



Appian for Insurance

Connected Claims: fraud case management.

Fraud claims cost U.S. consumers at least \$80 billion per year in the United States and €13 billion per year in Europe, according to the Coalition Against Fraud Insurance and Insurance Europe. In fact, it's estimated that insurers pay out up to 10% of claims costs annually on fraudulent claims.

And these costs are incurred despite widespread use of anti-fraud technology. However, rarely does this technology offer a single, unified view of all potential instances of fraud across all lines of business. Existing anti-fraud systems and processes often lack the ability to effectively track similar claims, including loss padding, collusion, and repeat offenders.

Further complicating matters, of course, is that fraud mitigation efforts must also account for the customer service side of claims adjudication. Generating false positives for fraud may upset those who have suffered legitimate losses.

So how can insurers balance the time, cost, and servicing aspects of a comprehensive, ongoing fraud case management initiative?

Better fraud detection is a business imperative.

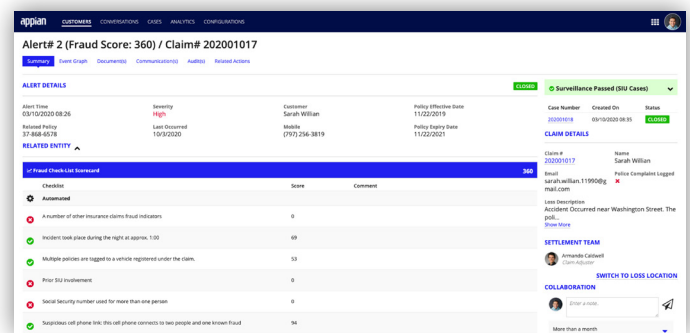
Built on the Appian Low-Code Automation Platform, the Connected Claims intelligent fraud case management module empowers insurers to detect fraudulent activity sooner by providing a single, consolidated view of fraud risk across all lines of business. A broader view of all data allows insurers to detect previously unknown fraud schemes and spot linked entities and crime organizations to minimize leakage.

Using advanced case management capabilities, insurers can improve investigator efficiency and ROI and enable more efficient and accurate investigations. In addition, insurers can capture all claims settlement amounts within a single system to reuse for similar claims in the future.

Improve fraud case management with low-code automation.

With Appian, insurers can optimize fraud detection, prevention, and management and achieve the following benefits:

- Streamline fraud handling operations with a configurable workflow that displays all information pertinent to a case.
- Leverage artificial intelligence to increase both the speed and accuracy of determining potential fraud cases.
- Better manage data from all sources, including claims systems, watch lists, third parties, and external databases or fraud services.
- Enable greater collaboration between internal and external stakeholders in the investigation process via a single view of all available data.



Improve fraud detection to mitigate claims leakage.

- **Optimize fraud case management with intelligent automation.** Leverage advanced case management capabilities and artificial intelligence to streamline fraud detection and prevention.
- **Gain full visibility into fraud operations.** Connect advanced fraud detection solutions to existing legacy systems to create a single, consolidated view of fraud risk to empower claims handlers to make more informed decisions.
- **More easily identify fraud before settlement.** Improve fraud detection accuracy and efficiency, including loss padding in claims, to reduce overall loss adjustment expenses.
- **Dramatically reduce time and cost to implement.** Leverage the speed and power of the Appian Low-Code Automation Platform to stay agile as new threats and risks emerge.

Take control of the entire claims life cycle.

With Appian Connected Claims, you can go beyond fraud case management and streamline each part of the claims life cycle, including the following:

- First notice of loss
- Claims operations and settlement
- Customer service
- Litigation and recovery management
- Field inspections
- Process mining

Leaders in insurance trust Appian.



Learn more at appian.com/connected-claims

Contact us at info@appian.com