Pohs Institute, one of the oldest insurance schools in New York State, was founded in 1921 by Herbert Pohs. Pohs Institute is one of the largest providers of insurance education in New York State, as well as an approved provider in New Jersey, Pennsylvania, Connecticut, Massachusetts, New Hampshire, Maine and Rhode Island. More than 250,000 men and women, eager to pursue a career in the insurance industry, have enrolled in Pohs Institute schools. Pohs Institute provides insurance instruction to large insurance companies and brokerages, as well as banks and financial institutions. The instructors are professional adjunct teachers from the insurance industry with an average of 10 or more years of industry experience.

This course will address the following topics:

- “Ethics” and “Fraud” Definitions
- Insurance Fraud Facts
- Insurance Fraud: The Hidden Tax
- Insurance Fraud Study Raises Concerns About Consumer Attitudes
- Indicators of Application Fraud
- Medical Mills
- Schemers & Schemes
- Indicators of Property, Casualty, Catastrophe, Rental and Vehicle Theft Fraud
- Staged Collisions - Fraud on the Road
- Bodily Injury Insurance Fraud
- Indicators of Workers’ Compensation and Workers’ Compensation Premium Fraud
- Insurers Accelerating Efforts to Fight Fraud & Control Costs
- Consumer Tips

This course includes:
- 12 Lessons with Case Studies
- Appendix with New York State Insurance Fraud Law
- 1 Online Final Exam
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<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Ethics” and “Fraud” Definitions</td>
<td>7</td>
</tr>
<tr>
<td>Report The Rip-Off: Insurance Fraud Facts</td>
<td>8</td>
</tr>
<tr>
<td>Insurance Fraud: The Hidden Tax</td>
<td>11</td>
</tr>
<tr>
<td>Four Faces</td>
<td>17</td>
</tr>
<tr>
<td>Insurance Fraud Study Raises Concerns About Consumer Attitudes</td>
<td>21</td>
</tr>
<tr>
<td>Indicators of Application Fraud</td>
<td>23</td>
</tr>
<tr>
<td>Report The Rip-Off: Insurance Fraud - Medical Mills</td>
<td>25</td>
</tr>
<tr>
<td>Report The Rip-Off: Insurance Fraud Facts - Schemers &amp; Schemes</td>
<td>27</td>
</tr>
<tr>
<td>Indicators of Property Fraud</td>
<td>30</td>
</tr>
<tr>
<td><em>Fraud Case of The Week</em></td>
<td>33</td>
</tr>
<tr>
<td>Indicators of Catastrophe Fraud</td>
<td>34</td>
</tr>
<tr>
<td>Case Study</td>
<td>37</td>
</tr>
<tr>
<td>Indicators of Rental Fraud</td>
<td>39</td>
</tr>
<tr>
<td>Indicators of Casualty Fraud</td>
<td>41</td>
</tr>
<tr>
<td>Staged Collisions</td>
<td>43</td>
</tr>
<tr>
<td>Report The Rip-Off: Insurance Fraud Facts - Fraud on the Road</td>
<td>44</td>
</tr>
<tr>
<td>Report The Rip-Off: Insurance Fraud Facts - Bodily Injury</td>
<td>50</td>
</tr>
<tr>
<td>Insurance Fraud</td>
<td>52</td>
</tr>
<tr>
<td>Indicators of Vehicle Theft Fraud</td>
<td>55</td>
</tr>
<tr>
<td>Indicators of Workers’ Compensation Fraud</td>
<td>58</td>
</tr>
<tr>
<td>Indicators of Workers’ Compensation Premium Fraud</td>
<td>58</td>
</tr>
<tr>
<td>Case Studies in Workers’ Compensation</td>
<td>60</td>
</tr>
<tr>
<td>Fighting Workers Compensation Fraud; Red Flags</td>
<td>61</td>
</tr>
<tr>
<td>Insurers Accelerating Efforts to Fight Fraud &amp; Control Costs</td>
<td>66</td>
</tr>
<tr>
<td>Consumer Tips</td>
<td>68</td>
</tr>
</tbody>
</table>
UNDERSTANDING THE DEFINITIONS OF
ETHICS AND FRAUD

ETHIC – noun - a moral standard

ETHICAL - adj.
1. having to do with ethics; of or conforming to moral standards
2. conforming to professional standards of conduct

ETHICALLY - adv.

ETHICS - noun pl.
1. the study of standards of conduct and moral judgment
2. the system of morals of a particular person, religion, group, etc.

FRAUD - a noun from the Latin fraus
1. deceit; trickery
2. Law: intentional deception
3. a trick
4. an impostor

FRAUDULENT - an adj.
1. Based on or using fraud
2. done or obtained by fraud

FRAUDULENCE - noun

FRAUDULENTLY - adj.
Billions of dollars are picked from American pockets each year by what many people consider a “victimless” crime. Most people do not even know it is happening.

This thievery is not occurring on the streets of urban America. Rather, it is happening in automobile repair centers, medical clinics, law offices and even the next-door neighbor’s house. Often white-collar criminals, including doctors and lawyers, have the quickest hands.

The crime is insurance fraud.

**How serious is the insurance fraud problem?**
Insurance fraud is one of the most costly white-collar crimes in America, ranking second to tax evasion.

To the insurance industry, insurance fraud has destructive capabilities that exceed even Hurricane Andrew, the 2\textsuperscript{nd} costliest disaster in United States history.

The National Insurance Crime Bureau (NICB) estimates that property/casualty-based insurance fraud costs Americans $20 billion annually. In contrast, Hurricane Andrew’s devastation resulted in $17 billion of damage.

Adding other insurance lines to the equation, like health, life and specialty insurance, the total cost of insurance fraud may exceed $100 billion per year.

According to the NICB, 10% of property/casualty insurance claims are fraudulent.

**Who pays for insurance fraud?**
Insurance companies, policyholders, taxpayers and the general public pick up the tab through increased insurance rates, higher taxes and inflated prices for consumer goods and services.

Ultimately, the consumer pays the price for insurance fraud. The NICB estimates that the average American household pays $200 a year in additional premiums to make up for the fraud.

**Who commits insurance fraud?**
Unlike the great western movies from yesteryear, insurance fraud perpetrators are not as easily identifiable as bank robbers and stagecoach bandits. They carry no masks, guns or safe cracking equipment. As the following NICB investigations revealed, insurance fraud perpetrators can be members of complex organized fraud rings or the next-door neighbor looking for a second income.

**Organized Fraud Rings**
Three generations of the Ballog Family pled guilty in Chicago for defrauding insurance companies of more than $750,000 in dozens of staged car accidents and thefts, faked falls and
bogus homeowner injury claims and burglaries.

Prosecutors say the Ballogs intentionally drove cars into poles at low speeds, drew blood from syringes and spread the blood on their mouths and noses. Days later, when they went to plead their cases with insurance adjusters, they stuffed cotton up their noses and in their mouths to appear swollen and put on makeup to look bruised.

To make the faked slip-and-fall accidents appear genuine, prosecutors say, they cut their noses with razor blades. One defendant, who suffered a compression fracture of his vertebrae in the early 1980s, claimed to have sustained the same injury in at least 17 other incidents in the 1990s.

The ring even had their own home-cooked fake vomit to slip on, made from potatoes and salad dressing.

**White-Collar Professionals**

An 18-month sting operation resulted in a grand jury indictment of seven medical doctors, one chiropractor and 12 health care workers on charges of offering kickbacks and falsifying insurance claims.

According to court documents, nine clinics billed nearly $60,000 for limited or non-existent patient care. Six clinics diagnosed investigators posing as patients as having soft-tissue injuries, even though all of the undercover investigators were physically fit. In a few cases, the undercover investigators were coached on what to say if asked about their treatments.

**Auto Repair Shops**

Five people working out of a Los Angeles area auto body shop were suspected of filing 40 bogus insurance claims worth a total of $300,000 for hit-and-run damage to vehicles they owned. They used these vehicles to stage several accidents after insuring them through multiple carriers. Insurance records indicated that most of the repairs were performed by one Los Angeles body shop.

NICB and California Department of Insurance investigators identified the fraud when they determined that most of the claims were identical, with all vehicles sustaining the same damage, and all accidents lacking witnesses.

**The Next-Door Neighbors**

Challenging the stereotype that fraud criminals are either thugs or white-collar bureaucrats, one Connecticut couple provided a textbook example of how to turn a hobby (collecting insurance policies) into a profitable and illegal sideline business.

This Hartford family - the husband, a plumber, and the wife, a school psychologist - appeared to be a picture of stability, complete with a five-year-old son and a nice suburban home. Yet as the Hartford Courant reported, they used their multiple policies to stage the largest insurance fraud scheme in Connecticut history.

Following a two-year investigation, the couple was arrested and charged with staging phony accidents and homeowners claims that cost 19 insurance companies more than $300,003. The NICB assisted the case by identifying suspicious claims submitted by member insurance companies.
companies.

Ironically, the couple’s son aided in the investigation. His father pleaded ignorance when inspectors from the State Attorney’s office found several parts from a Mercedes-Benz in the attic, but the boy volunteered that “my Daddy put those up there”. The parts are believed to be from a 1979 vehicle involved in several bogus claims.

http://www.nicb.org/reportripoff/factpages/insurancefraudoverview.html
Insurance Fraud - whether committed by sophisticated criminals, otherwise honest consumers, or by insurance company employees and owners - is an increasingly expensive burden on the US economy, taking money out of the pockets of all citizens. This illegal activity diverts vital resources away from businesses, law enforcement, the civil justice system, regulatory agencies and local emergency services.

There are no easy solutions to the problems of insurance fraud. Consumers, legislators, regulators, and insurers must work together over the long term to create an environment that either prevents insurance fraud or detects it easily when it occurs. The first step in this process is creating a baseline understanding of the problem and potential solutions. That is the purpose of this document.

What is Insurance Fraud?
Insurance fraud is any deliberate deception perpetrated against an insurance, company or agent for the purpose of unwarranted financial gain. It occurs during the process of buying, using, selling and underwriting insurance. Insurance fraud can also be perpetrated by an insurance agent or other employees in the insurance company.

What are the different kinds of fraud?
Insurance fraud is often classified as being either “hard” or “soft”. Hard fraud is usually a deliberate attempt either to stage or invent an accident, injury, theft, arson or other type of loss that would be covered under an insurance policy.

Sophisticated conspiracies involving medical doctors, lawyers and their patients/clients are widespread and one of the most costly forms of insurance fraud in the United States. A single crime ring can cost the insurance system millions of dollars a year.

Hard fraud is also committed by executives and employees within the insurance industry. An employee may defraud an insurance company by accepting bribes or kickback from body shops or doctors to verify false claims. Another example is an insurance agent who fails to remit policyholder premiums to the insurance company. The agent pockets the premiums and hopes the policyholder does not file a claim.

This internal fraud also includes con artists who set up phony insurance companies and collect premiums from unsuspecting consumers, but never or infrequently pay claims. When too many claims are filed or when regulators start investigating, the con artist disappears with the company assets.

Soft fraud, which is called opportunity fraud, occurs when a policyholder or claimant exaggerates a legitimate claim. One example is the car owner involved in a fender-bender who inflates the claim to cover the policy deductible or the cost of insurance premiums.
Soft fraud also occurs during the underwriting process when people apply for new or renewal coverage. Some people provide false information to lower insurance premiums or increase the likelihood that the application for insurance will be accepted. Examples include:

- Underreporting the number of miles driven.
- Giving a false location where a car is garaged.
- Failing to report an accurate medical history when applying for health insurance.
- Exaggerating the amount and value of items stolen from a home or business.
- Failing to report the accurate number of employees for workers’ compensation/coverage.

The extent of insurance fraud is difficult to quantify because many instances go undetected.

Comprehensive research to estimate the total cost of fraud has yet to be undertaken. However, studies focusing on specific aspects of insurance fraud suggest that the cost is enormous. The Coalition Against Insurance Fraud estimates the annual cost to be more than $85 billion per year - and growing. The amount is a hidden tax of more than $1,000 per family each year on the costs of goods and services.

These estimates of the costs of external insurance fraud suggest that it is the second largest economic crime in America, exceeded only by tax evasion. Individual studies also provide evidence of how pervasive the problem is:

- A study of injury claims from auto accidents in Massachusetts found that 48 percent have some aspect of fraud or abuse.
- A 1992 audit of workers’ compensation policies in Florida indicated 46 percent of employers underreported the level of their payroll or misclassified employee occupations.
- At least 30 percent of 302 property/casualty insurance company insolvency’s between 1969 to 1990 were due to fraudulent activities.
- A 1995 study by the Rand Institute for Civil Justice concluded more than 35 percent of people hurt in auto accidents exaggerated their injuries, adding $13 - $18 billion to the nation’s annual insurance bill.

What are some examples of hard fraud?

Hundred of news media reports underscore that insurance fraud is on the rise. To illustrate the range of cases, the Coalition Against Insurance Fraud released a list of 1996’s “top 10 Insurance Fraud Cases.” A summary of each case follows:

1. Two firefighters died while attempting to put out a fire at Stormy’s Seafood Restaurant in New Smyrna Beach, Fla. The fire was discovered to be arson-for-profit. The owner, Forrest Utter, was convinced of conspiracy, mail fraud, and arson resulting in the death of the firefighters. Strangely enough, three other properties Utter owned had also been destroyed by fire over the years.
2. A father and son team and two licensed insurance brokers were indicted in February on numerous fraud charges related to at least six years of selling phony commercial policies to at least 50 companies in the New York City area. Dean W. Sanders and his son, Scott E. Sanders, took an estimated $30 million. The pair even worked their scams from behind bars, as one or the other was imprisoned on other charges during the six years.

3. More than 100 people were indicted in Texas for their roles in a staged auto accident scheme. The ring may have taken in as much as $5 million with the help of at least two doctors and two lawyers indicted in the crimes. Some of the ring’s members had been operating since the late 1970s'.

4. Mark Kaplan, a former Beverly Hills doctor, was sentenced to eight years in state prison for masterminding one of the biggest workers’ compensation insurance scams in California history. Kaplan and his ex-wife were charged in a scheme that bilked insurers out of approximately $30 million dollars.

5. Glen H. Martin and his sister, Candace L. Cooper, were convicted in Orlando, Fla., on charges they looted $9.75 million in premiums from the failed Twentieth Century Life Insurance Co.

6. Caremark International Inc. agreed to pay $161 million in criminal and civil fines for paying kickbacks to doctors and submitting false billings to the government. The Northbrook, Ill., company pled guilty to paying doctors for patient referrals and defrauding government medical programs. The investigation focused on whether the company disguised kickbacks to doctors as research grants or payments for legitimate work.

7. The founders of California’s Amenmed Medical Corp. were arrested as part of a 50-count indictment charging the company bilked employers of an estimate $30 - $50 million in inflated or unnecessary medical expenses. Dr. James W. Eisenberg, Michael J. Lightman and 10 others, including four attorneys, allegedly used a statewide network of illegal medical referrals, treatment incentive programs and billing practices to collect as much as $2 million a month from insurance companies in the workers’ compensation system.

8. Forty-seven people, including 21 lawyers and 16 insurance company adjusters, were indicted in New York for allegedly defrauding companies by bribing claims adjusters to inflate settlements. The scheme was alleged to involved at least $39 million and was uncovered when an honest lawyer reported a contact by a middleman in the ring.

9. Bon Bon Pictures Company was ordered to pay an $11 million judgment and $4 million in damages to Fireman’s Fund Insurance Co. For an alleged 1991 scheme in which Bon Bon executives defrauded the insurer of millions of dollars in workers’ compensation premiums covering those involved in making “Three of Hearts,” which starred William Baldwin, Kelly Lynch and Sherilyn Fenn.
10. Raif Dentkas, once a Prudential agent, his wife, Figen (a.k.a. Laurie Elizabeth), and son Cahit, were indicted in Minneapolis for faking the couple’s deaths in two separate auto accidents in Dentkas’ native Turkey. Raif “died” first; his wife’s “death” followed a year later. The family collected more than $500,000 before the scam was uncovered. Clues included a letter to Prudential signed by Figen some two weeks after she supposedly died.

**Why has insurance fraud increased?**
The causes and factors behind insurance fraud are varied and oftentimes complex:

*Public attitudes*
Some Americans tolerate insurance fraud, mistakenly thinking it is a victimless crime. A 1995 Roper study for the Insurance Research Council found that 24 percent of Americans feel it was acceptable to pad a claim to make up for premiums paid in previous years. Nearly 40 percent of residents in large cities found the practice acceptable, as did those in New York, New Jersey and Pennsylvania.

An earlier Roper study found that 32 percent of Americans said it was acceptable to underestimate the miles they drive when applying for insurance coverage. Another 23 percent said it was OK to lie about where they garage their cars in order to lower auto premiums. Some people justify fraud because they feel the insurance premiums they pay are unjust.

*Insurer claims practices*
Many insurance companies unwittingly promote fraud by paying suspicious claims rather than fighting them. Insurers sometimes reason that it would be less expensive to pay a suspicious claim than to pay more in legal fees to fight them. Many insurers also resist fighting suspected claims for fear of multi-million-dollar “bad faith” lawsuits.

*High-risk insurance*
Mainline insurers sometimes are unwilling to provide high-risk insurance, making the marketplace susceptible to bogus insurance companies who come in to fill the void.

*Medical economics*
Large numbers of uninsured and under-insured patients, combined with cost-conscious managed care programs, have reduced health care profits in some segments of the medical industry. Some treatment facilities and health providers are tempted to make up the difference by inflating of fabricating claims of insured patients.

*Insufficient penalties*
Insurance fraud is perceived as a high-reward, low-risk proposition. With overburdened prisons, jail sentences usually are infrequent and light. Compared to trafficking in drugs, insurance fraud is safer and more rewarding in most instances. Additionally, doctors and lawyers are regulated by their peers through professional societies whose disciplinary systems too often provide little viable safeguards or remedies when members are caught or are suspected of defrauding.
Low law enforcement priority
In many cases, law enforcement and prosecutors have given top priority to reducing drugs and violence in society, shifting manpower and other resources away from insurance fraud and other white-collar crimes.

How are insurance regulators combating fraud?
Through the National Association of Insurance Commissioners, insurance regulators have created model legislation for states to enact that would make it harder for con artists to set up insurance companies. In many states, regulators are beefing up their oversight of insurer finances and their market practices, and several states have created insurance fraud units with law enforcement authority. Insurance regulators also initiated a call for a thorough federal fraud statute to make white-collar and internal fraud a federal crime.

In 1994, the omnibus crime bill attacked “white-collar” insurance fraud by setting prison terms and fines for individuals who embezzle, file false reports or steal funds from insurance companies, and it sets strict penalties for anyone convicted of submitting false financial information to state insurance regulators.

In addition, the crime bill extended the US mail fraud statutes to include overnight private mail carriers. Too often sham operators, realizing that mail fraud laws only cover the US Postal Service, sent material through private carriers without fear of federal prosecution.

How are insurance companies combating fraud?
Most major insurers have created specific entities within their claims departments to detect and investigate suspicious claims. These Special Investigative Units (SIUs) are often staffed by former law enforcement professionals. Additionally, in 1992 insurance companies created the National Insurance Crime Bureau, a not-for-profit organization dedicated to fighting insurance fraud and vehicle theft. Its activities include collecting information about more than 56,000 claims in 1995, a 30 percent increase in two years. NICB investigators have recorded a 34 percent increase in prosecutable and administrative actions since 1992. In addition, NICB and several other industry groups have created insurance fraud database networks now accessible online.

What are some of the possible solutions?
One solution against fraud is hitting hard at individuals who are defrauding the health care system by enacting stiffer penalties and extending current laws attacking Medicare and Medicaid fraud to cover all payers.

On the state level, the Coalition has developed model legislation to combat the problem; states can enact provisions that would:
• Make insurance fraud a specific crime with appropriate penalties, including restitution for victims.
• Require administrative action against licensed individuals or businesses – medical providers, lawyers, insurance agents, adjusters, contractors and body shops – upon conviction of insurance fraud.
• Establish fully functioning fraud bureaus in states with moderate or severe problems of fraud. The bureaus should have subpoena power and fining authority and should work with law enforcement and industry to investigate fraud.
• Require insurers to commit to specific plans on how they propose to prevent and detect fraud.
• Require claims forms and insurance applications to carry a warning that insurance fraud is illegal and a serious crime.
• Provide immunity to insurers when sharing fraud information with other insurers, fraud investigators and law enforcement.
• Require visual inspection of certain types of automobiles before insurance is granted to curtail “phantom” cars that are insured and subsequently reported stolen. This requirement, which is needed in states with high levels of auto insurance fraud, also would curtail the practice of insuring cars with existing damage.

http://www.insurancefraud.org/facts.html
FOUR FACES:
Why Americans tolerate — and don’t tolerate — insurance fraud

Executive Summary

Introduction and Background
This study was conducted to gain insight on why public tolerance of insurance fraud seems to be increasing. Both qualitative and quantitative research was used to understand how public attitudes about fraud are formed and what factors influence them. The coalition commissioned a national search firm to conduct a series of consumer focus groups as well as a telephone survey of 602 households in the US. Among the areas explored in the focus groups and survey include opinions about insurance fraud and insurance providers.

FOCUS GROUP FINDINGS
Respondents offered the following possible reasons for committing insurance fraud:
• To save money and reduce costs;
• To get expensive work done they would not otherwise be able to afford;
• To “get back” at insurance companies.

Respondents acknowledged that fraud leads to higher premiums, but believed that premiums would continue to rise even if fraud was eliminated. Respondents also felt that the public has a moral obligation to report fraud, but most said they would not report a fraudulent act themselves for various reasons.

Reasons cited why people resist committing insurance fraud include a strong sense of right and wrong and fear of being caught and punished. Respondents said insurers could discourage fraud by rewarding customers for “good behavior,” such as providing rebates or credits for not filing claims over a period of time, and aggressively pursuing customers who commit fraud.

QUANTITATIVE RESEARCH
The objectives of this research included:
• Understanding public perceptions of unethical behavior;
• Determining experience with and attitudes toward the insurance industry;
• Measuring public perception of unethical insurance behavior;
• Determining personal knowledge of, and experience with, insurance fraud;
• Measuring attitudes toward curtailing and punishing insurance fraud.

Using cluster analysis, researchers found that 98% of the sample could be grouped into one of our subgroups depending on their levels of tolerance for fraud. For the purposes of this study, the subgroups are identified as Realists, Conformists, Moralists and Critics.

• The Realists have a low tolerance for insurance fraud but realize that it occurs. They may feel some behaviors are justified depending on the circumstances but they do not advocate strong punishment. This group represents 21.6 percent of the survey’s respondents.
• The Conformists are fairly tolerant of insurance fraud, largely because they believe many people do it so that makes it more acceptable. For that reason, they tend to believe in more moderate forms of punishment. This group makes up 26.4 percent of the survey’s respondents.

• The Moralists have the least tolerance of insurance fraud. They believe there’s no excuse for this behavior and are the most willing to punish perpetrators severely. This is the largest group of respondents – 30.7 percent of the surveyed population.

• The Critics have the highest tolerance for fraud and tend to blame the insurance industry for people’s behaviors because they believe insurers do not conduct business fairly. They want little or no punishment for perpetrators. This group represents 21.2 percent of the survey’s respondents.

Demographically, the four cluster groups varied only slightly.

Survey Findings:
• Unethical behavior. Virtually all respondents (98%) believe using someone else’s credit card is highly unethical. They were somewhat less likely to consider as unethical the failure to declare income on a tax return. Two forms of insurance fraud – padding a claim and misrepresenting an incident to obtain coverage for a loss – fell in between at 91% and 93%, respectively.

• Insurance industry. Nearly three-quarters of respondents (73%) rate their company either very positive or fairly positive. Insurance agents are held in about the same regard regardless of cluster subgroup. The Conformists and the Moralists are more likely to feel positively about their company and the industry in general.

• Insurance premiums. More than half (63%) say they believe insurance premiums are either very reasonable or fairly reasonable. Among the cluster subgroups, the Conformists and the Moralists again are more likely to feel positively about insurance premiums and to rate them as very fairly reasonable.

• Claims experience. Respondents who had filed life and homeowners claims were more likely to have positive attitudes towards insurers.

Respondents who demonstrated a positive attitude toward insurers tended to have lower levels of tolerance for fraud.

Perceptions of Insurance Fraud
• Most respondents believe so-called “soft fraud”, such as padding claims, is common. The Conformists are the most likely cluster group to believe these actions are common, while the critics are the least likely to believe insurance fraud is common.

• About two-thirds agree that insurance premiums increase regardless of claims history and that companies make undue profits. About six in ten agree that people who commit fraud are only looking for a fair return on premiums paid; nearly the same number (56%) agree that rates are based on the assumption that fraud occurs.

• 63% of respondents felt that a person’s moral character was the prime deterrent to committing insurance fraud. Most respondents also said they were personally concerned about insurance fraud. Moreover, nine in ten respondents said they believe insurance

Ethics and Fraud ● Page 17
rates are higher as a result of fraud. When asked to estimate the amount by which premiums are higher as a result of fraud, the mean response was 37%.

**Personal Experience with Fraud**
- 31% say they know someone who has committed insurance fraud. However, only 17% of those respondents say they have reported someone for committing fraud.

**Curtailing and Punishing Fraud**
- Respondents overwhelmingly believe insurance companies should take a number of actions to curtail insurance fraud. About nine in ten respondents believe the industry should verify applications more carefully; inform people how fraud increases costs; lower premiums for people with few or no claims; investigate claims more thoroughly; and prosecute suspected fraud more often.
- 57% believe people should be prosecuted for lying and falsifying information. Nearly the same number (53%) say that denying the unjustified portion of the claim also is highly suitable. The Critics are far less likely to believe the suggested consequences were appropriate, and more likely to believe all claims should be processed with no questions asked.

**Recommendations**
The coalition recommends that the insurance industry develop and fund an intensive, ongoing public information campaign to educate the public about insurance fraud, specifically convince the Realists the insurance fraud is not a victimless crime and communicate to the Conformists the fraud is not as widespread as they believe it to be. Moralists need messages reinforcing their low level of tolerance for this crime, and the Critics must be convinced that fraud is a major contributor to the rise in insurance premiums and that insurers are working hard to detect and deter fraud.

**Other Recommendations include:**
- Careful and cost-effective verification of applications for misrepresentations of monetary value should be a standard practice by all insurance companies. This practice also should be communicated to applicants to dispel any possible notion that insurers do not check applications thoroughly.
- Claim submissions should be scrutinized for evidence of potential fraud and investigated accordingly.
- Company anti-fraud activities should be widely publicized so consumers know the risk of committing fraud and are aware of what insurers are doing to protect their customers from the cost of this crime. Diligent efforts need to be undertaken to uncover situations where anti-fraud efforts have led to reduced rates for consumers. Such cause-and-effect relationship needs to be well-publicized to convince consumers that they will benefit from anti-fraud efforts.
- In assessing which claims practices engender the most customer satisfaction, companies should consider the potential positive implications for attitudes about insurance fraud. The claims process should be viewed as an opportunity to build credibility with insurers, which likely will help to lower their tolerance for fraud.
• The insurance industry should explore the feasibility of a reward system to encourage the reporting of fraud.

• Prosecutors, especially elected officials, should recognize that consumers overwhelmingly support prosecution of insurance fraud. They should educate themselves about this crime, manage their resources in a way that allows more attention to be given to insurance fraud, and take an active and aggressive role in publicizing fraud cases.

Fraud bureaus, which are most familiar with the warning signs of insurance fraud, should play the lead role in consumer outreach and education about the nature and extent of insurance fraud. States lacking fraud bureaus should direct the insurance department to undertake the outreach efforts while evaluating the need to establish a bureau.

http://www.insurancefraud.org/FourFaces.html
Insurance Fraud Study Raises Concerns about Consumer Attitudes

According to the Washington, DC-based Coalition / Against Insurance Fraud (CAIF) for the insurance industry, and for the public as well, insurance fraud costs $85 billion per year. With such substantial damage, it is no wonder that the industry is making significant efforts to battle this cancer. The industry has decided that increasing public awareness of fraud is its main course of action. It sees this as a possible solution, but as yet, has apparently not made the inroads it has intended.

According to Dennis Jay, the Coalition’s executive director, the good news in the Four Faces survey is that those who firmly believe that insurance fraud is wrong represent the largest group. Those who are most tolerant of fraud are the smallest group. “There’s a large group in the middle that we believe exhibits attitudes amenable to change,” states Jay.

The coalition strongly believes that public attitudes are crucial to curtailing fraud. For example, a willingness to tolerate what’s known as “soft” fraud contributes to an atmosphere in which individuals may easily rationalize ripping off the system, knowing there’s little or no social stigma attached to these actions, says the Coalition, adding that public support is needed to pass legislative initiatives designed to curb fraud.

“Consumers’ pockets are being picked by perpetrators of fraud to the tune of more than $1000 per year for each American family,” said Ken McEldowney, coalition co-chair and head of Consumer Action. “This study shows that Americans rightly believe that fraud costs us money.

“We need to take the next step, recognize the problem belongs to all of us, and that the responsibility for the solution also lies with us,” he stressed.

About two-thirds of the respondents said they believe that insurance premiums increase regardless of claims history, and that companies make undue profits. About 6 in 10 agree that people are only looking for a fair return on premiums paid; almost the same number (56%) agree that rates are based on the assumption that fraud occurs. They are less likely to agree that people would not lie to insurance companies if they were treated with more respect (39%); that people are forced into this behavior to get insurance (33%); or that nobody tells the truth on applications (27%).

What does this tell us? It tells us that the public perception of the way the insurance industry operates is that, regardless of whether fraud increases or decreases, insurance rates will not be affected. Whether or not this perception is correct, it is the majority perception, and the insurance industry has done little to change it. While insurers have been more vocal in the last decade about the need for fraud prevention, they have not yet convinced customers that rates will go down if fraud is prevented, detected, and punished.

Most respondents said they were personally concerned about insurance fraud. Nine out of ten respondents said they believe insurance rates are higher as a result of fraud. The Conformists tend to justify fraud with their belief that everyone does it, while Realists are more likely to believe that premiums will continue to rise regardless of claims history, suggesting there’s no
incentive not to commit fraud. The Critics are more likely to cite insurers making too much money and causing people to lie to them. But the Moralists join them in being more likely to justify fraud as a way to get a fair return on premiums paid.

So again, we see a picture of most respondents linking fraud with an assumption that insurers will not pay a fair claim unless it is padded to get that fair return.

When consumers hear the words: fraud and insurance companies in the same sentence, (and this is not addressed in the study,) they are likely to think about other matters as well. Most recently, we have read about major life insurance companies cheating policyholders by “churning” existing life insurance policies just so that agents could take advantage of the “front loading” of commissions. If that is not fraud, it is certainly unethical behavior to the detriment of the consumer.

POSA and Kennilworth, to name just two scandals, was a fraud that years ago, was perpetrated by licensed insurance industry representatives. Those frauds caused many millions of dollars in losses to the insurance industry. Is it possible to convince the average consumer that those losses were not just passed on to consumers in the form of higher premiums?

The critical issue here is that the CAIF is correct. The public feels that insurance fraud is reprehensible but inevitable and that the insurance industry is going to do what it wants to anyway when it comes to premium rates. This perception exists despite the increased attention the industry has paid to exposing insurance fraud and combating it.

What has not been tried in the fight against insurance fraud is for the insurance industry -- companies, agents, brokers, MGAs, intermediaries, program administrators, etc.-- to disseminate information to the public that calls attention to ills in the industry that contribute to insurance fraud problems.

(From an article appearing in Rough Notes written by Phil Zinkewicz)
Indicators of Application Fraud

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, it is appropriate for the agent to review all applications for possible fraud. Determining the “fraud potential factor” of any application is facilitated when the agents are familiar with various fraud indicators.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, the underwriter should be made aware of the agent’s suspicions, and subsequent referral to NICB for further review may be appropriate.

<table>
<thead>
<tr>
<th>General Indicators of Application Fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Unsolicited, new walk-in business, not referred by existing policyholder.</td>
</tr>
<tr>
<td>o Applicant walks into agent’s office at noon or end of day when agent and staff may be rushed.</td>
</tr>
<tr>
<td>o Applicant neither works nor resides near the agency.</td>
</tr>
<tr>
<td>o Applicant’s given address is inconsistent with employment/income.</td>
</tr>
<tr>
<td>o Applicant gives post office box as an address.</td>
</tr>
<tr>
<td>o Applicant has lived at current address less than six months.</td>
</tr>
<tr>
<td>o Applicant has no telephone number or provides a mobile/cellular phone number.</td>
</tr>
<tr>
<td>o Applicant cannot provide driver’s license or other identification or has a temporary, recently issued, or out-of-state, driver’s license.</td>
</tr>
<tr>
<td>o Applicant wants to pay premium in cash.</td>
</tr>
<tr>
<td>o Applicant pays minimum required amount of premium.</td>
</tr>
<tr>
<td>o Applicant suggests price is no object when applying for coverage.</td>
</tr>
<tr>
<td>o Applicant’s income is not compatible with value of vehicle to be insured.</td>
</tr>
<tr>
<td>o Applicant is never available to meet in person and supplies all information by telephone.</td>
</tr>
<tr>
<td>o Applicant is unemployed or self-employed in transient occupation (e.g. roofing, asphalt).</td>
</tr>
<tr>
<td>o Applicant questions agent closely on claim handling procedures.</td>
</tr>
<tr>
<td>o Applicant is unusually familiar with insurance terms or procedures.</td>
</tr>
<tr>
<td>o Application is not signed in agent’s view (e.g., mailed in).</td>
</tr>
<tr>
<td>o Applicant is reluctant to use mail.</td>
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<tr>
<td>o Applicant works through a third party.</td>
</tr>
<tr>
<td>o Applicant returns the completed application unsigned.</td>
</tr>
<tr>
<td>o Applicant has had driver’s license for significant period, but no prior vehicle ownership and/or insurance.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Fraud Indicators Associated With Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Name of previous insurance carrier or proof of prior coverage cannot be provided.</td>
</tr>
<tr>
<td>o No prior insurance coverage is reported although applicant’s age would suggest prior ownership of a vehicle and/or property.</td>
</tr>
<tr>
<td>o Significant break-in coverage is reported under prior coverage.</td>
</tr>
<tr>
<td>o Question about recent prior claims is left unanswered.</td>
</tr>
<tr>
<td>o Full coverage is requested for older vehicle.</td>
</tr>
<tr>
<td>o No existing damage is reported for older vehicle.</td>
</tr>
<tr>
<td>o Exceptionally high liability limits are requested for older vehicle inconsistent with</td>
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</table>

Ethics and Fraud ● Page 22
applicant’s employment, income or lifestyle.

<table>
<thead>
<tr>
<th>Fraud Indicators Associated With Applicant’s Vehicle/Business</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Vehicle is not available for inspection.</td>
</tr>
<tr>
<td>o Photos are submitted in lieu of inspection.</td>
</tr>
<tr>
<td>o Vehicle does not appear to be appropriate for claimed address or income (e.g., a luxury vehicle in a low-income neighborhood).</td>
</tr>
<tr>
<td>o Vehicle has unusual amount of after-market equipment (e.g., wheels, high priced stereo, CB radio, car phone).</td>
</tr>
<tr>
<td>o Vehicle inspection by agent uncovers discrepancy between VIN listed on title/bill of sale, VIN plate on dashboard, and/or manufacturer’s sticker on door.</td>
</tr>
<tr>
<td>o No lien holder is reported for new and/or high value vehicle.</td>
</tr>
<tr>
<td>o Vehicle title or authenticated bill of sale cannot be produced.</td>
</tr>
<tr>
<td>o Applicant is seeking new business coverage and has never been in any or this type of, business in the past.</td>
</tr>
<tr>
<td>o Sound financial backing for the business to be insured is not apparent.</td>
</tr>
<tr>
<td>o Loss payee is not a legitimate lending institution (e.g., bank or finance company).</td>
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</tbody>
</table>

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Report the Rip-Off: Insurance Fraud Facts

Medical Mills: Quacks, Crooks and Con Artists

What is a Medical Mill?
A medical mill consists of medical professionals at times working with legal professionals and recruiters who rip off patients and insurance companies through unethical and fraudulent billing practices.

Types of Medical Mills
The degrees of fraudulent involvement in a medical mill often depend on the amount of risk medical professional is willing to take.

Fraudulent Physician
In this rare type of medical mill, everything from the doctor to the bills to the office itself is a fraud. Since patients with bogus injuries are often recruited, these offices contain little or no medical supplies, and actual treatment is rarely prescribed.

Double-Dipping Doctor
This type of medical mill does provide medical services, though the methods of treatment are often questionable, excessive or redundant. Patients are occasionally overcharged for services or, in some extreme cases, billed for services never rendered.

Creative Accountant
The most common type of provider fraud often goes unnoticed by the patient. The health care provider often provides quality treatment and service; however, on occasion, the bills are purposely inflated.

The Injuries
Typical fraud-related injuries involve soft-tissue sprains and strains like backaches, whiplash, and headaches. Injuries are often subjective and difficult to verify. Medical mill patients rarely spend any time in the hospital.

The Criminals
Medical and legal providers are the most trusted professionals. Instead of healing the sick and protecting the innocent, a handful of providers are abusing the public’s trust by “doctoring” insurance bills.

Unscrupulous Medical Providers
Dishonest medical providers often inflate bills or give unnecessary treatment in an attempt to collect extensive insurance reimbursements. Participants often include chiropractors, physicians, pharmacists and their office managers.
Unscrupulous Legal Providers
Dishonest attorneys purposely funnel patients to corrupt doctors or knowingly represent accident victims who are filing false or padded insurance claims. Participants often include personal injury attorneys, legal clerks and law office managers.

Cappers or Runners
Third-party middlemen who recruit insurance fraud perpetrators and befriend legitimate accident victims for medical mills. Favorite targets include laid off individuals, the chronically unemployed and immigrants.

Insurance Fraud Perpetrators
Pseudo patients are individuals who often fake or exaggerate injuries before visiting a medical mill. Common schemes include staging auto collisions, slipping and falling and faking injuries at work.

The Victims

Legitimate Accident Victims
In addition to being used as pawns in elaborate insurance fraud schemes, legitimate accident victims may be subjected to poor treatment or services by unqualified medical providers.

http://www.nicb.org/reportripoff/factpages/medicalmillplayers.html
Dishonest Claimants: Claimant Fraud

What is claimant fraud?
The most common examples of claimant fraud are injuries not suffered on the job or faked, exaggerated or prolonged injuries. The “injured” individuals usually claim soft-tissue traumas such as headache, whiplash and muscle strains to limit specific diagnosis by examiners.

Claimant fraud also includes multiple claims filed under identities and claims filed just before or just after an individual is terminated from a job.

Why does it happen?
The workers compensation system is rightfully biased toward the injured worker. The worker is given the benefit of every doubt in the claims process, making fraudulent claims easier and more lucrative.

The dishonest claimant is fueled by the temptation of receiving up to 66 percent pay (tax-free) for no work. Some claimants will even obtain a second job without notifying and still collecting benefits from their first employer.

Case: Paycheck Double Dipping
An anonymous caller to the NICB Fraud Hotline (1-800-TEL-NICB) reported a woman in South Carolina who was still receiving disability payments for an injury from the summer of 1994. However, she had started work at a different job which paid her cash.

When provided with this information, the claims manager authorized surveillance of the claimant to verify that she was actually working while still drawing the disability payments. Surveillance showed evidence that the claimant was not as injured as she still claimed to be. When confronted with the video, the claimant’s attorney volunteered to request an immediate hearing to enable his client an early return to work and end the disability payments.

Case: Tuition by Deception
With college costs skyrocketing, prospective students will try just about anything to come up with the money. One student actually coaxed a friend to shoot him in the shoulder blade during a staged robbery to collect workers’ compensation benefits and a settlement.
Dishonest Professionals: Medical Mills

What are medical mills?
This fraud involves legal and medical professionals who purposely over bill, bill for services not rendered, solicit workers to file fraudulent or exaggerated claims and file standardized (or “boilerplated”) diagnoses and bills.

A medical provider independently or conspiring with the claimant bills the insurers for nonexistent or highly exaggerated medical treatments. Dishonest lawyers then initiate negotiations on settlements based upon these fraudulent or exaggerated medical claims. Some medical mills may also use “runners” or “cappers” to recruit clients and solicit workers to file fraudulent or exaggerated claims.

Why do they exist?
Some doctors and lawyers manipulate the fact that the workers’ compensation system was designed to be no fault between management and labor. Unnecessary medical treatments and tests, plus litigation, have contributed to extraordinary costs.

Case: Operation What’s Up Doc?

The sting included an undercover investigation by two officers posing as a referral service that offered to steer workers’ compensation claimants to doctors and lawyers for a fee. The investigators mailed out flyers and met with some doctors and lawyers who took their offer and even counseled them on how to cover their tracks. In exchange for patient referrals, suspects were paid per patient fees (also called “capping”), while others agreed to kick back a percentage of the insurance payments.

Dishonest Employers: Premium Fraud

What is premium fraud?
Dishonest employers steal from the workers’ compensation system by misrepresenting one or more factors used to determine the workers’ compensation premium: payroll, employee job classification or loss history.

Understating Payroll: The most common of premium frauds occurs when employers cut the amount of their workers’ compensation premiums in half by reporting only a fraction of their actual payroll. Some dishonest employers exclude employees from the roster by paying them in cash or choose to incorrectly report employees compensation.

Misclassifying Employee Job Codes: Employers will intentionally misstate employees job codes (or misstate the nature of their business) to reduce their premium. For example, because a roofer has a higher job code than a secretary, an employer may purposely misclassify the roofer as a secretary to reduce their premium.

Experience Modification Avoidance: This includes a false history of losses, new or different
ownership, a change of company name or a different geographic location listed for the company on the policy application.

http://www.nicb.org/reportripoff/factpages/insurancefraudoverview.html
Indicators of Property Fraud

Detection – The First Line Of Defense

Most claims are legitimate, but many are inflated or fraudulent. Therefore, it is appropriate for the adjuster to review all claims for possible fraud. Determining the “fraud probability” of any claim is facilitated when the adjuster is familiar with various fraud indicators. These indicators should help isolate those claims which merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that a fraud has been committed.

All suspicious claims, though they may have to be paid for lack of conclusive evidence of fraud, should be submitted to NICB. There is no limit to the number of cases you may submit. No dollar value is too small for a questionable claim submission.

General Indicators of Application Fraud

Note: Adjusters should familiarize themselves with the following general indicators of insurance fraud which may apply to more than one type of fraud scheme. After review of the general indicators, the adjuster can then refer to the more specific fraud categories which follow. The following categories of fraud are separated merely to facilitate your understanding of the type of fraud. However, multiple forms of fraud may appear in a single claim.

- Insured is overly pushy for a quick settlement.
- Insured is unusually knowledgeable regarding insurance terminology and the claims settlement process.
- Insured is willing to accept an inordinately small settlement rather than document a claims loss.
- Insured contacts agent to verify coverage or extents of coverage just prior to loss date.
- Insured is recently separated or divorced.
- Suspiciously coincidental absence of insured or family at the time of the incident.
- Losses occur just after coverage takes effect, just before it ceases or just after it has been increased.
- Losses are incompatible with insurer’s resident, occupation and/or income.
- Losses include a large amount of cash.
- Commercial losses that primarily involve seasonal inventory or equipment, and that occur at the end of the selling season, e.g., a ski inventory loss in the spring or a farm machinery loss in the fall.

General Indicators of Arson-for-Profit or Fire-Related Fraud

Note: While arson-for-profit is unquestionably the most vicious and costly economic assault on the property insurance industry, claims personnel should also be alert to fraud which occurs when an Insured takes criminal advantage of an accidental fire.

- Building and/or contents were up for sale at the time of the loss.
- Suspiciously coincidental absence of family pet at time of fire.

Ethics and Fraud ● Page 29
Insured had a loss at the same site within the preceding year. The initial loss, though small, may have been a failed attempt to liquidate contents.

- Building and/or business were recently purchased.
- Commercial losses include old or non-salable inventory or illegal chemicals/materials. Insured or insured’s business is experiencing financial difficulties, e.g., bankruptcy, foreclosure.
- Fire site is claimed by multiple mortgagees or chattel mortgagees.

**Fraud Indicators at the Fire Scene**

- Building is in deteriorating condition and/or lacks proper maintenance.
- Fire scene investigation suggests that property/contents were heavily over-insured.
- Fire scene investigation reveals absence of remains of non-combustible items of scheduled property or items covered by floaters, e.g., coin or gun collections or jewelry.
- Fire scene investigation reveals absence of remains of expensive items used to justify an increase over normal 50% contents coverage, e.g., antiques, piano, or expensive stereo/video equipment.
- Fire scene investigation reveals absence of items of sentimental value: e.g., family Bible, family photos, trophies.
- Fire scene investigation reveals absence of remains of items normally found in a home or business. The following is a sample listing of such items, most of which will be identifiable at fire scene except in total burns.

  **Kitchen:** major appliances, minor appliances, normal food supply in refrigerator and cabinets.  
  **Living Room:** television/stereo equipment, record/tape collections, organ or piano, furniture (springs will remain).  
  **Bedroom:** guns, jewelry, clothing and toys.  
  **Basement/Garage:** tools, lawn mower, bicycles, sporting equipment, e.g., golf clubs (especially note if putter is missing from otherwise complete set).  
  **Business/Office:** office equipment and furniture, normal inventory, business records (which are normally housed in metal filing cabinets and should survive most fires.)

**Fraud Indicators Associated with the Loss Incident**

- Fire occurs at night, especially after 11:00 p.m. all business in person, thus avoiding the use of the mail.
- Commercial fire occurs on holiday, weekend or when business is closed.
- Fire department reports fire cause is incendiary, suspicious or unknown.
- Fire alarm and/or sprinkler system failed to work at the time of the loss.

**Fraud Indicators of Burglary/Theft Fraud**

- Losses include total contents of business/home including items of little or no value.
- Losses are questionable, e.g., home stereo stolen out of car, fur coat stolen on trip to Hawaii.
- Losses include numerous family heirlooms.
- Losses include numerous appraised items and/or items of scheduled property.
- Extensive commercial losses occur at site where few or no security measures are in effect.
- No police report or an over-the-counter report in situations where police would normally investigate.

**Fraud Indicators Associated with the Claims Process**

- Insured over-document losses with a receipt for every loss and/or receipts for older items of...
property.
- Insured’s loss inventory differs significantly from policy department’s crime report.
- Insured cannot provide receipts, canceled checks or other proof of ownership for recently purchased items.
- Insured provides numerous receipts for inexpensive items, but no receipts for items of significant value.
- Insured provides receipt(s) with incorrect or no sales tax figures.
- Insured provides receipt(s) with no store logo (blank receipt;)
- Loss inventory indicates unusually high number of recent purchases.
- Insured cannot recall place and/or date of purchase for newer items of significant value.
- Insured indicates distress over prospect of an examination under oath.
- Insured cannot provide bank or credit card records for recent purchases of significant value.
- Insured provides receipts/invoices from same supplier that are numbered in sequence.
- Insured provides receipts from same supplier with sequence numbers in reverse order of purchase date.
- Insured provides two different receipts with same handwriting or typeface.
- Insured provides single receipt with different handwriting or typefaces.
- Insured provides credit card receipts with incorrect or no approval code.
Coalition Against Insurance Fraud
FRAUD CASE OF THE WEEK

Twins often are known for doing everything in twos, and California brothers Robert and Michael Hartman are no exception. They bought matching Sony laptops, matching Surround Sound systems, matching espresso makers and more. Now they have matching insurance fraud indictments for falsely reporting those items stolen and collecting $40,000.

Oh, they have matching professions: they’re police officers.

The two claimed a burglar stole what was to be a host of Christmas presents from Robert’s house. They claimed $54,000 in lost property, collecting the $40,000 with an additional $23,000 on the way. Unfortunately, the insurance company discovered the two had already returned some of the items before the alleged burglary. More merchandise, prosecutors said, went back to the store after the “burglary.”

But this was not true of the surround sound systems. The salesman remembered the men and the systems well. He made the sale to the Hartmans and installed the products – two months after they were reported stolen, prosecutors said.

And yes, the men dressed alike for their court appearances.

http://www.insurancefraud.org/fraudoftheweek.html
Indicators of Catastrophe Fraud

Catastrophe related fraud and abuse primarily falls into three categories: insurance claim fraud, property repair fraud and fraud associated with claims and loss processes. Each category may involve bribery, kickbacks, misrepresentation, concealment, forgery and theft.

### Fraud Indicators of Claim Related Fraud

**Note:** Catastrophe insurance claims fraud includes inflated and totally fabricated losses, intentionally caused damages, claims for preexisting damage and backdated policies.

#### Insureds With Catastrophe Insurance Coverage (Earthquake, Flood, Hurricane, etc.)

- Insured declares extensive losses without physical evidence, photographs or documented receipts.
- Items claimed do not match claimant’s lifestyle, decor, house, occupation or income.
- Items claimed cannot physically fit in existing floor space.
- Lack of carpet indentation from alleged large furniture or appliances.
- Extensive commercial losses occur at site where few or no security measures are in effect.
- Insured is unusually knowledgeable regarding insurance terminology and the claims settlement process.
- Insured is overly pushy for quick settlement.
- Insured is willing to accept an inordinately small settlement rather than document all claims losses.
- On scene investigator reveals absence remains of items claimed and normally found a home or business.
- Investigation reveals absence of family photographs, heirlooms or items of sentimental value.

#### Insureds Without Catastrophe Insurance Coverage (Earthquake, Flood, Hurricane, etc.)

*Theft:*

- Affected area was not evacuated.
- Lack of security in the area.
- No other homes were damaged or destroyed in the affected area.
- Name or address on receipt does not match insured name and/or address.
- Insured has no documentation or receipts (stolen, damaged or thrown out).
- Insured submits a theft claim as a result of looting.
- Insured had all cash purchases.
- Insured claims items were new.
- Insured cannot properly describe items as to function or features.

*Fire/Flood Losses:*

- Insured property was not located in major damaged area.
- Property was in poor condition prior to loss.
- No other homes or businesses were damaged or destroyed by fire or flood in the affected area.

*Landlords:*
Although the renter maintains a tenant policy, landlord claims tenant’s contents.
Vacated rental property claimed as primary residence.

**Fraud Indicators of Property Repair Fraud**

*Note*: Property-repair fraud involves unethical, incompetent and dishonest building contractors, who employ a variety of illegal or questionable techniques. These include such activities as collecting on defective or unperformed service, damage inflation, insurance fraud conspiracy, bribery of insurance adjusters and kickbacks. Insureds may conspire with the repairer to cover their deductible, upgrade their property or repair preexisting damage or defects.

**Contractors/Providers:**
- Do not maintain a local office and/or have a local telephone number.
- Are not able to provide references.
- Want “cash” or payment up front.
- Have inadequate equipment to perform job.
- Arrive at loss site without being solicited.
- Offer below market prices that are “too good to be true.”
- Offer cash incentives to get the job.
- Estimate is very general, given in a lump sum.
- Are not bonded or are underinsured, and are not licensed or are newly licensed.
- Multiple contractors using same license.

**Indicators Associated with the Claims Process**

*Note*: Fraud related to the claims process includes people impersonating insurers and fraudulently collecting on their claims, forging and cashing claim payment drafts and using contractor damage repair estimates to collect for property damages never intended to be repaired.

- Insured unable to provide proof of identification and/or home ownership.
- Insured over-documents losses with a receipt for every item including older items of property.
- Insured cannot provide receipts, canceled checks or other proof of ownership for recently purchased items (i.e., warranty information, user manuals).
- Insured provides numerous receipts for inexpensive items, but no receipts for items of significant value.
- Insured provides receipt(s) with incorrect or no sales tax figures.
- Insured provides receipt(s) with no store logo (blank receipt).
- Loss inventory indicates unusually high number of recent purchases.
- Insured cannot recall place and/or date of purchase for newer items of significant value.
- Insured indicates distress over prospect of an examination under oath.
- Insured cannot provide bank or credit card records for recent purchases of significant value.
- Insured provides receipts/invoices from same supplier that are numbered in sequence.
- Insured provides receipts from same supplier with sequence numbers in reverse order of purchase date.
- Insured provides two different receipts with same handwriting or typeface.
- Insured provides single receipt with different handwriting or typeface.
o Insured provides credit card receipts with incorrect or no approval code.
o Insured claims the identical items under different policies or with a different insurance company.
o Insured cannot produce damaged item(s) for viewing.
o Insured claims un-repaired damages from a previous disaster.

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Report the Rip-Off: Insurance Fraud Facts

Insurance Professional Convicted of Fraud after
Northridge Earthquake Causes Industry Tremor

The Northridge, Calif. Earthquake struck the densely populated San Fernando Valley in northern Los Angeles on Jan. 17, 1994. It was one of the costliest natural disasters in U.S. history, with total damage estimated at $15 billion.

More than 12,000 buildings were destroyed during the earthquake, leaving thousands of people homeless. One of these victims was Carla Rawstron. She filed a claim with her homeowner’s insurance carrier, Safeco Insurance Company, and received $650,000 for structural damage to her home and $180,000 for the repair or replacement of its contents for a total of over $830,000.

To prove how much the personal property in her home was worth before it was allegedly damaged or destroyed, Rawstron submitted over a hundred receipts to Safeco. After talking with sales personnel from the stores on these suspicious-looking invoices, investigators discovered several of the receipts totaling $50,000 were fraudulent.

For example, when investigators went to Brookwyck Ltd. To check a $2,300 receipt for antique beds, the store was out of business. Rawstron had taken a blank Country Arcade store receipt, removed the top portion and inserted Brookwyck’s logo, filled in the purchase amount in her own writing and photocopied the fabrication. Other receipts were altered rather than fabricated. The Murata Pearl Company estimated replacing pearl earrings for $700. The receipt Rawstron submitted to Safeco said $1,700 after she added a 1.

Besides receipts for the replacement of personal property, some invoices misrepresented repairs. A rocking chair and bar stools were never fixed, contrary to the receipt from Dan’s Woodworking.

Several collectibles and hard-to-damage items were claimed as well. A Kincaid collector’s calendar Rawstron said was valued at $400 was actually only $30 according to a local gallery. Blankets, teddy bears, cassette tapes, a metal desk and brass coat racks were listed as destroyed.

During a disaster, fraudsters may attempt to file inflated insurance claims for alleged damage to their homes and personal property by altering or forging receipts. What makes this incident unusual is that Carla Rawstron was an insurance professional.

Rawstron was handling insurance claims for other earthquake victims at the same time she was committing fraud. She worked for her husband Robert’s long-standing and highly successful firm, Rawstron Insurance Services, in Westlake Village, Calif.. The company, which was not implicated in any wrongdoing, sold surplus lines from many companies including Safeco.
“If anyone should have known what she was doing was wrong, it should have been Mrs. Rawstron, since she worked in the insurance industry,” says Robert Fix, manager of the Special Investigations Unit at Safeco.

The series of events implies Rawstron was in fact at the epicenter of her own insurance fraud scheme. She testified under oath that the receipts she supplied to Safeco were valid. Shortly after, she corrected nearly all of her on-the-record comments. In January 1996, she admitted presenting a false insurance claim to Safeco, and concealing and misrepresenting facts.

With the foundation of her claim severely shaken, Rawstron attempted restitution on her own. In an unusual gesture, she sent Safeco three checks totaling $63,000 to reimburse the company for overpayments she said they made to her.

Rawstron’s restitution effort was taken into consideration during the prosecution process. In October 1998, she plead guilty to seven counts of felony insurance fraud violations for presenting false documents to receive insurance benefits.

The Ventura county Superior Court sentenced Rawstron to 60 days in county jail, five years’ probation and community service. In addition, she was ordered to pay restitution of $43,000 to Safeco, $3,500 to the National Insurance Crime Bureau (NICB) for investigative costs and $1,400 to the State Restitution Fund. Rawstron lost her license to sell insurance.

“We wanted a stiffer penalty than 60 days due to the seriousness and sophistication. Rawstron’s crimes carried a maximum sentence of 10 years in state prison and affected the entire community,” explains Deputy District Attorney, Lisa Lee from the Ventura County District Attorney’s office. “The perception is that white collar crime is not as bad as other crimes. Insurance fraud needs to be taken more seriously by the courts and by the public.”

The insurance industry continues to strengthen the building code for fraud-fighting within its ranks to prevent crimes of seismic proportions. NICB Special Agent Ron Michel cautions, “Insurance professionals are not immune from good investigative work done by insurance companies, law enforcement and the NICB to detect fraud. It’s getting harder to pull the wool over the eyes of the industry.”

As Rawstron serves time behind bars for committing catastrophe fraud, the industry still feels the aftershocks of the professional turned perpetrator.

http://www.NICB.org/reportnpofft/caught.html
Indicators of Rental Fraud

While most vehicles and trucks are rented for legitimate purposes, many times they are rented for the sole purpose of staging accidents, reporting them as stolen or exporting the vehicle out of the country to collect insurance settlements. To determine the “fraud potential factor” of rental fraud, insurance personnel and initial company employees should be familiar with the various fraud indicators associated with the rental and claims process.

### Fraud Indicators Associated with the Rental Process

- Renter provides a bad address and/or telephone number.
- Renter is unemployed or self-employed.
- Renter uses cash instead of a credit card, or a combination of both.
- Renter is unemployed, but uses cash to rent vehicle.
- Renter is moving a friend or family member but cannot remember address, if renting a truck.
- Renter does not want to rent dolly, boxes or moving pads, if renting a truck.
- Renter cannot remember new address, if moving.
- Rents from a dealer or agency “across town” as opposed to a closer location.
- Renter uses a PO Box as an address.
- Often elects to take the Property Damage Waiver coverage and all available insurance.
- Often elects to take the cargo coverage, if renting a truck.
- Renter is from out of the country or is local. Almost never is the renter from another state.

### Fraud Indicators Associated with the Accident and/or Claims Process

- Rental vehicle driven very few miles.
- Mileage is inconsistent with new address, if moving.
- The renter makes an allegation that a defect with equipment caused the accident.
- Renter is anxious to admit fault.
- Accident occurs shortly after rental inception.
- Renter and other parties involved in the accident know each other, work together, live together, are neighbors, or from the same country or ethnic background.
- Police are not called to the accident scene.
- Renter and/or claimants have a history of prior claims.
- Renter refuses to give a statement.
- Damage to vehicles is inconsistent with accident facts.
- Rental vehicle appears to have been intentionally damaged.
- Signs of pre-existing damage to claimant vehicle.
- Claimants allege to have repaired damage prior to vehicle being inspected or alleged to have paid large repair bill in cash, but has no receipt or one that appears altered.
- Many instances involve a single car accident, late at night, in a remote location, with no witnesses.
- Renter denies involvement in the accident.
- Multiple passengers are in the rental vehicle or other vehicle.
- Renter is uncooperative and/or cannot be located.
- Renter and/or claimants cannot remember where they were going, or where they were coming from.
- An attorney is contacted immediately after the accident.
Claimant’s description of accident suggests possible “set-up” accident.
- All claimed injuries are subjective in nature.
- Injuries claimed are not supported by physical damage.
- Claimants receive extensive and/or expensive treatment for minor injuries.
- Claimants travel across town to receive medical treatment.
- Renter and claimants aggressively pursue settlements.
- Several or all of the claimants treat with same clinic on same dates.
- Renter is not in the vehicle and there is an authorized additional driver who is driving at the time of the accident.
- Renter is a passenger in the vehicle and has authorized additional driver driving at the time of the accident.
- Renter is at fault and is not injured but all other passengers are.
- Renter does not know names, addressed, phone numbers and/or relationship between passengers.

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## Indicators of Casualty Fraud

### Fraud Indicators of Automobile Accident Schemes
- Either no police report or an over-the-counter report for an accident resulting in multiple injuries and/or extensive physical damage.
- Accident occurred shortly after one or more of the vehicles were purchased or registered, or after the addition of comprehensive and collision coverage to the policy.
- Insured has a history of accidents within a short period of time on one policy. Index returns indicated an active claim history.
- Insured has no record of prior insurance coverage although damaged vehicle was purchased much earlier than inception of policy and date of loss.
- Expensive, late model automobile was recently purchased with cash (no lien holders).
- Attorney’s lien or representation letter is dated the day of the accident or soon after.

### Indicators of Auto Physical Damage Fraud
- Serious accident with expensive physical damage claim, but only minor, subjectively diagnosed injuries, with little or no medical treatment.
- Despite expensive damage claims, the claimant vehicle remains drivable. Often, there are no towing charges for removing vehicle from the scene of the accident.
- Claimant vehicle was struck by a rental vehicle soon after the rental had occurred.
- Claimant vehicle is not to be repaired locally, but driven or shipped out of state for repair.
- All vehicles in a reported accident are taken to the same body shop.
- Claimant vehicles are not readily available for independent appraisal.
- Reported accident occurred on private property near residence of those involved.
- Claimant vehicle is repaired before the damage can be inspected.
- Claimant vehicle is parked in a way or at a location that makes inspecting the damage difficult.

### Indicators of Medical Fraud/Claim Inflation
- Three or more occupants in the claimant’s or “struck vehicle” all report similar injuries.
- All injuries are subjectively diagnosed, such as headaches, muscle spasms, traumas, and others.
- Medical claims are extensive, but collision is minor with little physical damage to vehicles.
- All of the claimants submit medical bills from the same doctor or medical facility.
- Medical bills submitted are photocopies of originals.
- Summary medical bills are submitted without dates and descriptions of office visits and treatments. Treatment extends for a lengthy period without and interim bills.
- Vehicle driven by claimant is an old “clunker” with minimal coverage.
- Insured, even though legally liable for accident, is adamant that claimants were responsible for accident, indicating that the insured may have been “targeted” by the claimants.
- Claimants retain legal representation immediately after the accident is reported.
- Minor accident produces major medical costs, lost wages and unusually expensive demands for pain and suffering.
- Past experience demonstrates that the physician’s bill and report, regardless of the varying accident circumstances, is always the same.
- Treatment prescribed for the various injuries resulting from differing accidents is always the same in terms of duration and type of therapy.

*Ethics and Fraud ● Page 40*
Medical bills indicate routine treatment being provided on Sundays or holidays.

## Indicators of Lost Earnings Fraud
- Employment information is for an unknown business, often with a post office box for address, or a street address in a residential area.
- Business telephone number is connected to an answering machine or answering service.
- Lost earnings statement is handwritten or typed on blank paper, not business letterhead.
- Claimant started employment shortly before accident occurred, or is self-employed.
- One or more elements of claim is questionable: e.g. length of absence, rate of pay, income incompatible with claimant’s residence.
- Efforts to verify lost wage statement with employer raise doubts about employer’s legitimacy or about the actual employment of the claimant.

## Slip & Fall and Food Products Liability
- Use of a prop, i.e.; broken glass, broken dental plate, etc. To support or inflate the claim.
- Presence of an overly enthusiastic witness at the scene of the incident.
- No supporting evidence of foreign or contaminated substance; claimant threw food out and has only the can, box or wrapper.
Staged Collisions: A 14-Point Checklist

Characteristics of Swoop and Squat Accidents

©Accident Investigation In the Private Sector: Vol. II
by Jack Murray

Staged accidents are creating huge legal defense fees and are driving up the cost of auto insurance. This is a 14-point checklist of indicators of a fraudulent accident. These are staged collisions, in which the vehicle in front stops abruptly and the victim driver finds himself responsible for a rear end collision. This type of accident will exhibit certain characteristics that should serve as red flags to any investigator:

1) The accidents often occur between intersections, in the middle of blocks.
2) Most accidents occur at times other than rush hours, when the traffic is not backed up.
3) Statement of the striking vehicle’s driver is essentially “the car in front stopped suddenly for no reason”.
4) The struck vehicle usually has several passengers.
5) There are seldom any children in the struck vehicle.
6) The age range of the struck vehicle’s passengers is between 17 and 40.
7) The damage involved is usually not severe, usually minimal. Yet all occupants of the vehicle claim injuries.
8) The striking vehicle is usually a late model, driven by a middle-aged person of affluent appearance.
9) The vehicle driven by the swoop and squatters are older models (anywhere from 10 to 15 years old).
10) The struck vehicle has had tire pressure in the rear tires lowered (causes more taillight damage and stops more quickly).
11) The struck vehicle frequently has paper tags
12) The struck vehicle will usually have uninsured, or under insured coverage, even though it has minimum liability as required by law.
13) A check of Insurance Indexes and/or civil records and drivers licenses, show one or more occupants has a history of similar accidents.
14) There are seldom any eye witnesses.

http://www.pimall.com/nasi/n.staged.html
Staged Collisions: Fraud in the Fast Lane

• **The Problem:** Staged vehicle collisions are a major contributor to the $20 billion property-casualty insurance fraud problem. Honest policyholders ultimately pay for this scam in increased insurance rates.

• **The Process:** Participants orchestrate vehicle collisions involving unsuspecting motorists and then team up with dishonest doctors, lawyers and auto repair shop operators, who inflate injuries and damage caused by these accidents. Bogus witnesses are positioned near the accused collision to support the criminal’s account and contradict the innocent driver’s testimony. In many instances, criminals inflict injury upon themselves, or claim hard-to-dispute soft-tissue injuries in order to collect on insurance claims.

• **Hot Targets:** Favorite targets for staged collisions are fully insured drivers not accompanied by passengers who could serve as witnesses. Luxury cars are often targeted because they offer the promise of extensive insurance coverage.

• **NICB Fact:** The big profiteers in most staged collisions are the professionals involved who typically receive the majority of each claim. In most scenarios, the cooperating passengers receive the smallest payout.

• **Unclear Identities:** In most staged collision schemes, participants juggle several identities at once, providing seemingly legitimate documentation for fraudulent claims. To confuse things further, many insurance fraud perpetrators use a post office box as an address for claim payment, and some perpetrators rent apartments containing nothing more than an answering machine.

http://www.nicb.cor.reportipaff/factpages/stagedcollisionoverview.html
Report the Rip-Off: Insurance Fraud Facts

Fraud on the Road

Putting a Dent in Staged Collisions

• NICB Crackdown
Armed with 200 trained investigators, the NICB partners’ insurance companies and law enforcement agencies teamed to target staged-vehicle collision rings and other organized forms of insurance fraud and vehicle theft.

The NICB also maintains a 300-million-record online system, NICB Online™, that provides claims representatives, NICB special agents and law enforcement officials with immediate access to questionable insurance claim information.

Information from NICB Online often results in additional investigative leads and a possible electronic paper trail against insurance crime perpetrators. For example, if insurance investigators search the NICB data base for claims listing a specific address, and eight different claims appear under one address, a question is raised and the claim gets a closer look.

• Scam Scan
In 1994, NICB-assisted investigations resulted in more than 4,200 prosecutable actions against alleged insurance criminals. The following examples represent recent NICB successes in staged vehicle collision cases:

Operation Sudden Impact - May 1995
A nationwide crackdown on staged vehicle collisions by the FBI, the NICB and various local law enforcement agencies resulted in the indictments of 126 individuals and search raids in 31 states.

Minnesota - April 1995
Twenty-seven Minnesota and North Dakota college students were charged with defrauding insurance companies of more than $500,000 in an elaborate staged accident scam.

Virginia - February 1995
Officials broke up a ring of con artists who allegedly collected $250,000 in fraudulent insurance claims. Six ringleaders were indicted for recruiting people to stage fender-benders and then setting up medical clinics and law offices to handle the cases.

Texas - January 1995
Officials charged over 100 people, including two Houston doctors and two lawyers, with participation in a massive fraud scheme featuring staged vehicle collisions and falsely claimed injuries. Currently at least $1.1 million in insurance losses have been calculated; total costs will continue to mount as investigations continue.
South Carolina - January 1995
Following an 18-month investigation, fourteen individuals were indicted and charged with mail fraud for their involvement in a staged automobile accident scam that netted nearly $600,000.

Arizona - November 1994
Officials charged 25 individuals, including doctors and lawyers, with numerous fraud-related counts. Twenty-one different Phoenix locations, including six chiropractic clinics and ten law offices, were searched. NICB investigators reviewed nearly 300 claims worth an estimated $12 - $16 million.

Illinois - October 1994
Thirty-one People were indicted and plead guilty for defrauding insurance companies of more than $750,000 in dozens of staged accidents and fake injury claims. The charges involved nearly 75 claims in 15 different states.

Indiana - October 1994
In an operation dubbed “Claimchaser,” twenty-nine individuals were indicted, including two doctors and a lawyer, for filing more than $250,000 in fraudulent insurance claims involving bogus accidents.

http://www.nicb.org/reportripoff/factpages/stagedcollisioncrackdown.html

HOW TO DETECT A DISFIGURED CLAIM

Here are a few indictors that a bodily injury claim may be fraudulent:
- Policy is new.
- Self-insured policy for a person who is not a doctor or lawyer carries unusually high exposure ($250,000, $500,000 or more).
- Policyholder is anxious to settle the claim and receive payment.
- Settlement amount is lower than expected.
- Claimant does not seek legal advice.
Bodily Injury Fraudsters Cost Insurance Companies an Arm and a Leg
Some people will do just about anything to collect insurance money. Take John and Wanda Fenrich in New York, for example. These self-insured claimants collected nearly a half a million dollars for allegedly losing various body parts in accident scams from 1992 to 1997.

The official investigation began when LeeAnn Fink, claims specialist in the Special Investigations Unit at State Farm, suspected something about John Fenrich’s latest claim was missing - and she wasn’t just referring to his pinkie finger, either.

In the 1996 claim, Fenrich told an allegedly made-up story about how he was ran over by an 1970 AMC driven by a reckless woman who ran a stop sign. As a result, he sustained serious injuries: an amputated left little finger and a lacerated left earlobe. State Farm sent Fenrich a settlement check for $85,000.

The part of the story that was missing was the real identity of the woman driver: Fenrich’s own wife Wanda. To disguise herself, she used her maiden name Gray and her mother-in-law’s address.

Following up on her suspicion, Fink checked the National Insurance Crime Bureau® (NICB) database and discovered John Fenrich’s long and questionable insurance history. Several hits came up showing he made other claims both before and after the hit-and-run accident involving his wife. Fink sent the list of claims to NICB Senior Special Agent Phil Blessinger, who immediately warned other insurance companies about the mishaps of the mangled married couple.

Missing Body Parts Don’t Grow Back
How many staged accidents and slip and falls did the Fenrichs allegedly orchestrate? It took Mary Flynn, Postal Inspector for the US Postal Inspection Service, a full week to write the eight-page complaint detailing the incidents. The complaint was submitted to the US Attorney’s office, Eastern District of New York, June 1998.

• One of the claims involved Melinda Gray, Wanda’s sister. John stated that Melinda ran him over in her car in 1992. His reported injuries were a fractured left wrist, a lacerated left earlobe, and neck and back sprain. The claim settlement amounted to $175,000. Recently, Joseph Reilly, Senior Investigator, NYS Insurance Fraud Bureau, interviewed Melinda. In a sworn statement, she said John and Wanda purchased a 1968 Plymouth and insured it for her, then used the vehicle to stage the automobile accident.

• Fenrich again met with misfortune when he went to get the mail out of his mailbox in front of his house in 1995. A 1989 Chevrolet Cavalier driven by Michelle Vandernoth allegedly swerved and ran right into him. The injuries on the insurance claim were to his left wrist and left earlobe. Michelle, who already owed the Fenrich’s $100, said they recruited her to help them stage the accident. The $500 they paid her was nothing compared to the $35,000 they got from the insurance company to settle the claim.
• The history of allegedly filing false claims doesn’t end there. While riding his bike, Fenrich claimed to have been struck by a car backing out of a parking space at Toys R Us on Christmas Eve. He suffered an injury to his groin area; photos and an examination provided proof. The claim would appear legitimate except that it was the second time Fenrich had reported sustaining the same injury as a result of getting hit by a car while riding his bike in a parking lot at a shopping mall. Coincidence or Crime?

• Here’s an incident with conflicting reports. Fenrich tripped in the parking lot at PETCO© in 1997. The certified police report says he tripped over a storm drain and lacerated his thigh. The allegedly forged police report Fenrich submitted to the insurance company says he tripped on broken sidewalk and lacerated his leg and groin area. The insurance company denied the claim. However, Fenrich didn’t give up. He filed a lawsuit with Staller Associates, Inc., the owner of the PETCO© building, whose insurer paid him $18,000 to settle the suit.

• Wanda Fenrich allegedly played a supporting role in her husband’s staged accidents; on a few occasions, however, she took center stage. Wanda tripped when her heel got caught in holes in the sidewalks outside several fast food restaurants on Long Island. She slipped and fell through the glass entry doors and suffered multiple chest lacerations. The suspicion is Wanda may have inflicted the injuries herself before arriving at the eating establishments.

The Fenrichs allegedly filed faulty documents with many insurance companies including Allstate, Commercial Union, Crum & Forster, Geico, Greater New York Mutual Insurance, Liberty Mutual, State Farm, Travelers, Utica Mutual and Zurich Insurance.

Insurance companies, the NICB, the US Postal Inspection Service, the NYS Insurance Fraud Bureau and the Nassau County Police Department used several investigative techniques to help solve the Fenrich case. They reviewed and charted numerous claim files, interviewed accident participants and set up surveillance of the Fenrichs’ house in Dix Hills, NY.

Criminal Record Severs Any Doubt
After reviewing the Fenrichs’ prolific pattern of claims, Blessinger asked the Nassau County Police Department to run a background check on them. Here’s what they found:

In 1990, John Fenrich had been arrested in shoplifting charges. The record of his fingerprints shows only nine. The note on the card says a tenth print could not be obtained because he did not have a left little finger.

Six years later, Fenrich declared the missing pinkie on a hit-and-run insurance claim. “Because of nerve damage to the amputated finger, it is conceivable Fenrich could have cut through the skin to make it look like a new injury for the accident,” Blessinger speculates.

Investigators Uncover Insurance Scam
It was time to cripple insurance crime at the source. John and Wanda Gray Fenrich were arrested in July for their ongoing scheme to allegedly defraud insurance companies into paying phony bodily injury claims. They were charged with five counts of mail fraud. The investigation into the accidents continues.
Since the Fenrichs have been out on bail pending a preliminary hearing, the couple has been sending letters to insurance companies to withdraw their claims. For now, the only extremity John and Wanda may be cutting off is their supply of insurance money, causing severe injury to their pocketbook.

http://www.nicb.org/reportripoff/caught2.html
What is bodily injury fraud?
Bodily injury fraud occurs when someone purposely fakes or exaggerates an injury to collect insurance benefits. Common ways of faking an injury range from intentionally stumbling over a cracked sidewalk or tripping over a toy at a neighbor’s house to slipping on a wet floor at a restaurant.

Common Bodily Injury Schemes:

Slip and Fall
Slip and fall scams are among the most widely practiced types of insurance fraud. In this scenario, the claimant threatens litigation against a person or organization from a bogus injury sustained because of allegedly dangerous conditions (e.g. slippery or broken surfaces) that cause an accident to occur. Ultimately, the business’s insurance company pays for the bogus accident.

Some schemers will go to great lengths to orchestrate these phony falls. Many carry water bottles to squirt the floor and prime the pavement for the planned accident. Some will skim or even break their knuckles to make the damage from the fall look more real. Others have even shot fake blood up their nostrils with syringes to make noses look broken.

The Fake Break
Some con artists will take advantage of a new or existing injury to make a bogus claim. One scenario goes like this: A person recently broke his leg; an accomplice cuts off the cast, helps him soak his leg and drives the injured person to the hospital; they later file an illegitimate insurance claim. Others will add a past injury (like a back injury) to a new injury claim to increase the monetary size of the claim.

The Yank-Down
Some insurance perpetrators purposely pull display items or store merchandise on top of themselves and then file an injury claim resulting from the “fallen” product.

The Big Trip
Others will take advantage of a broken or obstructed sidewalk or stairway to make a bogus claim. For example, the clumsy con artist may claim to have tripped over a child’s toy left on a stairway and then sue the homeowner for damages.

The Chew and Sue
This scam involves claims against “dangerous” food products. The hungry schemer will claim that ill-prepared food caused physical injury (i.e. broken glass in a salad, chicken bone in soup) and then submit a bodily injury claim.

Most Cons Use Props to Boost Up Their Claims
“Props” are the tools some cons use to pad their claims. For example, some may claim that when they fell, they also broke their expensive camera or glasses. Sometimes, claims of past injuries are added to new claims to help boost the payback.
Quick tips to catch slip and fall artists before they tumble out the door with expensive claims:

<table>
<thead>
<tr>
<th>BUSINESSES</th>
<th>CONSUMERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Install video surveillance equipment.</td>
<td>• Contact the establishment’s manager immediately. Tell them everything you witnessed.</td>
</tr>
<tr>
<td>• Run periodic in-store safety checks daily.</td>
<td>• Report Suspected slip and fall scammers to the NICB hotline at 1-800-TEL-NICB</td>
</tr>
<tr>
<td>• Send an employee along if the injured person is taken for emergency treatment</td>
<td></td>
</tr>
</tbody>
</table>

http://www.nicb.org/reportripoff/factpages/bodilyinjuryfraud.html
Indicators of Vehicle Theft Fraud

All vehicle thefts and all sales of total loss salvage sold by your company or left in possession of the claimant at the time of total loss claim settlement should be reported to NICB. Total loss salvage should include the current and four preceding model years as well as older model years if the vehicle is an expensive sports car, a truck-tractor, or any other valuable or luxury vehicle for manual reporting companies. Electronic reporting companies should report all model years.

<table>
<thead>
<tr>
<th>Indicators of Fraud Concerning the Insured</th>
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<tbody>
<tr>
<td>Insured:</td>
</tr>
<tr>
<td>o has lived at current address less than six months</td>
</tr>
<tr>
<td>o has been with current employer less than six months</td>
</tr>
<tr>
<td>o address is a post office box or mail drop</td>
</tr>
<tr>
<td>o does not have a telephone</td>
</tr>
<tr>
<td>o listed number is a mobile/cellular phone</td>
</tr>
<tr>
<td>o is difficult to contact</td>
</tr>
<tr>
<td>o frequently changes address and/or phone number</td>
</tr>
<tr>
<td>o place of contact is a hotel, tavern, or other place which is neither his/her place of employment nor place or residence</td>
</tr>
<tr>
<td>o handles all business in person, thus avoiding the use of the mail is unemployed</td>
</tr>
<tr>
<td>o claims to be self-employed but is vague about the business and actual responsibilities</td>
</tr>
<tr>
<td>o has recent or current material and/or financial problems</td>
</tr>
<tr>
<td>o has a temporary, recently issued, or out-of-state driver’s license</td>
</tr>
<tr>
<td>o driver’s license has recently been suspended</td>
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<tr>
<td>o recently called to confirm and/or increase coverage</td>
</tr>
<tr>
<td>o has an accumulation of parking tickets on vehicle</td>
</tr>
<tr>
<td>o is usually aggressive and pressures for quick settlement</td>
</tr>
<tr>
<td>o offers inducement of quick settlement</td>
</tr>
<tr>
<td>o is very knowledgeable of claims process and insurance terminology</td>
</tr>
<tr>
<td>o income is not compatible with value of insured vehicle</td>
</tr>
<tr>
<td>o claims expensive contents in vehicle at time of theft</td>
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<tr>
<td>o is employed with another insurance company</td>
</tr>
<tr>
<td>o wants a friend or relative to pick up settlement check</td>
</tr>
<tr>
<td>o is behind in loan payments on vehicle and/or other financial obligations</td>
</tr>
<tr>
<td>o avoids meetings with investigators and/or claim adjuster</td>
</tr>
<tr>
<td>o cancels scheduled appointments with claims adjusters for statements and/or examination under oath</td>
</tr>
<tr>
<td>o has a previous history of vehicle theft claims</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator of Fraud Related to the Vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vehicle:</td>
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<tr>
<td>o was purchased for cash with no bill of sale or proof of ownership</td>
</tr>
<tr>
<td>o is a new or late model with no lien holder</td>
</tr>
<tr>
<td>o was very recently purchased</td>
</tr>
<tr>
<td>o was not seen for an extended period of time prior to the reported theft</td>
</tr>
<tr>
<td>o was purchased out of state</td>
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</tbody>
</table>
- has a history of mechanical problems
- is a “gas guzzler”
- is customized, classic, and/or antique
- displayed “for sale” signs prior to theft
- was recovered clinically/carefully stripped
- is parked on street although garage is available
- was recovered stripped, but insured wants to retain salvage, and repair appears to be impractical
- is recovered by the insured or a friend
- purchase price was exceptionally high or low
- was recovered with old or recent damage and coverage was high deductible or no collision coverage
- coverage is only on a binder
- VIN is different than VIN appearing on the title
- VIN provided to police is incorrect
- safety certification label is altered or missing
- safety certification label displays different VIN than is displayed on vehicle
- has theft and/or salvage history
- is recovered with no ignition or steering lock damage
- is recovered with seized engine or blown transmission that was previously involved in a major collision
- is late model with extremely high mileage (exceptions: taxi, police, utility vehicles)
- is older model with exceptionally low mileage (e.g. odometer rollover/rollback)
- is older or inexpensive model and insured indicates it was equipped with expensive accessories which cannot be substantiated with receipts
- is recovered stripped, burned, or has severe collision damage within a short duration of time after loss allegedly occurred
- leased vehicle with excessive mileage for which the insured would have been liable under the mileage limitation agreement

### Indicators of Fraud Related to Coverage
- Loss occurs within one month of issue or expiration of the policy
- Loss occurs after cancellation notice was sent to insured
- Insurance premium was paid in cash.
- Coverage obtained via walk-in business to agent.
- Coverage obtained from an agent not located in close proximity to insured’s residence or work place.
- Coverage is for minimum liability with full comprehensive coverage
- on late model and/or expensive vehicle.
- Coverage was recently increased.

### Indicators of Fraud Related to Reporting
- Police report has not been made by insured or has been delayed.
- No report or claim is made to insurance carrier within one week after theft.
- Neighbors, friends, and family are not aware of loss.
- License plate does not match vehicle and/or is not registered to insured.
- Title is junk, salvage, out-of-state, photocopied, or duplicated.
- Title history shows non-existent addresses.

*Ethics and Fraud ● Page 52*
o Repair bills are consecutively numbered or dates show work accomplished on weekends or holidays.
o An individual, rather than a bank or financial institution, is named as the lien holder.

<table>
<thead>
<tr>
<th>Other General Indicators of Vehicle Theft Fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Vehicle is towed to isolated yard at owner’s request.</td>
</tr>
<tr>
<td>o Salvage yard or repair garage takes unusual interest in claim.</td>
</tr>
<tr>
<td>o Information concerning prior owner is unavailable.</td>
</tr>
<tr>
<td>o Prior owner cannot be located.</td>
</tr>
<tr>
<td>o Vehicle is recovered totally burned after theft.</td>
</tr>
<tr>
<td>o Fire damage is inconsistent with loss description.</td>
</tr>
<tr>
<td>o VINs were removed prior to fire.</td>
</tr>
</tbody>
</table>
Indicators of Workers Compensation Fraud

<table>
<thead>
<tr>
<th>The Claimant, Prior Claim History and Current Work Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Employee is disgruntled, soon-to-retire, or facing imminent firing or layoff.</td>
</tr>
<tr>
<td>o Employee is involved in seasonal work that is about to end.</td>
</tr>
<tr>
<td>o Employee took unexplained or excessive time off prior to claimed injury.</td>
</tr>
<tr>
<td>o Employee takes more time off than the claimed injury seems to warrant.</td>
</tr>
<tr>
<td>o Employee is nomadic and has a history of short-term employment.</td>
</tr>
<tr>
<td>o Employee is new on the job.</td>
</tr>
<tr>
<td>o Employee is experiencing financial difficulties and/or domestic problems prior to submission of claim.</td>
</tr>
<tr>
<td>o Employee recently purchased private disability policies.</td>
</tr>
<tr>
<td>o Employee changes physician when a release from work has been issued.</td>
</tr>
<tr>
<td>o Employee has a history of reporting subjective injuries.</td>
</tr>
<tr>
<td>o Review of a rehab report describes the employee as being muscular, well tanned, with callused hands and grease under the fingernails.</td>
</tr>
<tr>
<td>o First notification of injury or claim made after employee is terminated or laid off.</td>
</tr>
<tr>
<td>o Disputes the average weekly wage due to additional income (i.e. cash, per diem and/or 1099 income).</td>
</tr>
<tr>
<td>o Has several other family members also receiving workers’ compensation benefits or other “social insurance” benefits, i.e., unemployment.</td>
</tr>
<tr>
<td>o Demands quick settlement decisions or commitments.</td>
</tr>
<tr>
<td>o Demands quick payments for medical providers, etc..</td>
</tr>
<tr>
<td>o Is unusually familiar with workers’ compensation claim handling procedures and laws.</td>
</tr>
<tr>
<td>o Is consistently uncooperative.</td>
</tr>
<tr>
<td>o Surveillance or “tip” indicates that the totally disabled worker is currently employed elsewhere.</td>
</tr>
<tr>
<td>o Employee has submitted substantial material misrepresentation on the employment application.</td>
</tr>
<tr>
<td>o Employee comes to office for delivery of benefit checks, avoids use of U.S. mail.</td>
</tr>
<tr>
<td>o Employee refuses to allow visits or rehabilitation at home or specifies plenty of warning time prior to a visit.</td>
</tr>
<tr>
<td>o Employee participates in contact sports or physically demanding hobbies.</td>
</tr>
<tr>
<td>o After injury, employee is never home or spouse/relative answering phone states the employee just stepped out,” or may have to contact him/her by pager.</td>
</tr>
<tr>
<td>o Return calls to residence have strange or unexpected background noises which indicate that it may not be a residence.</td>
</tr>
<tr>
<td>o Employee protests about returning to work and never seems to improve.</td>
</tr>
<tr>
<td>o Employee cancels or fails to keep appointment, or refuses a diagnostic procedure to confirm an injury.</td>
</tr>
<tr>
<td>o Employee complains to carrier’s CEO or executive management at home office to press for payment.</td>
</tr>
<tr>
<td>o Social Security number provided does not belong to employee.</td>
</tr>
<tr>
<td>o Applicant refuses or cannot produce solid or correct identification.</td>
</tr>
<tr>
<td>o Employee’s family member(s) know nothing about the claim.</td>
</tr>
</tbody>
</table>
Circumstances of the Accident

- Accident occurs late Friday afternoon or shortly after the employee reports to work on Monday.
- Accident is not witnessed, or witnesses to the accident conflict with the applicant’s version or with one another.
- Employee has leg/arm injuries at odd time, e.g. at lunch hour.
- Fellow workers hear rumors circulating that accident was not legitimate.
- Accident occurs in an area where injured employee would not normally be.
- Accident is not the type that the employee should be involved in, i.e., an office worker who is lifting heavy objects on a loading dock.
- Accident occurs just prior to a strike, or near the end of probationary period.
- Employer’s first report of claim contrasts with description of accident set forth in medical history.
- Details of accident are vague or contradictory, inconsistent, and are not credible.
- Incident is not promptly reported by employee to supervisor.

Medical Treatment

- Diagnosis is inconsistent with treatment.
- Physician is known for handling suspect claims.
- Treatment for extensive injuries is protracted though the accident was minor.
- “Boilerplate” medical reports are identical to other reports from same doctor, do not identify by gender or get gender wrong.
- Workers’ compensation insurer and health carrier are billed simultaneously; payment is accepted from both.
- Summary medical bills submitted without dates or descriptions of office visits.
- Medical bills submitted are photocopies of originals.
- Extensive or unnecessary treatments for minor, subjective injuries.
- Treatment directed to a separate facility in which the referring physician has a financial interest (especially if this is not disclosed in advance).
- Referrals for treatment/testing to facility close to referring facility.
- Injuries are all subjective, e.g. pain, headaches, nausea, inability to sleep.
- Treatment dates appear on holidays or other days that facilities would not normally be open.
- Employee is immediately referred for a wide variety of psychiatric tests, when the original claim involved trauma only. These claims usually present with vague complaints of “stress.”
- Inappropriate expensive medical equipment prescribed for minor injury.
- Alleged injury relates to a pre-existing injury or health problem.

The Claimant’s Attorney

- Attorney becomes involved early in the claims process.
- Attorney is known for handling suspicious claims.
- Attorney lien or representation letter dated the day of the reported incident.
- Attorney threatens further legal action unless a quick settlement is made.
- Attorney inquires about a settlement or a buy out early in the life of the claim.
- Employee initially wants to settle with insurer, but later retains an attorney with increased subjective complaints.
- High incidence of applications from a specific firm.
- Pattern of occupational type claims for “dying” industries, i.e., black lung, asbestosis;

Ethics and Fraud ● Page 55
wholesale claim handling by law firms and multiple class action suits.
- Same doctor/lawyer pair previously observed to handle this kind of injury
- Employee receives all mail by and through his attorney.

Indicators of Workers Compensation Premium Fraud

<table>
<thead>
<tr>
<th>Indicators Associated with the Claims Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>o  The employee’s injuries are not consistent with the employee’s job classification or the nature of the business.</td>
</tr>
<tr>
<td>o  The employee’s listed occupation is inconsistent with employer’s stated business.</td>
</tr>
<tr>
<td>o  The employee disputes information supplied by the employer on the first report of injury.</td>
</tr>
<tr>
<td>o  The employee’s work address is different from the principal location shown in employer’s records.</td>
</tr>
<tr>
<td>o  The employee states that his/her employer is other than what is listed on the claim form.</td>
</tr>
<tr>
<td>o  The employee files for benefits in a state not endorsed on the policy.</td>
</tr>
<tr>
<td>o  The employee disputes the average weekly wage due to additional income (i.e., cash, per diem, and/or 1099 income).</td>
</tr>
<tr>
<td>o  Addition of many locations of DBAs on a small policy.</td>
</tr>
<tr>
<td>o  There are cross-outs and erasures on the injury forms.</td>
</tr>
<tr>
<td>o  Neither the employee nor the employer can be contacted at the principal location.</td>
</tr>
<tr>
<td>o  The employer refuses to cooperate in the claims investigation; refuses to provide employee with claim form.</td>
</tr>
<tr>
<td>o  The employer will not confirm wage information with documentation.</td>
</tr>
<tr>
<td>o  The employer has a history of “fighting” claims.</td>
</tr>
<tr>
<td>o  Employer’s accounts of accidents are routinely inconsistent with employees’ accounts, or employer’s version of the accident is not credible.</td>
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<tr>
<td>o  Employer’s witnesses to the accident are generally management personnel.</td>
</tr>
<tr>
<td>o  Accounts of independent witnesses to the accident differ from those of the employer.</td>
</tr>
<tr>
<td>o  Employee witnesses to the accident are pressured, threatened or intimidated by the employer.</td>
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<tr>
<td>o  The employer is routinely cited for safety violations.</td>
</tr>
<tr>
<td>o  The employer’s “independent” doctors routinely allege fraud.</td>
</tr>
<tr>
<td>o  Claims are received for classification codes that are not on the application and have not been added by endorsement.</td>
</tr>
<tr>
<td>o  A representative sample of injuries for classification codes indicates the claimant count of an employer is inconsistent with the employee count.</td>
</tr>
<tr>
<td>o  Employer claiming “independent contractor” status of employees.</td>
</tr>
<tr>
<td>o  Employer paying medical bills and not reporting injuries.</td>
</tr>
<tr>
<td>o  Numerous Certificates of Insurance on a small policy or claims reported on a Certificate of Insurance policy only.</td>
</tr>
<tr>
<td>o  The employee’s home address is a significant distance from the principal location (an unreasonable commute).</td>
</tr>
<tr>
<td>o  Contractors try to obtain a policy using a DBA other than the exact name on the license.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of Agent Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>o  Carrier review of policy reveals application is inaccurate.</td>
</tr>
<tr>
<td>o  Employee leasing firm reports a lower payroll than the previous employer.</td>
</tr>
<tr>
<td>o  Classification of individual employees is changed to a lower classification.</td>
</tr>
<tr>
<td>o  Agent requests to be present at an audit.</td>
</tr>
</tbody>
</table>

*Ethics and Fraud ● Page 57*
An audit or negotiable instrument review indicates premium dividend checks or premium refund checks were endorsed or negotiated by someone other than the named payee.

### Indicators Associated with an Audit

- Insured refuses or delays access to the premises for safety inspection or audit.
- An excessive volume of records is provided to overwhelm the auditor.
- Location visited is the same address as a different risk.
- Business logos are not present at audit location.
- Letterheads allow insured or producer to choose which entity he/she is representing.
- There is no permanence to the operation.
- Literature, publications or pictures appear consistent with the represented operations.
- Records are kept at a location other than the location where the auditor is asked to perform the audit.

### Indicators Associated with an Audit Payroll

- Cannot verify accuracy of the records.
- Payroll records are not disclosed for employees who file claims.
- Wages listed exceed estimates on the application.
- Audited payroll substantially exceeds estimated payroll.
- Payroll is inconsistent with certificates issued.
- Names of claimants are listed on W-2 forms.
- Payroll for first quarter results exceeds estimated payrolls.
- Small payroll submitted by large contractor or employee leasing operation.
- Payroll figures are reported which disagree with payroll reported to other entities, i.e., taxes.
- Audit findings result in employer paying large additional premium assessments.

### Indicators Associated with an Audit Application

- Unusual change of business ownership.
- Documents that have obviously been created or altered without proper forms.
- Documents with entries in improper places or otherwise completed in a manner that does not make sense.
- Poor-quality document photocopies which should be original or bear original signatures.

### Indicators Associated with an Audit Misclassification of Employees

- Industrial or construction enterprises with a work force reported primarily in low rate categories.
- Information received from workers or other insiders that employees are misclassified.

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What is workers compensation?
Workers compensation is a no-fault method of paying workers for medical expenses and wage loss due to on-the-job injuries – no matter what the cause of the injury.

Workers compensation laws vary with each state. Most states require 100 percent payment of medical and rehabilitation expenses for employees injured on the job and up to two-thirds wage-loss benefits (tax-free) while unable to work. In some states, the worker will receive job retaining and, in case of death, benefits for their families.

How does workers compensation fraud affect businesses?
False and exaggerated claims and premium fraud are making workers compensation fraud the fastest growing segment of insurance fraud.

The NICB estimates workers compensation fraud costs the insurance industry approximately $5 billion annually.

Workers compensation fraud also costs American businesses billions of dollars each year in higher premiums and hidden expenses, such as:

- production delays
- retraining costs
- equipment replacement costs

In some instances, businesses have been forced to relocate to another state. Unable to afford the rising cost of insurance for their employees, some companies permanently close their doors.

How does workers compensation fraud affect employees?
Employees, the group most likely to abuse the workers compensation system, also feel the effects from fraud in:

- layoffs
- raise or new-hire freezes
- company relocation
- cutback in work hours
- employer bankruptcy

How does workers compensation fraud affect consumers?
Simple, employers increased premium costs mean consumers pay higher prices for goods and services.

http://www.nicb.org/reportripafflfactpages/workerscomfraudoverview.html
Fighting Workers Compensation Fraud; Red Flags

By James Bond, L.E. Bond Investigations of California

The following represents material compiled from various sources including the California Department of Insurance, Alameda County District Attorneys, as well as from our own files.

Attorney Fraud
Such fraud arises when attorneys knowingly participate in the misrepresentation of the truth in order to either secure or deny compensation for their clients and/or themselves.

Examples:
- Knowingly assisting a client in pursuing a false claim.
- Soliciting a person to file a false claim.
- Knowingly pursuing collection of a lien the attorney knows to be fraudulent
- Related criminal acts that feed fraud, such as accepting consideration from or paying consideration to doctors, vendors, cappers, or other for referral of clients or settlement of cases.

Red Flags:
- The majority of claims in which a law firm is involved are of a highly questionable nature
- A letter of representation is received, but the applicant denies representation or meeting with the attorney
- In what is referred to as solicitation fraud, several employees from the same employer have reported similar injuries and are represented by the same law firm.

Adjuster Fraud
This occurs when a claims person purposely misrepresents the truth in order to either deny or support a claim; or offers or accepts any form of consideration for the referral or settlement of a claim.

Examples:
- Accepting a gift, such as a television or trip to Hawaii, from a doctor’s office in exchange for an implied promise or patient referrals.
- Knowingly referring cases for rehabilitation services that are not needed, in exchange for a rebate or other form of consideration
- Altering the evidence in a claim in order to support a denial.
Red Flags:
- Inconsistent application of cost-containment measures or agreement to pay above the fee schedule.
- Sloppy observance of procedure for referrals to outside vendors, or increase in the use of a particular vendor to the exclusion of others.
- Use of vendors outside the pre-approved vendor panel.
- Assignments made to vendors where the need for the assignment is questionable.
- Adjuster has social relationship with an applicant’s attorney or doctor.
- Adjuster is overheard soliciting, or is observed receiving, tickets or other gifts from vendors.
- Adjuster’s lifestyle grossly exceeds apparent income.

Employer Fraud
There are two types of employer fraud in workers’ compensation: that which is claims-related and that which involves policy premiums. This is an area where others outside the claims function - premium auditors, for example - also need to be vigilant for suspicious activity.

Employer-claims fraud occurs when an employer knowingly misrepresents the truth in order to avoid, deny, or obtain compensation on behalf of employees; or knowingly lies about entitlement to benefits to discourage an injured employee from pursuing a claim.

Employer-premium fraud occurs when an employer knowingly lies in order to obtain a workers’ compensation insurance policy at less than the proper rate.

Examples:
- Misrepresenting the risk or exposure for a given insured by underreporting payroll; misclassifying payroll; reporting an injury under insured company “A” when in fact the injured employee was an employee of uninsured company “B”; lying about the company ownership to avoid a high-experience modification.
- Employer tells the employee that the workers’ compensation benefits are available only if employee is off six months or more following an injury.

Workers Compensation Claim Red Flags
These Red Flags serve only to alert as to the possibility of fraud. The presence of any one by itself is not necessarily indicative of fraud, but it is a clue or lead to be further investigated for potential fraud.

- The injured worker is a new hire.
- The alleged injury occurs prior to or just after a strike, layoff, plant closure, job termination, completion of seasonal or temporary work, or notice of employer relocation, and so on.
- Applicant reports an alleged injury immediately following disciplinary action, notice of probation, demotion, or being passed over for promotion.
- Applicant has a history of personal injury, workers’ compensation claims, and/or of reporting “subjective” injuries.
- Applicant’s job history shows many jobs held for fairly short periods of time.
- The alleged injury relates to a preexisting injury or health problem.
- Applicant uses addresses of friends, family, or post office boxes; has no known permanent address and moves frequently.
- Applicant’s family members know nothing about the claim.
- Applicant was experiencing financial difficulties and/or domestic problems prior to submission of claim.
- Applicant has a high-risk activity, such as skydiving, or bungee jumping as a hobby.
- The applicant’s version of the accident has inconsistencies, is not credible.
- There are no witnesses to the accident or witnesses to the accident conflict with the applicant’s version or with one another.
- Applicant fails to report the injury in a timely manner.
- Accident or type of injury is unusual for the applicant’s line of work.
- Facts regarding accident are related differently in various medical reports, statements, and employer’s first report of injury.
- The Social Security Number provided does not belong to the applicant.
- Applicant refuses to or cannot produce solid or correct identification.
- Applicant avoids the use of US Mail; hand-delivers documents.
- Applicant cannot be reached at home during working hours although claims to be disabled from working; or message taker are vague and non-committal. Applicant is otherwise unavailable and elusive.
- Applicant’s lifestyle does not coincide with reported known income.
- Several applicant family members are receiving workers’ compensation, unemployment, Social Security, welfare, etc. income from workers’ compensation and collateral sources (unemployment, Social Security, long-term disability, etc.) meet or exceed wages after taxes.
- Applicant refuses diagnostic procedures to confirm injury, or refuses to attend a scheduled defense medical exam.
- Applicant’s co-workers express opinion that injury is not legitimate.
- Alleged injuries are all subjective, e.g. soft-tissue, pain, and emotional injuries.
- Applicant changes version of accident after learning of inconsistencies, misrepresentation or fabrication by any party.
- Applicant frequently changes physicians, or does so after being released to return to work.
- Physical description of applicant indicates muscular, well-tanned individual, with callused hands, grease under fingernails, or other signs of active work.
- Medical treatment is inconsistent with injuries originally alleged by employee.
- Applicant undergoes excessive treatment for soft tissue injuries.
- Treatment as reported by applicant is different from doctor’s statement in medical report.
- Applicant is examined by several doctors when one doctor could have taken all the information and reached a diagnosis.
- Applicant reports seeing a doctor for a very brief period of time; however, reports and billing indicates a lengthy visit.
- Applicant’s description of treatment indicates non-medical personnel rendering medical treatment.
- Applicant sends in medicals or reports that appear to be altered.
- Applicant lives far from medical facility, yet receives frequent treatment.
- Surveillance shows applicant’s activities are inconsistent with physical limitations related in medical reports and deposition.
• Surveillance or “tip” reveals totally disabled worker is employed elsewhere (especially suspicious if employment conflicts with work restrictions given by treating doctor).
• Applicant cannot describe either diagnostic tests or treatment for which employer was billed.
• The doctor ordered diagnostic testing that is not necessary to determine extent of applicant’s injury, or, diagnostic testing is performed, yet there is no request by doctor in medical files.
• Diagnostic tests are performed by a vendor not in close proximity to doctor’s office or applicant’s home, vendor uses post office boxes on all documents, or cannot supply diagnostic records.
• Doctor or medical clinic has ownership share in diagnostic group.
• Various reports by a doctor on different applicants’ cases read identically or similarly.
• Post office box used for a clinic/doctor address, instead of street address.
• Medical reports appear to be second or third-generation photocopies.
• Physician cannot be located at address shown on documentation.
• Doctor’s report never identifies claimant by gender or gets gender wrong.
• New or additional medical problems are alleged and attributed to the original injury.
• Specific “soft tissue” injury develops psychiatric overtones.
• Medical reports contain inaccurate terminology, spelling errors, variations in physician’s signature or are rubber-stamped with the doctor’s name.
• Medical facility uses multiple names or changes name often.
• RVS/CPT (Relative Value Scale/Current Procedural Terminology) codes show evidence of upgrading level of services.
• Billings are received for unnecessary or services not rendered.
• Medical facility has consistently billed both workers’ compensation carrier and auto, health, etc., insurance carrier, receiving payments from both.
• Applicant is unable to define medical ailments as listed on claim form.
• Lawyer’s letter or representation letter from medical clinic is first notice of claim.
• The lawyer’s letter is dated the same day as the reported incident or shortly thereafter.
• There is a repeated pattern of doctor/attorney referrals; the same doctor and attorney work together on a large volume of claims.
• Applicant states that a “friend”, whose name is no longer remembered, provided reference to attorney/clinic.
• Applicant alleges doctor or clinic found through a “hot line.”
• Applicant is overly pushy, demanding a quick settlement, commitment, or decision.
• Applicant is unusually familiar with claims-handling procedures, workers’ compensation rules, and proceedings.

Pursuing Red Flags
“Red Flags” do not automatically translate into guilt, but are indicators of potential fraud. They need to be followed up and, when appropriate, the SIU personnel in your organization should be consulted.

Remember what it takes to prove criminal wrongdoing, and always ask yourself these following questions when you suspect fraud:

• What was the lie?
• Was it knowingly or intentionally made?
• Was it made for the purpose of either obtaining or denying benefits, or (in the case of suspected premium fraud) for obtaining a policy of insurance at less than the proper rate?
• How is it material to the outcome?

James E. Bond is a licensed California private investigator whose firm, J.E. Bond Investigations, specializes in complex insurance defense investigations.

http://www.pimall.com/nais/n.ins.bond.html
Wheaton, IL — America’s property and casualty insurance companies are accelerating their assault on insurance fraud by expanding their fraud detection and deterrence programs as well as allocating significantly more money for these programs, according to a new study by the Insurance Research Council.

The Coalition Against Insurance Fraud reported in 2004 that the 2001-2002 State Fraud Bureaus reported that Criminal convictions increased 31 percent. Cases presented for prosecution rose 14 percent. Investigations initiated increased by nearly 18 percent. Referrals of suspected fraudulent actions were up 4.5 percent.

“The dramatic increase in the insurance industry’s fraud control efforts reflects the growing dimensions of the problem, the many benefits of aggressive anti-fraud initiatives, and public support for a tougher stance on fraud by insurers and law enforcement,” said Tern Troxel, IRC executive director.

The Insurance Research Council-Insurance Services Office reported in 2002 that more than two of five property-casualty insurers have increased spending to fight fraud over the last three years. More than four of five insurers have formal anti-fraud programs. About 11-30 cents — or more — of every claim dollar is lost to “soft” fraud (smalltime cheating by normally honest people), nearly half of property-casualty insurance companies say. Hardcore scams steal only a small fraction of that money.

Key factors contributing to the success of insurers in detecting fraud were identified as training, SIU investigations, centralized claims index databases, and the support of claims management — in that order of importance.

Public awareness, criminal fraud penalties, SIU investigations and training were cited as most critical to preventing fraud.

More than one-half of the responding companies also said they have broadened the scope of their efforts by implementing anti-fraud public information programs.

Various organizations have estimated all insurance fraud to cost insurance companies and their customers between $20 to $30 billion each year, or as much as $300 per American household.

Troxel cited a recent IRC closed claim study which found that one-third of auto accident injury claims appear to involve some form of fraud or claim padding.

He said the vast majority of claims with the appearance of fraud and claim buildup involve the exaggeration of injuries, medical treatment, wage loss, or some other element of the claim as a

*Ethics and Fraud ● Page 65*
result of a real accident. And while few claims appear to involve fake or staged accidents, excess payments that are attributable to claim buildup and/or staged accidents impose large costs on insurers and their customers.

Troxel also notes that the public has expressed increasing support for more aggressive efforts to combat fraud. A 1996 IRC study found that about 75 percent of the public was willing to pay one extra dollar on their auto insurance premium to investigate and prosecute insurance criminals, up from 66 percent in a similar 1991 survey.

In addition, 76 percent favored encouraging insurance companies to investigate claims more thoroughly for potential fraud before making payments – even if this delays legitimate payments, according to Troxel.

The findings are published in the IRC’s Fighting Fraud in the Insurance Industry. The Insurance Research Council is an independent, not-for-profit organization founded by leading property-casualty insurers, IRC provides timely and reliable information to all parties involved in public policy issues affecting insurance companies and their customers. The IRC does not lobby or advocate legislative positions.


Coalition Against Insurance Fraud

CONSUMER TIPS

How to avoid being victimized by insurance fraud

The extent of insurance fraud is difficult to quantify because much of it goes undetected. Insurance fraud cost each American family an estimated $1,000 a year. These are direct costs that raise the price of health insurance premiums, auto and homeowners premiums, and increases the price you pay for goods and services — an estimated total of $85 billion. In addition, insurance fraud scams steal the premiums consumers pay and leave them with unpaid claims, sometimes leading to financial ruin. These tips can help consumers avoid being taken in by fraud perpetrators:

• When purchasing insurance, contact the state insurance department to make sure insurance company is licensed and covered by the state’s guaranty fund, which pays claims in case of default.
• Be wary about buying insurance from door-to-door or telephone sales people.
• Find out how the insurer’s creditworthiness is rated by agencies such as Standard & Poor’s, AM Best Co. or Moody’s Investors Service. Most public libraries have copies of these reports.
• Make sure you receive a written policy within 60 days after you paid your first premium. That ensures that the agent forwarded the premium to the company.
• Never sign blank insurance claim forms.
• Ask for detailed bills for all services. Carefully check them for accuracy. Be sure you actually received the service or medical treatment listed. Watch for double-billing or unexplained excess charges.
• Be sure that “free” services really are free of charge and not hidden somewhere in the insurance bill.
• Be wary if, after any kind of accident, a stranger contacts you to offer “quick cash” or to recommend a particular medical clinic, doctor or attorney. They could be part of a fraud ring.
• Protect you insurance identification numbers as you would a credit card number.
• Carry a disposable camera in your glove compartment. If you’re in an accident, take as many pictures of the damage and all the people in the other car(s) as you can. Get the passengers’ names and telephone numbers along with the driver’s.
• If you suspect fraud, call the National Insurance Crime Bureau’s hotline at (800) TEL-NICB (635-6422)
§ 85.8 Exception

Notwithstanding the provisions of section 85.1 of this Part, an application for a determination that an aircraft acquired before the effective date of section 70(10-a) and before the effective date of this Part shall be allowed as an aircraft admitted asset if, not later than 45 days after the effective date of this Part an application for such determination is filed with the superintendent for prior written approval. The admitted asset value shall be allowed in the December 31, 1977 and subsequent annual statements, and shall be based upon the depreciated cost permitted by section 85.4 of this Part calculate from the date of purchase.

Stat Authority-Insurance Law, §§ 10, 21, 70.


Parallel Citation-Regulation 80.

PART 86. REPORTS OF SUSPECTED INSURANCE FRAUDS TO INSURANCE FRAUDS BUREAU; REQUIRED WARNING STATEMENTS

(Regulation 95)

§ 86.1 Introduction

This Part is hereby promulgated to establish procedures to effectuate the purposes of the Insurance Frauds Prevention Act (Chapter 720 of the Laws of 1981).

Stat. Authority.-insurance Law, §§ 10, 21; art. ill-B, §§ 38-b(S), 38-d.


Parallel Citation-Regulation 95.

§ 86.2 Definitions

The following shall govern the construction of the terms used in this Part:

A) “Claimant” means any person who attempts to obtain a benefit it from an Insurer.

B) “Commercial insurance” means insurance other than personal insurance.

C) “Insurance policy” has the meaning assigned to insurance contract by section 1101 of the Insurance Law, except it shall also include reinsurance contracts, purported insurance policies and purported reinsurance contracts.
D) “Insured” means the named insured, as defined in the policy, or an applicant for insurance.
E) “Insurer” means an insurer authorized to do an insurance business in this state including any organization exempted from compliance with the licensing requirements by the Insurance Law which is engaged in the business of insurance in this state. For the purposes of this Part, The Motor Vehicle Accident Indemnification Corporation, the New York Automobile Insurance Plan, the New York Property Insurance Underwriting Association, the Medical Malpractice Insurance Association and the underwriting members of the New York Insurance Exchange, Inc. shall be deemed insurers.
F) “Person” includes any individual, firm association or corporation.
G) “Personal insurance” means a policy of insurance insuring a natural person against any of the following contingencies:
   1) loss of or damage to real property used predominantly for residential purposes and which consists of not more than four dwelling units, other than hotels, motels and rooming houses;
   2) loss of or damage to personal property which is not used in the conduct of a business;
   3) losses or liabilities arising out of the ownership, operation or use of a motor vehicle, predominantly used for non-business purposes;
   4) other liabilities for loss of, damage to or injury to persons or property, not arising from the conduct of a business; and
   5) death, including death by personal injury, or the continuation of life, or personal injury by accident, or sickness, disease or ailment, excluding insurance providing disability benefit its pursuant to article 9 of the Workers’ Compensation Law.
A policy of insurance which insures any of the contingencies listed in paragraphs (1) through (5) of this subdivision as well as other contingencies shall be personal insurance if that portion of the annual premium attributable to the listed contingencies—exceeds that portion attributable to other contingencies.
A) “Statement” includes, but is not limited to, any notice, proof of loss, bill of lading, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical provider records, X-ray, test result and other evidence of loss, injury or expenses.
B) Claim form includes any document supplied by an insurer, directly or indirectly, to a claimant and which the claimant is required to complete or submit in support of a claim for benefits.

Stat. Authority.-insurance Law, § 10, 21; art III-B, II—b(3), 38-d.

Parallel Citation—Regulation 95.

Revised, 1994-1
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§ 86.3 Applicability

The provisions of this Part shall apply to all kinds of insurance authorized by section 1113(a) of the Insurance Law.
Stat. Authority.—insurance Law, §§ 10, 21; art. III-B, § I 38—b(3), 38-d.
586.4 Warning statements

A) All applications provided to applicants for non-automobile commercial insurance and all claim forms for insurance delivered to any person residing or located in this state on and after February 2, 1994 in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

All claim forms for personal automobile insurance delivered to any person residing or located in this State on and after February 2, 1994 in connection with policies of personal automobile insurance and claims arising under policies of such insurance shall contain the following statement.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.”

B) Location of warning statements and type size.

1) The warning statements required by subdivisions (a), (b) and (d) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size. On claim forms which require execution by a person other than the claimant, or in addition to the claimant, the warning statement required by subdivisions (a), (b) and (d) of this section shall be placed at the top of the first page of the claim form or on the page containing instructions, either in print, by stamp or by attachment and shall be in type size which will produce a warning statement of conspicuous size.

2) Notwithstanding the provisions of paragraph (1) of this subdivision, insurers may affix the warning statements required by this Part to all application and claim forms by means of labels and/or stamps during the period from February 2, 1994 to July 31, 1994. Notwithstanding the provisions of subdivisions (a) and (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.

Stat. Authority.-Insurance Law, §§ 10, 21; art 111-B, §§ 38-b(S), 38-d.
§ 86.5 Reports of fraudulent acts

Any person licensed pursuant to the provisions of the Insurance Law who determines that an insurance transaction or purported insurance transaction appears to be fraudulent or suspect shall submit a report thereon to the Insurance Frauds Bureau. Reports shall be submitted on the prescribed reporting form (IFB-l) contained in this section or upon the form developed by the United States Department of Justice upon a determination that a matter is suspect. The forms annexed hereto are hereby approved for use as specified in this Part.


§ 86.6 Separability provision

If any provision of this Part or the application thereof to any person or circumstance is held unauthorized by law, the remainder of this Part and application of such provision to other persons or circumstances shall not be affected thereby.

Stat. Authority.-insurance Law, §§ 10, 21; art Ill-B, §§ 38-b(3), 38-d.


PENAL LAW Article 176 INSURANCE FRAUD

ss176.0 Insurance fraud; definition of terms. The following definitions are applicable to this article:

1) “Insurance policy” has the meaning assigned to insurance contract by subsection (a) of section one thousand one hundred one of the insurance law except it shall include reinsurance contracts, purported insurance policies and purported reinsurance contracts.

2) “Statement” includes, but not limited to, any notice, proof of loss, bill of lading, invoice, amount, estimated of property damages, bill of services, diagnosis, prescription, hospital or doctor records, x-ray, test result, and other evidence of loss, injury or expense.

3) “Person” includes any individual, firm, association or corporation.

4) “Personal insurance” means a policy of insurance insuring a natural person against any of the following contingencies:

a) loss of or damage to real property used predominantly for residential purposes and which consists of not more than four dwelling units, other than hotels, motels and rooming houses;

b) loss of or damage to personal property which is not used in the conduct of a business;

c) losses or liabilities arising out of the ownership, operation, or use of a motor vehicle, predominantly used for non-business purposes;
e) other liabilities for loss of, damage to, or injury to persons or property, not arising from the conduct of a business;
f) death, including death by personal injury, or the continuation of life, or personal injury by accident, or sickness, disease or ailment, excluding insurance providing disability benefits pursuant to article nine of the workers’ compensation law.

A policy of insurance which insures any of the contingencies listed in paragraphs (a) through (e) of this subdivision as well as other contingencies shall be personal insurance if that portion of the annual premium attributable to the listed contingencies exceeds that portion attributable to other contingencies.

1) “Commercial insurance” means insurance other than personal insurance, and shall also include insurance providing disability benefits pursuant to article nine of the workers’ compensation law, insurance providing workers’ compensation benefits pursuant to the provisions of the workers’ compensation law and any program of self insurance providing similar benefits.

ss176.05 Insurance fraud; defined.

A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, self insurer, or purported insurer, or purported self insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of a commercial insurance policy, or certificate or evidence of self insurance for commercial insurance or commercial self insurance, or a claim for payment or other benefit pursuant to an insurance policy or self insurance program for commercial or personal insurance which he know to: (I) contain materially false information concerning any fact material thereto (ii) conceal, for the purpose of misleading information concerning any fact material thereto.

ss176.10 Insurance fraud in the fifth degree

A person is guilty of insurance fraud in the fifth degree when he commits a fraudulent insurance act.

Insurance fraud in the fifth degree is a class A misdemeanor.

ss1760.15 Insurance fraud in the fourth degree

A person is guilty of insurance fraud in the fourth degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one thousand dollars.

Insurance fraud in the fourth degree is a class E felony.

ss176.20 Insurance fraud in the third degree

A person is guilty of insurance fraud in the third degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of three thousand dollars.

Insurance fraud in the third degree is a class D felony.
ss176.25 Insurance fraud in the second degree

A person is guilty of insurance fraud in the second degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of fifty thousand dollars.

Insurance fraud in the second degree is a class C felony.

ss176.30 Insurance fraud in the first degree

A person is guilty of insurance fraud in the first degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one million dollars.

Insurance fraud in the fist degree is a class B felony.

ss176.35 Aggravated insurance fraud

A person is guilty of aggravated insurance fraud in the fourth degree when he commits a fraudulent insurance act, and has been previously convicted within the preceding five years of any offense, an essential element of which is the commission of a fraudulent insurance act.

Aggravated insurance fraud in the fourth degree is a class D felony.

ss114. Penalties for fraudulent practices

1) Any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer or purported insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of or the rating of an insurance policy for compensation insurance, or a claim for payment or other benefit pursuant to a compensation policy which he or she knows to: (I) contain a false statement or representation concerning any fact material thereto; or (ii) omits any fact material thereto, shall be guilty of a class E felony. Upon conviction, the court in addition to any other authorized sentence, may order forfeiture of all rights to compensation or payments of any benefit, and may also require restitution of any amount received as a result of a violation of this subdivision.

2) An employer or carrier, or any employee, agent, or person acting on behalf of an employer or carrier, who knowingly makes a false statement or representation as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such benefit or payment shall be guilty of a class E felony.

3) A person who knowingly makes a false statement or representation as to a material fact for the purpose of obtaining, maintaining or renewing insurance under this chapter, whether for himself or herself or for any other person or entity or for the purpose of evading the requirements of section fifty shall be guilty of a class E felony. In addition to any other remedy, the carrier providing insurance shall be entitled to restitution of any amount obtained or withheld as a result of a violation of this subdivision.

4) Consistent with the provisions of the criminal procedure law, in any prosecution alleging a violation of subdivision one, two or three of this section in which the act or acts alleged may also constitute a violation of the penal or other ~w, the prosecuting official may charge a person pursuant to the provisions of this section and in the same accusatory instrument with a violation of such other law.

Ethics and Fraud ● Page 73
§94  Withdrawal from fund

A. Any employer may, upon complying with subdivision two or three of section fifty, withdraw from the fund by turning in his insurance contract for cancellation, provided he has given written notice to the fund of his intention to withdraw not less than thirty days before the effective date of such cancellation. Upon receipt of such notice the fund shall, at least ten days prior to the effective date file in the office of the chairman a notice of such cancellation date. In no event shall the insurance contract be deemed canceled until at least ten days after the date of such filing, any earlier date mentioned in the notice to the contrary notwithstanding. If an employer withdraws from the fund upon complying with subdivision two of section fifty of this chapter, the new insurance contract with the stock corporation, mutual corporation or reciprocal insurer shall be deemed not to take effect until the cancellation of such employer’s contract with the state insurance fund has become effective.

(1996, chgd. By chap. 635, eff. 9/10/96)

Notwithstanding any of the provisions contained in subdivision five of section fifty-four, the fund may cancel a contract of insurance at any time during the contract period upon being furnished by an employer with proof satisfactory to the fund that he is no longer required to comply with section fifty by reason of his having discontinued, sold, transferred, assigned or otherwise disposed of his business and has ceased employing workmen or operatives; or, where the insurance contract has been issued to cover the operations under a specific contract or at a specified location, that such operations have been completed or discontinued and the employment of workmen or operatives in connection therewith has ceased; provided, however, such cancellation shall not become effective until at least ten days after notice thereof shall have been filed in the office of the chairman.

§ 95  Record and audit of payrolls

Every employer who is insured in the state insurance fund shall keep a true and accurate record of the number of his employees and the wages paid by him, and shall furnish, upon demand, a sworn statement of the same. Such record shall be open to inspection at any time and as often as may be necessary to verify the number of employees and the amount of the payroll. Any employer who shall fail to keep such record or who shall willfully falsify any such record, shall be guilty of a misdemeanor.

§ 95-a. 5(1996, repealed by chap. 635, eff 9/10/96)

§ 96 Penalties for fraudulent practices

1. Any person who knowingly makes a false statement or representation, conceals any material facts, or engages in any other fraudulent scheme or device for the purpose of obtaining, maintaining or renewing insurance in the state insurance fund at less than the proper rate for such insurance, whether for himself or herself or any other person or entity, shall be guilty of a class E felony. If a violation of this subdivision is alleged and such act could also constitute a violation of the penal law or any other law, the prosecuting official may charge such person pursuant to the provisions of this section and charge such person in accordance with such other law or laws. In addition to any other remedy, the state insurance fund shall be entitled to restitution for any amount obtained or withheld as a result of a violation of this subdivision.

2. For violations of subdivision one of this section, the state insurance fund shall have a right of

Ethics and Fraud ● Page 74
action to recover civil damages equal to three times the amount wrongfully obtained, or five thousand dollars, whichever is greater. The remedy provided in this section shall be in addition to any other remedy provided by law.

§ (1993, chgd. By chap. 729; 1996, chgd. by chap. 635, eff. 9/10/96)

§ 97 Inspections

The commissioners shall have the right to inspect the plants and establishments of employers insured in the state insurance fund; and the inspectors designated by the commissioners shall have free access to such premises during regular working hours.

§ 98 Disclosures prohibited

Information as required by the state fund, or its officers or employees, from employers or employees pursuant to this chapter shall not be opened to public inspection, and any officer or employee who, without authority of the commissioners or pursuant to their regulations, or as otherwise required by law, shall disclose the same shall be guilty of a misdemeanor.

§ 99 Reports of state insurance fund; examination by insurance department

The commissioners shall make separate reports to the superintendent of insurance concerning the state insurance fund at the same time and in the same manner as is required from mutual employer’s liability and workers’ compensation corporations by section three hundred seven of the insurance law, and the superintendent of insurance may examine into the condition of such state insurance fund at any time, either personally or by any duly authorized examiner appointed by him for the purpose of determining the condition of the investments and the adequacy of the reserves of such fund and such other matters as shall be in the jurisdiction of the superintendent of insurance.

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