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COURSE BROCHURE

AI for Insurance Claims Automation and Fraud Detection Course

11 – 15 April 2027
Sharm El-Sheikh

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Registered in the United Kingdom and Saudi Arabia

AI for Insurance Claims Automation and Fraud Detection Course

Ref: 67_1685 **Date:** 11 – 15 April 2027 **Location:** Sharm El-Sheikh **Fees:** 5500 GBP

AI for Insurance Claims Automation and Fraud Detection is a 1-week practitioner training course for claims handlers, claims team leads, special investigation staff and loss adjusters that ends with a claims triage and counter-fraud playbook for one portfolio. Digital first notice of loss, photo estimates and organised fraud rings now move faster than manual desk review. Jupiter Prime Training runs this AI for Insurance Claims Automation and Fraud Detection course for frontline claims practitioners.

Why Insurance Claims Automation and Fraud Detection Matters Now

Three pressures meet on the claims desk: claimants who submit photos and documents through apps and expect settlement within days, organised groups that stage collisions, inflate repair invoices or recycle medical bills across several insurers, and finance teams tracking leakage from overpayment and missed recoveries. A claims unit that automates simple files and routes suspicious ones to investigators settles honest customers faster and recovers more; one that does neither burns adjuster hours and pays avoidable losses. The course draws on ISO/IEC 42001 for AI management and the NIST AI Risk Management Framework NIST AI RMF for testing triage and detection tools.

Who Gains Most from Insurance Claims Automation and Fraud Detection

- Handlers who register, assess and settle motor, property and medical files every day
- Team leads who allocate caseloads and approve settlements above authority limits
- Investigators who receive referrals, interview parties and build evidence files
- Loss adjusters and repair-network coordinators who validate damage and invoices
- Claims system analysts who configure workflow rules, queues and referral alerts

A claims department gains most when handlers, investigators and its system analyst attend together and leave with shared referral rules and one set of queue thresholds.

Insurance Claims Automation and Fraud Detection Capabilities

Participants work hands-on with claim files, referral queues and detection scores, learning to decide which files a machine settles and which a person examines.

- Design first notice of loss triage rules by complexity and severity — claims team leads
- Specify straight-through settlement limits that balance speed and leakage — claims authorities
- Test anomaly scores against confirmed fraud outcomes — special investigation units
- Build link analysis of parties, vehicles, garages and clinics — investigators and adjusters
- Calculate referral queue capacity and false positive cost — operations planners
- Apply human review and appeal steps to automated claim decisions — complaints and conduct staff

Key Insurance Claims Automation and Fraud Detection Terms

- First notice of loss — the initial report of an incident by a policyholder that opens a claim file.
- Claims triage — sorting new files by complexity, severity and suspicion to route them to the right handler or automated path.
- Straight-through settlement — paying a simple, low-risk claim automatically without manual handling.
- Claims leakage — money lost through overpayment, missed subrogation or inefficient handling of valid files.
- Link analysis — mapping shared phone numbers, addresses, vehicles or repairers across files to expose organised rings.
- Referral hit rate — the share of files sent to investigators that turn out to be fraudulent or exaggerated.

Insurance Claims Automation and Fraud Detection Day by Day

Day 1: The Modern Claims Desk

- Claims Journey Map — From First Notice of Loss to Payment
- Leakage Sources Audit — Overpayment, Missed Subrogation and Delay
- Fraud Typology Catalogue — Staged, Inflated, Phantom and Organised
- Motor and Medical Claim Cases — Where Automation Already Works
- Claims Data Inventory — Notes, Photos, Invoices and Call Records

Day 2: Automating Intake and Triage

- Digital First Notice of Loss Forms — Capturing Usable Evidence
- Complexity and Severity Scoring — Routing to Desk or Field
- Document and Photo Recognition — Damage Estimates and Invoice Checks
- Straight-Through Settlement Limits — Authority and Leakage Thresholds
- Workflow Rules Engine Configuration — Queues, Diaries and Escalations

Day 3: Detecting Suspicious Files

- Red Flag Rules Versus Anomaly Scores — When Each Detects Better
- Link Analysis of Parties and Repairers — Exposing Organised Rings
- Text Mining of Adjuster Notes — Hidden Inconsistencies in Statements
- Duplicate Invoice and Billing Pattern Checks — Medical and Repair Networks
- Referral Hit Rate Tracking — Tuning Sensitivity for Investigators

Day 4: Fairness, Evidence and Control

- False Positive Cost Review — Honest Claimants Delayed or Questioned
- Human Review and Appeal Steps — Defensible Decisions on Denied Files
- Evidence Packs for Investigations — Audit Trail From Score to Finding
- NIST AI RMF Measure and Manage — Triage and Detection Tool Risk
- ISO/IEC 42001 Records — Ownership, Change Logs and Periodic Testing

Day 5: Practising the Claims Triage and Counter-Fraud Playbook

- Journey Map and Leakage Audit From Day 1 — Portfolio Baseline
- Triage Rules and Settlement Limits From Day 2 — Automation Design
- Detection Methods From Day 3 — Referral Criteria and Queue Sizes
- Review and Appeal Controls From Day 4 — Customer Safeguards
- Claims Triage and Counter-Fraud Playbook — Sign-Off Ready Operating Guide

Applying Insurance Claims Automation and Fraud Detection After the Course

- Sample one hundred closed motor or medical files, apply the new triage scoring and compare its routing with the handling path each file actually took.
- Run link analysis on the last quarter's referrals to find shared repairers, clinics or contact details, and brief the investigation unit on any clusters.

Insurance Claims Automation and Fraud Detection Questions FAQ

What is AI for insurance claims automation and fraud detection and why does it matter now?

AI for insurance claims automation and fraud detection is the use of triage scoring, document recognition and anomaly detection on the claims desk. It matters now because claimants expect fast digital settlement while organised fraud and leakage keep growing.

Which roles gain most from insurance claims automation and fraud detection training?

Claims handlers, team leads, special investigation staff and loss adjusters gain most. Claims system analysts also benefit, since they configure the rules, queues and alerts that the playbook defines.

How does insurance claims automation and fraud detection differ from an AI strategy course for insurance leaders?

It is a practitioner course for the claims desk, not a leadership roadmap. You configure triage rules, settlement limits, link analysis and referral queues on real file types rather than ranking enterprise AI investments.

What do you bring back from insurance claims automation and fraud detection training?

You bring back a claims triage and counter-fraud playbook for one portfolio. It sets routing rules, settlement limits, detection methods, referral criteria and customer safeguards ready for sign-off.

Insurance Claims Automation and Fraud Detection: The Way Forward

The claims triage and counter-fraud playbook informs the first desk decision: which file types settle automatically and which go to investigators. Handlers, team leads and the investigation unit use it daily. After the first month, revisit referral hit rates and false positive reviews, because fraud groups adapt quickly once they notice which patterns are being flagged.