurance, whether concerning goods or persons in the context of maritime transport operations. With changes in criminal acts, fraud and deception in this field have emerged. Among its most important manifestations we find:

- **Fraud resulting from the multiplicity of insurance contracts:**

In addition to fraud arising from the insured party's deliberate error⁴ :

Maritime activity has another method based on fraud, namely the multiplicity of insurance contracts. This occurs when several contracts are concluded with different insurers for the same item, the same interest, and the same risk, during a simultaneous time period. For instance, in Algerian legislation, according to Article 33, paragraph three, of Order 95-07 relating to insurance, proving the insured person's bad faith leads to the contract's invalidity from a civil perspective. The burden of proof lies with the insurance company to prove deliberate exaggeration in assessing the value of the insured object, and to prove the insured person's intent to conceal the fact of the multiplicity of contracts. This was confirmed by the jurist "Lambert-Faivre" (Lambert-Faivre), who stated that proving fraud leads to the invalidity and cancellation of all contracts once the fraud is uncovered, whether it occurs before the occurrence of the risk or after it. This results in the insurer being released from the obligation to pay compensation.

To invalidate the contract, it is required that the multiplicity be accompanied by bad faith and that the insurance amounts exceed the true value of the insured things. However, if the amounts are equal to the value or less than it, there is no basis for invalidation because there is no financial harm to the insurance company, and the insured party receives actual compensation that does not exceed their loss. The general principle in transactions is to presume good faith; whoever alleges otherwise—that fraud occurred—must prove it according to the applicable general rules. Thus, the conditions for the establishment of multiple insurances are⁵:

- The unity of the insurable interest
- The unity of the sum that is the object of insurance
- The concurrence of the same insured risk across all contracts
- The matching of the insurance periods (for example, the contracts cover a single maritime voyage)

- **Fraud resulting from combining the insurance amount and compensation:**

The insured person is prohibited from combining the insurance amount (paid by the insurer) and the compensation amount (paid by the person responsible for the damage) in order to prevent being compensated twice for the same harm. Accordingly, the injured party must choose whether to seek recourse against the insurance company or to sue the person other party responsible. In this regard, custom favors first recourse against the insurer based on the insurance contract, after which the insurer later steps into the insured person's shoes in recourse against the person who caused the damage. If the insured person chooses to bring a liability claim against the third party,

⁴ Baris, Soyer, *Marine insurance fraud*, 1st edition, British Library Cataloguing in Publication Data, by Inform Law from Routledge, New York, 2014, p. 8

⁵ Alouane Iman, Leila Krache, *op. cit.*, p. 361

they must prove fault, whether it results from the act of the person themselves or from the acts of their subordinates subject to their control⁶.

Therefore, the crime of fraud and deception in the insurance sector is considered a flexible and time-evolving crime. It has continued to adopt new methods and forms in which the insured person resorts to fraud against maritime insurance companies using the means commonly known in insurance activity, while keeping pace with modern technology and exploiting its outcomes. These methods vary depending on the legislations and the capacity of insurance companies in each country to confront them and limit their effects.

02_ The crime of fraud and deception in insurance companies

This element will be addressed by covering each type applicable to persons, and what relates to the issue of the damage resulting from insurance fraud.

a_ The type applicable to persons

A persons' insurance contract consists in guaranteeing that the insurer covers risks that affect the individual's person—namely the harm that may befall them throughout their life. Examples include life insurance, in which the insured/assured pays the insured amount when the risk occurs for example, the insured's suicide or the insured's life may be attacked by the beneficiary, with the aim of accelerating payment of the compensation. These are as follows:

- **Fraud resulting from the insured's suicide against his own life:**

A debate was raised regarding the extent to which this contract may be considered a contract of insurance, considering that the risk appears to be certain to occur, whereas the general rule in an insurance contract requires that the risk be contingent. However, the prevailing view is that, even if death is certain, the date of its occurrence is not determined. Thus, the element of contingency exists. Therefore, life insurance is an obligation under which the insurer undertakes to pay a specific amount to the beneficiary upon the death of the insured, in return for a single or periodic premium. The insured risk consists in the risk of death, and it has three basic forms⁷:

_ Temporary death insurance: This is a contract under which the insurer undertakes to pay the insured amount to the beneficiary if the insured dies within a specified period set in the contract. If death does not occur during this period, the insurer's obligation ends, or its liability is discharged, and all premiums that were insured become due/are retained.

For that reason, this type of persons' insurance is used for persons exposed to unusual risks, such as pilots, sailors, workers in munitions and arms factories, as well as employees in nuclear research centers.

Insurance for the survival of the beneficiary: The insurer pays the insured amount to the beneficiary on the condition that the beneficiary remains alive after the insured's death. If the beneficiary dies before the date fixed for death with respect to the insured, the insurer is released from its obligation to pay the insured amount. Thus, the condition for entitlement to this amount is that the beneficiary remains alive after the insured's death. For this reason, this type is called survival insurance (i.e., insurance for the beneficiary's continued survival).

⁶ Abdel Razzaq Ben Khrouf, *Private Insurance in Algerian Legislation, Part One : Maritime (Land) Insurance*, Dar Al-Khaldounia, Algeria, 2017, pp. 255–256

⁷ Asma Hoggas, Khadidja Amraoui, *Investigate the crime of fraud in insurances*, Ma'alim Journal for Legal and Political Studies, Volume 05, Issue 01, 2021, p. 74

Life insurance (whole-life insurance): This is a contract concluded between the insurer and the insured. Under it, the insurer undertakes to pay the insured amount to the insured or to the beneficiary upon the death of the person insured on their life, at any time the death occurs. If the insurer must pay the insured amounts for the benefit of one person or several persons designated in the contract, Algerian legislation has prohibited the acquisition of insurance coverage in the event of death if the insured commits suicide of their own free will and with awareness within the first two years of the contract. Accordingly, coverage does not apply to suicide in accident insurance. The insurer bears the burden of proving the insured's suicide, while the beneficiary bears the burden of proving the insured's loss of consciousness.

- **Fraud resulting from the beneficiary's assault on the insured's life:**

According to the Algerian legislator's orientations, where the beneficiary is subject to a ruling due to the killing of the insured, the beneficiary is not entitled to the insured amount in the event of death, and the insurer is only obligated to pay the balance amount included in the contract to the other beneficiaries, provided that at least two annual premiums have been paid in advance. Thus, the insured is the insurer of their own life, while each person who is covered (i.e., the insured's assignee) and the beneficiary is detached from them—yet they may be the same person. Hence, it is assumed that a person insures another person's life for their own benefit, and then, at the same time, becomes the beneficiary and the applicant for insurance. However, this may turn into fraudulent conduct: the insurer may approve the insurance contract, relying on the insurance applicant as the beneficiary at the same time, and then the latter may betray that trust and intentionally cause the insured's death or take steps to have the insured killed. In that case, the insurance contract requires that the beneficiary be entitled to the insured amount as soon as the insured dies. Nevertheless, if the beneficiary (or insurance applicant) is the same person who caused the insured's death, then they lose their right to the insured amount. But if the matter involves a group of beneficiaries or heirs, the remaining entitled persons have the right to receive the insured amount on the condition that they have paid at least two annual premiums⁸.

b_ The type related to damages

At times, the insured becomes a victim of their own greed and avarice, and resorts to attempting fraud against the insurance company by committing crimes of fraud causing harm.

Fraud resulting from the insured's intentional error:

General insurance rules require that the insured may not insure against intentional fault; because intent removes the characteristic of "contingency" on which the concept of insurable risk is based. Once the act is committed intentionally, the occurrence of harm becomes certain and is linked purely to the person's own will, which eliminates the element of risk and contradicts public policy. This prohibition aims to prevent deception in order to obtain insurance amounts through unlawful means and to avoid encouraging the occurrence of accidents. In cases where the occurrence of intentional harm is alleged, the insurer bears the burden of proving the existence

⁸ Darbāl Amāl, Fraud in Insurance, Master's thesis in comparative business law, Faculty of Law, University of Oran 02, Algeria, 2011–2012, pp. 78–79

of criminal intent in order to remove coverage. The default position is that compensation is owed as soon as the fault covered by the insurance occurs⁹.

- **Fraud resulting from the insured's exaggeration in proving the value of the damage:**

The insured is required to provide accurate and truthful information regarding the risk and the damage, and to avoid exaggerating the estimates. The insurance contract is classified among “good faith” contracts. This includes limiting losses to actual losses such as medical treatment and necessary accommodation expenses, or the costs of providing alternative housing if the health situation requires it. The insured may only recover necessary expenses, without exaggerating the choice of the most costly treatments. The judge also has discretionary power in determining appropriate compensation for each case¹⁰.

As for cases of bad faith—such as providing false information or concealing material information that affects the assessment of the risk—the legal consequence is the invalidation of the contract in accordance with Article 21 of the Algerian Insurance Law. This results in depriving the insured of compensation, and recovering what was previously paid to them, while the insurer retains the paid premiums as an acquired right, and the insured is obliged to compensate the company for damages caused by their deceit.

Second: Fraud in insurance between prevention and punishment

Given the increase in fraud and deception in the insurance field, states have moved toward taking a set of preventive and effective measures to prevent the situation from worsening. This requires identifying various acts of corruption and fraud occurring in insurance through criminalizing them in the eyes of the law, which was adopted by the American and Algerian legislator as international models that criminalize such acts within the insurance sector.

01_ Mechanisms for detecting fraud in insurance companies

Before addressing the punitive aspect, comparative legislation considers it necessary to issue a prior warning through a proactive or preventive criminal policy in order to prevent the occurrence of crime, by raising awareness among insurance companies about the risks of insurance fraud and its negative repercussions on different dimensions.

a_ Moving toward the establishment of a comprehensive strategy to address the risks of insurance fraud

Formulating an anti-fraud strategy within insurance companies requires creating an integrated framework that defines its objectives and principles. Its importance lies in answering essential questions related to choosing the best methods of confrontation, identifying the available options, and framing the procedures and tools relied upon in practice. This strategy is shaped through exchanging ideas and views among the company's stakeholders, especially the compliance,

⁹ Muhammad Hussein Mansour, *Insurance Provisions*, Dar Al-Jami'a Al-Jadida for Publishing, Egypt, without mention of the year, pp. 54–93.

¹⁰ Nassira 'Alali, *Assessing compensation for bodily injury from the perspective of Islamic jurisprudence and the provisions of positive law (Civil Law)*, *Journal of Law and Political Science*, Volume 3, Issue 2, 2017, pp. 340–341.

auditing, and internal control functions, as well as risk management, in addition to the legal and financial departments—thereby strengthening commitment, joint cooperation, and the benefit of accumulated expertise.

Practically, this strategy should include the following elements¹¹:

- Clarifying the approach and method used.
- Adopting the company's core values as a fundamental reference.
- Defining the key concepts and identifying the main risks.
- Explaining the organizational structures and determining the responsibilities of the involved parties.

b_ Developing control systems over various operations and insured information

Control in the insurance sector differs from one company to another depending on the nature of work. Still, the most important control systems relied upon are:

- **Relying on a risk inspector (inspector of risk)**

The risk inspector does not have a legal obligation toward the insurance company to follow and monitor the risk continuously. Rather, their intervention is limited to cases involving risks of a special nature—whether because of the magnitude of the guarantees required or because of the specificity of the risk itself. In some European countries, such as France, the inspector intervenes to express an opinion on whether to accept insurance within certain financial limits; if the value exceeds those limits, the decision to accept or refuse becomes the inspector's competence. As for industrial risks, the inspector's involvement is essential, since their technical expertise allows them to determine the real insurance needs of the institution and assess the type of risk. The inspector's field oversight forms part of their responsibility toward the declarations provided, which contributes—through objective investigation—to limiting cases of false declaration¹².

- **The prior expert**

The role of the prior expert is to verify the material existence of the insured items, especially those with high value. This procedure helps block the path of dishonest insured persons who may seek to commit fraud by insuring fictitious property and then claiming that it was lost or stolen in order to obtain compensation¹³.

- **Monitoring customer files ("insured persons")**

These files help insurance companies conduct material monitoring of the elements declared, while the intangible elements require greater care from the insurer through collecting and organizing information related to the insured persons. The development of automated/IT

¹¹ _ Odilon Audouin, Nicolas Ricchiuto, organiser et piloter le risque de fraude dans l'assurance, l'argus de l'assurance, l'argus Édition, 2013, p. 66.

Politique de prévention et de lutte contre la fraude et la corruption, Inter-Parliamentary Union, 2012, p. 04.

¹² Christian Strulovici, sinistralité de crise, Revue Risque, No. 16, SCEPRA, Paris, December/October 1993, p. 71.

¹³ Hassan Nacif, The role of insurance companies in attempting to combat fraud—an applied study on insurance companies in Algeria, Doctoral thesis in sciences in the field of economic sciences, specialization in economics of finance and banks, Faculty of Economic Sciences, Commercial Sciences and Management Sciences, University of M'hamed Bougara, Boumerdès, Algeria ; discussed and approved on 14 May 2018, p. 82.

systems has improved the quality of these files and the speed of access to them. They include the following information¹⁴:

- _ Personal identification data of the insured person.
- _ Prior insurance information (insurer name, policy number, contract duration).
- _ Detailed information about the insured item.
- _ Reasons and the date for termination of the previous insurance.
- _ Historical record of the risk (number of occurrences and their dates).

These files do not aim to exclude people from insurance, but rather serve as an advisory means that enables companies to identify suspicious operations or those that violate contractual rules, in order to avoid becoming victims of any insurance fraud.

- **Controlling professional fraud through internal control**

Internal control in the insurance sector is considered one of the most important mechanisms for limiting the expansion of criminality in this sector—particularly fraud—so that internal control takes place through¹⁵:

- _ **Protecting employees' contract management:** Insured persons may be employees of the insurance company itself, which requires implementing special monitoring procedures for managing their contracts in order to prevent fraudulent acts, whether individually or through collusion. Such contracts must be classified precisely within the information system, with the requirement that all operations related to the employee's insurance account be carried out by someone else. Moreover, the employee must be prohibited from performing any action on their personal account under any circumstances.

- _ **Regulating the commissions system:** Insurance company employees obtain incentives linked to commercial operations. This may motivate some to adopt fraudulent behaviors aimed at inflating the business volume in order to reach the commission ceiling targeted. To limit this, the company can activate control mechanisms by setting a specific ceiling for commissions, while ensuring proportionality between the commissions granted and the nature of the corresponding insurance products.

d_ Adopting modern technology techniques to address insurance fraud risks

Digital transformation has become an essential pillar for improving operational efficiency and enhancing service quality. While risk management was traditionally tied to human expertise and manual procedures, digital technologies today have become the central driver of this process. Digitization enables companies to process insurance files—from underwriting to claims management—with greater effectiveness by adopting artificial intelligence. In addition, big data analytics strengthens institutions' capacity to monitor risks in real time and respond quickly. Automation also improves internal performance and reduces human error. Furthermore, processing large quantities of historical information and claims makes it possible to predict future patterns with high accuracy. Through automated underwriting and pricing systems based on advanced algorithms, companies have become better able to assess risks and set fair prices for

¹⁴ Sylvie Revol, *déclaration frauduleuse de risque et de sinistre en assurance*, IARD, Institut des Assurances, Aix-Marseille University Press, 1984, p. 46.

¹⁵ _ Hassan Nacif, *op cit*, p. 103.

_ Odilon Audouin, Nicolas Ricchiuto, *op cit*, p88.

products, supporting effective strategic decision-making. More than that, digital transformation has accelerated the rate of claims verification and the payment of compensation with less effort and cost. This technical development not only facilitates procedures; it also strengthens customer trust and consolidates the positive image of insurance companies in the market¹⁶.

e_ Managing performance indicators and reporting systems in combating fraud

Performance indicators and reporting systems are considered the most important tools relied upon for organizing insured operations. Through them, performance is assessed and fraud in general is identified, and sufficient evidence is obtained regarding whether insurance fraud has occurred or not. The most important of these are¹⁷:

- **Leadership of indicators and reports:** Defining precise indicators enables the fraud-combating officials to carry out their tasks with high efficiency. Like any institutional function, fraud prevention and combating require performance effectiveness to translate results and to control the resources and tools needed. This process begins by measuring the efficiency of implementing procedures, the limits of control, and risk assessment, then develops to include measuring the results of prevention, detection, and investigation.
- **Performance indicators (KPIs):** Used to ensure that controls are implemented and their effectiveness is proven against each risk. Among the most prominent: the number of fraud cases detected and the files studied.

Measuring the level of accomplishment of the controls (implementation rate).

Assessing the extent to which the implemented controls comply with standards (compliance rate).

_ Prevention and detection indicators

_ Number of recorded professional alerts.

_ Number of reports submitted to security and judicial authorities.

_ Fraud detection rate within a specified time period.

_ Success rate of inquiries and investigations.

_ Counting cases of internal and external fraud.

_ Total financial amounts lost due to fraud annually.

- **Reporting systems:** Reports dedicated to presenting a case or an alert are classified into two types (internal and external). They aim to monitor activity and inform management and committees of the company's level of risk exposure:

Incoming reports, representing dashboards prepared by the central fraud-combating unit, to measure the extent to which field control carried out by anti-fraud personnel is being achieved and how effective it is.

Outgoing reports directed to senior management, the two audit and risk committees, and the central committee. These reports aim to inform about fraud operations whose value exceeds a certain threshold and to clarify the risk exposure level and the quality of the procedures used.

¹⁶ Walia Ali Afzal Abdulkarim Al-Sheikh Jafar, "The Impact of Digital Transformation on Insurance Risk Management Using Scenario Analysis and Stress Testing", Arab Journal for Scientific Publishing, Issue 7 – No. 71, 2024, p. 117.

¹⁷ Jean Luck Souriguet, Emmanuel Fernandez, *Le contrôle interne bancaire et la fraude*, Dunod, France, 2006, p. 154.

02_ Establishing criminal liability rules for fraud in the insurance sector

After taking the preventive side, the role of punitive criminal policy aimed at deterrence comes into play, especially when prevention is proven ineffective. Modern comparative legislations have generally moved toward criminalizing fraud and swindling in general. However, the American legislator has specifically criminalized insurance fraud, as has the Algerian legislator, who has extended the scope of criminalization of swindling and fraud across both a substantive aspect and a procedural aspect.

A. Insurance fraud under American law as a first model

Insurance fraud refers to any deceptive practice intended to obtain an unlawful financial compensation from insurance companies. These practices are legally classified as both civil and criminal offenses at the same time. They cause annual losses for the insurance sector estimated at about 80 billion dollars, which in turn leads to an increase in costs for all consumers. Detecting these crimes is highly difficult due to their secretive nature. Investigators and public prosecutors classify fraud schemes into two types¹⁸:

_ **Hard fraud:**the least common type; it consists of the criminal intentionally destroying property in order to obtain the insurance value.

_ **Soft fraud:**it occurs through exaggerating the value of legitimate claims, or providing incorrect information when obtaining the policy in order to reduce the premium.

- **Laws and legislation related to insurance fraud under American law:**

Insurance fraud is classified as a felony in most states and at the federal level, and not merely as a misdemeanor. The rules of criminal liability for 2026 are based on a combination of federal laws and state laws. They target any intentional act of deception in order to obtain an unlawful benefit from an insurance company. Perpetrators of such acts are punished by the text of Article 1033 of U.S. Code Title 18 under insurance fraud crimes, with imprisonment for up to 10 or 15 years, depending on factors such as the value of the embezzled funds or prior criminal history. In the event that it is proven that you used U.S. mail or wired/wireless communications services to commit the fraud, charges may be added under federal laws related to fraud by mail or by wire communications. In addition, fines reaching hundreds of thousands of dollars may be imposed, and these financial penalties may destroy the defendant's savings after release. The defendant may also be subject to a monitoring period, which may include strict conditions such as mandatory periodic follow-ups and drug-detection testing. In this regard, the most important laws are¹⁹:

_ 15 U.S.C., Ch. 20 - McCarran-Ferguson Act Recognizing State Regulation of Insurance

_ 15 U.S.C., Ch. 65 - Liability Risk Retention

_ 12 U.S.C., Ch. 16 - Federal Deposit Insurance Corporation (FDIC)

_ 7 U.S.C., Ch. 36 - Crop Insurance

_ 42 U.S.C., Ch. 50 - Flood Insurance

_ 5 U.S.C., Ch. 87 - Federal Employee Life Insurance

_ 5 U.S.C., Ch. 89 - Federal Employee Health Insurance

¹⁸ Wex Definitions Team, insurance fraud, Information, Cornell Law School, for link <https://www.law.cornell.edu> review in 04_05_2026, at 21 :54

¹⁹ Lawyers, Blog The ultimate guide to the federal insurance fraud statute, FEDERAL INSURANCE FRAUD STATUTE, NYC Criminal Defense, February 27, 2025, <https://www.nyccriminalattorneys.com>

- **The practical side in embodying insurance fraud:**

Swindling and insurance fraud take multiple forms, due to differences in insurance fields. The most important of these are the automobile insurance and life insurance sectors. Here we find the most important stations and judicial aspects²⁰:

- Alleging the occurrence of fictitious accidents or the repetition of claims for a single accident.
- Claiming compensation for injuries unrelated to the accident or alleging wage loss.
- Inflating vehicle repair invoices.
- Registering the vehicle in a geographic area different from the actual place of residence in order to reduce the premium.

_ Charges were brought against (A, R), a 32-year-old from Whetakers, with four insurance fraud counts and four counts of obtaining property through fraud; all of them were felonies. Private agents from the criminal investigations division of the Davis insurance department are accused of pursuing automobile insurance claims with State Farm Mutual Automobile Insurance Company, for a vehicle that was involved in staged accidents, which it is alleged he did not own. According to arrest orders, they obtained payments totaling USD 13,642.42 as a result of these claims.

_ Charges were brought against (J, S), 27 years old, from Fayetteville, with one count of insurance fraud; it was a felony. According to the arrest memo, the accused filed a claim with Progressive Premier Insurance regarding damages allegedly done to his vehicle and to another man's vehicle, claiming that the damage occurred after he obtained an insurance policy, while it had happened before that.

_ Charges were brought against (J, R), 42 years old, from Hickory, with an insurance fraud charge, which is a felony. Private agents from the criminal investigations division of the insurance department are accused of having Robert submit a cost estimate for vehicle repairs valued at USD 28,995 from a non-existent company to support an automobile insurance claim with Geico.

B. Insurance fraud under Algerian legislation (second model)

The Algerian legislator addressed swindling and fraud in general, while adopting the generality of terminology at both the substantive level and the procedural level.

- **At the substantive level (in the Penal Code)**

By virtue of Articles 372 and 14 of the Penal Code, the Algerian legislator classified the offense of swindling as a misdemeanor, specifying its original penalty as imprisonment from one year to five years. He also established additional penalties that include deprivation of national rights and restriction of residence for a period ranging between one year and five years, which are penalties subject to the discretionary authority of the judge of the merits. In contrast, the legislator increased the penalty up to imprisonment for ten years (a felony) in the case where the insured person targets a state-owned insurance company, in accordance with Article 382 bis²¹.

²⁰ MIKE CAUSEY, Insurance Fraud is a Felony !, NC OF INSURANCE, NCDOJ Advisory Memo relating to NPN Override, <https://www.ncdoi.gov>

²¹ _ Law No. 25_14 dated 8 Safar 1447, corresponding to 3 August 2025, includes the Code of Criminal Procedure, J, R, A 54.

_ Article 14 (amended by Law No. 06-23) : The court, when deciding in a misdemeanor, and in cases specified by law, may prohibit the convicted person from exercising one or more of the national rights mentioned in Article 9 bis 1, for a period not exceeding five (5) years. This penalty applies from the day on which the custodial penalty ends or upon the release of the convicted person.

It is worth noting that the Algerian legislator punishes attempted insurance swindling, i.e., once execution begins by using deceptive maneuvers aimed at influencing the insurance company so that it hands over compensation—by presenting the insured person’s forged documents to support his false claims—pursuant to the provisions on attempt in Articles 30–31 of the Penal Code. The offense remains in the stage of “attempt” from the moment deceptive means are used until the act of delivery is completed. If the insured person does not receive the compensation amount for a reason beyond their will, the act is considered punishable attempt²².

The reasons for the lack of completion of the offense include: the insurance company’s discovery of the fraud, the intervention of a third party to reveal the maneuver, or the police discovering the scheme and arresting the accused before the funds are received.

The Algerian legislator has equated the penalty between the completed offense and the attempt, according to Article 372 of the same law, which provides for punishing any person who “obtains receipt of... or begins to do so”. The penalty consists of imprisonment from one (1) year to five (5) years and a fine from 100,000 DZD to 500,000 DZD. In all cases, in addition to that, the court may also impose on the offender deprivation of one or more of the rights provided for in Article 9 bis 1 and a prohibition on residence for a period of one (1) to five (5) years. The penalty is aggravated to imprisonment of up to ten (10) years and a fine up to 1,000,000 DZD if the misdemeanor is committed against a group exceeding three (3) persons, pursuant to the same Article. Also, if the offense causes harm to the state or to local communities or to institutions or public law bodies subject to public law, the perpetrator is punished with imprisonment from two (2) years to ten (10) years in other cases²³.

- **At the procedural level (in the Code of Criminal Procedure)**

Criminal prosecution in offenses involving fraud against maritime insurance companies consists in initiating the public lawsuit against the insured person. By virtue of the general rule, the public prosecutor is considered the plaintiff and is the body granted by Algerian legislation the authority to initiate and conduct the lawsuit, in accordance with Article 39 of the new Algerian Code of Criminal Procedure No. 25-14.

As an exception, the injured party (“the insurance company”) may participate by bringing the lawsuit through submitting a complaint accompanied by a civil claim. However, the right to bring and prosecute the public lawsuit remains reserved exclusively to the public prosecutor. It is the prosecutor who undertakes all procedures aimed at securing the conviction of the insured person, starting from opening the investigation and presenting evidence, and ending with appealing the judgments and enforcing them. From the penal perspective, and since the penalty for the misdemeanor of fraud exceeds imprisonment of more than three years pursuant to the text of Article 372 of the Penal Code, the investigating judge may issue an order for placing the insured person in pretrial detention for four months, based on the text of Article 201 and subsequent articles of the Code of Criminal Procedure. The public lawsuit, when brought before the courts, is

²² Asma Hoggas, Khadidja Amraoui, op cit, p 77

²³ Article 382 bis, as amended by Law No. 01-09 and Law No. 24-06 of 29 Shawwal 1445, corresponding to 28 April, Official Gazette No. 30, amending and supplementing Ordinance No. 66-156 of 18 Safar 1368, corresponding to 8 June 1966, containing the Penal Code, Official Gazette No. 49

followed by an attached civil lawsuit arising from the fraud offense, where it is decided directly after the judgment in the penal aspect.

This connection aims to facilitate the insurance company's procedures and enable the judge to be fully informed of all the circumstances of the case on both the criminal and civil sides. This assists in assessing the civil compensation that repairs the damages suffered by the victim as a result of the insured person's fault²⁴.

Conclusion

In conclusion, it can be said that the topic of insurance fraud in the Algerian and American systems between theory and application in determining the rules of criminal liability is among the most important doctoral subjects in the international arena, due to the seriousness of the methods used to target insurance companies with the aim of increasing compensation to the insured in an unlawful manner. However, contemporary criminal policy in both Algerian and American legislation has addressed this issue through an objective dimension and an additional criminal dimension in the first, fraud is treated as a misdemeanor, while in the second, it is treated as a felony, The American legislator proved to be more precise and more structured in criminalizing the act of insurance fraud, showing that this offense is flexible and adapts to legal and technical loopholes. It focuses on strict financial penalties and custodial penalties, as well as federalism and multiple levels of supervision. Meanwhile, the Algerian legislator seeks through its recent amendments (2024–2026) to harmonize the penal code and criminal procedure code by providing protection to the insurance sector.

Results of the study :

- This study showed that fraud and deception have become a serious threat to the insurance sector in various fields, due to the variety of their methods and the criminals' intelligence, particularly in light of the development of digital technology and the multiplicity of sources of compensation.
- There is a difference in the orientations of both the Algerian and American legislator in defining the rules of criminal liability for the act of insurance fraud, between legal treatment and legal classification (legal characterization).
- Both the Algerian and American systems are consistent in considering fraud and deception as an intentional offense that requires a special criminal intent, represented by the intention to obtain compensation unlawfully, by resorting to deceptive methods and means designed to mislead insurance companies.
- Through contemporary criminal policy, it is evident that the preventive, anticipatory and technological dimension in the American system surpasses the Algerian one in the punitive dimension, as well as in the progression and individualization of punishment.

Recommandations of the study :

- In general, and Algeria in particular, there is a need to enact a special law to combat insurance fraud operations, combining substantive and procedural rules, instead of having them scattered across the penal code, the criminal procedure code, and other insurance laws.

²⁴ Alouane Iman, Leila Krache, op cit, p 366

- It is necessary to require insurance companies especially Algerian ones to move toward using modern technology techniques, namely “artificial intelligence” systems, to connect data among the various actors involved in protecting information and data with customs administration, the police, insurance companies, judicial authorities, and governmental bodies, in order to strengthen efforts to detect different forms of manipulation that lead to insurance fraud and deception.
- Strengthening the role of regulatory bodies in the insurance sector by granting them independence, while ensuring they act under a supervisory authority that prevents them from exceeding their powers, through their effective and anticipatory contribution to planning, monitoring, and reducing criminal opportunities and various forms of fraud and deception starting from the moment the contract is underwritten.
- It is recommended to establish a unified national database within the country among its provinces, linking all insurance companies in various fields with judicial and governmental authorities through a centralized, secure information system for exchanging information on fraudsters. This would reduce and limit the loopholes of insurance fraud and deception and prevent an insured person from insuring the same risk with multiple companies.
- Making use of the efforts of advanced countries in addressing the risks of insurance fraud by strengthening the exchange of information related to the operations and behaviors involved in insurance fraud and deception, as well as judicial strategies with comparative systems such as the American system particularly in international marine insurance claims and companies with an international dimension, which most clearly embodies the international aspect.

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