

Exposing the Shadows: How Fraud, Waste, and Abuse Compromise Motor Third-Party Accident Claims

Category: Insurance

written by Om Prakash | October 12, 2026



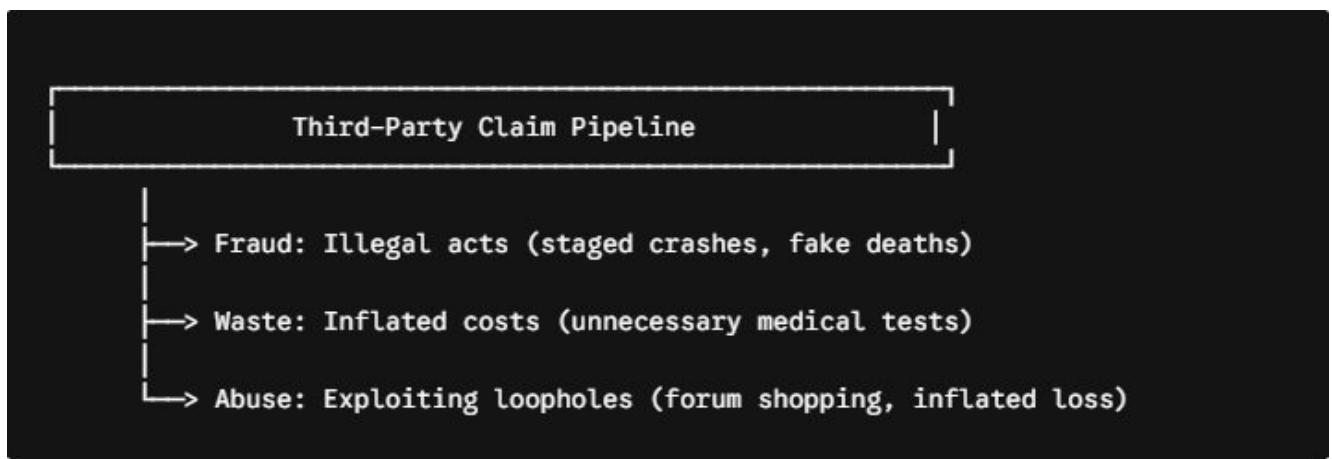
JAMSHEDPUR, JHARKHAND – Third-party motor accident compensation claims are designed to provide a vital financial safety net for victims of road crashes and their grieving families. However, a growing web of systemic **Fraud, Waste, and Abuse (FWA)** across India's legal and insurance landscape threatens this essential protection.

From fabricated death certificates and exaggerated permanent disability scores to coordinated staged accidents, FWA in Motor Accident Claims Tribunals (MACT) inflates motor insurance premiums, drains public sector resources, and delays relief for genuine victims.

Driven by recent judicial crackdowns, including mandatory Special Investigation Teams (SITs) and digital database integrations ordered by the Supreme Court of India, insurers and law enforcement are actively reshaping the battle against motor insurance fraud.

What is FWA in Third-Party Claims?

Third-party insurance is legally mandatory under the **Motor Vehicles Act**. While **First-Party** insurance covers damage to the policyholder's own vehicle, **Third-Party** coverage handles liabilities owed to external victims—paying compensation for bodily injury, permanent disability, or accidental death.



#image_title

Within the motor insurance sector, FWA takes three distinct forms:

- **Fraud:** Intentional deception for illicit financial gain. This includes staging fake collisions, retrofitting non-road deaths into hit-and-run motor cases, or using forged disability certificates.
- **Waste:** Inefficient practices or systemic friction that needlessly consume capital. Examples include redundant medical examinations, excessive litigation delays, and uncoordinated administrative overhead.
- **Abuse:** Exploitation of legal procedures or medical frameworks without direct forgery. Examples include

exaggerated pain-and-suffering assessments, misleading income declarations, or duplicate claims filed across multiple jurisdictions.

Modus Operandi: Anatomy of MACT Frauds

Investigations conducted by state Special Investigation Teams (SITs) and insurance risk-management divisions reveal how syndicates manipulate the claim adjudication pipeline:

1. Fraudulent Vehicle Implantation

When an uninsured or unidentified driver causes a fatal crash or serious injury, syndicates often “implant” a fully insured vehicle into police records after the incident. By bribing local contacts or altering First Information Reports (FIRs), non-insured collisions are recast as third-party liability claims against insurance firms.

2. Death & Injury Conversion

Natural deaths, industrial accidents, and self-inflicted injuries are frequently reformatted into road traffic accidents. Deceased individuals from natural causes have been documented as “victims” of fictitious night-time hit-and-runs, allowing syndicates to collect payouts.

3. Exaggerated & Forged Disability Certificates

Permanent partial or total disability awards rely on medical board certifications. Fraudulent schemes often involve corrupt medical practitioners issuing inflated disability assessments (e.g., certifying a minor fracture as a 70% permanent functional disability) or issuing forged certificates

altogether.

4. Forum Shopping & Duplicate Claims

Claimants and unscrupulous legal representatives exploit geographical jurisdictional loopholes. The same injury or death claim is sometimes simultaneously filed before multiple MACT benches across different states or concurrently under the *Employees’ Compensation Act* and the *Motor Vehicles Act* to extract double payouts.

Impact Breakdown: Who Pays the Price?

FWA in third-party claims creates widespread financial and institutional harm, affecting victims, policyholders, and insurers alike:

Affected Stakeholder	Direct Consequences	Broader Systemic Impact
Genuine Crash Victims	Extended litigation (3–7 years); heightened scrutiny on valid claims.	Financial distress, delayed medical care, loss of faith in legal remedy.
Vehicle Owners / Public	Annual increases in third-party premium rates across vehicle segments.	Higher cost of vehicle ownership and transport costs nationwide.
Insurance Companies	Multi-crore financial leakage; inflated loss ratios in third-party portfolios.	Reduced capital availability for innovative, low-cost micro-insurance plans.
Judiciary & Police	Backlog of thousands of contested claims before MACT courts.	Resource strain on police departments and judicial benches.

#image_title

Legal & Regulatory Response: Supreme Court Interventions

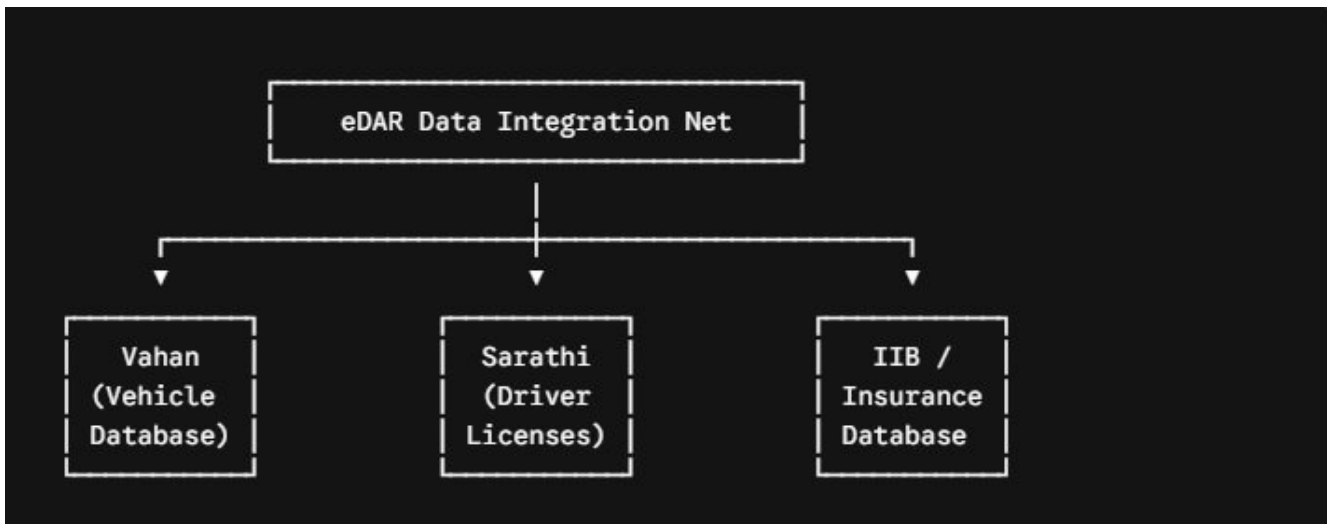
The judiciary and regulators have taken a strict stance against organized insurance fraud.

Mandatory State SITs

In landmark proceedings addressing suspicious compensation petitions, the **Supreme Court of India** mandated that states establish dedicated **Special Investigation Teams (SITs)** headed by senior police officers to investigate fake MACT claims and prosecute offending syndicates, lawyers, and medical personnel.

Digital Integration & eDAR

To dismantle paper-based forgery, the Supreme Court mandated the rollout and integration of the **Electronic Detailed Accident Report (eDAR)** portal.



#image_title

The eDAR system links road crash records directly with central databases, including:

- **Vahan:** Central vehicle registration network.
- **Sarathi:** Driving license verification system.

- **Insurance Information Bureau (IIB):** Live policy and claims repository.

By cross-referencing accident details, driver identities, and policy numbers automatically within 48 hours of an incident, eDAR creates an immutable digital trail that prevents vehicle implantation and duplicate filings.

Modern Detection Tools

Insurers and investigative agencies are utilizing modern technology to identify fraudulent claims before funds are disbursed:

1. **AI Predictive Risk Scoring:** Machine learning models scan incoming MACT notices against historical fraud patterns—flagging suspicious delays in FIR filings, recurring geographic hotspots, or high-risk legal representatives.
2. **Biometric & Tele-Medical Verification:** Medical boards and insurers now require digital Aadhaar-linked verification and standardized medical coding for disability assessments.
3. **Geofencing & Digital Forensics:** Telematics, mobile tower records, and surveillance footage are routinely audited to verify if a suspect vehicle was present at the accident scene during the claimed timeframe.

Looking Ahead

Eliminating FWA in third-party motor accident claims requires ongoing collaboration between law enforcement, insurance carriers, medical boards, and the judiciary.

As digital integrations like the eDAR portal mature, the window for fraudulent claims continues to close. Striking out

fraudulent claims ensures that compensation reaches genuine crash victims promptly, preserving the integrity of India's road safety and social security systems.