FRAUD PREVENTION IN ONLINE PROCESSING OF INSURANCE CLAIMS: BASIS FOR ENHANCED GUIDELINES

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CERTIFICATION AND APPROVAL SHEET

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CERTIFICATION OF ORIGINALITY

This is to that this dissertation titled, "**FRAUD PREVENTION IN ONLINE PROCESSING OF INSURANCE CLAIMS: BASIS FOR ENHANCED GUIDELINES",** is my work, within my knowledge and beliefs, materials previously issued or created by others, or materials accepted by a university or higher education institution for the awarding of another degree or diploma. Is not included. That is because it is clearly pointed out in the text.

I also receive support from others regarding style, presentations and linguistic expressions, but I declare that the intellectual content of this paper is the result of my work.

GENER N. CADAG
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Date: _____

DEDICATION

To my loving family,

Most especially to **Ms. Maritess**

my mother, Vilma

My dogs **"Wolfie and Milo"**,

my children, **Chris Joseph**, and **Chris Emmanuel**

and to those, who in one way or another,

had been instrumental in the completion

of this study, this humble piece of

graduate work

is dedicated.

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The **Almighty Father,** from whom we owe everything**.**

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ABSTRACT

Claim management is a major concern for insurance companies. Effective claim management can save your company effort and money while improving customer satisfaction and customer retention. Although manual paperwork may be required, tools and technologies such as claim management software can help businesses automate processes to increase profitability. The claim process is an important moment in customer relationships in non-life insurance. To maintain and expand market share, insurers need to focus on improving their customers' experience through online processing

The purpose of this investigation was to improve the fraud prevention policy when processing insurance claims online. In particular, we are looking for answers to achieve the following goals: 1.) To determine the degree of effectiveness of online claims processing for motorcar insurance. 2.) To identify the different variables that help in preventing fraud. 3.) To know the recommendation offered by the respondents on insurance training. 4.) To describe the different fraud in claims processing for motorcar insurance in terms of gravity. 5.) To develop an enhanced policy on how to prevent fraud in motorcar insurance claims.

A descriptive method was used in this study. In selecting 60 car employees and customers, researchers used the purposive sampling and structured questionnaires were used as the primary means of 60 respondents. Random interviews with owners, managers and customers were conducted as part of a meeting with a group of respondents. Statistical tools used to display, analyze, and interpret data are percentages, weighted averages, Likert scales, and rankings.

The most important conclusions are: 1.) Younger generations or young professionals still preferred to insure their vehicles in the event of an accident, especially in these times when traffic is increasing, with the service provider's excellent insurance concept. 2.) More and more male customers prefer insurance services. They are more aggressive driving style. These drivers assume a high probability of an accident. 3.) Married vehicle owners are more responsible driver. It is believed that by getting insurance coverage for the utility of the vehicle, they will appreciate their vehicle more. 4.) College graduates are already employed, so it is assumed that they already have a vehicle when their income increases. Similarly, not all employees decide on their degree. 5.) The level of claims processing transactions is the fast-tracking transaction they used, significantly reducing the latency of both claims handlers and customers from the previous peak of weeks to just days. 6.) They will pursue strategies to further im-

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prove the process for processing claims online, adapting technologies such as service access and payment processing to claims, and providing quality service to our customers. 7.) Various training programs in the field of modern technology will greatly help employees acquire knowledge of modern technical equipment. Insurers may require video quality and fair and impartial processing if they have sufficient knowledge of claim processing and claim adjustment. 8.) If the processor and adjuster are unaware that the fraud case is involved, have no knowledge of the underwriting aspect, and can handle the fraud without using the latest technology, then the car insurance claim needs various serious fraud cases.

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THE PROBLEM AND ITS BACKGROUND

Introduction

Insurance fraud detection is used to track and analyze data to identify anomalies and provide real-time monitoring to prevent fraud such as theft, billing and payment fraud, cyber-attacks, and false claims.

Markovskaia (2020) emphasized that fraud detection is a complex aspect of classifying whether a transaction is legal or fraudulent. This system is essential to protect the interests of insurers and insured in a variety of areas such as health, transportation and infrastructure. However, it can be resolved through fraud analysis with certification, governance, risk and compliance for effective fraud management. Advances in insurance fraud detection are due to the integration of technological advances such as artificial intelligence, machine learning and internet connectivity. During the pandemic, subsequent digitization of operations, an increase in instances of cyberattacks, and theft of personal information propelled detection services. In addition, the emergence of e-commerce retail channels, mobile banking applications, authentication solutions, and face and voice recognition systems has fueled industry growth. The market grew as the healthcare sector witnessed increased investment in suspicious claims and insurers' fraud detection services around the world.

In addition, with the existence of advanced fraud detection services, SMEs are implementing fraud scanning in their systems to protect their business; thus, contributing to the development of the market (Buruga, 2019).

Insurers rely on predictive models using instances of spoofing action. Machine learning algorithms with new data are much more capable of detecting fraud, eliminating human error and separating fraud models by identifying outliers (Buruga, 2019)

The anti-fraud system can be equipped with a database of images accessible to the insurance company. In order to identify suspicious claims that can be made by statistical analysis on insurance agents' computers, insurers must provide the steps, then make publicly available instructions to insurers. insurance, law enforcement and other organizations for suspected, observed or acknowledged insurance fraud.

For further investigation, many companies use computers and statistical analysis to identify suspicious claims. It would be costly for insurance companies to spend staff to verify fraudulent claims. Car insurance premiums are the highest in fraud claims, with an average increase of £50 across the broader market (Horne, 2018).

There are identified instances of fraud that have been submitted by scammers, such as false collision reports. running away, not reporting changed circumstances, not confirming changed circumstances and modifications, car

dumping, ghost brokers, ghost rentals, cash grabs and closing are all forms of fraud. auto insurance fraud (RAC, 2020).

Ghost hiring is an emerging form of fraud, estimated at around £60 million per year (Action Fraud, 2020). This is where criminal gangs set up fake car rental companies and send bogus replacement requests where their cars are "fixed". In some cases, the same vehicle was found to be "rented" by more than one person at the same time.

During the investigation, you can verify the authenticity of the claim by analyzing and cross-referencing the data from the source. It helps investigators identify the relationship between the complainant and fraud, such as social network analysis.

Artificial intelligence plays an important role in managing insurance fraud because data sources vary from stage to stage: The impact of analysis is amplified with the help of artificial intelligence (AI), which can screen large datasets, identify patterns and anomalies based on algorithms, and flag cases for review. Technology has two purposes, it not only provides insurers with fraud prevention tools, but also provides fraudsters with advanced fraud prevention methods. , WNS Perspective (2020).

According to NerdWallet (2017), one of the most effective ways to combat fraud is to use data technology to reduce the time required to detect fraud. Advances in analytical technology are crucial in the fight against scams, as they keep up with the sophisticated ring that is constantly developing new scams. As

the number of fraud cases increases, so does the need for fraud prevention technology. Detection of fraud requires concrete evidence of deception, inconsistent statements, or improper conduct. Insurers combine tools to improve fraud detection programs (Insurance Fraud Bureau, 2020).

Traditional approaches, such as the use of automated alerts and business rules, are enhanced by predictive modeling and link analysis to examine relationships between elements such as people, places, and events. Artificial intelligence is a tool used to detect fraud before payments are made. These new strategies will be used when the claim is first filed. Suspicious claims are flagged for further consideration, but other claims are processed normally. Car insurance payments were one of the most important elements of the insurance industry at the time, known as the window for insurance companies. Auto insurance is designed to cover the insured's loss and liability in the event of a loss or accident, with financial compensation to the driver or owner who has damaged another person or property. Covers. It is a legal requirement to have car insurance before using or owning a car on public roads. Car damage is an insurance company form term based on an insurance policy.

The insurance company will verify the legitimacy of the claim before canceling the insured's claim. It's a social tool used to mitigate loss of income and is nowadays considered a floating business. Timely claim resolution is important for policyholders. Insurance effectiveness depends on the satisfaction of policyholder processing and timely payment of claims (Ashturcar, 2017).

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Claim management is central to all insurance companies. An effective process saves customer satisfaction and customer retention time and money by using management software. This claim processing involves risks and extensive paperwork that allow companies to streamline their processes. By updating the process and using the appropriate technology, adjusters can manage large monetary claims. Insurers need to focus on improving the customer experience in order to maintain market share and improve customer acquisition (Logian Blog2020).

Insurance customers expect a company to resolve claims quickly to their satisfaction, as high customer satisfaction can give the company a competitive advantage. Reducing the time required is a way to reduce the number of customer complaints and improve service (Bato, 2017). There are two types of insurance, the Compulsory Third Party Liability (CTPL) covers liability to third parties but does not provide compensation to the driver. Comprehensive liability (COMPRE), on the other hand, provides broader compensation to cover damage, theft and injury to yourself and your property. There is also additional coverage for damage to the driver.

Depending on the agreement between the insurer and the insured, some of the coverage may apply to the specified policy. Knowing the importance of fully comprehensive car insurance combines the benefits of liability insurance with the benefits of independent property and casualty insurance, which provides the highest level of security. You will find that comprehensive car

insurance is extremely valuable and offers coverage that is not available otherwise. The security provided by this type of insurance policy is truly valuable as it provides the highest level of security for the car (Insurance Dekho, 2020). To process the claim, the in red must prepare the requirements through online filing: vehicle registration and official receipt, driver's license with official receipt, police report or certified Affidavit, cost estimate, photo, Insurance policy, non-claim certificate by a third party, medical certificate, birth certificate, bank statement for personal injury claim, and death certificate for death. These requirements form the basis for adjusters to determine the recoverability of claims.

Claim processing is a complex system underlying the insurer covered by the insurance policy, where the customer submits a claim containing all information regarding the type of damage and associated costs (Markovskaia, 2020)

The assessor or adjuster reviews the claim, determines if it covers the claim, and proposes a settlement to pay the claim. Experts can also reject claims depending on the legitimacy of the insurance terms. This process is when someone's full amount is paid by the insurance company. There may also be disputes over the number of claims and the processes that may be brought to court. Nonetheless, those who are unfamiliar with what should and should not be aware that the claim settlement can be abused. Therefore, the insured needs to review the paperwork and be encouraged to settle it out of court at a fearless

cost, saving time and effort. Negotiating a fair settlement and receiving payments are important steps, but if you make a car accident or personal injury claim, it is essential to understand the terms of the policy in order to evaluate your car insurance job. The policy covers the damage (Policy Bazaar, 2021). The insured needs to know what to expect when starting to process a claim. The usual behavior is to bring the damaged device to a priority store or car dealer for cash repair. If the insured is not satisfied with the terms and conditions, they will have to follow the negotiations. A technical group called a roving adjuster takes the initiative to inspect damaged units and evaluate the final grade of the adjuster. How much will an insurance company pay for the recommendation of the adult guardianship system? Claim settlement is just one aspect of the insurance claim management process, which involves several stages, starting with submission. The stage defines whether the claim is valid and the amount the insurance company will pay. The insured expects the company to resolve claims quickly and to provide high customer satisfaction. Reducing insurance claim processing time with a competitive advantage of high customer satisfaction is a way to reduce the number of customer complaints and improve service (Carey, 2020).

Technological advances and innovations continue to evolve, helping humanity reach its goals relatively easily. Today's insurers leverage and integrate progress and its protocols and policies to minimize errors, make precise adjustments, and systematically follow procedures. In the highly

competitive insurance market, new and effective insurance claim management practices are one of the keys to maintaining market share and profits. Insurers can transform their billing process by leveraging modern billing integrated with robust business intelligence, documents, and content management systems. This effectively improves claim processing and enables insurers to reduce claim costs and improve compound ratios, claim processing efficiency, and customer retention and acquisition bring profits to the company.

As Allayyanavarmath (2019) states, insurance is already having a huge impact on our society, like claim management. It's complicated, but it has the driving force to build trust in people. In the current situation, data-intensive processes such as billing and management require processing and analysis of various information (medical reports, accident reports, repair quotes, digital invoices) that needs to be captured in the billing form. Even paper-based information validation can be time consuming, reducing the efficiency of grievance processing and the overall quality of customer service. The proposed insurance claim system is an automatic insurance facility that begins with customer registration. Employers can register directly with the insurance company either online or through automated transactions.

Currently, the insurer's business capacity claims system must range from notification to settlement. Many have already started automating the claims process. In this way, the cost of time and complaints has been reduced. These insights help customers save millions of damage costs through proactive

management. Insurers can also depend on how much money they have in place for insurance reserves (Buruga, 2019).

As Chinczewski (2018) points out, artificial intelligence is specific to global insurers, such as leveraging artificial intelligence in identifying business rules to identify claims that are suitable for automated processes. You can find the best claims process for your privileges. For instance, Italian insurance that is going to develop a system to find the sophisticated process of claims. An Italian insurance carrier is going to develop a "best-match" routing approach to finding the best-experienced claims. Instilling this upgraded scheme within the business is an underestimated element of a digital renovation. Top and middle management in claims must succeed in this new proposition; otherwise, they will risk themselves in finding digital transformation to remain in the business.

Currently, Insurance companies launch express vehicle insurance claims and settlements by allowing customers to upload pictures taken by mobile devices. This type of insurance claim is processed by an online statement and is processed manually or automatically. However, due to the large daily claims, the system and the responsible person are fooled by repeated claims for the same claim, causing great losses to the insurance company. Therefore, a fraud prevention check is required before processing a claim. Insurance fraud is a fraud committed against an insurance company for financial gain. It can be deceptive in that deceptive works are being made in the vehicle garage to exaggerate accident reports. False claims are often an exaggeration of valid

automotive policy claims. The vehicle of the car owner with minimal damage asks the garage to create a fake incident report. This results in widespread damage that requires a settlement of claims that is greater than the amount actually payable.

Background of the Study

Auto insurance is one of the major components of the non-life insurance industry. This is called the insurance company window. Auto insurance is used to cover damages and liability in the event of loss, accident or other event related to the insured's vehicle. The insurance claim process begins when the customer makes a claim. Claim settlement is one aspect of claim management. During the duration of the claim, the service process includes the person who submits the claim from the beginning. The phase determines whether the claim is worth the amount paid by the insurance company. Insured customers expect a company to resolve claims quickly and satisfactorily, as high customer satisfaction gives the company a competitive advantage. Reducing customer dissatisfaction, loyalty, and retention rates are important aspects of financial service providers.

Improving the claims management system and minimizing cost bidding is a viable solution. The higher the damage cost, the lower the profitability. Customer satisfaction, customer preference, and customer loyalty are important intermediate values for financial service providers (Bato, 2017). In the past,

insurers used manual claims using tools and equipment, slowing down the clains process. But now, many insurers are addressing the insurance industry's need for innovative technologies that will modernize the digitization of claims processing.

According to Brüggemann (2018), in claim value proposition, the value that an insurer can provide to its customers through the claims process goes beyond traditional post-billing management. Claims promise that insurers must go beyond traditional claim management to provide their customers as part of the claim process. It aims to provide the best customer experience that supports digital processes. Insurers should aim to adopt an analytics-driven approach to the automated billing process in all cases. Insurers need to provide value-added services and collect customer feedback to continually improve service delivery, ease of use, and performance, in addition to addressing customer claims.

Fraud is common in the insurance industry, as evidenced by the experience of one of the leading insurance companies, especially when it comes to car insurance claims. Some experts have caught many scams by using the latest technology and coordinating with other companies. They carry out fraud investigations, as falsely reported that the vehicle was stolen. This type of deception is sometimes referred to as carnap me. In this case, the scammer purchases a policy to protect the vehicle in the event of an accident or loss. A few weeks later, they claim that it was carnap, but in reality, they hide it, disassemble it, sell it, and sell the parts. Another reading to consider is a garage

exchange scam. The garage owner or mechanic exaggerates the increase in income by replacing damaged parts with good parts of the car and documenting their reality. In addition, Malayan insurance assessors have discovered a so-called fake type of system. Fraudsters use fake photos and documents to buy units from another insurance company that is already considered total loss, insure the target insurance company, and file an insurance claim a few weeks later.

Another false allegation discovered by Malayan Insurance is a triggered accident targeting a fraudster to become a targeted driver for an innocent driver. The criminal pulls in front of the victim to brake and does not give the innocent driver the hope of stopping in time. This is a very dangerous act, endangering your own life and the life of an innocent driver. (BOS refers to the experience of fraud by Malayan companies. One of the car fraud cases is when an insurance company presents a claim filed by a customer. She is said to have been beaten by one because of her notarized affidavit.

The unknown lane reverses and escapes after the collision, and after investigation by outside experts, the incident occurred at a specific date and time in the incident and was driven by a specific name with a fake driver's license. Therefore, the claim was dismissed because they violated the policy provisions of the Insurance Law regarding concealment.

By using the latest technology throughout the system, assessors can easily verify the Land Transport Office license and insurers can prevent fraud by improving their claim system and analytics strategy.

Theoretical Framework

Auto insurance is required to be issued by an insurance company to avoid public liability and protect against possible accidents on the road. The law requires all owners of a vehicle to be insured. Auto insurance protects the owner of the vehicle from damage and is responsible for the owner of the vehicle. Driving a car in a public place without insurance is a criminal offense under the Automobile Law (Mitra, 2015).

According to Gamage (2019), car insurance is an integral part of everyday life, protecting the lives and property of road vehicles and third parties from accidental damage, including natural disasters and many other accidents. It played an important role. During the Covid-19 pandemic, the biggest challenge facing the insurance industry is managing the insurance claim process.

As Super (2020) points out, the COVID-19 pandemic has largely changed the way we interact with others. Many insurers have adapted to this and rely on contactless virtual car insurance claims. This pandemic gave car insurance enough time to update the system. One-way auto insurers meet their customers' needs is to provide digital products that can be used throughout the billing process (Tom, 2020).

According to Naylor (2017), the insurance sector needs a transformation in management style   and customer engagement. The main theme of this chapter is the change in production costs through intensive end-to-end automation. He also said that progress can be made by transforming the insurance system from a product to a database service model. This allows staff to survive and increase profit flow. Online insurance claim processing is an interaction between an insurer selling an insurance product and its customers, and is the payment of compensation if the interaction occurs completely or almost exclusively on the Internet (Parushiva, 2015).

In a study by Naylor (2017), he summarized the innovations that underlie the turmoil in the insurance sector, including the Internet of Things, cloud computing, big data, artificial intelligence, hyper-scaling, speech recognition, and visual recognition. Blockchain and cultural alternation of generations. He argued that while each of them is important, destructive changes only occur when they are all combined, as each success depends on the other.

When processing a car insurance claim, some claimants allege fraud. Insurance fraud is a serious problem and it is widely recognized that traditional methods of combating fraud are inadequate. Insurance is a fast-paced industry and processes a lot of data. The main problem in the insurance industry is fraudulent claims, which are considered cheating for personal financial gain. The presence of multiple fraudulent claims affects not only insurance companies but

also policyholders. Fraud is not detected by the insurance company, so premiums will increase to cover the loss (Nandhini, 2018).

Insurance fraud is a deception against the financial interests of an insurance company. Fraud can occur during various transactions by applicants, policyholders, third party claimants, or professionals providing services. Insurance agents and company employees may commit insurance fraud such as excessive claims; misrepresentation of facts in insurance claims. Injuries and damages that have never occurred, and allegations of staging accidents (Nerdwallet, 2017).

As Singh (2019) stated, the insurance industry faces multiple challenges due to fraud cases. Losses caused by fraud affect stakeholders. Even undetected scams can lead to significant losses, bad processes, and loss of trust. In recent years, fraudulent activity by policyholders has increased significantly. Insurers can fraudulently omit facts and hide details when making claims, resulting in significant loss of money and customer value (Kathri, 2019).

According to Panigrahi (2018), insurers, or insurers, need to protect themselves from the losses that result from fraudulent claims covered by policy holders

Conceptual Framework

Claim adjustment is the process of determining legal liability coverage, and the insurance company promises policyholders a fair and impartial

settlement. In order to process the claim, the policyholder must submit the insured's claim, which is a basic requirement that the adjuster may require. This includes all information about damages and related costs. This information is important for insurance assessors considering insurance claims. These documents form the basis for determining the collectability of a claim. Today, the insurance industry employs online invoice filing, cost-reducing electronic innovation, and efficient processing and office time that can result from rapid billing status from document filing to bill settlement. Submitted documents are processed efficiently, resulting in faster payments. Online billing processing eliminates the need to file paper bills, speeds up the billing process, and simplifies record keeping and rapid document uploads

According to Balgos (2020), he has been filed a claim and the insurance company is obliged to confirm its truth and scope without undue delay in order to pay within (5) business days. Once the claim has been created to process the claim and assigned to the assessor to determine if the insurer is responsible for the loss incurred under the terms of the insurance contract. Using the latest technology and online billing, insurers can prevent fraud cases. Illegal fraud undermines the financial stability of an insurer, but the damage caused is more widespread. These intentional actions have a significant impact on all the activities of the insurance company. Fraud losses and risks can lead to loyal customer price increases and additional time and validation before insurers pay legitimate claims.

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The research paradigm is an approach for conducting research. This is a conceptual framework of thoughts or beliefs in theory. This is a paradigm of graphical representation of the conceptual framework. Shows what the conceptual framework wants to convey. The researcher will apply the Input-Process-Output model in the study.

INPUT	PROCESS	OUTPUT
1.Profile of the respondents 2. Procedures of online claims processing 3. Benefits of online transformation 4. Limitations of online claims processing 5. Different fraud in insurance claims	Utilization of the ff: 1. Questionnaires 2. Interviews 3. Collection of data 4.Interpretation of the collected data 5. Evaluation of data	Enhanced Guidelines on how to prevent fraud in insurance claims processing

Feedback

Figure 1.1

The paradigm of the Study

The figure illustrates the paradigm of the study using the **Input-Process-Output** scheme. The first box is labeled **INPUT** consisting of the profile of the respondents, procedures of online claims processing, benefits of online transformation, limitations of online claims processing, and different fraud in insurance claims.

The second box is labeled **PROCESS**, consisting of the questionnaires, interviews, collection of data, interpretation of the collected data, and evaluation of data.

The Third box is the **OUTPUT** or the outcome which develops a guide on how to prevent fraud in insurance claims processing.

The small box at the bottom is the **FEEDBACK** or information about reactions to the guide that was developed to be used as a basis for improvement.

Based on feedback from respondents, this policy serves as a complement to real estate insurance. These guidelines are not just focused on the importance of online billing to the company. Instead, we'll elaborate on what to do to improve billing and prevent fraudulent car insurance transactions. In the Philippines, there is no research on online claim processing directly related to car insurance fraud. Therefore, researchers have conducted this type of research.

Objectives of the Study

The study sought to know the effectiveness of online claims processing for motorcar insurance in Malayan towards developing a guide for fraud prevention.

Specifically, it aims to attain the following objectives:

1. To show the demographic profiles in terms of the following:

    1.1 Age;

    1.2 Gender;

    1.3 Civil Status;

    1.4 Highest Educational Attainment;

2. To determine the degree of effectiveness of online claims processing for motorcar insurance.

3. To identify the different variables that help in preventing fraud.

4. To know the recommendation offered by the respondents on insurance training

5. To describe the different fraud in claims processing for motorcar insurance in terms of gravity.

6. To develop an enhanced policy on how to prevent fraud in motorcar insurance claims.

Scope and Limitations of the study

This study focused on analyzing the effectiveness of online car insurance claim processing in Malayan in developing a fraud prevention guide. Respondents were interviewed and given a questionnaire to answer the question. The 60 respondents were policyholders / claimants, car insurance assessors, and car claim managers at Makati and Manila offices in Makati and Manila. They were randomly selected for the fiscal year 2020-2021. They were asked about the effectiveness of online car insurance claim processing in Malayan, fraud prevention, and suggestions for improving claim processing. This study did not focus on the development of prototype online processing programs or other technical details, but only described the appropriate process to follow in processing online insurance claim transactions. The company already has online processing procedures, so this research is solely intended to improve procedures or practices

Significance of the study

Online claim processing for car insurance is of great interest in the industry. This study was considered important and made the following valuable contributions:

Insurance Industry. This survey will be of great help to the insurance industry in using online technology to ensure its effectiveness. This provides an effective tool for claims processing, especially in pandemic situations, especially

when submitting non-personal documents. Applicants can submit the required documents using digital technology via Viber, Messenger, email, and other digital flat forms. The insurance industry needs to know that digitalization has led to better customer service. Online damage reporting is faster, more effective, more convenient, and more customer-friendly. Policyholders and claimants can use online technology to file claims, inspect damaged cars, issue adult guardianship, and even transfer funds to complete online payments. You need to know that you can. The applicant is only waiting for the specified amount to be paid.

Claims Leads. As the person responsible for each claim unit, they should know how to market the company they work for. They should know the history and logic behind the visual attributes that represent their business. It also helps managers create a culture of integrity and excellence and communicate expectations to employees, suppliers and customers. Businesses need to get the attention of potential customers before they can serve them. Business leaders need to know that they need to be distinguished and remembered from other companies that offer the same products and services. These branded intangible assets are the usual way for marketing executives to differentiate their brands from consumers and perform better than physical products.

Motorcar Adjusters. This study helps insurance assessors determine the scope of liability of an insurer. We can respond to claims for property damage caused by damage to the building, personal injury or property damage of a third party. They were related to property. Adjusters use the results of this investigation to review insurance claims and determine the appropriate amount for settlement.

The Policy Holders. This investigation will help them determine the effectiveness of online claims processing. Today, innovation is the key to transforming the automotive claims sector, which can lead to immense efficiency in payments, but these changes are timely and effective with uncertainty and suspicion. It is a channel of the claim process. Not all policyholders are equally network savvy, so you can get help online. If in doubt, an explanation is available on the insurance company's website.

Company's Management. In the face of fierce competition in digital technology, claims management is an important business process in the industry, and customers want better, faster service. With a powerful online billing process, you can use automation to further reduce costs. Even if the insurer is large or needs an efficient claim management system, the majority of customers surveyed online before purchasing an insurance product now have access to the insurer's services. In using an online application, insurance companies need to act swiftly to improve the customer experience. A simple process from a device

with a smartphone set is a feature of the customer's management system. Applicants can track the status and decisions regarding the application. Customers need to know that they can save a lot of time if they can execute transactions online. You can also increase transparency and prevent billing fraud by providing customers and insurance companies with access to the billing process.

The Researcher. This study finds it useful to learn the effectiveness of online car insurance claim processing, create fraud prevention guides, and use online techniques when processing claims with digital transformations that integrate customer value. It helps to know the reason that a targeted approach to developing new value propositions that set high standards and pursue end-to-end digitization of the customer journey in the event of complaints. It also helps the insurance industry learn about the Internet, which can streamline the claims process quickly and effectively. Researchers also need to know why the insurance industry is currently adopting digital transformation. He also needs to investigate why digital technology is changing the way insurers work.

Future Researchers. As enterprise migrations are constantly changing, this will help future researchers gain a foothold if they need updated versions of their research in the future. For example, they want to know how insurance affects people's lifestyles. And why do they need to understand the benefits of the insured's property to mitigate losses. Another way to handle insurance

claims has emerged, such as the use of blockchain technology. This has a direct impact on the insurance industry.

Respondents. As potential customers in the future, they can participate in the study. They will be able to help future companies develop guidelines on how companies should create positive and effective company names. In the future, these futurists may discover additional visual identifiers that may be useful in a company's marketing strategy. There are still undeveloped types of companies that need similar findings, such as online business. One source from this study is the influence of participants' religious orientation on brand preferences. Perhaps future researchers will also study other types of orientation that affect customer behavior.

Definition of Terms

To better understand the study, researchers have defined the following terms according to their conceptual and operational implications:

AAC (External Adjuster). An insurance assessor unrelated to the insurance company that provides insurance services with service fees.

AAC Report. Comprehensive investigation reports are produced by outside experts from the assigned claims to investigate specific damages.

Acts of Nature. This is a type of insurance that protects your vehicle from damage caused by natural disasters.

Account Executive. The role of insurance account manager focuses on the insurance company's sales goals and business expansion.

Adjuster. A person who investigates the cause of complaint settlement.

Adjuster Recommendation Report. This is a cash compensation recommendation report with an amount based on the valuation of his damaged vehicle or asset.

Affidavit of Desistance. It is the petitioner's written affidavit that the petitioner is no longer interested in pursuing an action against others.

Affidavit of loss. It is usually required when requesting replacement of lost documents or items.

Alarm Sheet. This is a document provided by the Philippine National Police Highway Patrol Group and signals all PNP employees.

Asset Recovery Management. This is the insurance department that has succeeded in ensuring all recovery from other insurance companies and vehicles declared as a constructive total loss by the claim department.

Assignment Slip. This is the transfer of legal rights under the insurance contract to another party.

Authorization to Pull out. This is a letter from an insurance company that allows or allows someone to pull out a damaged unit to transport it from another location.

Authority to Pull Out. It is the act of pulling out from the repair shop or the insured's place of residence or storage to another location.

Authorized Driver Clause. It is an insurance policy that clearly states that the insured is permitted to drive the vehicle based on the Driver's License Law. Bank information is a name and account number that uniquely identifies your bank account and is used by insurance companies to send and receive payments electronically.

Bank details. Details such as bank name, account number, etc. uniquely identify the bank account and are used specifically electronically when the insurance company transfers or receives payments.

Barangay Incident Report. The case was investigated and carried out by a barangay officer.

Birth certificate.   This is an official document issued to record a person's birth, including identification data such as name, gender, place of birth, and ancestors.

Branch Claim. An insurance claim was filed to branch.

Bodily Injury. It is the cause of a car accident that injures another person. Personal injury liability insurance helps cover the loss of their medical expenses and income as a result of their injury.

Camille.   Insurance companies provide policyholders with insurance services such as towing and emergency response for a fee.

Car Dealership. A dealer or local car dealership is the business of selling new or used cars at the retail level under a dealership agreement with the car manufacturer or its sales subsidiaries.

Carnapped Claim. This is the act of forcibly seizing a car owned by another person without permission.

Cash settlement. This is the payment method used for certain futures and options contracts where the insured has the right to settle claims on a cash basis.

Certificate of No Claim. It is a letter that indicates the third party's insurance company that certifies the involvement in the vehicular accident and that he did not file any claims with them.

Certificate of Non-Recovery. This is a document provided by the PNP Highway Patrol Group for insurance purposes and indicates that the unit has not recovered after 90 days of searching.

Chassis Number. It is a dedicated vehicle ID that the vehicle receives from the manufacturer.

Check upon Release (CUR). It is a memorandum of Car Dealership to insurance industries the repaired unit will release to the owner until the insurer settled the payment for the restoration of the unit.

Check Releasing Unit. A unit of the insurance claim department responsible for processing insurance claims.

Client Information Sheet Form. This is a formal document customer profile template that collects information about age and address.

Claimant. A person who reports a claim to an insurance company. This person is the one who suffers harm as a result of injury or accident.

Claim Check. The insurance company pays the insurance benefits to cover the damages.

Claims Support Associate. The clerk receives the billing documents and registers.

Claims Monthly Committee. A monthly claims meeting means that topics related to that day will be discussed.

 Compulsory Third-Party Liability (CTPL). This is a claim for damages that covers the costs incurred when the owner uses the insured's car to cause physical injury or death to a third party in an accident.

Conduction sticker of the unit. It is used to allow legal use prior to its initial registration.

Constructive Total Loss Claim. This happens when the cost of repairing the vehicle is at least 75% of the vehicle's current market value. It is also related to insurance claims settled for the full amount of the relevant coverage.

Compensability of the claim. It is a decision point in the processing of a claim wherein the claimant is being paid.

Comprehensive Coverage. It is a car insurance policy that covers damages to a vehicle that are not caused by a collision.

Corporate Accounts. For investment accounts that are favorable to the company, the name of the person authorized to do business on behalf of the company must be given to the company.

Corporate Secretary Certificate. It is a written document by the corporate secretary used to certify corporate acts or records.

Death certificate. A death certificate is an official statement signed by a doctor that describes the cause, date, and location of a person's death.

Driver License. It is a document permitting a person to drive and operate any classified type of motor vehicle. Issued by the Land Transportation Office (LTO).

Empirical study. This is a phenomenon observed and measured based on empirical knowledge, not theory or belief.

Engine Number. For identification, the car chassis number and the car engine number are two different numbers and are unique.

Estimate. This is an estimate from a workshop consisting of the actual cost of a damaged vehicle consisting of replacement and associated labor.

Evaluation Survey Report. This is a report that accurately shows the cost of the parts that are allowed to be replaced and has been repaired and replaced according to the evaluation.

Excess Bodily Injury Coverage/Voluntary Third-Party Liability (EBIC/VTPL). This cover covers compensation that exceeds the limits set by the CTPL cover. This protects the insured from liability for death or personal injury of a third party as a result of an accident caused by the insured's vehicle.

Ex Gratia. Payment if the claim is rejected. The percentage of the billed amount is shown based on the percentage of the business consideration.

Ex Gratia Routing Slip. This is a document in which a fixed amount of rejected claims are transferred for approval by various insurance authorities.

Face 2 Face. It is a form the of the face-to-face interview with the claimant thru smartphones Viber, Messenger, or zoom meetings

Follow Up Letter. It is a letter informing the claimant to submit the required documents needed to process the documents.

Fraud. Fraud involves misrepresenting facts by deliberately withholding important information or providing false information to other parties. Deliberately misrepresenting the truth or refraining from important facts in order to cause others to act in a way that is detrimental to them.

Fraud Prevention. Fraud prevention is the implementation of strategies to detect fraudulent transactions and banking operations and prevent those actions from causing financial and reputational damage to customers and financial institutions.

Incident report. This is a formal record of facts related to occupational accidents, injuries, or near misses. Its main purpose is to clarify the circumstances and conditions that have led to the prevention of future accidents.

Indemnity. This is a comprehensive form of insurance coverage for damages or losses. Under this Agreement, one party agrees to be liable for any potential loss or damage caused by the other party. It may also refer to damages.

Individual Accounts. It is an individual business or asset being insured

Insurance Adjuster. An employee of the insurance claim department who reviews insurance claims and determines a reasonable amount of settlement. This can be any type of claim. Claim investigation and evaluation is an integral part of the professional role in the process.

Insurance Agents. Insurance is a representative of insurance who negotiates and sells insurance policies

Insurance Arbitration. It is a legal action to resolve an insurance dispute between an insurance company and a policyholder, rather than having the insurance company and the policyholder file a lawsuit against the arbitrator (insurance committee).

Insurance Brokers. An insurance broker is someone who advises people about the need for insurance and negotiates a paid insurance policy on behalf of the insurance company.

Insurance Claim. This is a formal request to an insurance company that requires payment based on the terms of the insurance policy. The insurance company confirms the eligibility of the claim and pays the insured or the claimant.

Insurance Commission. It is the governing body that oversees the insurance market to promote and promote sound and prudent insurance management and business practices.

Insurance Company. A financial institution that offers a variety of insurance policies to protect individuals and businesses from the risk of financial loss from regular premium payments.

Insurance Coordinator. Responsible for coordinating with people from multiple departments on behalf of the employment department. The insurance coordinator usually reports to the insurance manager.

Insurance Liability. This is an insurance product that protects the insured from claims for injury or damage to others or property.

I**nsurance Policy Coverage**. The level of risk or liability that an individual or group covers with insurance benefits such as car insurance, life insurance, or a more exotic form.

Insurance Policy. This is a contract represented by an insurance contract in which an individual or group receives financial protection or compensation for losses from an insurance company.

Insurance Premium It is the amount of money an individual or business pays for an insurance policy.

Investigation Report. This is a document detailing the findings after a formal complaint has been filed or after an incident has occurred.

. **Letter requestor cash settlement**. This is a letter from the insured, the claim is settled in cash, and the insurance check clearing agency issues a check to be paid to the claimant.

Limitation as to Use Clause. This is an insurance policy clause that limits the amount of liability of one contracting party to the other.

Letter of Authority. This is a warranty from the insurance company and states that the workshop can start repairing the vehicle.

Loss Control Unit. It is the art of claims department t that cater vehicle inspection and damage the damaged vehicle.

Loss of Use Coverage. Insurance against unavailability, known as Supplementary Living Expense Insurance (ALE), helps cover any additional costs that may be incurred.

Makeup Repair Fraud. When repairing with top-level issues, minimal damage seems overkill for mass damage, and workshops increase repair costs.

Malayan Insurance. It is a leading non-life insurance company in the Philippines. Founded in 1930, Murray provides customers and public peace of mind through superior service, quality insurance coverage, and rapid processing and resolution of fair and valid claims.

Marriage contract. This is a contract signed before and after the wedding and provides a set of private, bespoke rules for splitting a couple's assets if the couple divorces or dies. This is the digital system Malayan Insurance uses to process bills online. Car insurance fraud is a plot to make false or exaggerated claims for damages, including property damage or personal injury as a result of an accident.

Motorcar Claim. This allows one party to indemnify the other party in return for the direct loss or damages of the subject vehicle and pay all claims for death or personal injury and property damage of the third party due to ownership. or the operation of the vehicle.

Motor Data. This is a professional information system for car diagnosis and repair. It covers a wide range of cars and brands and has an easy-to-use and flexible interface with cross-references and other interactive features.

Motor Vehicle. Also called an electric vehicle or automobile, it is a self-propelled vehicle with ordinary wheels that does not run on railroad tracks and is used for transporting people and freight.

Motor car insurance. Auto insurance is insurance that protects policyholders in the event of financial loss to the insured's vehicle as a result of an accident or other damage. Comprehensive car insurance covers damages to third parties and third-party assets, as well as personal damages.

Notarized affidavit of incident. It is a legal document that tells you your version of the story, it's just a story of the facts of the case. This is usually an

alternative to police reports, which is also a requirement for cars in a negligent claim.

No-Fault Indemnity Coverage. The generous consideration for this law is included in Section 391 of the Insurance Law. This is a provision that the insurer is obliged to pay the insured to a third party who is injured or died in an accident without proof of negligence or negligence.

Official receipt of medicines. It is a list of all prescriptions that were filled for a patient during the specified period along with their values.

Online Claims Processing. The processing is the continuous input of a transaction into a computer system. The opposite of this system is batch processing, where transactions are allowed to batch process documents and are entered into the computer system in batches. Processing also refers to a transactional method in which a company uses an interface on the Internet to receive product orders and process payments from customers. Online processing is very popular because it makes the company's sales operations more efficient and allows users to communicate with the online interface to suit their needs.

Online Settlement of Claimant.   This is a damage report from the subject risk and is first forwarded to the insurance company representative over the internet.

Own Damage Claim. It tends to provide the insured for the loss or damage of the insured's vehicle with liability insurance for the risks listed below.

The following hazards are subject to a comprehensive policy. Riots and strikes, malicious damage. Robbery, theft, robbery.

Parts Canvasser. Those who are fully engaged in the automobile insurance business by ordering and requesting parts quotations in writing.

Parts Catalog. This is a manufacturer-issued book that contains illustrations, part numbers, and other relevant data for the product or its parts.

Passenger Personal Accident (**Auto PA**). This insurance provides road peace of mind to the insured car owner and his drivers and passengers by covering the inevitable damages caused by accidental personal injury or death, a risk not covered by car insurance.

Payment Process. This is the process of insurer wherein payment for client and repair shop is taking place.

Photos of the damaged unit. Image of damaged parts of the vehicle. Shows the registration number of the damaged part and the corresponding vehicle.

Plate Number. This is a metal or plastic plate attached to a car or trailer for official identification.

Police report. It is generated by the investigating officer who responds to a request for assistance at the scene of a car accident. The police report is a summary of information regarding the motor vehicle collision containing both facts related to the accident, and the opinions of the investigating officer.

Policyholder. Anyone who has an insurance policy with an insurance company, or who has an agreement with an insurance company, or an organization provides insurance against risk.

Proof of Ownership. This is a document that contains specific details about items that have been lost or damaged as part of your claims. It is used to document that you own the item and then to allow you to properly compensate for the loss.

Release of Claim. This means that one or more parties will make a legal claim against the other party in exchange for reasonable consideration (that is, something of value that the party releasing the legal right has not yet been entitled to). A written contract that agrees to waive.

Repair Shop. This is a wide range of services to meet all car maintenance needs, including brakes, gearboxes and wheel alignments.

Routing Slip for Constructive Total Loss. The invoice will be sent by the insurance company to the approved signatories to approve the vehicle total and corresponding compensation details.

Roving Adjuster. An in-house adjuster who does inspection and evaluation of the damage.

Schedule of Indemnities for Bodily Injury and/or Death Clause. This is a policy schedule in which compensation is respected in handling deaths, professional cost injuries, and hospital costs for the services provided.

Security Building Incident Report. This is a type of accident report investigated by a building guard who witnessed an accident that occurred on the premises.

Social Media. Websites and applications that allow users to create and share content and join social networks.

Statement of Account of medical expenses. It is a detailed list of total costs that an injured claimant has to pay and is one of the basic insurance requirements for handling a personal injury claim.

Statement of Claim. It is a form fact sheet designed to help you draft a statement of claim.

Storage Fee. This is a payment from the water storage yard or the car storage yard and the cost ends on the day the vehicle is housed.

Subrogation. A term used to describe the rights of most insurers to sue the insured against a third party who has caused damage to the insured.

Theft. Car theft is a crime in which someone steals (or tries to steal) a car that is not theirs.

Third-p**arty Insurance**. Protect individuals or businesses from loss by third parties. An example is car insurance. This will compensate the insured if another driver damages the insured's car.

Third-party insurance (TPPD). This is insurance purchased to protect you from the claims of others. Third parties provide compensation for claims

and losses incurred by non-insured drivers, principal, and thus drivers not covered by insurance.

Third-Party Property Damage Claim. If the driver is claiming insurance from another insurance company, this is called third party damages. It is called a third party because you are filing a claim with an insurance company that may not have a policy.

Third-Party. The insurance company will send a notice of compensation from the perpetrator who has damaged the insured's vehicle. The insurance company will charge a third party for the amount paid for the damage suffered by the insured.

Walk-in Client. It is a person, as a customer, patient, or claimant who arrives without an appointment.

Wire Transfer of Fund. It is a remittance of funds among a network of banks or remittance agencies around the world. The sender provides the recipient's name, bank account number, and remittance amount to pay for the transaction at the sending bank.

Chapter 2

REVIEW OF RELATED LITERATURE AND STUDIES

Innovative insurance claim technology can provide information on how to make the payment process faster, more effective and prevent fraudulent claims. Based on this, this chapter describes the integration of domestic and foreign literature and research to strengthen the concept and framework of research.

Foreign Literature

Settlement of motor claims is one of the most important elements of the Northern Life insurance industry, called the insurance company window. This insurance is intended to provide benefits for losses and liabilities that the insured may be exposed to in the event of a loss or related concern. We also provide financial compensation for injuries caused by vehicle drivers or owners that may result in personal injury or property damage. It is a legal requirement to have car insurance before using the vehicle on public roads. A car insurance claim is a formal claim against an insurance company that requires payment under the terms of the insurance policy. The insurance company confirms the eligibility of the claim and pays the insured or the claimant (on behalf of the insured). Once approved, insurance is a social tool primarily adopted by civilized societies, reducing the loss of family income due to unforeseen circumstances. This is

the fastest growing business. Insurance is the busiest and fastest growing business.

Timely claim resolution is an important aspect of service for policyholders. The image and effectiveness of an insurer depends on the policyholder's satisfaction with the timely processing and resolution of claims (Ashturkar, 2017).

Claim management is a central aspect of all insurance companies. This is an effective process that saves the company effort and finances and improves customer satisfaction and retention. Claims processing included manual tasks and paperwork, but technologies such as claim management software allow enterprises to automate the process. By updating legacy processes and implementing the right technology, claiming companies can manage more monetary claims and increase profits. Therefore, if you want to improve your claims, you should make the evaluation and improvement of your claim management process one of your priorities (Ashturcar, 2017). In addition, an effective claim management process will utilize software to automate payment and communication tasks, which saves the company time and money by reducing the number of skilled staff needed for administrative tasks and reducing the costs associated with human error and fraudulent claims can create trouble and problems that can be difficult to fix and may lead to the settlement of fraudulent claims. But software can take over and automate these manual tasks, limiting the risk of human error and compromising claims

Human error during claims handling can create trouble and problems that can be difficult to fix and may lead to the settlement of fraudulent claims. But software can take over and automate these manual tasks, limiting the risk of human error compromising claims. To keep up with the competition, insurance providers need to offer low premiums while making a profit. And by using an effective claims management system to keep costs down, companies can offer competitive premiums that can give providers an edge over their competitors (Logican Blog 2020).

The same article also states that the insurance industry is a highly competitive industry and customer satisfaction is essential to winning the competition. For many claims, companies are using technology to streamline the claims management process through a seamless customer experience, and customer expectations are higher than ever. Policyholders expect easy interaction with their providers, rapid claim resolution, and transparency of insurance information. Companies that use technology to improve the efficiency of billing can make it easier for customers to submit and compare bills and increase overall satisfaction. User-friendly mobile applications or online portals provide an easy way for customers to interact and communicate with their providers, and billing management software automates communication with customers while expediting billing through various payment stages. By improving

customer satisfaction, claiming companies can benefit from reduced customer loyalty, positive reviews, referrals, and complaints.

Technology and human analysts detect fraud in claim processing as intelligent software uses data analysis to examine claimant payment history and identify criminal fraud by identifying insurance claim patterns. Human analysts can use a combination of digital and human analysis to perform validation checks on documents and materials that support claims. Companies can detect and avoid both criminal fraud and opportunistic claims, but unfortunately all insurers receive fraudulent claims. The claims management process needs to capture these claims before proceeding with settlement. In an article by Bruggemann (2018), "The Claims of the Digital Era: How to Get Started with Insurers," Attackers Are Changing the Competitive Environment and Raising Customer Expectations, and Insurers Integrate Digital Technology into Their Operations to Keep Up. It states that it is necessary.

The insurance industry is in the midst of turmoil. Customers are using digital channels, and technologies such as connected cars, smart home solutions, and artificial intelligence are leading the era of new products based on data and analytics. Attackers Insurers with digital business models such as Lemonade in the United States, Youse in Latin America, and Nexible in Europe use digital applications such as chatbots to satisfy the process of purchasing insurance and reporting claims. To as new attackers are chasing customers,

companies need to act swiftly to integrate digital technology into their operations. For the non-life insurance industry, the digitization of claim functions has great potential to harness the value of digitization. The claims department needs to transform to become a customer-centric, digital-enabled organization with three basic areas of claims management: customer experience, efficiency, and effectiveness. In our experience, the digital claims feature improves the performance of all three KPIs and creates great value.

Digital redesign of claims integrates a consistent customer-oriented and value-oriented approach. Insurers adopt a customer-centric mindset, starting with the most relevant customer journeys and reassessing customer interactions end-to-end. For maximum effectiveness, the claims department must first develop the desired future state of digital value propositions and digital claims capabilities, and then prioritize them on the transformation roadmap. Successful digital transformation of claims begins with setting high standards and developing products that are worth pursuing the digitization of the claim customer journey. The development of an innovative customer journey can be achieved through integration with three areas: artificial intelligence and digital technology, digital integration of the claims ecosystem, and new digital operating models. It also has five elements of strategic management and tools to transform claims into digital capabilities to improve performance: excellent customer experience, analytics-driven claims processing and automation, loss

prevention services, value-added services, and customer feedback. It also describes the continuous improvement by the company.

In the article "Automating insurance claim processing in the digital era written by Markovskaia (2020) , he explained that insurers' digital transformation has been slow in the past. Many are now seeing tech startups being launched to meet the needs of the innovative tech industry. One of the areas that urgently needs to be digitized is billing. Insurers also recognize the growing importance of innovation. Eighty percent of insurers agreed that technology is no longer steadily advancing, but exponentially.

Automation Hero, a typical example is a major insurance company startup. Optical Character Recognition (OCR) is one such system. Designed to read and digitize handwriting, it's a simple concept with great potential. Currently, some insurance claims are filed online, but this is still plagued by poorly written documents such as drug prescriptions and contractor notes. Without optical character recognition, manual labor is spent decoding and recording handwritten information. Traditional OCR was trained using dictionaries, which wasted time collating words against large databases and choosing the wrong word.

You can also use robotic process automation and AI in claim automation to automatically flag insurance assessors for fraudulent claims and warn of pre-determined flags. For example, insurers could reduce life insurance claim processing time by using a specific system to automatically validate death

certificates on government websites. The system can also automatically send common invoices for approval, speeding up the process and reducing the need for manual labor. In the future, data can be analyzed at incredible speeds, potentially reducing processing times from weeks to minutes. Using a combination of systems means that enterprises can perform advanced billing processes such as risk monitoring, prevention, and mitigation. Future drivers will incorporate telematics into their vehicles, as well as existing vehicle technologies such as Tesla's vehicles. This system can send you information about your driving behavior and routes and renew your insurance on a regular basis. In the event of an accident, the telematics system can send this information directly to the insurance company along with an image for artificial intelligence to automatically approve the claim.

In the words of Gartner (2016),he said that insurance organizations are using data for business intelligence. Traditionally, historical data forms the basis of strategy, billing, underwriting, and product development. However, increasing use of big data (BD) practices in the insurance sector will increase the amount, variety, and speed of data that creates opportunities to improve business processes, customer value, and risk management in complex information ecosystems. Is being promoted by. For example, the speed of connected devices has exploded in recent years due to cheap sensors, bandwidth, and processing using smartphones as the main gateway to the Internet of Things (IoT). This new connected "smart" world offers opportunities to collect and

process data more efficiently, creating opportunities and challenges for all businesses, including the insurance sector (Eldridge et.al., 2015).). Insurers use the latest technology to process car claims, raising the question of whether using online processing is effective and helps prevent fraudulent claims. In the Insurance Nexus (2021) article, "The Role of Data and Analysis in the Detection of Insurance Fraud," fraudulent fraud has a negative impact on an insurer's financial stability, but the damage done is widespread. is. These actions have a long-term impact on all the activities of the insurance company. Fraud losses and risks not only raise the price of loyal customers, but can also require additional time and investigation before the insurer pays a legitimate claim. This increased pressure on vulnerable customers can carry the risk of damaging reputation and credibility and increasing policy switching. The fraud detection unit and internal auditor control the data and systems used to store and process fraud detection. As automated processes become more prevalent, IT plays a role within rogue units. Real-time service availability increases the importance of IT in budgeting and decision making. Regardless of IT or fraud background, team members need to be well trained to understand modern threats. As many units are still growing, team members have two roles: IT professionals and fraudulent analysts.

In the same article, it was stated that the damage assessment unit needs system integration to store data for fraud detection. Unfortunately, many organizations still have freedom, which completely masks the fraud threats that

exist today. Data-driven insurers are struggling to integrate information about billing and underwriting touchpoints. This operational convergence is very important. The conversation is summarized in three questions that insurance companies need to answer for their business model. The cost of advancing data analysis within your organization, fraudulent losses that have a significant impact on your current or future operations, and fraud that creates bad publicity and customer experience. Will it deteriorate? Insurers believe they are in control of the industry and its fraud, despite the delay in adopting new technologies. Insurers working on the urgency of data due diligence believe that data can make a meaningful difference to their customers. According to Fletcher (2021), insurers and their fraud teams are beginning to learn what new actions to deal with fraud look like. Predictive analytics play a role in understanding entity analysis, who people are, and what they are claiming. The analytics engine can now perform checks and raise concerns during the process.

It was also mentioned that the fraud detection changed the procedure in relation to the insured. Insurers can now perform predictive and entity analysis as new information is added. Not only does this improve fraud detection capabilities, but it also allows insurers to assess fraud risk. Some companies are beginning to offer high-value insurance policies to direct high-risk policyholders to other service providers. Today's insurers have moved from a reactionary stance to a proactive effort to maintain bad deals. Insurance companies recognize the economic benefits of trying to keep fraud away from the business

cycle by identifying fraud at the time of registration. The transition from a responsive survey of data and insights at the practitioner level to an aggressive survey of industry-level trends and patterns using analytical tools was a step forward. Fraud experts are skilled in devising ways to gain access to and manipulate data. Staff need to be trained in these systems and new fraudulent tactics. By focusing on technical excellence, you can fight fraud and protect the long-term interests of Zurich and our customers (Woerner, 2021). The use of analytics to detect fraud in the insurance industry is essential to the future viability of the market. The new technology significantly improves the underwriting process, which allows rules and procedures to be applied before insurance policies are issued. Technically, Kayıkcıoğlu (2021) states that handwriting scanning, image processing, and smartphone geocoding can be used for advanced fraud solutions. The article "Insurance fraud and optimal claim adjustment strategies" for liability insurance companies describes when a claimant can consistently misrepresent his or her claim in a claim fraud. In this aspect, claim validation is not a deterrent to fraud, and the settlement strategy consists of a compensation profile that associates insurance payments with the amount of the claim. Optimal compensation profiles include systematic underpayments of claims to prevent excessive damage, and the scope of underpayments turns out to be limited by expected legal costs and potential malicious claims.

The main verifiable implication of the theory is that underpayments should be large in the damage class, where loss exaggeration is easy. An empirical analysis of personal liability claims in road accidents supports this prediction. This suggests that debt insurers choose a claim payment strategy to reduce the incentives for claimants to exaggerate losses.

Local Literature

In the article "Improvement of non-motor claims processing of a non-life insurance company" written by Bato (2017), he said claim resolution is only one aspect of the claim management process. This process involves several steps from the person submitting the claim. Determines whether the claim is valid and how much the insurance company will pay. Insurance customers expect the company to resolve claims quickly and satisfactorily because customer satisfaction gives the company a competitive advantage. Reducing the time it takes to process an insurance claim is one way to reduce customer complaints and improve service. In general, delaying a claim costs more money to the insurance company. The higher the damage cost, the lower the profitability. Customer satisfaction, customer loyalty, and customer loyalty are important goals for financial service providers.

According to Sanchez (2020), many Filipinos see insurance as a liability rather than a source of funding for future security. However, the concept changed when insurance coverage introduced coverage to customers with

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existing needs or with medical conditions. As a result, the insurance penetration rate in the Philippines has increased, and total premiums now account for about 1.4% of GNI.

According to the the article "Car insurance essentials: The authorized driver clause" written by Escolango (2020), he noted that car insurance includes a permitted driver clause that covers vehicles that the owner is not driving. This clause requires that the driver of the vehicle has permission from the owner to drive the vehicle. An equally important requirement is that the nominated driver must have a valid, unexpired driver's license issued by the Land Transport Office. Examples of authorized drivers include: the owner's regular driver, whether paid or unpaid, a friend or family member, or even an employee of a car repair shop. Therefore, if the insured's vehicle is involved in a car accident, is driven by a licensed driver and has a driver's license, the insurance company covering the vehicle may be liable for damages. However, if you do not have a license or have expired, you will not be able to make a claim to the insurance company. Finally, theft can occur if the driver of the insured's vehicle is neither the owner nor an authorized person. Also, if the car insurance has a theft clause, the vehicle owner has the right to claim the insured's vehicle for loss from the insurance company. Also, if an unauthorized driver drives and causes an accident, you cannot put pressure on the insurance company or force damages

by an illegal driver. Instead, you can only be held liable for the loss of the owner's vehicle due to theft.

According to Laurel (2019), the Land Transportation Office has imposed a driver's license restriction and conditional law that strictly enforces all drivers who drive vehicles of all kinds. In the event of a breach, appropriate sanctions and penalties will be imposed and the car insurance claim may be denied if it is determined that a breach of the permitted driver clause has occurred. Motorcycle / electric tricycle b). Gross vehicle weight (GVW) up to 4,500 kg c). Vehicles with a gross vehicle weight exceeding 4,500 kg d). Automatic coupling up to a gross vehicle weight of 4,500 kg e). Automatic coupling with a gross vehicle weight of over 4,500 kg f). Articulated vehicle g) with a permissible gross weight of 1,600 kg or less. Combined vehicle 1,601 kg Total vehicle weight to 4,500 kg Total vehicle weight h). Combined vehicle with a total vehicle weight of 4,501 kg and LTO driver's license requirements. I wear glasses. j) Please ride only with the equipment for the upper limbs. k) Please ride only with equipment dedicated to the lower limbs l.) Journey only on day M) A person with normal hearing will accompany you.

Related Studies

Much to desire of the researcher to include related studies, and after diligent searches, unfortunately, he could not find any studies that is related to his own research.

Synthesis and Relevance of Reviewed Literature and Studies

The reviewed literature mentions auto insurance as one of the key components of the non-life insurance industry, called the insurance company window. Auto insurance is designed to cover the losses and liabilities that an insured may incur in the event of vehicle-related damage, accidents, or certain events. It provides financial compensation for damages caused to others or their property by the driver or owner of the vehicle. It is a legal requirement to have car insurance before using or owning a car on public roads. A car insurance claim is a formal claim against an insurance company that requires payment under the terms of the insurance policy. In addition, the insurance company will check the eligibility of the claim and, after it is approved, pay the insured or the claimant. Insurance is primarily a social tool used by civilized societies to mitigate family income losses due to unforeseen circumstances. Insurance is the busiest and fastest growing business. Timely claim resolution is an important service aspect for policyholders.

Claim management is assumed to be central to the insurance company. An effective billing management process can save your company time and money and improve customer satisfaction and retention. Claims processing involved manual tasks and a lot of paperwork, but tools and technologies such as claim management software can also help businesses streamline or automate their processes. By updating legacy processes and implementing the right technology, billing organizations can manage their financial billing volume

to achieve profitability. Therefore, if you want to improve your claims, you should make the evaluation and improvement of your claim management process one of your top priorities. Similarly, this study focuses on handling claims in non-life insurance customer relationships to maintain and expand market share and improve customer acquisition and retention. Claims are always processed by the insurance assessor, who can review multiple claims in one day and manually code the invoice in an incomplete or suspicious document. This may have worked well in the past, but today insurance companies can make hundreds of claims a day. In addition, this study helps to understand the idea that many insurers are now embracing digital transformation and innovative technologies that make claim processing an accurate and fast process and reduce claim management costs. This transformation can be used by insurers to shift regular transactions from claim handlers to intermediaries such as agents, brokers and customers.

Second, it must be understood that the success of digital transformation in automated billing begins with new value propositions that set high standards and drive the digitization of the billing customer experience. In addition, this study wants to know about the following new areas: 1. Effectiveness of online claim processing for car insurance companies. 2. Benefits of online conversion for car insurance claim processing in terms of fraud prevention. 3. Find out why the insurance industry is currently adopting digital transformation. 4. Restrictions on online claim processing for car insurance. 5.5. The impact of online billing

processing on fraud prevention. 6. Other insurance claim processing fraud. 7.

Create guidelines to prevent fraud through online processing.

Chapter 3

RESEARCH METHODOLOGY

This chapter describes the research procedures used in this study, including data sources, data collection procedures, and statistical tools and techniques used in data analysis and interpretation.

Method of Research

The researcher used an unstructured interview in which no fixed sample or set of questions were involved. Interviewers ask questions based on responses and are used to get more details about using online application processing. This includes open-ended questions with an informal approach to probing questions to prove respondents' answers. The research method is fact-based research with complete and accurate interpretation of the results. Its purpose is to know "what exists" or what is happening with a certain phenomenon. As this study focuses on the effectiveness of online auto insurance claims processing, the descriptive research method is the most appropriate method to be used in the hope of making recommendations based on the research findings.

Population, Sample Size and Sampling Technique

The researcher used purported sampling as a non-probability illustration selected based on the characteristics of the population and the purpose of the study known as judgmental, selective, or subjective sampling.

Description of Respondents

The respondents of this study were 60 employees and covered in auto claims. The researcher believes that the respondents provided reliable and valuable data needed for this study. These officers include auto adjusters and auto claim handlers from randomly selected Malayan Insurance.

The following tables show the distribution of respondents on age, sex, marital status and education level.

Table 3.1 presents the frequency and percentage distribution of the customer respondents' description as to age level.

As noted on the table, rank 1 are those respondents at the "36-40" bracket with 20 respondents out of 60 or equivalent to 33 percent. In Rank 2 are those in the "31-35" bracket with 18 respondents which is equivalent to 30 percent. Completing the ranking at Rank 3 are those in the "26-30" age bracket with 11 respondents which is equivalent to 18 percent.

Table 3.1

Customer Respondents as to Age

Age Level	f	%	Rank
25 and below	2	4	5.5
26 – 30	11	18	3
31 – 35	18	30	2
36 – 40	20	33	1
41 – 45	6	10	4
46 – 50	1	1	7
51 and above	2	4	5.5
Total	**60**	**100**	

This shows that the majority of claim respondents are between the ages of 36 and 40, which means they are young professionals working in auto insurance adjusters and appraisers with in-depth knowledge of the industry. auto insurance claim fraud and several auto claimant respondents have experienced claims fraud. And the next number of respondents were in the group of 31-35 people with little knowledge of claims, but no experience in filing claims. Those between 26 and 30 years old with 18%. These are new insurers and policyholders who know almost nothing about fraudulent claims.

Table 3.2

Customer respondents as to Gender

Gender	f	100%
Male	39	65
Female	21	35
Total	**60**	**100**

Table 3.2 shows the frequency and percentage distribution of the customer respondent description as to gender.

As shown on the table, the "male" got 39 respondents out of 60 or equivalent to 65 percent, while the "female" got 21 respondents which is equivalent to 35 percent.

This shows that there are many male respondents who work as a claims adjuster in the insurance industry relative to his female counterpart. The difference is not that big. However, the number of male and female respondents recruited as modifiers was almost equal. However, it could be implied that men are more interested in knowing about different fraud prevention measures in dealing with online complaints. Because, in the insurance claims industry, most fraud handlers are men compared to women, and male adjusters are more likely to do eye exams and investigate stolen vehicles. more damaged. It is very likely that the incident occurred in remote, remote areas that would put the female

operators at risk. Part of identifying cases of fraud is conducting interviews with people who may have witnessed the incident.

Fraud investigations are very risky as most of them are accidents staged or fabricated by malicious actors with no intention other than insurance claim. Sometimes, when insurance refuses to cover claims, these fraudsters call with insults, threats, and threats to adjusters denying their claims. In this regard, much of the claims industry would rather hire a male employee with the courage and ability to perform a dangerous task than hire a female claims handler.

Table 3.3

Customer Respondents as to Civil Status

Civil Status	f	%	Rank
Single	25	42	2
Married	32	53	1
Separated	3	5	3
Others			
Total	60	100	

Table 3.3 presents the frequency and percentage distribution of the customer respondent description as to civil status.

As noted in the table, rank 1 are those respondents in the "married" category with 32 respondents out of 60 or equivalent to 53 percent. In Rank 2 are those in the "single" category with 25 respondents which is equivalent to 42 percent. In Rank 3 are those in the "separated" and "others" category, the majority of respondents are policyholders and adjusters who process auto insurance claims and know the importance of using online claim processing as it will lead to greater trust , reduces the risk of claims fraud and can speed up claim processing times. Online Fraud Prevention is a fraud detection tool that reduces losses to the insurance industry, and when claims processing is automated, the chances of fraud detection increases.

Table 3.4

Customer Respondents as to Educational Attainment

Educational Attainment	f	%	Rank
College Units	1	2	3
College Graduates	56	93	1
Master's Degree Holder	3	5	2
Total	**60**	**100**	

Table 3.4 presents the frequency and percentage distribution of the customer respondent description as to educational attainment.

As may be gleaned on the table, majority are "College Graduates" which is rank 1 with 56 respondents out of 60 or 93 percent. Rank 2 are those with "Master's Degree" category with 3 respondents equivalent to 5 percent. Completing the ranking are those in "College Units" category with 1 respondents equivalent to 2 percent.

It can be concluded that there is a larger number of respondents who are university graduates than those who respond with only college units. Because most of the insurance industry prefers to hire a college graduate instead of choosing a candidate with only university units because employers are looking for a potential employee with a combination of technical ability in report writing, skills in developing databases for fraud prevention using online processing of insurance claims. The company is also looking for employees with good insurance claims, good communication skills, and leadership abilities. One of the benefits of college graduates is the ability to navigate and apply innovative technology for use in their essential work-related applications.

Insurers generally trust people with more education and value college degrees, because they believe that a preference for a liberal arts education is preparation for more than a specific job.

Research Instrument

The researcher gathered the needed data by using the following instruments:

Questionnaire. The tool used by the researcher to collect data is a survey questionnaire. It aims to know the efficiency of online auto insurance claims processing, what benefits online conversion brings to auto insurance claims processing in preventing fraud, why insurance industries are now adopting digital transformation, the effectiveness of the online process in improving the auto insurance business guidelines, recommendations respondents made on insurance training insurance, as well as the severity of different frauds for insurance. Data collected from respondents is analyzed, organized and interpreted.

Interview. The researcher personally conducted an informal unstructured interview to supplement the questionnaire responses and to clarify some questions that the interviewees did not answer clearly. The interview was conducted in a natural conversation with respondents to collect data. The researcher uses open-ended questions and data collected from respondents. The researcher should keep in mind the interviewer's opinion on the topic of online insurance claim processing. Respondents were considered the primary data source for the study, as talking to them was one way to gather data and gain knowledge about their perceptions of the effectiveness of claims processing. online auto insurance.

The researcher solicited respondents for their views on preventing insurance claim fraud. The first draft of the questionnaire was prepared by the

researcher based on these readings. He presented the project to his advisor, who in turn made the necessary edits, exclusions, and additions. The researcher considered all of these suggestions when revising the questionnaire.

The questionnaire was validated by presenting it to 10 non-response employees of the study.

Data Gathering Procedure

The researcher prepared a letter to the head of the insurance company. After approving the letter, the researcher personally distributed the questionnaire to the respondents. The researcher then sought the respondents' consent to is-sue the questionnaires. After finding that the questionnaires were valid and reli-able, copies were distributed to the respondents. With the help of colleagues, he personally ran the distribution to 60 purportedly selected employees. After giving respondents enough time to respond and get 100% back.

Statistical Treatment of Data

Questionnaire data   were aggregated, tabulated and statistically processed to ensure validity, reliability, and interpretability. The researcher used the following statistical tools.

Frequency and Percentage Distribution.   This was used to determine the profile of   respondents, what benefits   online conversion has to auto

insurance claims processing in terms of fraud prevention, why the insurance industry is now is applying digital transformation, online claims processing limitations for auto insurance, as well as recommendations on preventing fraudulent claims submissions made by respondents. Percentage is defined as a number expressed as 100. It has been used to represent numbers from 0 to 1 and is used to compare things.

Formula:

$$P = \frac{f}{N} \times 100$$

Where:

P = percentage
f   = frequency
N = number of respondents

In this study, percentages were applied to analyze responses to questions related to respondents' characteristics such as age, gender, and education level. The value is the frequency of occurrence of each variable and the total value is the sum of the frequencies.

Weighted Mean. To evaluate the efficiency of online auto insurance claims processing, a weighted average was applied. Respondents' responses are grouped into five and weighted accordingly. The weights are multiplied by the number of answers in each category and added and divided by the sum of the products.

Formula:

$$WX = \frac{f \times 100}{N}$$

Where:

f   =   frequency

N   =   number of respondents

Likert Scale. To assess the quality of the responses on the rating scale, a five-point Likert scale method to measure the respondents' level of agreement with the effectiveness of online processing was used. Each statement has responses, ranked by effectiveness from "5" meaning extremely effective to "1" meaning ineffective. Respondents rate each cognitive item by choosing one or more than five possible answers. Therefore, the score is the weighted sum of the tested answers.

Numerical Equivalent	Scale	Interpretation	
4.50 - 5.00	- 5	Extremely Effective	(EE)
3.50 - 4.49	- 4	Very Effective	(VE)
2.50 - 3.49	- 3	Effective	(E)
1.50 - 2.49	- 2	Somewhat Effective	(SE)
1.00 - 1.49	- 1	Not Effective	(NE)

Also, to qualify for rating scale responses, a five-point Likert scale method to measure the severity of various claims insurance frauds was used. Each statement has five responses, ranked by severity from "5" meaning very serious to "1" meaning not too serious. Respondents rate each cognitive item by choosing one or more than five possible answers. Therefore, the score is the weighted sum of the tested answers.

Numerical Equivalent	**Scale**	**Interpretation**	
4.50 - 5.00	- 5	Very Serious	(VS)
3.50 - 4.49	- 4	Serious	(S)
2.50 - 3.49	- 3	Neither	(N)
1.50 - 2.49	- 2	Not Serious	(NS)
1.00 - 1.49	- 1	Not Very Serious	(NVS

The equivalence score assigned to each item indicating the existence of conditions perceived by respondents would be determined by estimating the weighted mean that became verbally descriptive.

Chapter 4

PRESENTATION, ANALYSIS, AND INTERPRETATION OF DATA

In this chapter, the researcher presents the information gathered regarding the effectiveness of online auto insurance claims processing, the effectiveness of the online process to improve fraud prevention, recommendations for Suggestions made by respondents about insurance training, severity of fraudulent insurance claims in Malayan Insurance using key tools, questionnaires and interviews. Structured questionnaires were distributed to respondents after the researcher explained the purpose and importance of the study. Respondents are also assured of the security of their identities and that their answers will not be used to harm them, their businesses or their families. Collected data are presented in tabular form. Each picture receives its corresponding interpretation and analysis. The tables are presented in the order of the questions in the questionnaire. In this section, the analysis begins with a table on the effectiveness of online complaints because the tables on demographic profiles were presented in chapter 3 in the "respondents of the study" section.

Objective 2. On the Degree of Effectiveness of Online Claims Processing

for Motorcar insurance

Table 4.1

On the effectiveness of online claims processing for motorcar insurance.

Indicators	*WX*	*I*	*Rank*
a. In retrieving records	4.00	VE	6
b. In identifying genuine client	3.78	VE	7
c. In fast tracking transactions	4.63	EE	1
d. In minimizing manpower effort	4.03	VE	5
e. In determining original documents	3.65	VE	8
f. In familiarization with processes	4.43	VE	4
g. In cost-cutting	4.48	EE	3
h. In promoting insurance services	4.52	EE	2
i. In overall decision-making	3.60	VE	9
Average Weighted Mean	4.13	VE	

Legend:

Numerical Equivalent		Scale	Interpretation
4.50-	5.00	5	Extremely Effective (EE)
3.50-	4.49	4	Very Effective (VE)
2.50-	3.49	3	Effective (E)
1.50-	2.49	2	Somewhat Effective (SE)

1.00-   1.49   1   Not Effective (NE)

Table 4.1 shows the weighted mean and the corresponding perceptions of the respondents on the degree of effectiveness of online claims processing for motorcar insurance.

As illustrated on the table, "In fast tracking transactions" is Rank 1 with weighted mean of 4.63 or equivalent to verbal interpretation "Extremely Effective".

Because respondents estimate that the wait time for customers to process requests has been significantly reduced to just a few days compared to the previous two-week wait time. This online processing eliminates the cumbersome paperwork that adds to transaction delays. According to the old handling method, customers had to be present in person to facilitate transactions and bring their vehicles to the facility for physical inspection. In the new process map, insurance industries are now adopting the latest technological gadgets and devices to facilitate inspections even without an insurance representative's physical presence. , the company is currently using online platforms along with tools like web conferencing digital signature generator, video checker, PDF scanner, email, Viber and messenger to enable off-site processing web.

Rank 2 is "In promoting insurance services" with a weighted mean of 4.52 or equivalent to verbal interpretation "Extremely Effective", while Rank 3 is "In cost-cutting". Respondents are those who believe that using online claim

processing significantly reduces payment processing time. Previously, when filing claims, claimants had to go to the insurance company to file, which was a waste of time and money. But using the method of the modern online system, he changed the handling of complaints quickly. In addition, the insurance industry saves a lot by not using printed materials and purchasing equipment such as fax machines, copiers and shredders. By using an online platform, the insurance industry can provide quality service to customers. Policyholders can view the latest policy, insurance promotions, premiums, and claim status by visiting the insurance company's website. Payment of premiums and claims can be made by bank transfer within a short time. Other insurance services such as insurance promotions, advertisements and other lines of insurance products can be sent via email, Instagram, Messenger and even Viber. By using the customer relationship method, it helps the insurance company to save money on promotional products and advertising.

In rank 4 is "In familiarization with process" with weighted mean of 4.43 or equivalent to verbal interpretation "Very Effective". By using online claims processing, the adjuster or claims processor can familiarize themselves with the claims process, as electronic copies can be made available. There are claims methods that can be found on the online platform that can be used as a guide to resolving claims.

The last in the ranking at Rank 9 is "In overall decision-making" with weighted mean of 3.60 or equivalent to verbal interpretation "Very Effective".

With online claims processing, the regulator can decide and verify whether the claims documents are complete and appropriate; while the claim processor can also decide whether the claim is indemnified or not. And by using an online system, it is easy to approve the settlement process and pay by online bank transfer to the fund. This type of procedure does not require the applicant to visit an insurance office for the transaction. The use of this advanced technology allows regulators to decide appropriately whether a claim is fraud or a legitimate case.

Objective 3. On the Different Variables that Help in Preventing Fraud

Table 4.2 shows the frequency and percentage distribution of the responses on analyzing the effectiveness of online process to enhance fraud prevention.

It can be viewed from the table, "faster access to claim process" is rank no 1 with 54 respondents equivalent to 12.9%. Respondents' responses showed that using modern technology it shortened the claims processing process and adjusters acted on claims immediately. Using online claim processing, it allows the insurance processor to track the case and can access documents and provide the status of the claim.

Rank 2 is "Improved claim processes" of 53 respondents with a total 12.7 percent. From the results it can be determined that using online claims processing increases the efficiency of claims resolution as determined by the

ratio of outputs to inputs, moderators have more transparent control over data and the

ability to understand where they reside and trade them for value. Likewise, the online claims process has reduced claims settlement time, the number of customer complaints, improved services provided, and increased satisfaction levels. Digital transformation is one area where results can be achieved. For example, use software to manage the entire claims process starting with the user and with a degree of automation, speeding up the process, minimizing costs, and reducing fraud.

Table 4.2

Different Variables that Help in Preventing Fraud

Indicators	*f	%	Ranking
a. Embracing digital transformation	44	10.6	5
b. Digital technology changes work styles in insurance companies	49	11.8	3.5
c. Online processing plays a vital role in fraud control	30	7.2	8
d. Digital transformation allows the insurer with the tools to give customers excellent service.	48	11.5	6
e. Improves claim processes	53	12.7	2
f. Reduces cost and time in claims processing	49	11.8	3.5
g. Customer gets a bird's eye view of their claims	23	5.5	10
h. Does faster access to claims process	54	12.9	1
i. Synchronous process increases productivity			

and profits	28	6.7	9
j. Online process automation will be a core business			
operation	39	9.4	7
*Multiple response	**417**	**100%**	

Rank 3.5 is "Digital technology changes work styles in insurance Companies" and "Reduced cost and time in claims processing" both with 49 respondents and 11.8 percent. Digital technology can improve the productivity and optimize the workflow of adjusters so they can focus on the most important task at hand. By adopting these innovations, claimants' files could be uploaded and edited, and claim handlers and claimants were updated via video conferencing where ever they and even inspection of damaged equipment can be done through online video investigation. Digital technology has better security before hackers can easily break in. Companies today are starting to proactively update their systems with computer security software. It also increases communication as the technology revolutionizes communication methods by using different web pages that can be linked to the entire file and notification center thus increasing the level of interaction. of employee. Digital technology, productivity and efficiency are increased to be able to meet deadlines and satisfied customers.

Rank 5 with 44 respondents equivalent to 10.6% is "Embracing digital transformation cannot be avoided". The adoption of digital technology can

transform business performance towards increasing revenue, improving customer experience, and reducing costs. If a company does not use digital technology, it will fall behind. This can lead to reduced sales and reduced profits. Using digital technology can make a difference in a business and give it an edge over its competitors. If you want to be a competitive player in the industry, it is important to strengthen your technology adoption strategy by leading and growing ahead.

Rank 6 is "Digital transformation allows the insurer with the tools to give customers excellent service" with 48 respondents or equivalent to 11.5%. This can be seen in today's digital transformation, providing insurers with the opportunity to engage their policyholders in modern service. Customers want a seamless experience regardless of channel, because of the way you connect all of your company's digital channels to deliver an exceptional customer experience. Digital transformation will reduce the number of customer complaints, improve the experience and increase satisfaction, which can lead to a positive business transformation in terms of revenue growth.

Rank no 7 with 39 respondents equivalent to 9.4% is "Online process automation will be a core business operation. Today, automation will be an essential business activity, as it increases and accelerates productivity levels, potentially reducing claims and generating revenue.

"Online processing plays a vital role in fraud control" Is ranked with 30 respondents and equivalent to 7.2%. The results show that few believe that

online processing can play an important role in combating fraud, but the use of online settlement can include waste and manipulation, payment abuse and laundering. money, and insurance applies a piecemeal tactic to prevent fraud. Claims fraud is rampant and claims fraud is on the rise. To combat fraud, insurance uses technology to predict conventional tactics, uncover new conspiracies, and decipher organized fraud rings. Through the database, the insurer captures all types of data available through the divisions and feeds it into the analysis process by continuously monitoring transactions, social networks and risk anomalies. I is needed to instill company culture through data visualization at all levels, including optimizing forensic workflows and using multi-layered security techniques. In such statements, we can say that online processing plays an important role in the fight against fraud.

In rank 9 with 28 respondents equivalent off 6.7% "Synchronous process increases productivity and profits", Synchronous process increases productivity and profits. Whether a transaction is made in person or in person, the person in charge of a particular transaction will be forced to act quickly and in real time as customers are waiting in line and expecting immediate service. This should not be postponed to a later date as the client has spent a lot of time and effort at the insurance company's office. If the transaction is virtual and asynchronous, employees will simply delay service to the next day, or worse, to a later date. Maximizing the productivity of a particular employee will also maximize the cost of wages paid to them, as they serve as many customers as possible on any

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given day, which will result in a good fit between expenses and income, and ultimately, increase profits for the company.

Rank 10 is "Customer will be getting a bird's eye view of their Claims" with 23 respondents or 5.5 percent. In the online claim process, policyholders can access the status of their claim, by going to the website provided by their insurance company. Have they viewed scanned documents or they It is possible to simply send a message or simply call the adjuster in claims as the data generated by the insurance processing system can notify the customer of the status of their claim in just a few days or even in seconds while they are talking on the phone.

Objective 4. On the Recommendation Offered by the Respondents On Insurance Training

Table 4.3 shows the frequency and percentage distribution of the response to the recommendation offered by the Respondents on Insurance Training.

As noted in the table rank 1 is" Familiarization with latest technology" with 53 respondents equivalent to 10.6% because it is important for adjusters to be knowledgeable about modern technology and the importance of this modern new innovation to help expedite the settlement of insurance claims and the pros and cons of it. As illustrated on the table rank 2 is "Familiarization on all aspects of insurance process with 50 respondents equivalent to 10%.

Seasoned insurance adjusters should know all aspects of the claims process from filing a claim or posting documents online to whether indemnification is available, claims evaluation red flag, generate damage assessment through video investigation, provide customer claim status, insurance and agent negotiation, release LOA provide information that the claims filed have a history of being denied or that they have been included in a list of red flag cases. Also due to the adaptation of the insurance industry to modern technology, the insurance industry cooperates to provide information on fraud cases.

Table 4.3

On the Recommendation offered by the Respondents on Insurance Training

Indicator's	*f	%	Rank
a. Training of personnel on Philippine Insurance Code	35	7.0	9
b. Training on Cybersecurity law	33	6.6	10
c. Familiarization on all aspects of Insurance process	50	10	2
d. Familiarization with preceding insurance cases in the past	49	9.8	3
e. Familiarization with tell-tale signs of Insurance fraud	48	9.6	4
f. Training on Business and Professional Ethics	26	5.2	12

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g. Constant retraining on Company Policy	40	9	8
h. Familiarization with latest technology	53	10.6	1
i. Constant reshuffle of job assignments	44	8.8	6
j. Constant field inspection	41	8.2	7
k. Training on proper evaluation of police Reports	47	9.4	5
l. Training on professional ethics to prevent illicit transactions	32	6.4	11
*Multiple response	**498**	**100%**	

and transfer payment process.

Rank 3 is the "Familiarization with preceding insurance cases in the past" with 49 respondents or 9.8%. By using the banking system, all the candidate's classified information along with their application was recorded on the database. Regulators can easily open the system to view claims history. the system will provide information that claims filed have a history of denial or have been placed on the red flag list. Also due to the adaptation of the insurance industry to modern technology, the insurance industry cooperates to provide information on cases of fraud.

.   Rank 4 is the "Familiarization with tell-tale signs of insurance Fraud" with 48 respondents with a total 9.6%. The claims process should be familiar with the signs of insurance fraud. Auto insurance fraud ranges from misrepresenting policies and inflating claims to staging accidents and filing claims for injury or damage without never happening until the false reports of stolen vehicles. Fraud can involve unexpected mishandling, improper payments and money laundering,

insurance is required to take an effective approach to fraud prevention. To combat fraud, an insurance adjuster should be aware of the various indicators if the accident occurred in the early hours of the morning, the amount of the loss is large but supported only by a notarized affidavit, the numbers listed contact not contactable, brokers and agents are not aware of the claim after checking with them, claim documents sent by unauthorized stores or not have a license. Estimate provided by agent but accompanied by letter of cash payment and letter from policyholder authorizing a person to act on their behalf dealing with insurance. By knowing these metrics, claim processors can prevent fraud.

Rank 5 with 47 respondents with average of 9.4% is "Training on proper evaluation of police reports". Police report is one of the basic requirements in the processing of an insurance claim as it provides information that occurred in the accident, police report means an unbiased report of the incident. work of a third party. This can be more effective for proof than what appears to be a rumor or telling the story from your or another driver's point of view. Insurers will need police reports and if you decide to file a personal injury claim, reporting will be invaluable.

Rank 6 is Constant reshuffle of job assignments with 44 respondents equivalent to 8.8%. Continuously changing job structures is an important method in insurance operations to prevent adjusters from becoming familiar with their assigned accounts, which can also avoid friendly relations with their clients. them to avoid colluding with a fraudulent claim.

Job rotation or cross-training means that an employee in a department acquires skills over a period of time as a hands-on approach to enriching and expanding job assignments and eliminating employee fatigue due to tedious tasks when changing tasks. The challenge of these new tasks can encourage employee enthusiasm and improve employee morale to increase output. It stimulates work morale and cultivates their interpersonal relationships by transferring medical staff to different units within the same department.

Rank 7 is "Constant field inspection" with 41 respondents and with 8.2% average. It can be concluded that continuous on-site inspection is crucial during the claim process, especially in the case of major damages that cannot be visualized with pictures or during a live video survey. route, especially these parts are located inside the engine compartment and in the subframe of the vehicle by doing an actual or field inspection by the cruise adjusters he can verify the damage reality of the vehicle and can provide a relevant and complete assessment survey report.

Rank 8 with 40 respondents with equivalent of 9% is "Constant retraining on Company Policy". It is important to retrain employees according to company policy because policies are consistent with company rules, provide a clear definition of why and who they exist, provide information about where and how they apply. They also suggest ways to enforce guidelines and the consequences of violating a policy. All of this is written in clear and simple sentences so that everyone can understand it easily. Policies are a guide on

how to handle different situations that may affect employees. These strategies and goals are used to manage interpersonal conflicts, complaints, requests, and other concerns involving employees. Policies provide a guideline for decision makers or leaders to follow when faced with such situations.

Rank 9 is the Training of personnel on Philippine Insurance Code with 35 respondents with 7%. It is very important for claim processors to know the Philippine Insurance Code as it contains claims handling instructions. You will also find there insurance law as an expert. The current process is in accordance with the provisions of the law.

Rank 10 with 33 respondents and with 6.6% is the "Training on Cybersecurity law". There is an important factor as to why employees should be trained in cybersecurity laws, to protect their data. Every business with an online presence should invest in advanced cybersecurity measures, including firewalls, encrypted connections, data leak protection, and ransomware protection. A powerful spam filter should be configured to prevent phishing emails from being sent to your employees, prevent email spoofing, and scan incoming/outgoing emails. Employees should be aware of the use of anti-virus software, and it should also be used and updated regularly to help secure endpoints.

It is no longer realistic to expect one IT department to be able to mitigate all IT security risks. Your entire team should be trained to raise their awareness of specific threats, including phishing and phishing scams. All employees must provide strong passwords and backup data.   At rank 11 spot with 32

respondents at an average of 6.4% is "Training on professional ethics to prevent illicit Transaction.

A strong ethical culture in your company is important for protecting company assets. Ethics is integral to promoting increased productivity and teamwork among employees. Ethics allows employees to feel a strong connection between their values and your company's values. They express such emotions through increased productivity and motivation. Ethical conduct in the workplace promotes a culture of ethical decision-making. It also improves accountability and transparency when making business decisions and prevents illegal transactions.

Objective 5.   On the degree of Gravity of the different fraud in claims processing for motorcar insurance.

Table 4.4 shows the weighted mean and the corresponding perceptions of the respondents on the degree of seriousness of fraud in insurance claims. Rank 1 is "Hard fraud, a deliberate act of staging fake incidents" with weighted mean of 4.82 or equivalent to verbal interpretation "Very Serious". This means that the majority of respondents consider this style as common. There are actually policyholders who think that signing up for an insurance plan is a way to get dirty money at the provider's expense. They will try to plan carefully to commit fraud at the expense of a company, in this case Malayan Insurance. Scamming insurance policy providers is now big business for some people,

and they are very good at it. If insurance adjusters do not pay attention to every detail, this type of risk will always go unnoticed.

Rank 2 is "Exaggerated claims" with weighted mean of 4.62 or equivalent to verbal interpretation "Very serious". Also, in addition to fabricated claims, there are also people who actually claim that they were in an accident, but the amount claimed is a different story. They increased the amount to more than 200% of the actual damage cost.

Table 4.4

On the Degree of Seriousness of Fraud in Insurance Claims

Indicators	WX	I	Rank
a. Hard fraud, a deliberate act of staging fake incidents	4.82	VS	1
b. Soft fraud, providing false information	4.47	S	5
c. Staged auto accidents and false claims injury	4.43	S	6
d. Exaggerated claims	4.62	VS	2
e. False claims for damage that already existed	4.23	S	9
f**.** Submission of fake documents, police, etc.	4.52	VS	3.5
g. False reports of stolen vehicles	4.35	S	7.5
h. False claims than an accident happened after a policy was purchased	4.52	VS	3.5
i. Buy-out incident report scam	4.35	S	7.5

j. Claimants who concealed that a person excluded from coverage by their policy was driving at the time of accident	4.22	S	10
Average Weighted Mean	**4.45**	**S**	

Legend:

Numerical Equivalent		**Scale**	**Interpretation**
4.50-	5.00	5	Very Serious (VS)
3.50-	4.49	4	Serious (S)
2.50-	3.49	3	Neither (N)
1.50-	2.49	2	Not Serious (NS)
1.00-	1.49	1	Not Very Serious (NVS)

As illustrated in the table rank 3.5 is "Submission of fake documents, police reports, etc." and "False claims that an accident happened after a policy was purchased" both with a weighted mean of 4.52 or equivalent to "Very serious".

Forged documents submitted by forged claimants are one of the biggest contributing factors to a pure scam claim, without these documents these forged claimants could not claim fake insurance claims, scammers spend money to buy fake documents or they bribe police or traffic officers to report the incident. They also create fake documents and they tend to hire people and use them as tools to claim insurance. There are many processes an insurance processor must follow to prevent these types of insurance scams. One of the things to consider is improving fraud alerts by carefully checking submitted application information. Create a dedicated team to conduct insurance fraud investigations.

They should also implement countermeasures to prevent fraud using special tools to prevent fraud, such as claim automation, these types of solutions optimize public processes claims, improve efficiency, and improve the customer experience. This allows humans to handle complex underwriting, investigation and arbitration cases, while technology like Artificial Intelligence can handle high volume, less complex and small scale cases, increasing service speed and error reduction. Additionally, by partnering with anti-fraud groups, such as accredited claims adjusters, who specialize in combating insurance fraud.

False claims are filed after purchasing a policy. In this type of fraud, scammers buy a full loss unit from other insurance companies and file a claim with the target insurer. In such scams, the scammers make big money. They do it explicitly without the modifiers noticing. Their method is that after buying the car with total loss, they will keep it for about a month or two, and they will secure fake incident reports and fake documents to submit to the insurance company. The target and target of the scam is a highly organized group not just the police. employees are their accomplices but also bogus insurance agents, brokers and insured who make a lot of money for this type of fraud. These are the people who put pressure on the regulators to speed up the processing of requests. Due to the long-term nature of the business, insurance companies have used a variety of methods to find the red and gray areas of claims. They even use modern technologies to prevent claim fraud.

Rank 5 is "soft fraud Soft fraud providing false information" with weighted mean of 4.47 and is equivalent to "Serious". This is a type of fraud that provides false information when filing an insurance claim. This is a common case of fraud involving exaggerating a minor damage claim into a legitimate claim or lying when signing up for auto insurance to get a lower premium. Soft fraud does more to increase the compensation for their claims. Specific examples of soft fraud include driver disappearance, or when a person fails to notify their insurance company about all drivers in a household. When people inflate the value of stolen equipment or include old damage as part of a new claim. There is also what we call location Lies, when people use someone else's address to register and insure their car because they know the insurance rates are lower in that area.

As illustrated in the table, rank 6 is "Staged auto accidents and false claims injury" with a weighted mean of 4.43 and equivalent to verbal interpretation "Serious". One type of insurance fraud is a staged auto accident. This is also an organized accident, when the driver dispatches the unsuspecting motorist to make a false insurance claim. The way of making fake accident compensation to claim compensation from the insurance company is like lying that these fraudsters intentionally beat innocent parties so that they can claim and get the compensation value in the fake accident. There are many examples of staged road accidents. The "Swoop and Squat" pattern involves two cars, one operating as a vehicle next to the victim, while the other "swoops" into the

victim's vehicle and abruptly stops, causing a rear-end collision. The first car is usually full of riders who, claiming to have been injured in even a low-speed crash, file fraud claims with the insurance company. "Sideswipe" involves the victim's vehicle drifting into the next lane while making a turn. The author of this scam crashed into a car that had just drifted into his lane. Declaring his innocence, the author then submits a claim to his insurance company. Crash for Cash scammers choose their victims carefully. They keep an eye out for drivers who appear to be fully insured but are less likely to make a fuss. The criminal, in a vehicle in front of the victim, braked for no apparent reason, and the victim did not have time to react and collided with the vehicle in front. However, there are ways to avoid this age-old collision that policyholders should drive with caution and not follow. Leave enough space between you and the vehicle in front of you; prevent hazards; look over the vehicles in front of you. and adjust your driving speed to weather, road and traffic conditions. Be careful when accepting the right of the path. Always pay attention to the position of other vehicles around you in case you need to take action. Such fraud has a huge impact on the insurance industry in terms of premiums and revenue when unavoidable.

As noted in the table, rank 7.5 are "False reports of stolen vehicles" and "Buy-out incident report scam" both with a weighted mean of 4.35 or equivalent to "serious". This is also considered a fake case of car theft "Blocking the car" is taking another person's car with the intention of taking it without that person's consent or using violence or threats another person or by force.   This fraud

occurs when an insured vehicle is reportedly stolen in a vehicle that has been stolen or is not taken at all, then it would be a fraud. The purpose of this fraud is to recover an insurance claim for a stolen vehicle. These scammers will hide the car and then report the car lost to the insurance company in the hope that the insurance will reimburse the amount based on the market value at the time of the loss, these counterfeiters will file a claim. claim stolen car insurance using such fake documents. These bogus documents could be police reports, alarm sheets, traffic management group complaint sheets, non-recovery certificates. The bad guys can take advantage of this to profit by using tricks. To combat covered fraud, insurers must ensure that they interact with legitimate stakeholders. Insurers should prioritize investing in real-time identity verification using software solutions that define various fraud prevention fundamentals.

Rank no 9 is "False claims for damage that already existed" with a weighted mean of 4.2the 3 or equivalent to verbal interpretation "serious". This is another fraudulent claim occurring in the auto insurance industry. This kind of vehicle misrepresentation existed before the scammer bought an insurance policy. The vehicle has been severely damaged or may have fallen into total loss. These bogus claimants will file a claim after a few months to get a financial return from the insurance and if the insurance adjuster does not analyze the documents he may be responding to such activities. This type of fraud has a significant effect on the financial systems of the insurance sectors. Using modern technology can go a long way in resolving fraud claims.

The last in the ranking at rank 10 for Table 4.4 is "Claimants who concealed that a person excluded from coverage by their policy was driving at the greatly help time of accident' with a weighted mean of 4.22 or equivalent to verbal interpretation "serious". Road accidents involving motor vehicles are now more common than ever. In fact, it is one of the leading causes of premature death in the country. Road accidents often cause damage and injury not only to the occupants of the collision vehicle, but also to third parties such as bystanders and nearby vehicles. However, there are cases where the owner of the vehicle involved in an accident is not the driver of it. The question is whether the victim can go directly to the insurance company that has issued the insurance policy for the aforementioned vehicle and claim the damage suffered.

Car insurance policies often include a clause, an authorized motorist provision, that essentially covers vehicles that are not driven by their owners. The provision requires the driver of the said vehicle to have been authorized by the owner to drive that vehicle. An equally important requirement is that this driver must carry a valid and unexpired driving license issued by the Land Transportation Department. The insurance policy contains a provision under the authorized motorist provision, the main purpose of providing the policy is to require a non-insured person to drive at the order of the insured, as their regular driver or with their permission such as friends or family members or employees of an auto repair or service shop who are duly licensed drivers and are not disqualified from operating a motor vehicle. When the insured is no longer in

breach in the event of a claim, he will indemnify the insured owner for loss or damage to the vehicle but will limit the use of the insured vehicle to: 1. The insured person himself; or 2. Anyone driving at their command or with their permission. There are times when a claim is denied on the day of death. The driver of the vehicle is ineligible because his license is only a student's license and he does not have a valid professional driver's license or he does not comply with the limitations set forth in the license.

Therefore, if the insured vehicle is involved in a traffic accident driven by an authorized person with a valid driver's license, the insurance company paying for the vehicle may be liable for the damage. In the event that the license is absent or expired, it is not possible to file a lawsuit against the insurance company. Meanwhile, if the driver of the insured vehicle is not the owner or authorized person to operate the vehicle, the act may be considered theft. If the insured violates this, he will hide unauthorized drivers and place fake drivers with authorized licenses so they can claim the insurance company. This type of fraud greatly affects the financial loss of the insurance company as well as the policyholder if not avoided.

Chapter 5

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents a summary of the study. It includes the findings obtained from the data, the conclusions drawn from those findings, and recommendations made based on the findings and conclusions.

Summary of Findings

This study was conducted to provide a guide as a basis for developing an improved policy on how to prevent auto insurance claim fraud. Descriptive research methods and survey techniques were used. The main tools used for data collection were questionnaires and structured and unstructured interviews that were randomly used to gather more information from respondents.

All indicators were assessed by selected respondents from Metro Manila. Due to a number of limitations, the questionnaires were distributed online using a survey platform. The responses to the questionnaire were supplemented by an interview method conducted through phone calls, video calls and instant messaging. Based on the collected data, the researcher came to the following conclusions:

1. **On the effectiveness of online claims processing for motorcar insurance.**

   The first Three (3) in rank are: **a**. "In fast tacking transaction" with a weighted mean of the f 4.63 and is equivalent to verbal interpretation of "Extremely Effective", **b**. "In promoting insurance services" with a weighted mean of 4.52 and is equivalent to "Extremely Effective", and **c**. "In cost cutting" with a weighted mean of 4.52 is also equivalent to "Extremely Effective".

2. **To determine the different variables that help in preventing fraud.**

   The first four (4) in rank are: **a.** "Faster access to claims process" with 54 respondents or 90%, b. "Improved claim processes" with 53 respondents or equivalent of 88%, **c**. "Digital technology changes work styles in insurance companies" with 49 respondents or 82% and "Reduced cost and time in claims processing" also with 49 respondents or 82% and **d.** "Online processing plays a vital role in fraud control" with 48 respondents with corresponding 73%.

3. **On the Recommendation offered by the Respondents on Insurance Training**

   Out of the Eleven (11) Indicate to the first Three (3) in rank are: **a.** "Familiarization with latest technology" with 53 respondents or 88%, **b.** "Familiarization on all aspects of insurance process" with 50 respondents or 83% and **d.**

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"Familiarization with preceding insurance cases in the past" with 49 Respondents or with corresponding 81%

4. **On the Degree of Gravity of Fraud in Insurance Claims**

The first Three (3) in rank are**: a.** "Exaggerated claims" with a weighted mean of 4.65 and is equivalent to verbal interpretation of "Very Serious", **b.** "Hard fraud, a deliberate act of staging fake incidents" also with weighted mean of 4.65 and comparable of "Very Serious", and **c**. "False claims than an accident happened after a policy was purchased" with a weighted mean of 4.52 and is corresponded to "Very Serious".

Conclusion

Establishing good control over the insurance business is one of the management's goals to avoid fraudulent claims from customers. The key to preventing fraud in online processing is creating improved guidelines for efficient and cost-effective operation.

Based on the summary of findings from the data gathered, the following conclusions are drawn.

1. The online claims processing reduces the waiting time both for fotohe claim processors and clients for just a couple of days.

2. The use of online claims processing speeds up the service access to process and settle claims of payments and produces quality service to the clients.

3. Training programs will familiarize employees with the use of technology. An insurance processor can provide a fair and quality settlement if they have sufficient knowledge of claims processing and liability resolution.

4. There are various fraud with different degree of severity. Among the cases, exaggerated claims are the most serious.

Recommendations

Based on the findings and conclusions, different variables and recommendations were made by respondents regarding insurance education to help prevent fraud. In this agreement, several recommendations were proposed to improve the fraud prevention policy. The recommendations are as follows:

1. The company may continue utilizing and shortening online processing. The company may even offer more insurance services to take advantage of notable customer turn-out because of the good promotion brought about by the online processing.

2. The use of online claim process may be applied in claim settlement to prevent fraud and may recognize suspicious patterns and characteristics indicative of fraud.

3. Training programs may lead to better processes by gaining skills and may be considered as an indispensable way of keeping an organization competitive.

4. The insurance companies may consider getting more vigilant on fraud and may also adopt modern technology to optimize the processes and evaluate data of the policy holders, claimants and the history of claims being filed.

G.N.C ONLINE PROPOSITION ON FRAUD PREVENTION

Proposition 1: Effectiveness of Online Processing

1. Online claim fast-tracking will be effective in fast-tracking insurance transactions.

2. Online transactions will eliminate voluminous paper works and reduce delays.

3. Insurance companies should adopt sophisticated technology and use online platforms to facilitate remote inspections.

4. Online processing reduces processing and turn-around payment settlement that will result in saved time and money.

5. Online processing helps the claim processor in familiarizing themselves with the process by just downloading forms and procedures.

6. Online processing helps claims adjuster and processors to easily make decisions like approval and payment process.

Proposition 2: Preventing Fraud

1. Fraud can be prevented if there is fast processing of claims. The chance of committing fraud will be rendered because of time constraints and the shorter process that can speed up the action of the processors.

2. Online claims processing increases the efficiency of claim settlement for more transparent control over the data.

3. Online processing reduces the number of customer complaints and improves services and heightened satisfaction.

4. Online processing changes the work styles of the employees. It enhances their productivity and minimizes working routine resulting for them to be more work-focused.

5. Online processing can positively transform business performance with regards to increasing revenue, reducing costs, and improving customer experience.

6. Online processing will now be a core business operation because it increases and speed the level of productivity which is able to reduce complaints and brings revenue.

7. Online processing gives the clients a bird's eye view of their Claims that Policy holders can access the status of their claims, by viewing their documents, their sent messages, or the call made to the insurance.

Proposition 3: Insurance Training

1. Insurance processor and adjusters should familiarize themselves with the latest technology to help speed up the process.

2.   Insurance prospects should be familiar with all aspects of insurance processing from filing and review of claims and assessing those "red-flag" claims.

3. Processors should be familiar with the preceding cases in the past so that they can easily open the system to view the history of a particular claim.

4. Processors should be familiar with the tell-tale signs of fraud such as misrepresenting facts, inflating insurance up to staging accidents and submitting claim forms that never occurred.

5. They should also be familiar with Police reports as one of the basic requirements in processing of insurance claims that provides the information of what transpired during the accident.

6. Insurance personnel should be constantly reshuffled, an important method to prevent insurance adjusters from familiarization with their assigned accounts. This can also avoid having friendly ties with their clients to avoid connivance to a fraud claim.

7. There should be constant field inspection, especially in extensive damage that cannot be seen in pictures or in an online video survey.

8. There should be a regular training on employee definitions in any policy providing clear definition of why and for whom they exist, and information on where and how they apply.

Proposition 4: Gravity of different Frauds

1. Hard fraud, a deliberate act of staging fake incidents should be monitored because this fraud is the most serious fraud. Policyholders will go out of their way to carefully plan a fraud at the expense of a company.

2. Exaggerated claims are also "very serious" fraud. Policyholders padded the amount to an extent higher by 200% than the actual cost of damage.

3. Submission of fake documents, police reports, and false claims that an accident happened after a policy was purchased are "very serious". Fake documents submitted by false claim-making are in anyone of the biggest contributors to making a clean fraud claim.

4. Soft fraud by providing false information is "Serious". This is the type of fraud that provide false information when filing an insurance claim this is a common fraud case that involves exaggerating small damage of claim to a legitimate claim.

5. Another type of "serious" insurance fraud is stage auto accidents, also called a staged crash, when drivers maneuver unsuspecting motorists in-to crashes to make false insurance claims.

6. False reports of stolen vehicles and Buy-out incident report scam are also "serious" considered as fake car napped cases, with the intent to gain a vehicle belonging to another.

7. False claims for damage that already existed are all the so "serious". Another fraud claim that occurs with motorcar insurance industry that is already existed even before the fraudster bought an insurance policy.
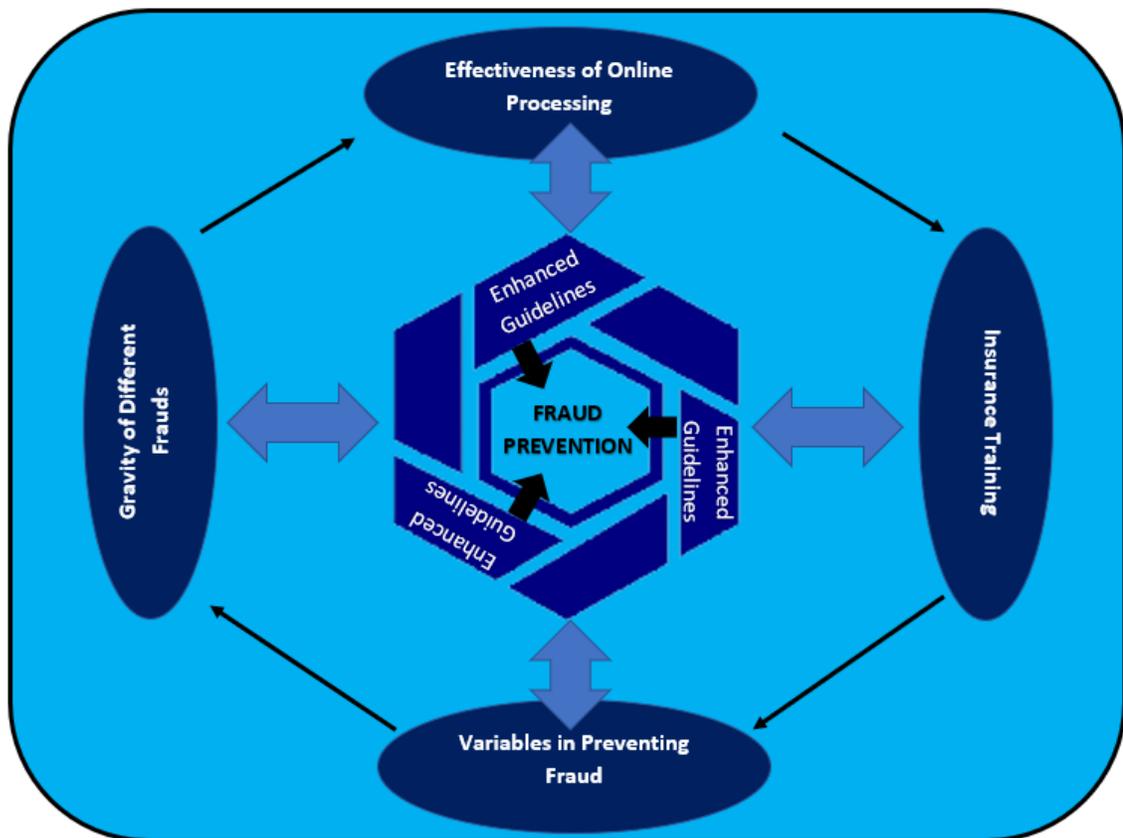

Figure 5.1

Framework for Online Claims Processing

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APPENDIX A: SURVEY QUESTIONNAIRE

Dear Respondents:

This is a questionnaire for the study entitled, *" Fraud Prevention in Online Processing of Insurance Claims: Basis for Enhanced Guidelines*"

Please answer the questionnaire as accurately and honestly as possible. There is no wrong answer, do not leave any item unanswered. Rest assured that your answer would be treated with utmost confidentiality.

(Sgd) GENER N. CADAG
Researcher

1. On the Profile of the Respondents

Please give the necessary information about yourself by checking or writing in the space below.

Name (Optional): _____

1.1 Age
_____ 25 and below
_____ 26 – 30
_____ 31 – 35
_____ 36 – 40
_____ 41 – 45
_____ 46 – 50
_____ 51 and above

1.2 Gender
_____ Male
_____ Female

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Project 8, Quezon City, Philippines

1.3 Civil Status

_____ Single
_____ Married
_____ Separated
Others, please specify _____

1.4 Highest Educational Attainment
_____ Vocational – Technical Graduate
_____ College Units
_____ College Graduate
_____ Master's Units
_____ Master's Degree Holder
_____ Doctoral Units
_____ Doctorate Degree
Others, please specify _____

2. On the effectiveness of online claims processing for motorcar insurance.

Direction: Please indicate by a checkmark (✓) if how effective online processing is in the following area of insurance claims processing using the following scale:

5 = Extremely Effective
4 = Very Effective
3 = Effective
2 = Somewhat Effective
1 = Not Effective

	5 (EE)	4 (VE)	3 (EI)	2 (SE)	1 (NE)
In retrieving records	___	___	___	___	___
In identifying genuine client		___	___	___	___
In fast tracking transactions		___	___	___	___
In minimizing manpower effort	___	___	___	___	___
In determining original documents		___	___	___	___
In familiarization with processes	___	___	___	___	___

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In cost-cutting   ___   ___   ___   ___

___

In promoting insurance services   ___   ___   ___   ___   ___
In overall decision-making   ___   ___   ___   ___   ___

3. **On analyzing the effectiveness of online processes to enhance fraud Prevention.**

   Direction: Please indicate by a checkmark (✓) if which of the following variables help in preventing fraud (*you may check more than one)*

   _____   *embracing digi*tal transformation cannot be avoided
   _____ digital technology changes work styles in insurance companies
   _____ online processing plays a vital role in fraud control
   _____ digital transformation allows the insurer with the tools to give cus-
   tomers
         excellent service.
   _____ Improved claim processes
   _____ reduced cost and time in claims processing
   _____ customers will be getting a bird's eye view of their claims
   _____ faster access to claims process
   _____ synchronous process increases productivity and profits
   _____ online process automation will be a core business operation

4. **On the recommendation offered by the respondents on insurance training**

   Direction: Below is a list of some recommendations given by respondents on how to train in insurance. Please **check** those that apply to you. (You may check more than one)

   _____ Training of personnel on Philippine Insurance Code
   _____ Training on Cybersecurity law
   _____ Familiarization with all aspects of the insurance process
   _____ Familiarization with preceding insurance cases in the past
   _____ Familiarization with tell-tale signs of insurance fraud
   _____ Training in Business and Professional Ethics

_____ Constant retraining on Company Policy
_____ Familiarization with the latest technology
_____ Constant reshuffle of job assignments
_____ Constant field inspection
_____ Training on proper evaluation of police reports
_____ Training on professional ethics to prevent illicit transactions

5. **On the different fraud in claims processing for motorcar insurance.**

Direction: Please indicate by a checkmark (✓) if how may the different
fraud in insurance claims be described using the following scales:

5 =   Very Serious
4 =   Serious
3 =   Neither
2 =   Not Serious
1 = Not Very Serious

	5 (VS)	4 (S)	3 (N)	2 (NS)	1 (NVS)
Hard fraud, is a deliberate act of staging fake Incidents ………………………………………..	___	___	___	___	___
Soft fraud, providing false information of a Legitimate auto claim ……………………………..	___	___	___	___	___
Staged auto accidents and false claims of injury Exaggerated claim ………………………….…	___	___	___	___	___
False claims for damages that have already existed …………………………………………	___	___	___	___	___
Submission of fake documents, police report, etc. ……………………………………	___	___	___	___	___

False reports of stolen vehicles ………………..   ___   ___   ___   ___
___

False claims that an accident happened after a

   policy or coverage was purchased ……......   ___   ___   ___   ___
___

Buy-out Incident report scam ………………..   ___   ___   ___   ___
___

Claimants who concealed that a person excluded

   from coverage by their policy was driving at the

     time of accident ………………………….. ___   ___   ___   ___   ___

… Thank you for your cooperation…

APPENDIX B: TABULATION OF DATA

On the effectiveness of online claims processing for motorcar insurance

INDICATORS	TOTAL	Weighted Mean	Ranking
In retrieving records	240	4	6
In identifying genuine client	227	3.78	7
In fast tracking transactions	278	4.63	1
In minimizing manpower effort	242	4.03	5
In determining original document	219	3.65	8
In familiarization with processes	266	4.43	4
In cost-cutting	269	4.48	3
In promoting insurance services	271	4.52	2
In overall decision-making	216	3.60	9
Average		4.13	

On the different fraud in claims processing for motorcar insurance

	TOTAL	Weighted Mean	Ranking
Hard fraud, a deliberate act of staging fake incidents	289	4.82	1
Soft fraud, prioviding false information	268	4.47	5
Staged auto accidets and false claims injury	266	4.43	6
Exaggerated claims	277	4.62	2
False claims for damage that already existed	254	4.23	9
Submission of fake documents, police report, etc.	271	4.52	3.5
False reports of stolen vehicles	261	4.35	7.5
False claims than an accident happened after a policy was purchased	271	4.52	3.5
Buy-out incident report scam	261	4.35	7.5
Claimants who concealed that a person excluded from coverage	253	4.22	10
Average		4.45	

APPENDIX C: CERTIFICATE OF EDITING AND ORIGINALITY
CHECK

This document certifies that the manuscript listed below was edited for the proper English language, grammar punctuation, spelling, and overall style.

Dissertation Title

FRAUD PREVENTION IN ONLINE PROCESSING OF INSURANCE CLAIMS: BASIS FOR ENHANCED GUIDELINES

Researcher
GENER NUAL CADAG

Date Issued
December 20, 2021

Dr. Emma Cortez Iyo PhD
English Editor/Specialist

I hereby certify that this manuscript has been evaluated using Assignment proof originally Check System with 20% similarity index, <1% Internet sources, <1% publication, and 1% student papers. I have analyzed the report produced by the system and based on it, I certify that the references in the manuscript are in accordance with good scientific practice.

Verified through assignment proof by:
Engr. Delaney C. Ofrecio
Research Director

APPENDIX D: STATISTICIAN'S CERTIFICATE

STATISTICIAN'S CERTIFICATION

This is to certify that this research study entitled, "**FRAUD PREVENTION IN ONLINE PROCESSING OF INSURANCE CLAIMS: BASIS FOR EN-HANCED GUIDELINES**" was prepared and submitted by Gener N. Cadag in partial fulfillment for the degree of Doctor in Business Administration has been statistically reviewed by the undersigned.

Mr. Rufino U. Viernes, MAT
Statistician

APPENDIX E: CURRICULUM VITAE

Gener Nual Cadag
Bldg. D-453 Smile Citihomes Condo
Brgy., Kaligayahan Zabarte Road
Fairview Quezon City
Mobile # :09209116039
Email Address: genercadag@yahoo.com
cadagghie@gmail.co

OBJECTIVE:

- To secure a challenging position in a reputable organization to expand my learnings, knowledge, and skills
- Secure a responsible career opportunity to fully utilize my training skills while significantly making contributions to the success of the company.
- To obtain a high-level position where I can maximize and share my training abilities.
- To obtain a position that will allow me to use my strong passion for a career growth
- To enhance my professional skills in a dynamic and fast-paced workplace
- To use my skills in the best possible way in achieving the company's goals

EDUCATIONAL ATTAINMENT

Graduate School (currently enrolled)   - Doctors Degree in Business
Administration
AMA University
June 2019- present

Postgraduate   - Master's Degree in Business
Administration
Metro Manila College
Novaliches, Quezon City
June 2013 April 2016
Thesis Writing- Effectiveness of Motor
car Insurance Claims Processing in
Sampled Insurance Companies

Tertiary   - Polytechnic University of the
Philippines
Bachelor of Science in Hotel and Res
taurant Management
Old Sta Mesa Manila
June 1989 – April 1993

EMPLOYMENT HISTORY

Villagers Montessori College   Part-Time Professor
December up to present

Malayan Group of Insurance Company   - Assistant Claims Manager
1996 – up to present

PERSONAL BACKGROUND

Age   -   50 years old
Date of Birth   -   July 21, 1971
Gender   -   Male