



Insurance fraud in Norway

Statistics on cases detected in 2025

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Foreword

Insurance is based on mutual trust between policyholder and insurer, where it is assumed that the policyholder will provide accurate and honest information both when applying for cover and when making a claim. Experience from specific cases and surveys of the public reveal that this is not always the case. Each year the insurance industry is defrauded of substantial sums, and not all of this fraud is detected. An increasing focus on preventive action means that more and more cases are being picked up as early as the application stage. This spells major savings for insurers, and these also benefit customers in the form of lower prices.

1. Introduction

These statistics from Finance Norway Insurance Services provide a picture of detected insurance fraud and the products affected. The aim of this report is to highlight the extent of insurance fraud and its cost.

Insurers uncover numerous cases of insurance fraud every year. The claims that are rejected amount to substantial sums – money that is intended for honest customers. Those who defraud insurance companies are defrauding all those around them.

The report is divided into eight sections. Section 2 provides a general overview of the total number of frauds detected in 2025, while Sections 3-5 look specifically at fraud in three segments: personal non-life, commercial/agricultural non-life and personal sickness/disability insurance. Section 6 looks at who commits the frauds and where the most frauds are detected. Developments in criminality and new trends in insurance fraud demand constant attention, both to prevent such crime and to ensure that the industry is not exploited by criminals, and Section 7 provides an insight into this work. Finally, Section 8 contains a glossary of terms.

The data in the report have been obtained from insurers that are members of Finance Norway Insurance Services. Only cases detected as fraud as set out in the Norwegian Insurance Contracts Act are included in the report.

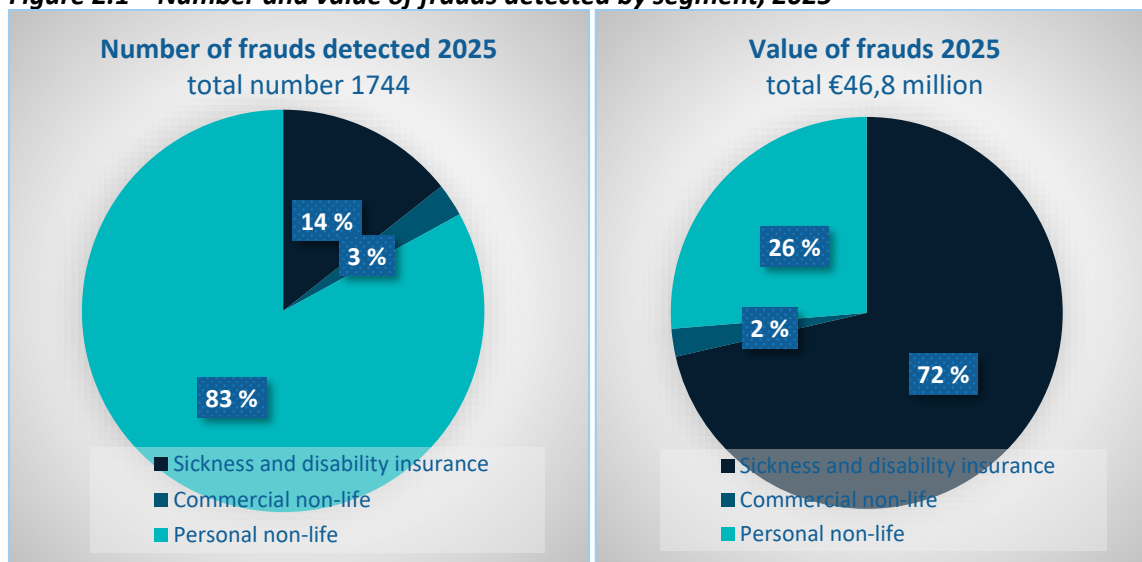
Claims rejected with reference to the Insurance Contracts Act account for around half of the claims rejected by these companies. Instances of other situations where insurers may refuse to pay out are where the customer has been grossly negligent or contravened the terms of insurance, or where money laundering is suspected (such as where the customer cannot explain the origin of funds). Claims rejected for these reasons are not covered by this report.

All monetary figures have been converted from Norwegian kroner (NOK) to euros (EUR) based on the foreign exchange reference rate of 9 March 2026 (1 EUR = 11.1545 NOK; 1 NOK ≈ 0.0896 EUR).

2. Detected fraud in 2025 – overall figures

Insurers are very focused on detecting insurance fraud.

Figure 2.1 – Number and value of frauds detected by segment, 2025



The insurance industry rejected a total of 1,744 claims with reference to the Insurance Contracts Act in 2025, compared with 1,752 in 2024. The combined value of these rejected claims was €46,8 million (*exchange rate page 19)

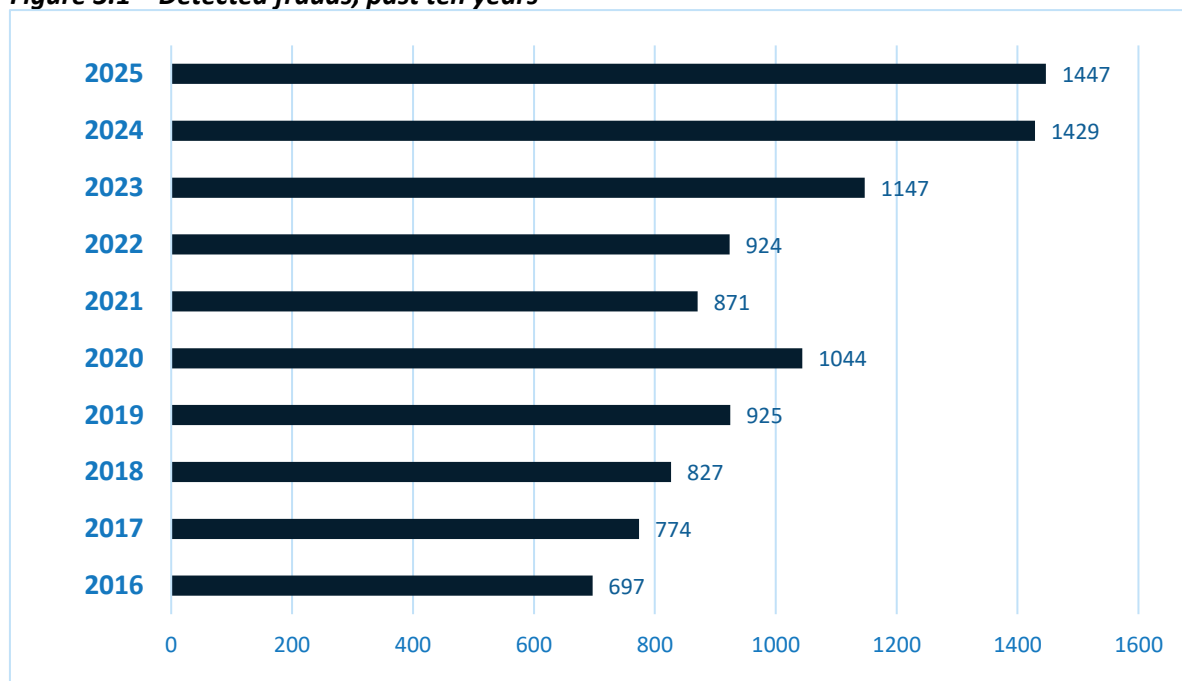
Table 2.1 – Overview, 2024 and 2025

	Number of claims 2025	Number of claims 2024	Value of frauds detected (EUR) 2025	Value of frauds detected (EUR) 2024
Personal non-life	1,447	1,429	12,3	12,8
Commercial non-life	46	63	1.1	1.0
Sickness and disability	251	260	33,4	29,6
Total	1,744	1,752	46,8	44,1

When it comes to sickness and disability products, a distinction can be drawn between the number of cases of fraud detected and the number of policies concerned. The 251 cases detected in 2025 covered a total of 278 sickness and disability policies. It is not possible to make the same distinction in non-life insurance, although a person may very well have had more than one claim rejected.

3. Detected fraud in personal non-life insurance

Figure 3.1 – Detected frauds, past ten years



A total of 1,447 cases of fraud were detected in this segment in 2025, compared with 1,429 cases in 2024 and 1,147 in 2023. The total value of personal non-life claims rejected was €12,3 million in 2025, €12,8 million in 2024 and €13,0 million in 2023.

There were relatively few cases in 2021, presumably as a result of pandemic restrictions. Most of these restrictions were lifted in 2022, although there were still a few in place at the beginning of the year. 2020 was a special year, with extensive travel restrictions introduced in March which led to large numbers of cancellation claims on travel insurance and may have presented an increased opportunity for fraud.

The average value of cases detected in 2025 was around €8 500, compared with €9 000 in 2024 and €11 300 in 2023. There is considerable variation in the sums involved, with the largest in 2025 being €534 000 and the median €2 9 00 (i.e. there were equal numbers of cases above and below this amount).

The number of frauds detected in a particular area will often reflect how much priority the industry is giving that area and the volume the area represents.

For the most part, frauds are detected internally by the insurer. One important instrument in this context is the central claims database FOSS¹.

¹ See definition in Section 8.

Figure 3.2 – Types of fraud, past five years

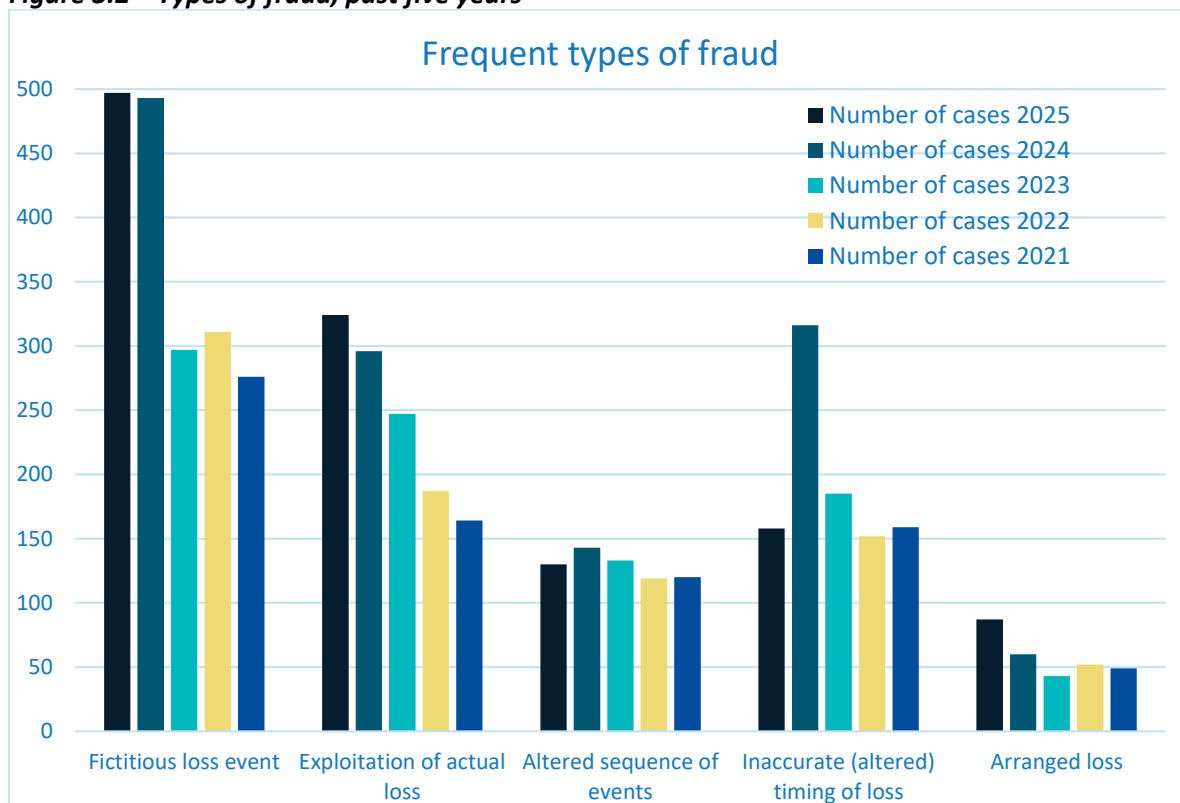


Figure 3.2 shows data back to 2021. Most cases detected are where the customer reports a fictitious loss or exploits a genuine loss event. The largest sums relate to arranged losses. The types of fraud committed vary with the type of product. Frauds on travel policies will often be very different to those on buildings and motor policies. The most common type of motor-related fraud is exaggerated claims, while the most common type of travel insurance fraud involves a fictitious loss.

Table 3.1 – Detected frauds by class of business, past five years. Percentage share

Class	2021	2022	2023	2024	2025
Motor vehicles	40.3	31.3	31.7	32.0	38.9
Contents/effects	37.3	41.3	39.8	38.7	34.3
Travel	12.3	18.9	22.1	23.7	21.6
Buildings	4.8	5.0	3.4	3.3	2.8
Leisure boats	1.7	1.7	1.3	1.2	0.8
Valuable items	2.6	1.3	0.5	0.3	0.6
Other/unknown	0.9	0.9	1.0	0.8	1.5

Table 3.1 shows that motor and contents insurance frauds are most common. Motor insurance accounted for 563 of the 1,477 cases in 2025, contents for 497 and travel insurance for 305. There were particularly few travel insurance frauds in 2021 due to extensive travel restrictions

during the pandemic. The number of contents-related cases fell to 497 in 2025 but have otherwise been rising in recent years.

Trends in the number of cases detected may have to do with individual insurers' efforts and priorities, but also with the type of fraud.

Table 3.2 – Types of loss, motor vehicles. Percentage share

	2021	2022	2023	2024	2025
Theft (of and from)	11.4	11.5	12.0	12.8	7.3
Material damage/comprehensive (external factors, collision)	73.1	77.9	73.9	71.4	80.3
Fire	4.7	1.4	4.2	1.8	1.8
False documents	0.3	0.3	1.7	0.2	0.9
Accidents involving personal injury	-	-	-	-	-
Other	6.1	5.5	4.8	5.4	6.9
Vandalism	2.6	1.7	3.1	3.6	1.6
Recovery	0.3	0.7	0.0	1.1	0.8
Liability	1.5	1.0	0.3	3.8	1.2

A total of 563 frauds with a combined value of €5,4 million were detected in connection with motor insurance in 2025, giving an average value of €9 600. The median was €2 9 00, and the single largest case had a value of €0,1 million

Most cases (80%) concerned collisions and other damage. These had an average value of €9 600. Theft of/from vehicles accounted for 7% of cases, with an average value of €17 500.

Figure 3.3 – Types of motor insurance fraud, past three years

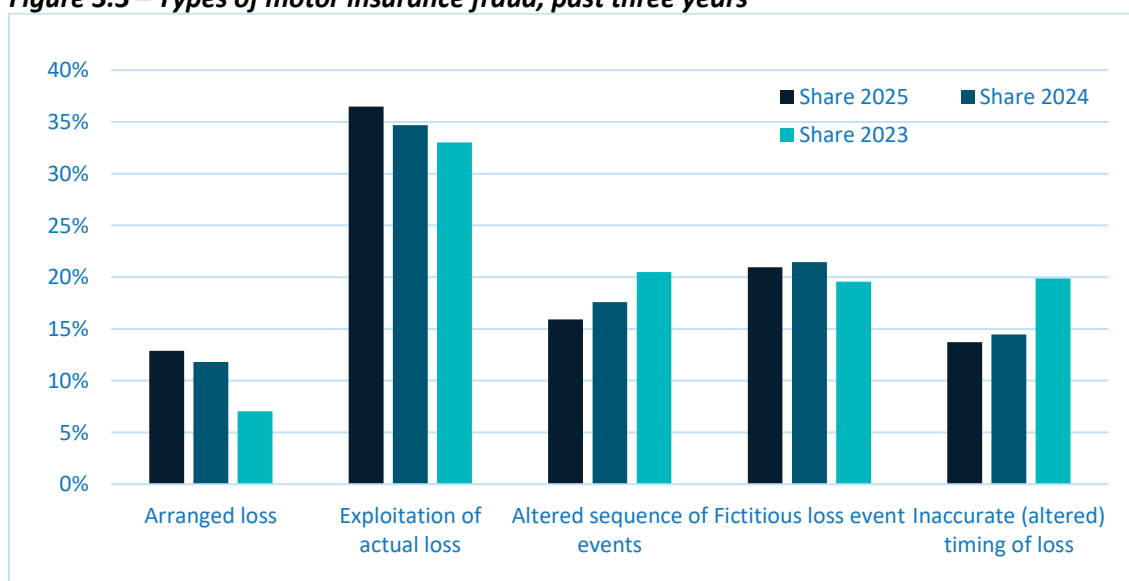


Figure 3.3 shows that exaggerated claims and fictitious losses account for the largest share of motor insurance fraud. It also shows a slight increase in arranged losses in 2025. Arranged losses were more widespread a few years ago, but the share fell gradually from 23% in 2018 to 7% in 2023 before rising again somewhat over the past two years to 13% in 2025.

Table 3.3 – Types of loss, contents/effects products, past five years. Percentage share

	2021	2022	2023	2024	2025
Theft/break-ins	34.2	29.8	30.2	27.6	27.8
Fire	4.6	2.6	2.6	1.6	3.0
Material damage	35.7	37.2	38.6	37.6	39.0
Water-related damage	4.0	2.4	2.4	3.2	1.6
External factors	8.0	13.1	14.0	17.7	18.5
Other, including false documents	12.0	13.4	11.2	11.2	9.7
Hold-ups	0.9	1.3	0.9	1.1	0.4
Vandalism	0.6	0.3	0.2	-	-

Thefts/break-ins and material damage account for the largest share of frauds in the contents/effects class. A total of 497 frauds were detected in connection with contents/effects cover in 2025, compared with 553 in 2024 and 457 in 2023. The total value of cases in 2025 was €2,8 million, giving an average value of €5 600. The largest case had a value of around €0,2 million, and the median was €2 7 00.

Fictitious losses account for the largest share of cases and made up 48% of the total in 2025.

Table 3.4 – Types of loss, travel products, past five years. Percentage share

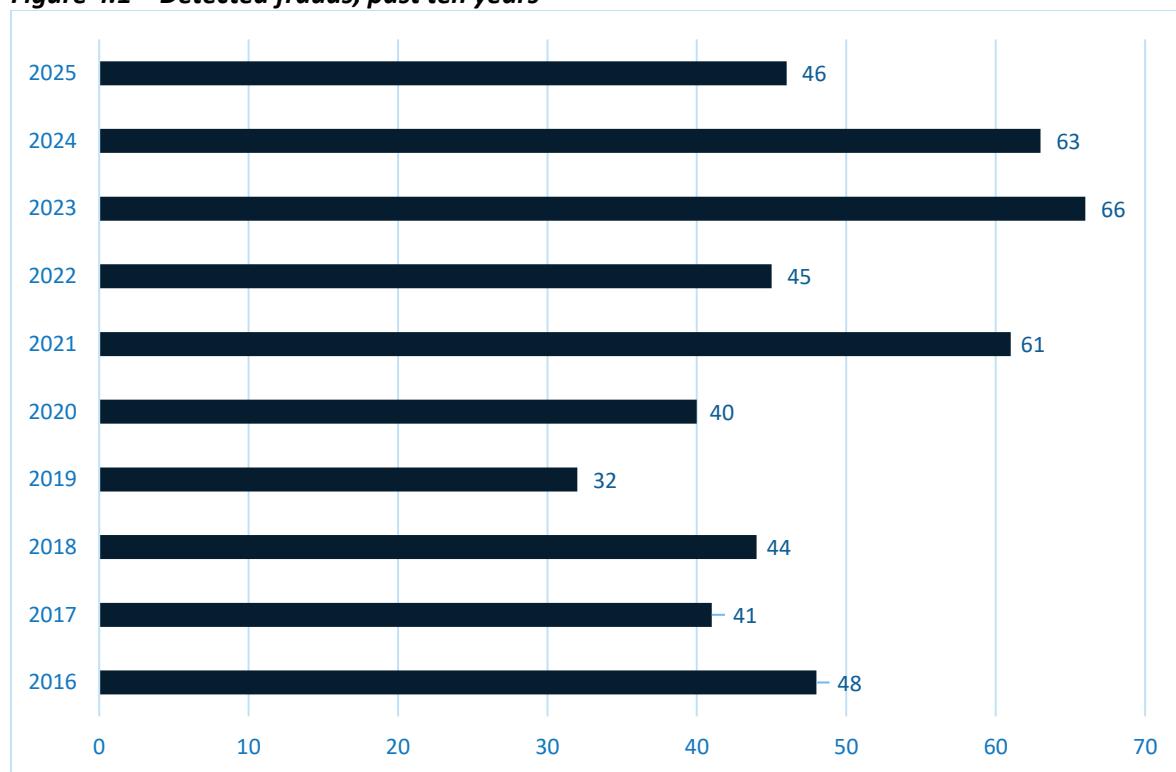
	2021	2022	2023	2024	2025
Loss/theft of luggage	70.1	61.1	66.1	65.5	63.0
Accident/illness	15.0	14.9	19.5	10.9	11.8
Material damage	5.6	5.1	2.0	5.6	5.2
Hold-ups	3.7	3.4	5.1	7.1	6.9
Break-ins	-	-	-	-	0.3
False documents	0.9	5.1	0.4	0.3	0.3
Other	4.7	10.3	4.3	10.6	12.5

Travel insurance fraud is most commonly associated with theft/loss of luggage. Of a total of 305 cases detected in 2025, 192 related to the theft or loss of luggage. There were also 36 frauds related to accidents/illnesses.

The average value of travel-related frauds detected in 2025 was €3 100. The single largest fraud was theft-related and had a value of €22 200.

4. Detected fraud in commercial/agricultural non-life insurance

Figure 4.1 – Detected frauds, past ten years



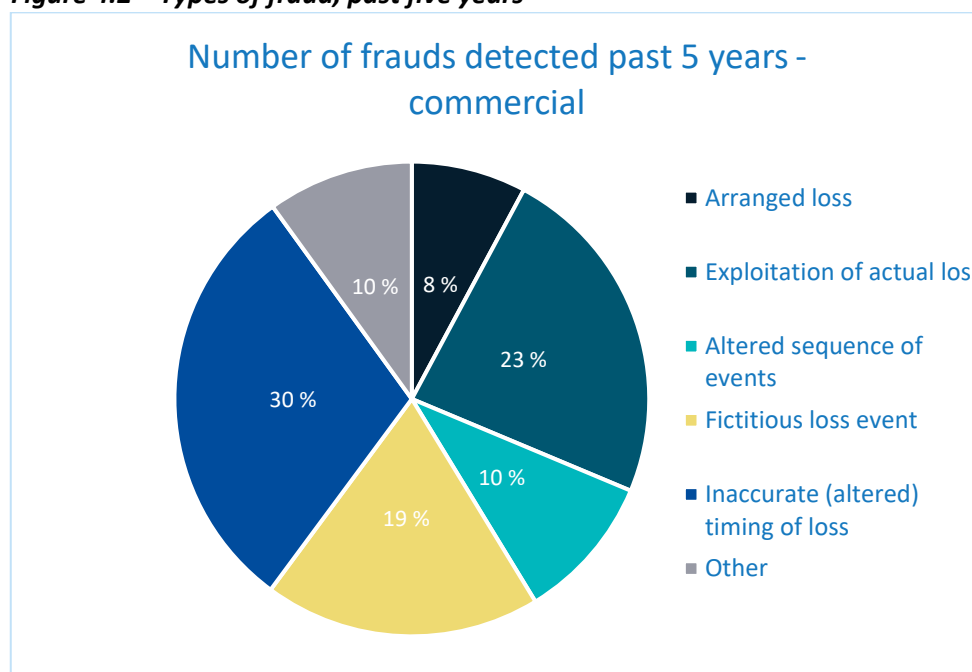
In the commercial and agricultural market, 46 fraudulent claims with a combined value of €1,1 million were rejected in 2025, the largest of these amounting to €0,1 million. This translates into an average of €23 300 per case. The median was €1 7 00. Thus there were a few larger cases, but also many small ones.

Table 4.1 – Detected frauds by class of business, past five years. Percentage share

	2021	2022	2023	2024	2025
Car/van	24.6	40.0	36.4	12.7	34.8
Industrial/commercial	42.6	33.3	25.8	42.9	39.1
Transport	-	-	1.5	9.5	2.2
Occupational injury	3.3	4.4	1.5	1.6	-
Travel	1.6	-	-	1.6	-
Contents/effects	1.6	-	-	-	-
Agricultural	-	-	4.5	-	-
Farm machinery	1.6	8.9	9.1	4.8	8.7
Livestock etc.	24.6	11.1	7.6	23.8	10.9
Other	-	-	-	-	-

Of the 46 cases detected in 2025, the largest share was in the industrial/commercial class.

Figure 4.2 – Types of fraud, past five years



A total of 46 frauds were detected in 2025. Figure 4.2 shows types of fraud in the commercial and agricultural segments combined over the past five years. The largest share of cases involved altered timing of loss, but exaggerated claims and fictitious losses are also common.

Most cases are picked up internally by the insurer, often via the FOSS² claims database.

² See definition in Section 8.

5. Detected fraud in sickness and disability insurance

This section of the report covers personal sickness and disability insurance as set out in Section 10-1 of the Insurance Contracts Act.

Insurers report sickness and disability insurance cases that have been rejected due to fraud. This includes both application fraud and claims fraud.

The figures here do not include fraud detected at the application stage.

Figure 5.1 – Detected frauds, past ten years

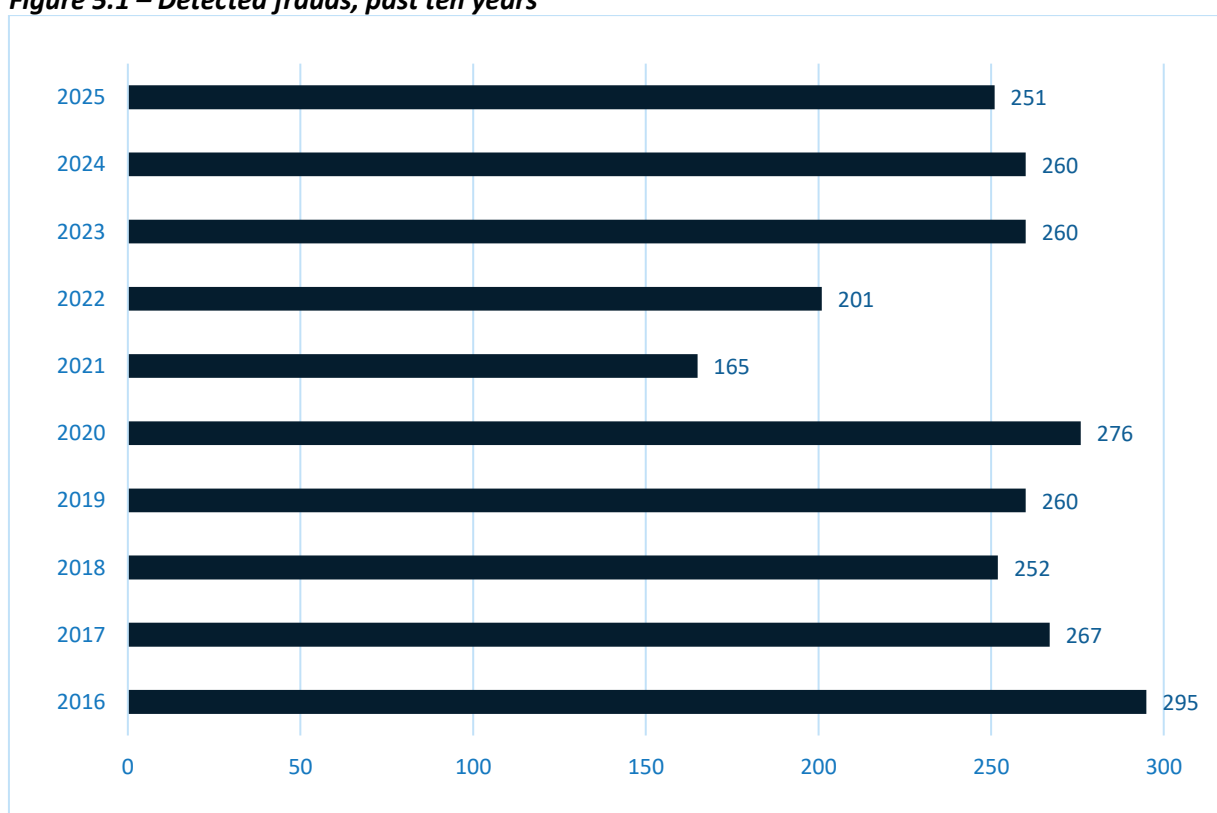


Figure 5.1 shows the total number of fraud cases in 2016-2025. A total of 251 cases of fraud were detected in the sickness and disability segment in 2025, compared with 260 in both 2024 and 2023. These related to 278 policies in 2025, 293 in 2024 and 296 in 2023. This is because each case can cover more than one sickness and disability product.

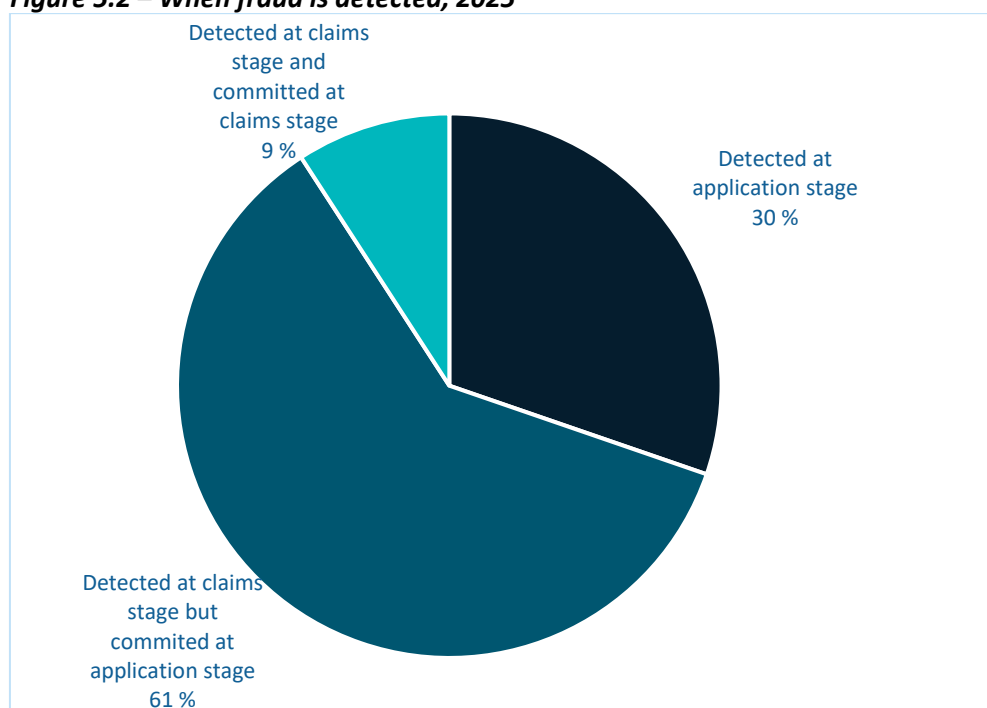
Excluding frauds detected at the application stage, the combined value of sickness and disability cases detected in 2025 was €33,4 million. In both 2024 and 2023, the figure was around €29,5 million.

The average value of cases detected at the claims stage was €0,2 million in 2025 and around €0,2 million in 2024 and 2023.

Insurers put considerable resources into preventing and detecting fraud.

The ROFF³ claims database, which is managed by Finance Norway, is an important tool in insurers' work on detecting fraud.

Figure 5.2 – When fraud is detected, 2025



Detecting fraud at the application stage is a priority for insurers. Experience shows that those who knowingly provide incorrect information when taking out insurance often have fraudulent intentions. The probability of these people claiming on the insurance at some point is high.

Figure 5.2 shows that 30% of fraud cases detected in 2025 were picked up at the application stage. The figure for 2024 was 25%.

All in all, 91% of cases detected in 2025 were application fraud.

³ See definition in Section 8.

Figure 5.3 – When fraud is detected, past six years

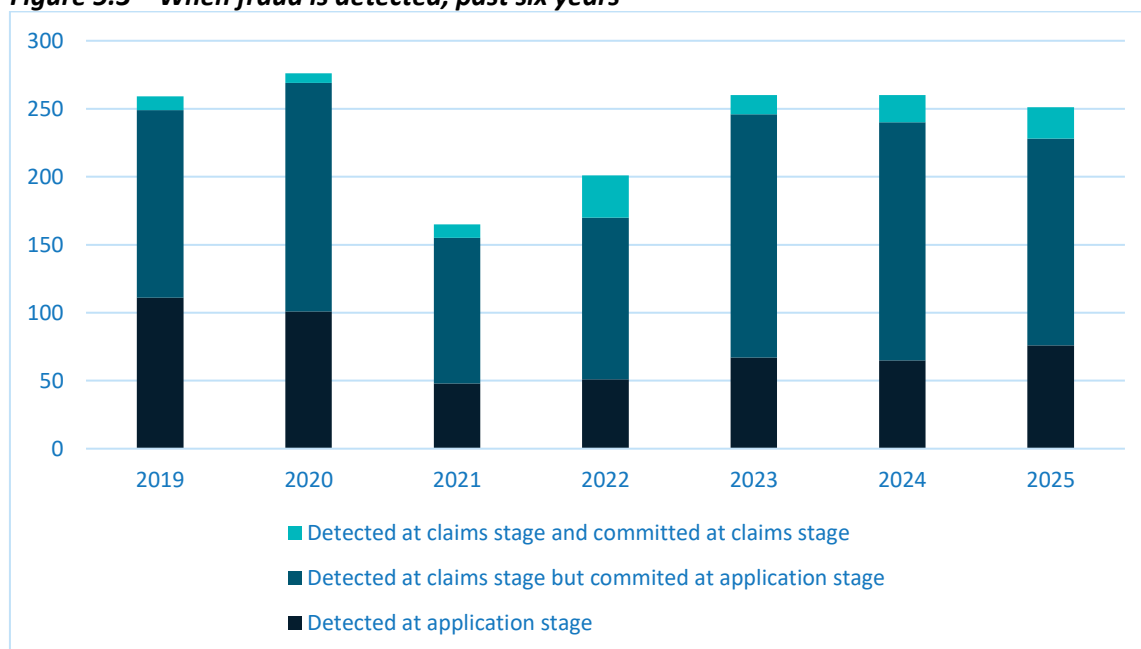
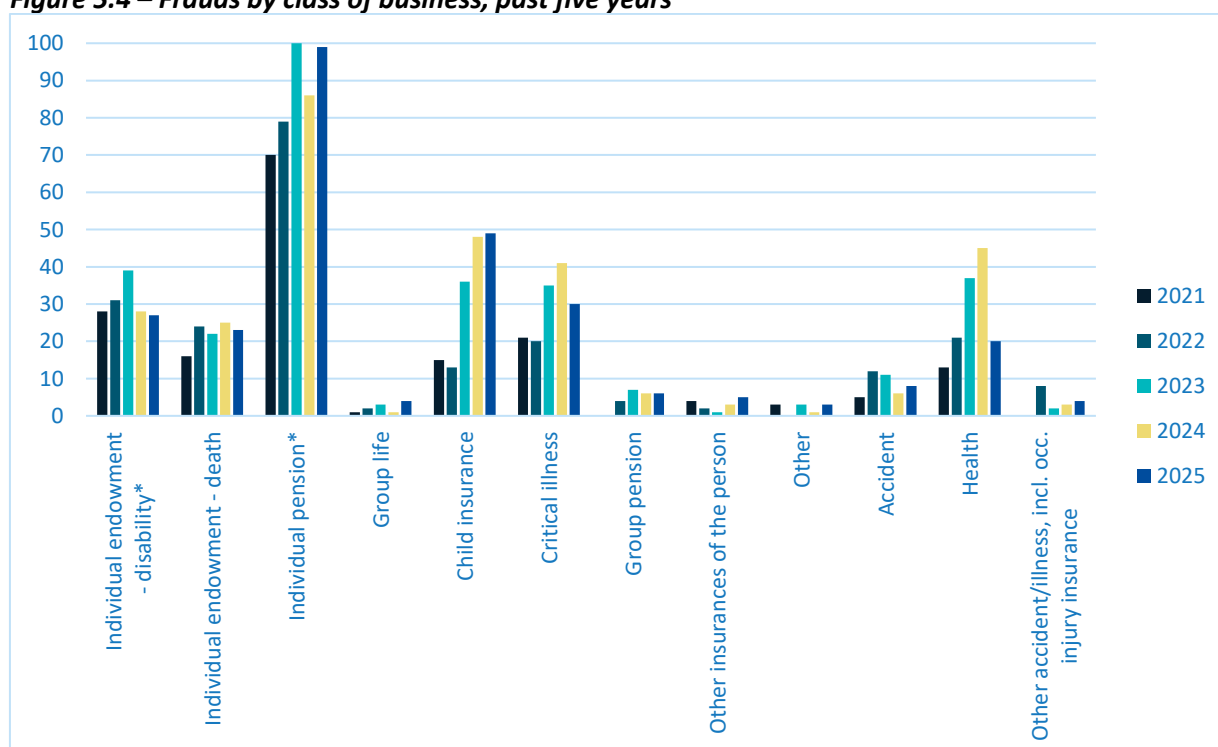


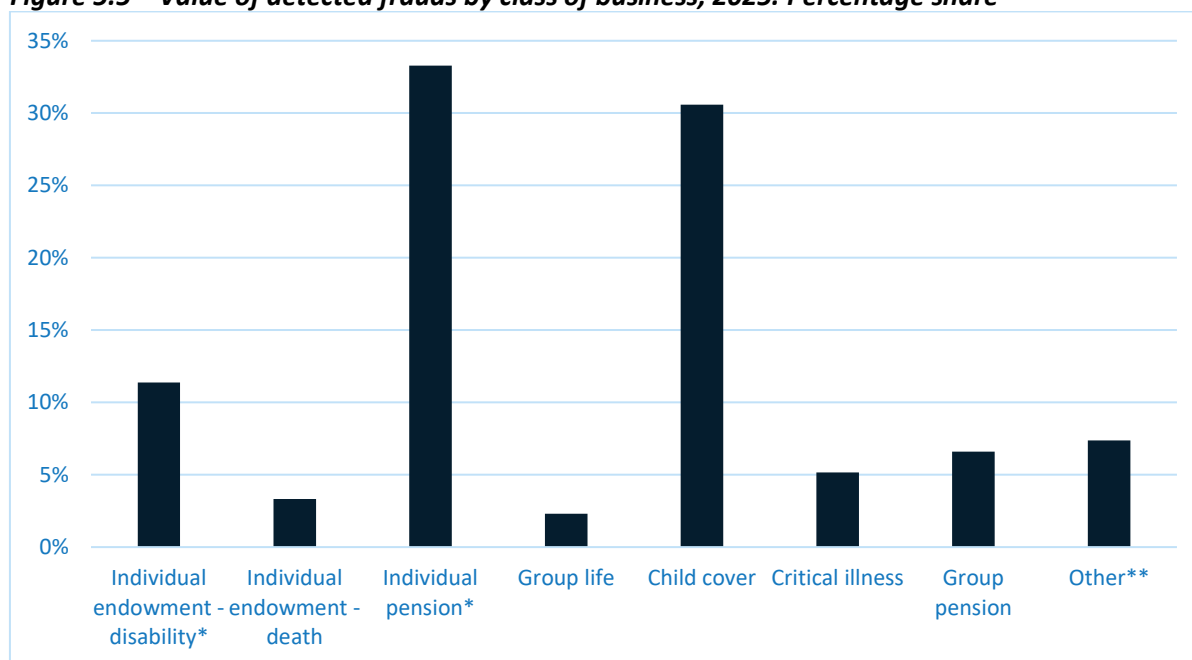
Figure 5.4 – Frauds by class of business, past five years



*Including waiver of premium

In recent years, the largest number of fraud cases detected has been in individual pensions. As Figure 5.4 shows, 2025 was no exception. This type of cover accounted for 36% of cases of fraud in sickness and disability insurance in 2025, 29% in 2024 and 34% in 2023.

Figure 5.5 – Value of detected frauds by class of business, 2025. Percentage share



*Including waiver of premium

**Including accident, health, medical and life insurance and other accident/illness such as group occupational injury

Figure 5.5 presents a breakdown of the value of frauds picked up during claims settlement, including both application and claims fraud.

The amount of fraud detected in each class of business can vary from year to year in both number and value. There are several possible reasons for this, but one contributing factor is that insurers may prioritise different areas in different years.

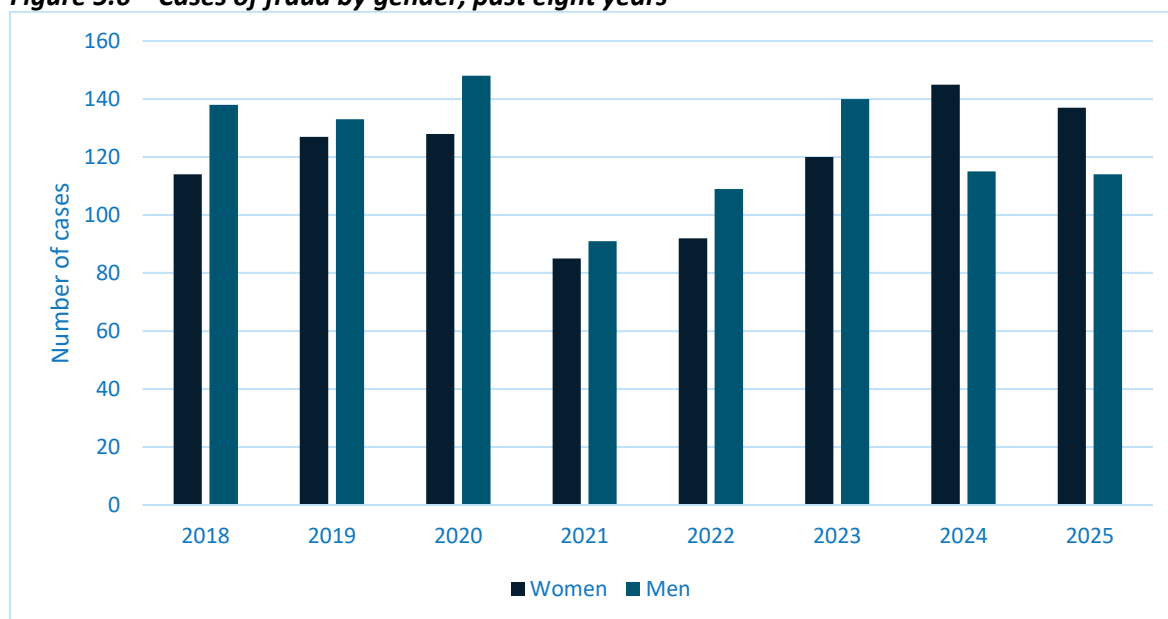
Table 5.1 – Value of detected frauds by class of business, past three years. Thousand Euro

	2023	2024	2025
Individual endowment – disability*	3 800,0	3 200,0	3 800,0
Individual endowment – death	400,0	900,0	1 100,0
Individual pension*	14 100,0	11 600,0	11 200,0
Group life	100,0	0,0	800,0
Child cover	6 800,0	7 800,0	10 300,0
Critical illness	1 900,0	1 400,0	1 700,0
Group pension	400,0	1 800,0	2 200,0
Other insurances of the person	0,0	100,0	400,0
Other	100,0	100,0	0,0
Accident	800,0	700,0	400,0
Health	200,0	400,0	100,0
Other accident/illness, incl. group occupational injury	1 000,0	1 600,0	1 600,0

*Including waiver of premium

Individual pension is the class of business where the most fraud was picked up in 2025, in terms of both number of cases and value. Frauds detected at the claims stage in this class amounted to €11,1 million, or 33% of the total for sickness and disability insurance. Table 5.1 shows movements in the value of frauds detected at the claims stage for each type of cover over the past three years, including both application and claims fraud.

Figure 5.6 – Cases of fraud by gender, past eight years



Men accounted for more fraud than women in previous years, but women were behind the majority of detected cases of sickness and disability insurance fraud in both 2024 and 2025. Women accounted for 55% of detected cases in 2025. By way of comparison, men accounted for 54% of cases in 2023.

6. Who commits insurance fraud?

There is no standard profile for the perpetrators of insurance fraud. They can be found in every layer of society – from successful investors to organised criminals. Together, they make honest customers have to pay more in insurance premiums. Where insurance fraud is part of organised crime, any payouts from the insurance industry help finance further crimes. Insurance fraud has effects well beyond the industry itself and is a social issue. It is therefore important for the insurance industry to help raise awareness of this in the media and through information campaigns.

Few cases are detected where the customer is below the age of 20. This is probably because members of this group are largely still insured through their parents.

Figure 6.1 – Frauds detected by age and product, 2025

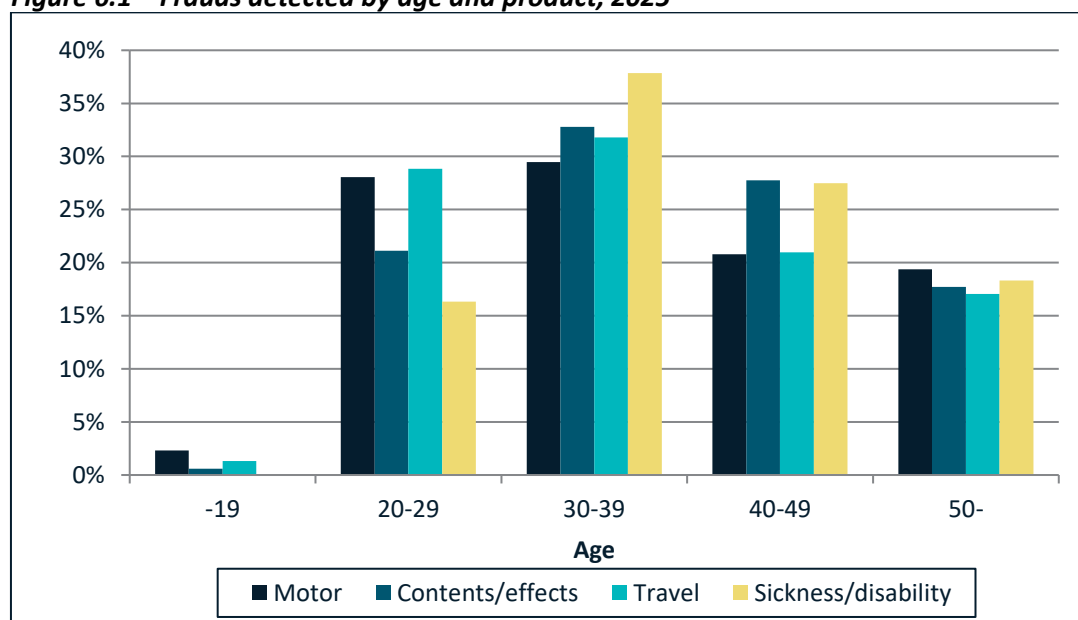


Figure 6.1 breaks down cases of fraud by product and age group. The 30-39 age group is the most active in travel, contents and motor insurance fraud, with the 20-29 age group not far behind for motor and travel insurance.

The 30-39 age group also accounts for the most fraud when it comes to sickness and disability insurance. Older people generally account for more fraud in sickness and disability than in non-life insurance. This may be because younger people are more likely to have travel cover, but fewer will have sickness and disability insurance.

Overall, men were behind 66% of insurance fraud in 2025, and women 34%. Women accounted for 55% of sickness and disability cases, but only 31% of non-life cases. Women are less underrepresented when it comes to contents and travel, where they were behind 38% and 39% of cases respectively.

Figure 6.2 divides the total number of cases by age and gender and shows not only a general preponderance of men, but also that both genders are most active aged 30-39.

Figure 6.2 – Breakdown of cases by age and gender, 2025

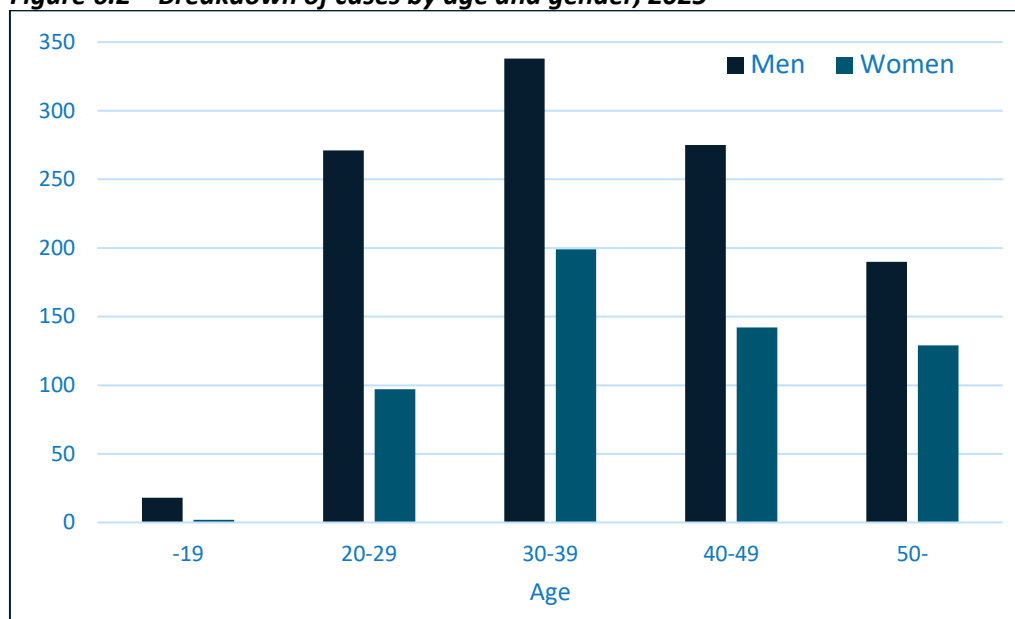
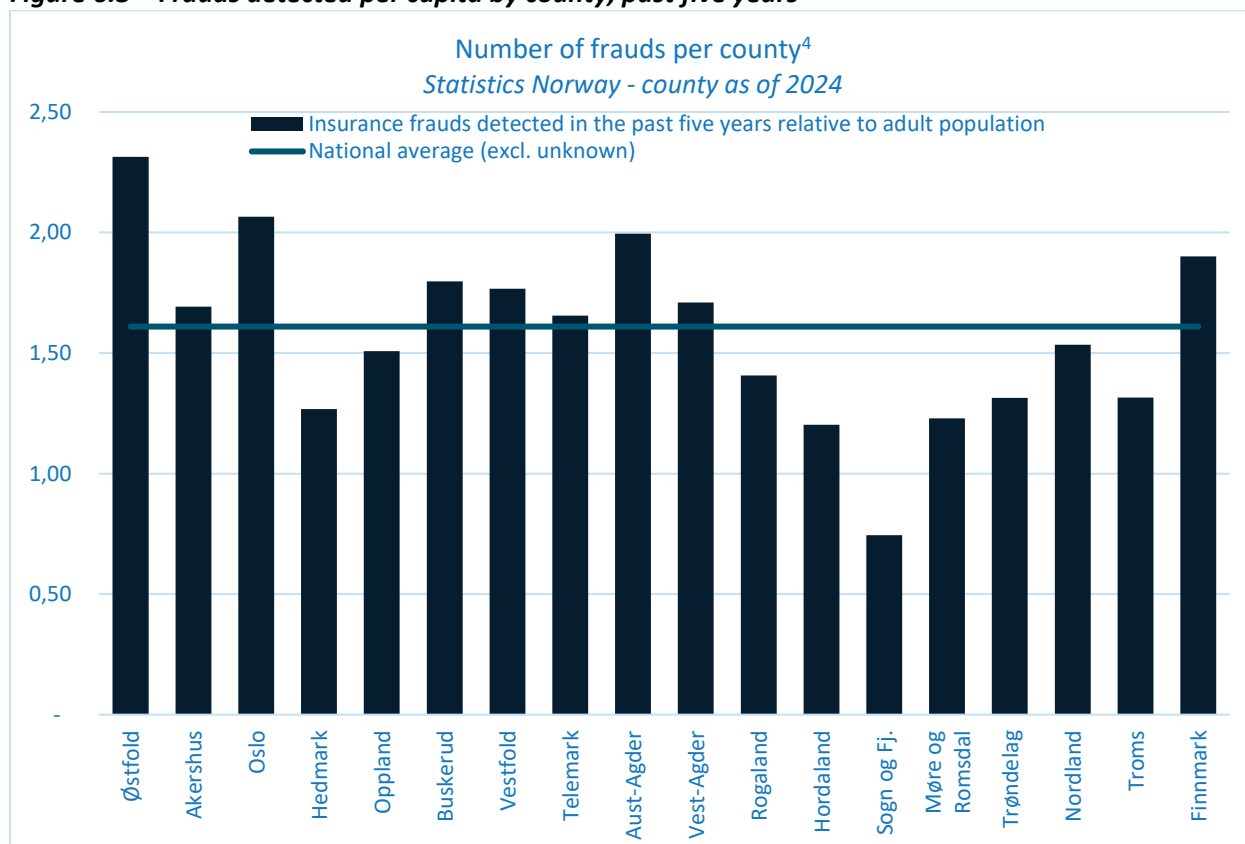


Figure 6.3 – Frauds detected per capita by county, past five years



The county breakdown here is as before the boundary changes in 2020 with some adjustments for the situation in 2025.

The number of cases of detected fraud in non-life insurance and sickness/disability products as a whole relative to the number of inhabitants in each county⁴ is highest in Østfold, Oslo, Aust-Agder and Finnmark. Akershus, Buskerud, Telemark, Vestfold and Vest-Agder are also above the average, while some counties perform better than average. Even though the figures cover a five-year period, the number of cases detected in some counties may still be very small, so conclusions must be drawn with great care, and the figures may also be influenced by insurers' chosen focus areas. The use of population data from 2025 may also skew the picture slightly, as some counties may have seen more population growth than others.

⁴ Population aged 18-79 in each county based on county boundaries at the time. Source: Statistics Norway. Innlandet and Vestland have been split into Hedmark/Oppland and Hordaland/Sogn og Fjordane as they were before the boundary changes in 2020.

7. Insurers' preventive work

Social responsibility

Experience shows that not all customers give insurers correct information. A substantial number of insurance frauds are committed each year, resulting in insurers paying out more than they should and, in turn, higher premiums for all customers. It is in society's interest that insurers carry out investigations to confirm or rule out suspected insurance fraud.

As can be seen from this report, insurance fraud can come in many forms and in all areas of society – everything from the individual exaggerating a contents claim to organised gangs using payouts to fund serious crime. The range of cases is considerable, and in contrast to many other types of crime there is no standard profile for the perpetrators of insurance fraud.

Each year, insurers detect numerous attempts at application fraud, where customers deliberately provide incorrect information when taking out insurance. A typical example is where a customer buys a disability policy and withholds information about a serious pre-existing condition. Insurers have found that application fraud of this kind may eventually lead to fraudulent claims for insurance benefits. It is difficult to put a value on preventive work to minimise application fraud, but it undoubtedly leads to major savings for insurers which then benefit customers in the form of reduced premiums.

Prevention and collaboration

Insurance customers expect both the police and insurers to take action on financial crime. A consistent policy on reporting cases to the police makes it clear to criminals, police and society as a whole that fraud is a problem insurers take seriously.

Those found guilty of insurance fraud may lose the right to policy benefits and become uninsurable. They also risk a criminal record. The insurance system is built on mutual trust between insurer and insured. Breaches of this trust are serious and are therefore often heavily punished by the courts. Insurance fraud is punishable by up to six years in prison, with custodial sentences even for small amounts.

Recent years have seen the insurance industry working even more closely with organisations such as the police and the benefits office (NAV). NAV and insurers see many of the same trends in sickness and disability. The private and public sectors have a joint responsibility to prevent and combat this type of crime, and the National Insurance Act provides for the exchange of information between insurers and NAV.

Both the police and insurers have found that crime has become more complex and organised in recent years. The insurance industry too is being targeted by gangs and other forms of organised crime. Luxury cars and other valuable items are important status symbols in the gang world, and it is more than likely that such assets will be financed with the proceeds of crime. Most of these items are insured. Where a policyholder lives off crime, there is a high risk of the insurer being exposed to both money laundering and fraud. Investigating and preventing insurance fraud is therefore an important part of the battle against organised crime.

To combat crime effectively, it is important to share information, and close collaboration between the public and private sectors has often proved the key to success. To this end, insurers and Finance Norway actively contribute knowledge and experience to the Norwegian Police University College, both for standard police training and for special courses and studies.

The Committee on Insurance Crime (FKF)

The Committee on Insurance Crime focuses on co-ordinating the prevention, detection and management of insurance crime and serves as an advisory body for Finance Norway Insurance Services' board and management. It identifies industry-wide problems and risks that are best solved together and seeks joint solutions to the extent permitted under competition law.

The committee contributes to the publication of relevant reports and annual fraud statistics and provides input and data for information campaigns. Its responsibilities also include matters concerning the government's work on laws and regulations in the area.

8. Definitions

- **Insurance fraud:**
Where a policyholder claims, or attempts to claim, benefits from an insurer to which the policyholder is not entitled. This report covers only cases detected as fraud as set out in the Norwegian Insurance Contracts Act. Where the policyholder knowingly provides incorrect information when taking out insurance in order to obtain cover the policyholder is not entitled to, and this is picked up at inception.
- **Application fraud detected at the application stage:**
Where the policyholder knowingly provides incorrect information when taking out insurance in order to obtain cover the policyholder is not entitled to, and this is picked up at inception.
- **Application fraud detected at the claims stage:**
Where the policyholder knowingly provides incorrect information when taking out insurance in order to obtain cover the policyholder is not entitled to, and this is picked up when a claim is made.
- **Claims fraud:**
Where the policyholder knowingly provides incorrect information about an insurance event to obtain a larger payout than the policyholder is entitled to.
- **Individual endowment – disability:**
Cover taken out by the individual. A form of life insurance that pays a lump sum following the insured event whatever the cause (sickness or accident). Waiver of premium cover is a periodic benefit following disability that is linked to individual disability endowment products.
- **Individual endowment – death:**
Cover taken out by the individual that pays a lump sum in the event of death whatever the cause (sickness or accident).
- **Individual pension:**
Annuity insurance taken out by the individual that pays out in regular instalments.
- **Group life:**
Cover taken out by the individual or by an employer that pays a lump sum in the event of death or disability whatever the cause (sickness or accident).
- **Child cover:**
Primarily a sickness and disability product for children that pays out as specified in the individual insurer's terms of insurance.
- **Critical illness:**
A form of sickness insurance that pays a lump sum if the insured develops a condition defined in the individual insurer's terms of insurance. May be taken out individually or collectively.
- **Group pension:**
Occupational pension cover for employees in both the private and public sectors. A form of life insurance that pays out in regular instalments.
- **ROFF:**
Database of insurance applicants and policyholders for insurers that are affiliated to Finance Norway and sell life insurance or other insurances of the person where there is a health assessment at inception. Insurers can search the database when selling policies

and when processing claims for disability benefits. Insurances of the person on special terms and rejected applications for cover are registered in ROFF. The database does not contain health information, but this may be obtained from the insurer with the applicant's consent. Further information (in Norwegian) can be found on Finance Norway Insurance Services' website: <https://www.forsikringsdrift.no/omrader/roff/>

- **FOSS:**

A central database where Norwegian insurers register reported claims. The register provides an overview of the number of times each policyholder has claimed on insurance. The aim of the database is to streamline non-life insurers' claims processing in terms of preventing and reducing insurance fraud. The database may only be used when registering claims. Further information (in Norwegian) can be found on Finance Norway Insurance Services' website: <https://www.forsikringsdrift.no/omrader/foss/>