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CALIFORNIA FAIR CLAIMS SETTLEMENT CERTIFICATION

THIS COURSE PROVIDES THIRD PARTY ANNUAL CERTIFICATION OF COMPLIANCE WITH THE CALIFORNIA FAIR CLAIMS SETTLEMENT TRAINING REGULATIONS, TITLE 10, CHAPTER 5.

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FAIR CLAIMS CERTIFICATION RULES

Under California law, all licensees and claims agents must undertake thorough and adequate training regarding the California Fair Claims Settlement Practices Law. Compliance with the law requires adjusters to read and understand California Code of Regulations Title 10, Chapter 5 (found at the end of this course) carry a copy in their claims manual and abide by clear written instructions regarding claims procedures to be followed to effect proper compliance.

A COPY OF YOUR CERTIFICATION SHALL BE MAINATINED AT ALL TIMES AT THE PRINCIPAL PLACE OF BUSINESS AND PROVIDED TO THE COMMISSIONER UPON REQUEST.

ANNUAL CERTIFICATION MUST BE COMPLETED ON OR BEFORE SEPTEMBER 1 OF EACH CALENDAR YEAR.

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INSURANCE FRAUD

The Role of Insurance Professionals

Fraud can occur during the application period, and it can occur when loss claims are filed. A vigilant agent and adjuster should be alert for the possibility of fraud and be thorough in gathering information to support an application or a loss claim.

Beyond this responsibility, insurance professionals should understand that the intent of ***fraud statutes*** in the insurance code is to ***restore legitimacy and integrity***. This mission requires the cooperation of everyone--insurance professionals, employers, employees, doctors, lawyers and law enforcement.

Officials and experts suggest that the best way to start this process is to put your own "house" in order.

- Not only must agents and adjusters be honest and law abiding, but they must also avoid any appearance of impropriety. Don't be guilty of what it is we are trying to eradicate. Remember that when gifts, tickets, free meals, or vacations are offered or accepted as compensation, inducement, or reward for the referral or settlement of a claim, it is a felony.

- Do not accept application, underwriting or claims information that you know to be false as a basis for determining policy premiums or coverage. That is an unlawful act.

- Do not accept or make any material representations that you know to be false as justification to accept or deny a claim for benefits. Also, do not make knowingly false statements with regard to entitlement to benefits with the intent of discouraging an insured from claiming benefits or pursuing a claim.

You are required to ***report suspected fraud*** when you have knowledge of or a reasonable belief that a fraudulent act has been committed. The reports must be submitted simultaneously to the Department of Insurance and the local district attorney's office. This is not optional; it is state mandated. This requirement carries with it the responsibility to assure that all reports are made in good faith, without malice, and are based on facts obtained by reasonable efforts.

Until there is a conviction in a court of law, there is only suspected fraud. Use discretion and avoid accusations of fraud--or you could find yourself and your company party to a libel or slander suit. Your civil immunity protections for reporting suspected fraud are limited and only cover you when reporting to an authorized governmental agency.

A final caveat: No insurance carrier, agent, adjuster, self-insured employer, or third-party administrator has the right or authority to make any agreement to not report or pursue

suspected fraud. For example, an agreement to not investigate or report suspected fraud, as a means of facilitating finalization of a claims case, is an illegal act. Insurance fraud is a criminal act and is in the purview of only prosecutorial agencies such as district attorneys, the State Attorney General, and the U.S. Attorney.

Insurance Fraud Overview

Trends & Statistics

In order that you may more fully comprehend the seriousness of insurance fraud and its cost to both the insurance industry and society as a whole, let us spend a little time getting an overview of insurance fraud using information from various sources.

Note the following:

- Insurance fraud ranks second only to tax evasion as the most costly white-collar crime in America.
- Property/casualty-based insurance fraud costs Americans $20 billion ANNUALLY.
- When fraud in the health, life and specialty insurance lines is added, insurance fraud costs could exceed $100 billion a year.
- NCIB estimates that 10 percent of property-casualty claims are fraudulent.
- According to NCIB estimates, the average American household pays $200 a year in additional premiums to cover the costs of fraud.

National polls on the subject of insurance fraud have yielded the following:

- The public ranks insurance fraud a 9 on a ten-point serious crime scale.
- Seven percent of those polled reported that they had personal knowledge of a case of insurance fraud.
- Six percent of those polled had been asked by a body shop operator to falsify or exaggerate an insurance claim.
- Two percent had been asked by a health care provider to falsify or exaggerate a claim.
- Two percent had been asked by an attorney to falsify or exaggerate a claim.
- Two percent had been asked by others to falsify or exaggerate a claim.

Thus, TWELVE PERCENT of those polled had been asked to falsify or exaggerate an insurance claim. But even more alarming is the report that approximately SEVENTEEN PERCENT of adults polled feel that it is all right to cooperate with doctors, chiropractors and attorneys to falsify or exaggerate workers' compensation claims in an effort to get money from insurers.

Unfortunately, many people view insurance companies as vast, bottomless money pits, the "deep pockets" that can fork over large amounts of money and not be diminished. Such a view ignores the basic nature of insurance, which is that it is a social device which allows people to POOL a certain amount of resources to cover a certain type and amount of risk. And although an insurer's reserves might seem vast to a lay person, those reserves are carefully calculated to cover the KNOWN risks of those who have put resources into the pool.

Thus, when an automobile insurer issues a policy, the premium, which is the amount of resources the applicant is contributing to the pool, is determined by the amount of RISK this applicant represents. And this risk has been determined by the applicant's age, his or her driving record, the conditions under which the vehicle will be driven, and any other variable which might help identify risk,

When losses exceed the resources the insurer has to cover them, obviously, more resources must be found. And since by resources we mean dollars--clearly, insurance rates go up. This is why insurance fraud is considered a "social" crime--because its effects spread throughout society, forcing innocent insureds to help pay for someone else's fraudulent claim.

Further in this course we will present specific methods by which agents and insurers can help prevent insurance fraud. Now, let us say generally that insurance agents should make it a practice to instruct applicants in the insurance process, helping them to understand that it is to the benefit of themselves as well as to others to keep loss claims within legitimate limits.

Fraud Vs. Abuse

What is fraud? What is abuse? What is the difference between them? Because abuse is a very broad term, it is easy to confuse the two.

Abuse Defined: Insurance abuse is any practice that uses the system in a way that is contrary to either the intended purpose of the system or the law. This includes some behavior that is not criminal and some that is, most significantly fraud.

Fraud Defined: In the simplest terms, Fraud occurs when someone knowingly lies to obtain some benefit or advantage, or to cause some benefit that is due to be denied. If there is no lie, there may be abuse but it is not fraud.

Some Forms of Abuse

Merely filing a claim that is not warranted or violating the rules of industry, in the absence of fraud (a lie) or kickbacks, may be abuse but it is not criminal. Noncompensability per se does not constitute fraud unless the specific elements of fraud are present. Similarly, overtreatment by a physician might represent only a difference in opinion; although it could appear excessive and possibly abusive, it does not necessarily constitute fraud. Typical abuses of the system also include magnification of complaints or disability that fall short of an outright lie, or an overutilization of benefits. For example, soft tissue injuries give rise to subjective complaints that cannot be either proven or disproven.

The presence or absence of a specific, provable lie is the deciding factor. To separate fraud from abuse, it is necessary to look for the lie or misrepresentation, whether written or oral.

For example, returning to work while receiving temporary disability payment might be abuse, or it might be fraud, depending upon the circumstances. As the law now stands, claimants have no legal obligation to advise anyone when they return to work, nor do they have an obligation to certify their continuing disability status. If temporary disability payments continue when the claimant has returned to work--and no one ever asks the claimant "are you working?"--there is

an abuse of temporary disability benefits, but there is no lie and therefore no fraud.

However, using the same example, if someone, such as the adjuster or the doctor, specifically asks the claimant "are you currently working?"--and the claimant replies "no" and thus lies, and that lie is relied upon to determine the amount and payment of temporary disability--there is fraud.

Criminal Abuse

Though not legally a fraud, offering or accepting ***kickbacks*** for the referral or settlement of cases is a reportable and highly prosecutable crime. Kickbacks indirectly feed the problem of fraud and, as a result, cause damage to our society and our economy. Consequently, the legislature has determined that both fraud and the kickbacks that can contribute to it are punishable criminal acts; a single fraudulent transaction can be punished by up to 5 years in prison.

Fraud

In separating criminal fraud from abuse, remember these *key elements*:

- There is always a false representation--the lie.
- The lie must be intentional or knowingly made.
- The lie must be made for the purpose of obtaining a benefit the claimant is not due, denying a benefit that is due, or obtaining insurance at less than the proper rate.
- The lie must be material, that is, it must make a difference: "If the truth had been told, would you have done anything differently?"

Insurance Concepts

We have already said that insurance is a social device whereby people may contribute resources to cover the risks of all members of the pool. This is a general definition, but several points in it are worthy of further discussion as we enter our study of insurance fraud.

First of all is the concept of a POOL of people. This pool is, of course, the policyholders of an insurance company. But note that APPLICATION must be made before a person can enter the pool. And note also that the application asks for certain information which the insurer deems essential if it is to accurately determine the amount of RISK the applicant adds to the pool.

Anyone in the field understands this concept: in fact, the understanding becomes taken for granted, so that filling out an application becomes almost automatic. But when we expand our understanding, and are aware of why certain information is asked for, and why it is required, we will no longer simply "fill out an application." We will understand that we are helping a person apply for admission to the pool, and that he or she is admitted, not only his or her resources will be added, but also any risks which have been specifically guaranteed by the other members of the pool.

Insurance ***actuarial departments*** spend a great deal of time, expertise, and money

endeavoring to determine precisely how much premium should be attached to a particular type and amount of risk. Their ***purpose*** is to make sure that ***NO ONE brings more risk to the pool than resources***--and also, that no one brings more resources than risk. In other words, legitimate premiums should represent, as exactly as possible, the correct proportion of resource to risk.

Yet another concept is essential for insurance to work properly. That is the concept of risk. ***RISK*** refers to future potential loss. Again, actuarial departments are responsible for determining all the various kinds of risks that may be attached to insured people, insured property, and insured legal entities, such as corporations. They do this by constantly reviewing actual losses in various classes of risks against their projected losses, and by making adjustments accordingly.

For example, while for many years applicants for health and life insurance have been asked about smoking habits, recent research results that prove more conclusively the relationship between smoking and various life-threatening illnesses has made it possible to more accurately calculate the risk smokers add to the pool, and to make the premiums for smokers more adequate in covering that added risk.

But because risk does refer to ***potential future loss***, it cannot be calculated with total accuracy until after a loss has occurred. Insurers can and do add a certain percentage to their loss reserves to account for this lack of total accuracy in predicting losses. But they CANNOT predict what fraudulent claims will do to those reserves, just as a bank or other financial institution cannot predict whether it will be robbed, and, if so, how much will be taken.

Crime of any sort disrupts the social fabric. While highly visible crimes such as armed robbery and murder get public attention, less visible crimes such as insurance fraud are spreading consequences across the public at large. Insurance fraud attacks the very basis of the insurance contract, which is trust between the insurer and the insured. The insurer must be able to trust that information on an application for insurance or a loss claim is true, and the insured must be able to trust that the information will be acted upon in a timely and efficient fashion. Unfortunately, one of the results of ***insurance fraud*** is that it ***breeds suspicion***, so that in many instances, legitimate claims take longer to process because of added procedures to detect fraud.

Principle of Indemnity

The Principle of Indemnity is central to the effective operation of insurance. Simply put, the principle of indemnity states that ***the purpose of insurance is to restore an insured to the pre-loss condition***, insofar as that is possible. In the case of a property / casualty loss, restoration is measured in terms of the value of property lost or liability protected. In the case of life and health coverage, indemnity speaks more to the restoration of an economic loss resulting from the death or injury of the insured.

Sometimes, as in the case of the loss of an easily replaceable object, restoration is a simple matter. For example, Howard Scott has just purchased a new automobile. He drives from the dealership to his office, and parks the car in his usual spot. A building is going up next door to the lot. A crane operator is lifting a heavy load of building materials to an upper floor when the cable breaks and the load crashes down onto Howard's car. This claim will be fairly easy to

determine, since there can be no question as to the present value of the car, and since there are no injuries to complicate matters.

But few claims are so easily handled. In most cases, the human factor enters into the claim process, and complicates it. There is a saying to the effect that nothing so increases the value of something like losing it. And insurance adjusters would surely agree with that. Particularly when a major disaster strikes, and emotions are high, the value people place on lost objects can escalate.

For example, when Hurricanes Erin, Opal and Katrina hit, claim adjusters found that people had family antiques and heirlooms in beach houses, that TV sets and other lost appliances were hardly out of their boxes, and that large and expensive wardrobes had been swept out to sea.

And, faced with piles of rubble, or, in some cases, an empty lot where a house had indeed been swept away, it was difficult for adjusters to determine what actually was the value of the losses insureds had sustained.

Were these people committing deliberate fraud? In some cases, most certainly. In others the stretching of the truth--or falsification of the value of lost property--could be attributed largely to the helplessness people feel when confronted by a major disaster over which they have no control. More than physical objects are gone when an entire home disappears, and people tend to compensate for feelings of loss and rage by trying to get something back--in the case of these hurricanes, money from insurers with which to reestablish themselves.

Such a situation, with a very large number of insureds sustaining major losses in the same period of time, represents one extreme in claim management. But out of extremes come lessons that can be applied to more ordinary circumstances. Householders who rebuild in the Florida panhandle would be well advised to maintain accurate and up-to-date documentation of the value of items put in their beach houses, because in an effort to reduce either deliberate fraud or emotional overstatement of property value, insurers will require something other than an insured's memory and word.

Let us get back to the idea of indemnity--restoring an insured to the pre-loss condition. Such restoration should occur across the entire spectrum of variables insured: physical property, and also physical injury, and mental and emotional strain. Note that each of these classes of loss presents a whole array of possible risks. Note also that ***insurance policies*** are written to either ***INCLUDE or EXCLUDE*** certain identifiable risks.

What is the premise upon which a risk is included or excluded? Primarily, the ability of the insurer to determine to a fairly accurate degree the value of possible losses. For example, a standard fire policy will insure a dwelling for a certain amount, and, if the dwelling is totally destroyed by fire, the insurer will pay the full face value of the policy after duly processing the claim. And the premium to cover this risk will be determined by, among other things, the building materials used, the availability of a fire department and fire plugs, the use of the building, and whether or not it is occupied.

If the property is insured to value, the property-owner should receive enough from the policy to rebuild, particularly when the value of the land on which the building stood is considered,

But in flood insurance, if a dwelling is totally destroyed by a flood, the insured will not receive the face value of the policy, because the damage floods do cannot be accurately predicted, and thus premiums cannot be determined that will build up sufficient reserves for an insurer to be able to pay the face value of policies in case of loss.

Property and casualty policies routinely exclude damage caused by such things as acts of war, insurrection, riots, etc., simply because it is impossible to accurately predict the possible occurrence of such things, and also because it is impossible to accurately predict the possible losses,

There are many, many examples where the principle of indemnity can serve only as a guide in settling claims. For instance, a person who has lost both legs in an accident CANNOT be restored to pre-loss condition, no matter how much money is available to settle the claim. And so a careful process of determining the dollar value of the loss is begun, using such criteria as the person's age, employment, leisure activities, family situation, and so on.

The long-time trend in this country is for juries to award very high amounts of money in personal injury cases. It is not unusual to find cases in which people working at minimum wage levels receive enormous awards from juries, not to make up for loss of lifetime earnings, but because of sympathy with what the person has endured. Nor is it unknown for the injured and those working for them to exaggerate the pain and suffering, the mental distress, and the emotional fall-out of the injury in order to play upon the sympathy of juries.

What is missing when juries vote emotionally rather than rationally? Primarily, a misunderstanding of the nature of insurance--that its purpose is to remediate, insofar as is possible, the effects of an accidental law. But the word ACCIDENTAL is also significant. The risks that insurance covers will not automatically happen. Even death, which life insurance covers, is unpredictable. It will certainly come, but whether today, tomorrow, next year or ten years from now, is rarely known. When an ACCIDENT does occur -- a completely unexpected happening over which we have no control -- the victim certainly should not have to pay for any of the consequences of the accident -- medical expenses lost time at work, cost of future care, etc. -- but neither should the victim BENEFIT by the accident to an extent that is unreasonably above the value of the actual loss.

This is an idea juries find difficult to comprehend. And so do many policyholders when the accident or loss happens to them. Intellectually we know that no amount of money can restore a lost limb, emotionally we feel that if the victim has to be legless, if he or she lives in a somewhat luxurious manner -- this will somehow make up for the loss.

It is just this sort of thinking that creates an atmosphere in which people who would never rob a bank, escalate their claims by exaggerating their loss so as to get payment for intangible effects, A beautiful young woman who has severe facial scars as the result of a car accident will ordinarily get a much larger award from a jury than say, an elderly woman.

While insurance companies and courts cannot make people think with their heads instead of their hearts, increasing abuses in the matter of jury verdicts in personal injury cases have led to campaigns to set legal limits on such intangibles as pain and suffering. But despite the existence of, such laws, human beings are human beings, and when they suffer a loss, many of them will try to get more money than the amount that represents a reasonable and possible

restoration to their pre-loss condition.

And so we have a situation in which there are ***two types of people who commit insurance fraud***. The first class, is made up of people who quite deliberately figure out ways to get more money from a claim than they should legitimately have. The second class is made up of people who see insurance companies as "deep pockets" with endless amounts of money to be spent, and who consider the intangible suffering and emotional state of victims to be a measure of how much compensation they should receive.

But whether performed by professional crooks or by misguided or muddy-thinking individuals, insurance fraud is a serious crime, one that insurers and insureds must work to prevent.

Insurable Interest

The concept of insurable interest is not only essential to the nature of insurance, it is also an important element in fraud. Let us look at the two words which make up this phrase to better understand its meaning. First of all, what is the meaning of INSURABLE? Simply put, this means that losses that may occur from a particular risk can be identified, AND quantified BEFORE the loss occurs. By IDENTIFIED, we mean that the losses can be named: for example, a woman insures her jewelry. Each piece, with a description and an appraised value, will be listed on the jewelry schedule. It is thus. IDENTIFIABLE.

And by QUANTIFIED we mean that the possible loss may be MEASURED in TWO ways. First of all, the dollar value of the item at risk may be measured, and second, the PROBABILITY of loss maybe measured. Quantifying a risk is of vast importance determining premium.

Take the example of the jewelry. The dollar value of the item in question will be determined by a professional accepted by the insurer. The nature of the item and its use will help determine the probability of loss. For example; there is a higher risk of loss when a piece of jewelry is worn in public, at places -where jewel thieves would expect owners of expensive jewelry to go.

Does jewelry, represent an insurable risk? Certainly it does. If it is stolen, or lost, its monetary-value can be replaced, even if the particular piece of jewelry cannot.

Having looked at INSURABLE, now let us took at INTEREST. In terms of insurance, this simply means that a person or legal entity (such as a corporation) has a legal or financial connection to the item at risk, and will suffer some harm as a DIRECT result of a loss, should it occur. Thus a person who owns stock in a corporation has a legal--and, in this case also financial--connection to the corporation. A homeowner has a legal and financial connection to the property he or she owns.- should the -house be destroyed by fire, he or she would suffer a financial loss, but would also be exposed to laws regulating the removal of debris; the securing of dangerously damaged buildings, etc.

Thus an ***INSURABLE INTEREST*** refers to the legal and/or financial connection a person or legal entity has in a piece of property, either tangible or intangible, that is at risk to a possible loss which can be identified and quantified before it might occur. It is obvious why the concept of insurable interest is essential to the nature of insurance. *Unless a person will suffer some harm as a direct result of a loss, there is no reason why they should participate* in any instruments, such as insurance, which may be used to mitigate the effects of the loss, should it

occur. Note that it is important that the harm be a direct, not indirect, result of the loss. The significance of this becomes evident in suits in which lawyers attempt to establish a connection between an event-the loss-and the problems their clients are having.

Particularly in gray areas such as pain and suffering, mental anguish and the like, demonstrating that there is a direct connection between, say, a client's depression or other emotional state and the event is essential if the plaintiff's claim is to succeed.

And, of course, the law defines ***certain relationships*** that in themselves ***establish insurable interests***. For example, spouses, children, and parents are in the first rank of those understood to have an insurable interest in the death of a spouse, parent or child. Certain business relationships-employer to employee, for example-are also understood to establish an insurable interest, as when an employer takes out key man insurance on an employee.

Mystery writers often use this idea of insurable interest to create a motive for a crime, and, in real life, there are all too many examples where the existence of an insurable interest did motivate a crime such as arson, theft, and even murder. We shall examine such cases later in the course.

Establishing Loss

It is when an insured is establishing loss that the opportunity for fraudulent claims arises. Many elements in the loss claim may be fraudulent, with lies being told about the extent of damage, the pre-loss condition of the damaged person or property, the value of the damaged property, and so on. Let us examine the various elements in a loss claim, and see where this process is vulnerable to fraudulent claims.

First of all is the ***TIME of loss***. The time is important for several reasons. The policy holders have an obligation to file claims of loss in a certain time frame, or else there is a danger that the claim will not be honored, or, if honored, will not be paid at full value. When a major disaster, such as a hurricane, flood, or something of that nature, strikes, insurers normally extend the time limit for claims to be filed, knowing that the sheer number of claims and the extent of damage will prevent insureds from filing in a timely manner.

But there is another element in the time a loss occurred that is significant. For example, suppose that a homeowner has purchased the materials for a new roof, and has receipts showing that the materials were purchased before the date a hurricane struck. Suppose the insured homeowner has not yet put the new roof on when a hurricane strikes, one so severe that it blows off or damages all the roofs in the area, including the homeowner's old roof. Now suppose that the homeowner claims that he had already replaced the old roof, and uses the receipts showing the purchase of the materials as proof. He claims that he and his sons replaced the roof prior to the date the hurricane struck, and thus claims reimbursement for a new roof instead of the old one that would have depreciated in value to the point where it would bring very little return if claimed. Insurance adjusters are all too familiar with claims that manipulate time so as to receive a greater amount when the claim is settled.

Exaggerations are also made about the pre-loss condition of the damaged item or person. As mentioned before, adjusters often find that a home consumed by fire or a hurricane or some other cause contained items of more than ordinary value, items that did not have to be listed on

a separate schedule, but must still be counted in determining the amount of a claim. And, since the forms the insured fills out when claiming loss of contents of an insured property do not ask for proof, there is ample opportunity for householders to lie about the value of what they have lost.

Thus an insured who has a kitchen full of odd china may claim the loss of an almost new full set of china for twelve. A tool-box that may have held a couple of hammers and an assortment of inexpensive tools suddenly contains expensive drills and top-of-the-line items that are costly to replace. A few simple fishing poles become costly rods and reels. Such false claims are endemic in the industry, for a very good reason. Adjusters have just so much time, and insurers' claims departments are also constrained in terms of the amount of time and effort they can put in settling claims.

When a major disaster strikes, such as the double-barrel blow of two major hurricanes within two months time that struck the Florida panhandle in August and October of 1995, there are entirely too many individual claims for adjusters and claim departments to nit-pick over a set of china or a box of tools. Since householders usually stay within reason--if fraudulent claims can ever be called reasonable--insurers write off the cost of inflated claims concerning the loss of household goods as part of the cost of doing business--although the entire pool of policyholders will end up paying for this higher cost when rates are adjusted to make certain insurers have adequate loss reserves.

Unfortunately, not only insureds are guilty of inflating the size of a loss. In the aftermath of those two hurricanes, property owners could be heard bragging about the size of the check they would get when their claims were settled, amounts that could not have been received were fraud not involved. The greater part of the damage during Hurricane Opal was from a twelve foot tidal surge driven by winds of 145 miles per hour. This tidal surge pounded the beach, sucking sand from under the concrete foundations of town-homes and condos. With no foundations left, these structures toppled forward into the sand: many were reduced to rubble, and none of this type of structure stood.

But since flood insurance does not pay the face value of the policy, only a percentage which is determined by a complex formula which is applied after every such major loss, property owners who lost their beach houses because of the tidal surge stood to get far less than the amount of money it would take to rebuild. Windstorm insurance, however, does pay the full face amount of the policy. So if property owners could claim that the winds preceding the tidal surge had caused some damage before the tidal surge came in, they could get the full amount of that loss claim from their windstorm policies.

Thus, many policyholders were able to claim that their roofs had blown off before the buildings collapsed, taking the roofs with them. They claimed that the wind had blown in windows and doors, and had blown household items away. In some instances, such a scenario may well have been true. But in others, particularly where buildings built right on the beach were concerned, and especially when those buildings were on concrete foundations instead of pilings, such claims were dubious. Still, they were made.

Creative property owners found many ways of making fraudulent claims in the aftermath of Hurricane Opal. Rental units that were not indeed rented during the period of the storm and in the weeks afterward were suddenly full of tenants who had not been able to come to Navarre

because their accommodations had been destroyed. And so the renter was able to claim loss of rental income for a certain period during which repairs were made.

In all too many instances, it is only the honesty of the policyholder that makes insurance work. And in a society in which personal codes of ethics seem to be increasingly rare, to depend upon the honesty of policyholders may be a mistake. People may be honest in such matters as returning lost property that they have found, or making a child go back to the store to return an item he or she has stolen. They may be honest in filing their income tax returns, or in not taking advantage of a mistake a clerk has made in giving them change.

But when it comes to filing an insurance claim, a temptation of another sort arises. After all isn't the purpose of insurance to protect the insured against loss? When the insured purchased the homeowners' policy, didn't the agent say that if anything happened to their property, the policy would pay enough to get it replaced?

Yes to all of those things. Well, then--if a hurricane blows through my home, ruining the contents, shouldn't my policy pay enough to get them replaced?

Yes to that, too. The problem comes in when policyholders don't WANT the contents replaced. They don't want a kitchen full of odd lots of pots and mismatched glasses and china. They don't want a ten year old blender on its last legs, or a toaster with only one slot that works. They want everything brand new. And, unless they paid a premium figured on the assumption that everything in the home was brand new, they cannot have that.

The value of the contents of a household is, after all, set by the householder when the policy is bought. Nor can a householder, at that time, claim a HIGHER value for the home's contents than actually exists. He or she cannot, in other words, OVERINSURE property. Actuarial departments have determined ratios that set parameters of allowable amounts of unscheduled contents insurance in relationship to the value of the house. A house that may be insured for, say, $110,000, could hardly be expected to have unscheduled contents valued at $150,000. If such an application came in, you may be sure that questions would be asked, and that proof of contents' value would have to be shown.

This is the whole purpose for having ***schedules*** attached to property insurance for such things as antiques, art work, jewelry, and other valuables. The ***values*** attached to these items must be determined by ***AUTHORIZED appraisers*** within each field, and such appraisals must be submitted to the insurer before the coverage is in force.

You can understand, then, the problems that arise when the average homeowner suffers a loss. No matter that he or she or they said, at the time they bought the coverage, that they understood the policy, and what and how it would pay. All they know is that yesterday they could cook their meals and today their stove and pots are gone. It is only human not to want to go to second-hand stores and flea markets to replace household items swept away by a storm or flood. On the other hand, it is not reasonable to expect an insurer to pay claims large enough to send the insureds off to buy brand-new items to replace what they have lost.

And so policy owners give in to temptation, inflating the value of lost items so that the amount of their check to settle the claim is sufficient to replace most of what they lost. This is what we might term emotional dishonesty, in that the emotions caused by personal loss over-ride what

might be the limits policyholders would otherwise observe. But the cost to the insurers is just as great as if the dishonesty were conscious and intended.

Yet another reason policyholders are tempted to inflate the size of their loss lies in the fact that most people do not understand the concept of ***DEPRECIATION***, and how that can affect the dollar amount they can claim. After all, not everyone deals with that concept every day--or even every month. In practical terms, which is the way most people think, an item has value as long as it can be used. And while items with working parts, sewing machines, lawn-mowers, automobiles and the like--are more obviously losing value the longer they are used, few people stop to think that the sheets on their beds, the pots on their stove, the watch on their wrist, also are losing value with every passing day.

But when an adjuster is determining the amount of loss in terms of contents, he or she will give the policyholder a form that has places for the lost or damaged items to be fisted, described--and also a place for the approximate age. It is when filling out such a form that policyholders may become aware for the very first time that what they have lost was a house full of aging, and therefore almost valueless, items. So on top of the shock of the flood or fire or hurricane itself, they now have the shock of seeing their lost possessions in a new, and most unfavorable, light. Follow that with the realization that they will get very little for the contents of their home, and you can understand, if not condone, why such people lie. But is also in establishing loss that people other than policyholders find opportunities to gain at the insurers' expense.

For example, a great majority of medical expense claims are filed, not by the insured, but by the health care personnel/organizations who deliver the care. And, there are all sorts of opportunities for fraud and abuse here. The problem has become so severe that insurers in the health care field such as TRIGON/Blue Cross Blue Shield are issuing pamphlets in their communications to policyholders asking for help in reducing these false claims.

One such example has a cover announcing: FRAUD & ABUSE ALERT! Inside, there is a plea to HELP US SAVE YOUR DOLLARS!, followed by this text:

> *Health care fraud and abuse affects everyone. Blue Cross and Blue Shield has a special unit dedicated to detecting and deterring fraudulent and abusive activity. You can help. Compare the itemized bill you receive from your provider to your explanation of benefits. Things to look for-Were insurance payments made for medical services that were not performed? Were duplicate payments made for the same medical service or treatment? Were medical insurance payments made for someone who was not an eligible Blue Cross and Blue Shield member? Was there any misuse with this medical insurance? If the answer to any of the above questions is YES, contact us on our toll-free Fraud Hotline, 24 hours a day, seven days a week. Callers may identify themselves or remain anonymous. Our voice mail will take your confidential call; please leave detailed information, If you choose not to remain anonymous, your call will be returned by our representative. Each incident uncovered and stopped saves your and all our customers' money. That is as important to us as it is to you. OTHER HELPFUL HINTS: If you are seeing the doctor for the first time, talk to someone who has seen the doctor and is satisfied with the services. Ask questions about billing practices before scheduling an appointment. Request an itemized bill before leaving the doctor's office. Insist on a receipt that shows the balance due if you are required to make a payment. Be aware of the environment and ask questions: if you are not satisfied, leave*

the office. We want to assure you that the vast majority of claims filed are accurate and appropriate. But inappropriate claims have a significant impact on health care costs. Statewide, such claims cost an estimated $1 million per day. (Note: this pamphlet was issued by Blue Cross Blue Shield for only one state--meaning that in JUST ONE STATE, fraudulent claims cost that insurer $365 MILLION PER YEAR!) This affects all of us in the form of higher health care costs.

The text in this pamphlet is interesting in a number of respects, and shows a deep awareness of human nature. Note that the questions about the payments ask the insured to do things that normally, we would expect anyone to do: review a bill, and make certain that no charges were made for services not rendered. Why would an insurance company have to ASK policyholders to check their bills for accuracy? Primarily, of course, because in many cases, the policyholder makes no co-payment, and when a co-payment is made, it is relatively small. Thus, because the policyholder does not feel that the payments have come or will come from his or her pocket, little to no interest is taken in examining the bill. Only if an insurer can get the message across to policyholders that fraudulent claims DO cost them money will policyholders take an active interest in fighting abuse and fraud.

Note, too, that people who call to report fraud may remain anonymous. Relationships between physicians and their patients vary, but usually, patients have a certain dependency on their physicians which may militate against them reporting fraud. Further, the very people who may be careless about checking bills may be the same ones who consider their physicians minor gods who can do no wrong. Insurers are left wide open to abuse and fraud from dishonest medical practitioners when these conditions exist. A further complication is that medical practitioners ARE caretakers who relieve pain, cure disease, and in general are seen as saviors alleviating human suffering, whereas insurers are money-crunchers. Patients would thus be reluctant to 'tell off ' a person who looms large in their personal welfare to a distant corporation with whom they have no contact at all. All of these factors unite to create an environment in which unethical medical practitioners may file false claims and get away. When insurers issue pamphlets such as the one just cited, however, they are pointing out, however subtly, that policyholders are colluding with fraudulent claims when they do not actively review their bills, the payments made, and report any discrepancies.

Thus, in the process of filing claims, there are several possibilities for abuse and fraud. First, a policyholder may make a fraudulent claim on his or her own. Second, the policyholder and adjuster may collude to file a fraudulent claim. And third, other parties such as medical practitioners may file fraudulent claims, depending upon the nature of their relationship with patients and the fact that most people do not pay a great deal of attention to a bill someone else has paid to help them get away.

Forms of Insurance Fraud

We will begin our study of fraudulent uses of insurance by examining fraud in the personal insurance field: life insurance; accident and health insurance, and workers' compensation insurance.

Life Insurance Fraud

Because of the nature of life insurance, there are limited ways in which fraud can be committed. An applicant can attempt to conceal life-threatening or even terminal conditions on an application. Second, a death can be faked. Third, proceeds from a legitimate death can be diverted to the wrong beneficiary

The first of these methods is not easy to implement, simply because even if the applicant is successful in concealing pertinent medical facts during the application process, once he or she dies, the cause of death would probably lead the insurer to investigate the client's prior medical condition. Once the concealment was discovered, the policy would be automatically void, and no monies would be paid.

Staging a death, on the other hand, has been and is being used more frequently. Before the days of computers and desktop publishing systems, staged deaths appeared more in fiction than in fact. Certainly, there were highly-publicized cases of people whose private planes went down in supposedly-impenetrable swamps or forests, people who later turned up alive long after hefty insurance claims had been paid. One case involved a scenario worthy of a Hollywood film. A young man, the rather never do well son of a prominent family, went off to Australia to make a life--and a fortune. He married there and fathered a child, gradually establishing renewed contact with his family back in the States. Then came a message from Australia: the young man had fallen overboard from a ferry crossing from the mainland to an island and had drowned. His grieving family sent plane fare to the widow and child, welcoming her into their midst and giving her a home.

Imagine their surprise when she told them that, far from being penniless, she was the beneficiary of a multimillion dollar life insurance policy which their son had only recently taken out. Since the job he had held in Australia did not pay much, his parents were impressed that he had invested so much in protection for his wife and child.

The insurer was not so impressed. At first they suspected suicide, but found that they could not prove that to be the case. After a long investigation, they reluctantly paid the claim, but kept the case open. It was a good thing they did. The wife banked the money and settled down into life in her new home. Months passed, and then the wife told her in-laws that she wished to go back to Australia where she had been born. This seemed a natural enough wish.

But when the young woman went to the bank and asked for a transfer to a bank in Australia, the bank complied with the insurer's request that they be notified if she made such a move. An insurance investigator then tracked her. Sure enough, not long after she and the child arrived in Australia, a man appeared in her life. Although his hair was a different color and he wore a beard and mustache, and weighed more than the dead husband had, the investigator felt certain that this man and the dead man were one and the same.

This proved to be the case. When confronted alone, the wife, who had born the burden of suspicion from the start, confessed their scheme. Under his clothing, her husband had worn a survival suit that enabled him to stand the frigid waters and to breath until he could safely emerge on land. He had gone to a hide-out which they had set up, one stocked with all the provisions he would need. And there he had stayed, growing his beard and mustache, while his wife played out her part of the charade.

Both were tried and convicted for fraud, and imprisoned, as well as having return all monies the insurer had paid. So what put the insurer onto them? After all, people do fall off boats, and they do drown, several things. First of all, the size of the premium compared to the couple's income sounded an alarm. Thus, everything about the claim was gone over with a careful eye. And someone, examining the watermark on the paper the young woman used in writing the letter to tell them about her husband's death, made a discovery. That sort of paper was not sold in Australia, but only in the United States. This might not have been significant: the young man could have brought a stock of such paper with him when he went to Australia, However, there was one little fact he did not know. The paper in question had not been manufactured until AFTER the date he left the States. Thus, he could not have taken it with him, nor could he have purchased it there. This meant the young woman had to have gotten the paper in some other way.

When questioned, she admitted that they had a cohort back in the States, a lawyer who drew up the letter the young woman sent. He mailed it to her in Australia; she signed it, and mailed it in the envelope he had also addressed. The type on the letters was compared to the type on his office machine. They matched, in best detective story style. And why did they need to bring the lawyer in? Simply because the young woman pleaded that she did not have enough expertise to successfully carry the fraud through alone.

Now, schemes do not have to be so elaborate. Desktop publishing has made it possible for people wishing to stage a death to produce authentic-looking copies of death certificates. And there are officials in some Caribbean and African countries who will accept a fee for certifying that a death has occurred. In a highly transient world, it becomes increasingly difficult to use the old procedures when an insured dies.

For example, an insurance investigator was asked to check out a life insurance claim for the death of a nine year old child who was supposed to have died in a taxi accident in a West African nation, where he was staying with his grandparents while his parents established themselves in New York. The policy was new, which was the first sign that something might be wrong. When an investigator went to the grandparents' home in the West African town, the child was playing in the front yard. A local official had signed the death certificate in return for a fee.

According to a spokesman for the Coalition Against Insurance Fraud, there has been an alarming increase in the number of reports of such swindles, especially in cases where the death has happened abroad. Nor is the selling of false death certificates restricted to officials abroad. In Los Angeles County, what look like official death certificates are sold on the streets for anywhere from $500 to $1000.

While many fraudulent life insurance claims involve relatively small policies--perhaps on the theory that insurers will be less likely to use resources investigating smaller claims-there are cases where substantial amounts were involved. In one such case, a young man used his own medical records, changing the name to one of a mythical brother, to get a life insurance policy in the fake name in the amount of $2 million. He filed a claim using a fraudulent obituary--which had appeared in the local paper--and a fraudulent proof of death, as well as a fraudulent police report. He was detected, and charged with insurance fraud.

Sometimes the very thoroughness of a claim alerts insurers that a fraud might be going on. Relatives of a deceased insured usually do not know what they need to submit to prove their claim, so when a beneficiary is quick to provide all needed documentation of the death, insurers are warned. And, of course, the absence of a body throws a red flag. That is why deaths abroad raise suspicion, as do instances of cremation when other warning signs exist.

A third form of life insurance fraud is the diversion of beneficiary funds. Consider the situation described in a 1984 court case (Crobons vs Wisconson National Life). Here, even the agent was part of a last minute fraud to replace the name of a legitimate beneficiary with an unnamed beneficiary.

The case began as an ordinary life insurance sale between agent and client. Years later, however, the client became gravely ill and lapsed into a coma. Some family members soon realized that the beneficiary of the insured's policy was a relative whom they did not approve. The agent agreed to come to the hospital and change the beneficiary.

The agent's big mistake was agreeing to witness a change in beneficiary knowing full well that the client was in a coma. After death, the damaged beneficiary filed an action against all parties, including the agent. The beneficiary designation was eventually reversed.

In another case, an agent was dragged into a situation involving an elderly woman and her son (a bad seed). The woman purchased an annuity from the agent many years ago. The bad son eventually convinced his mother that she should surrender the contract and put the money in the bank. She was not sure about it so she asked the agent to stop by and discuss it. At the meeting, the agent could see that the son was trying to influence his mother and wanted to remain outside their conflict. Before leaving, he handed the woman a withdrawal form to sign and return to him if she decided to go ahead. Unfortunately, the agent signed the form as a witness. The bad son later found the unsigned form, forged the mother's name and sent it in. When the monies arrived, he deposited the check and as a signer on her bank account he was able to withdraw $100,000. A few months later, the good son called the agent and advised him that the signature on the withdrawal was forged. To date, there is no resolution in this matter but you can be sure that the agent is concerned about his role.

Accident And Health Insurance Fraud

Fraudulent claims in health and accident insurance are much more frequent than in the life and annuity fields. For one thing, it is obviously easier to overstate or lie about physical injury and/or illness than it is to fake a death. And it is easier to stage an accident to account for the injury than it is to create a believable death.

Do people actually fake accidents, or stage one just so they can file a claim? Look at these examples. A family in Las Vegas staged a variety of "slip and fall" and auto accidents in Illinois, Wisconsin, and Ohio. Eight family members admitted to collecting ONE MILLION DOLLARS in false claims. A man, working alone and using more than 24 false names, claimed to have staged more than 200 fake accidents across the country over a twenty year career of defrauding insurance companies with false claims. An insurance investigator assembled a paper trail of 71 slip-and-fall claims that had been paid to him by more than 50 different insurers and business, claims ranging from tripping on torn carpet to slipping on water to being bumped by cars backing out of store parking lots. Caught and charged with insurance fraud, this man could get

twelve years in prison, as well as being fined $750,000 for each count of insurance fraud.

All of these are examples of bodily injury fraud, and represent several types that insurance adjusters have become all too familiar with. Slip and fall scams are favorites of those out to get insurance benefits fraudulently, and some of its users go to great lengths to stage fake falls. Some squirt the floor with water from a hidden bottle- others have put fake blood up their noses with a syringe so that their claim of a broken nose will be more believable.

The fake break is another favorite scam: it takes advantage of a new or existing injury to make a false claim. For example, a person has recently broken his or her arm, which is in a cast. An accomplice removes the cast, soaks the limb, then drives the person to the hospital for treatment, setting the stage for a false claim. Or, an old back injury might be added to a new injury to increase the size of the claim.

Some false claims come from people who have pulled items from store shelves so that they fall on top of them and cause an "injury" for which they can claim benefits. This is the ***Yank Down scam***. Or people on the lookout for opportunities for false claims find a broken or obstructed sidewalk or stairway, and then stage a fall by tripping. And there are always those who ***Chew and Sue***, claiming they have found broken glass in their salad, bone in the soup, etc.

The National Insurance Crime Bureau advises businesses to install video surveillance equipment, to run periodic in-store safety checks daily, and to send an employee along if the injured person is taken for emergency treatment. They advise consumers who witness an accident to contact the business' manager immediately, and to report everything witnessed,

More elaborate are cases of staged auto collisions, which involve more than one person. In fact, so profitable are such collisions that rings are formed to do nothing but stage them. The National Insurance Crime Bureau describes the seven steps of a staged auto collision: first, the ringleader, who is usually a corrupt attorney or doctor, hires a "capper," the person who will actually coordinate the collision and recruit people to claim injury as a result of it. Second, the capper promises financial rewards to get passengers involved. Third, the group makes a script of the details of the collision and the injuries they will claim. Fourth, the accident occurs, Fifth, the capper sends the cooperating passengers to an unethical attorney who will represent them in their claims. Sixth, the lawyer sends the passengers to an unethical medical provider who will inflate medical expenses for injuries which may not exist. Seventh, the attorney gets the insurer to agree to an out-of-court settlement for the victims involved. The resulting payment is divided among the people involved.

The fact that the innocent driver of the other car will now have a higher auto insurance premium to pay, and will have an accident on his or her driving record, does not matter to such rings, but matters very much to the person driving the other car. Thus, drivers should be careful not to put themselves in a situation where someone can use them to stage an accident. Avoiding tailgating helps. And, if involved in an auto accident, one should always make sure the police are called. It is also helpful to keep a disposable camera in the car to take pictures of actual damages and of the passengers in the other car. It might be found that these passengers have no reasonable excuse for all being in that particular car at that particular time, which could be a signal to the insurer to carefully investigate the claim.

Auto accidents can be staged by just driving a car off the road: after such an accident, the driver

can claim that another auto forced him or her off the road. A man in Pennsylvania formed a group which included his wife, his father-in-law, his sister-in-law, two close friends and his baby sitter whose sole purpose was insurance fraud. For years this group ran cars into trees and poles, slipped and fell, lost valuables, and were robbed. They took in more than TWO MILLION DOLLARS from a multitude of insurance policies, making their biggest score from a single auto accident from which they collected $495,651 from 13 insurers. The ringleader bragged to a friend that every time he went to the hospital because of his accident-caused bad back, he made $80,000.

By the time the ring was caught, the ringleader and his wife had a $400,000 house, a $300,000 duplex, investment property, $100,000 in jewelry, $40,000 in stock, a $39,000 boat, and a succession of luxury cars. He was finally convicted of mail fraud in a US. District Court in connection with faking accidents and concocting actuaries over a period of ten years and sentenced to eight years behind bars. Other members of the ring were also convicted and were given probation of their jail sentences, but were required to make restitution of the $1.4 million they had collected from 30 insurance companies for claims that were faked, staged, or enhanced.

Nor is fraud in the health and accident field restricted to patients. There is only a certain amount of money that can be made filing fraudulent individual claims, There is far greater amount to be made forming fraudulent insurance companies and other such scam like these:

- A British citizen based in Atlanta used several insurance and reinsurance operations to take in an estimated $72 million in premiums for health, disability, and business insurance from 5,500 policyholders, and then refused to pay out claims.

- A man in Maryland build a complicated network of almost 50 insurance companies and sold spurious medical malpractice insurance to hundreds of doctors.

- Two brothers operated hundreds of medical clinics and mobile labs in Southern California that offered free physicals to get patients to come in. They then billed insurers for thousands of dollars per patient for serious medical problems which did not exist, and may have gotten as much as ONE BILLION DOLLARS from these false claims.

- A large national chain which operates psychiatric hospitals was charged with admitting thousands of patients to its institutions who did not require hospitalization, and then treating them at inflated prices.

- A network of 100 in the New York metropolitan area, which included free-lance claims adjusters, employees of insurers, as well as policyholders, used staged accidents and inflated claims to defraud insurers of $43 million dollars before they were caught.

- One hundred seven defendants, including medical providers, police officers, lawyers and alleged bus passengers, formed a ring which staged bus accidents and then had people hop on, claiming injuries.

- A California firm set up "self-funded" health insurance plans from small businesses. It collected millions in premiums, moved the money into personal accounts, and left unpaid

claims totaling $10 million.

The fact that money can be moved out of the country, and that the people who perpetrate these frauds can get out before they are caught, makes insurance fraud on this scale attractive to those with a criminal mind. Once safely abroad, particularly if the money is in accounts in countries which will not reveal ownership of accounts, the criminals enjoy a life of luxury and ease, leaving policyholder victims to deal with their losses as best they can.

But the tide has begun to turn, as Commissioners of Insurance look for signs that a company is in financial trouble, and may be using fraudulent practices to stay afloat. In a two year period, thirty-two insurance executives in Louisiana were sentenced to prison terms ranging from five to ten years. All had been involved in falsifying records to keep their companies' insolvency from being known. Many insurance companies looking for ways to make money fraudulently use alien reinsurance companies--companies that, since they are outside of the U. S., don't get a lot of attention from state insurance commissioners.

However, whether insurance fraud is done by one person claiming a back injury where none exists, a gang of people staging fake auto accidents, or insurance executives stealing millions, it is, ultimately, the insurance consumer who pays the price in higher premiums. Insurance fraud is then a crime against society, for it threatens a device which helps take care of the unavoidable events that cause loss.

Workers' Compensation Fraud

There is one type of insurance fraud which hits society with a double blow, and that is workers' compensation fraud. The reason such fraud constitutes a double blow is that not only is the employer's workers' compensation insurance being defrauded, but the time the employee is away from the job creates a loss in productivity for the company. Another effect of workers' compensation fraud is that when it is prevalent, honest employees are suspect when they appropriately claim benefits for job-related illness or injury.

Remember that workers' compensation insurance covers injuries, illness, and death, suffered as a result of JOB-RELATED events. The injury, illness, or death must have occurred within the employee's SCOPE OF EMPLOYMENT, whether within the premises of the business, or outside of them at the employer's direction. And, because workers' compensation insurance is biased toward the workers, on the theory that if it is not, more powerful employers will be able to deny claims, a situation exists in which the employee making a claim is given every benefit of the doubt. This situation offers a temptation to easy money--in some cases, up to 66 percent of regular pay, on which no taxes have to be paid, for doing nothing.

States do not have the same workers' compensation laws, but all of the laws set up a no-fault method of paying medical expenses and wages lost due to job-related injuries, illness, or death. Some states offer job retraining, and death benefits to families. A majority of states require employers to pay 100 percent of medical expenses, and also any rehabilitation expenses incurred. Wage loss benefits are less generous, but may be as high as 66 percent.

The National Insurance Crime Bureau estimates that workers' compensation fraud costs almost $5 BILLION annually, and that in addition, it costs American businesses more billions in the form of higher premiums, and in other less obvious losses such as production delays, retraining

costs, and equipment replacement costs.

Nor are fellow employees, no matter how honest they are, free from the consequences of workers' compensation fraud. Companies strapped by high premiums and loss of productivity may have to use strong measures to stay afloat: they may lay off workers, put a freeze on raises and new-hires, cut the number of hours people work, or even relocate to a state with less stringent workers' compensation laws, Some companies have filed bankruptcy or gone out of business as a result of workers' compensation costs. And, once again, it is the consumer who ultimately pays, since higher premiums for employers will result in higher prices for the goods and services offered for sale.

Workers' compensation fraud usually falls into one of three types: a worker cooperates with dishonest professionals such as medical practitioners and lawyers, to exaggerate a real injury or validate a false one, a worker takes a second job while collecting workers' compensation. benefits from someone else; a worker claims that an injury suffered off the job occurred in the scope of employment, and thus claims and collects benefits.

Unfortunately, an NICB survey revealed that IO percent of adults interviewed believe it is okay for a worker who sustains an off-the-job injury to claim that it occurred on the job, reflecting that businesses are viewed as impersonal, deep pockets whose money, apparently, comes from some source having nothing to do with consumers at all.

In such a climate, it is not surprising that instances of detected workers' compensation. fraud have been on the rise.

The NICB has developed guidelines for employers to use when trying to identify possible fraud, and has listed ten indicators. The injured worker is disgruntled, or is about to be fired or laid off, the injured worker is a seasonal worker, and the job is about to end; the injured worker takes more time off than the injury would appear to need; the injured worker is having financial difficulties; the accident happens late on Friday afternoon, or when the worker returns to work on Monday; the accident has no witnesses; the accident happens just before workers strike, or near the end of a worker's probationary period; the diagnosis given is not consistent with the treatment the worker claims; the injured worker has a history of staying in jobs only a short time-, the accident occurs in a place where the employee making the claim usually would not be.

Any one of these indicators by itself does not mean that fraud is going on. Nor would the presence of several indicators prove fraud. But the presence of these indicators would indicate that a careful investigation should be made.

And, there are professionals, unethical doctors and lawyers, who take advantage of the fact that workers' compensation is set up so that there is no fault laid at either the employer's or the employee's door. Doctors perform tests and provide treatments that are not needed, while lawyers threaten litigation in order to get the sums their clients claim. An NICB survey showed that 17 percent of adults in this country think it is all right to work with lawyers, doctors, or chiropractors to falsify or exaggerate workers' compensation claims, making the temptation for professionals to indulge in insurance fraud that much stronger.

Nor are workers and unethical professionals alone in attempting workers' compensation. fraud.

Employers are also guilty. The method they use to defraud the system if to misrepresent one or more of the variables used to set their workers' compensation. premium. They falsify the amount of their payroll, or they falsify the employee's job classification, or they falsify their loss history. When falsifying payroll, they report only a portion of it. They may cover this false record by paying some employees in cash, or by fisting the wrong compensation for employees. Employers use job classifications to defraud by fisting high risk employees as having lower risk jobs. And they falsify their loss history either by an outright lie, or by using a different owner name, a different company name, or even a different location for the company when they apply for workers' compensation. Of course, when a loss occurs, these false statements will be revealed. But in the meantime, the employer has gotten away with lower premiums.

Formerly, if an insurer had not actually loss money to insurance fraud, the perpetrators were not prosecuted. But that has changed, and across the country, the law is actively prosecuting those who even attempt insurance fraud.

Take the case of Joseph Francis Brooks, 46, who orchestrated a hold-up with his cousin Pierre Lamont Taylor so that Taylor could file a false workers' compensation claim with his then-employer. On August 14, 2002, their elaborate plot was brought to fruition. Taylor was working for United Parcel Service (UPS) when the "assailant" approached him, firing a bullet into his right leg. Taylor reported the made-up ordeal to UPS and filed a claim with Liberty Mutual Insurance, UPS' workers' compensation insurer. In November 2004, Liberty Mutual doled out a lump sum disability payment of $250,000 to Taylor, who shared the wealth with Brooks.

A former friend of Taylor's tipped off Liberty Mutual to the scam, and Taylor eventually confessed to Maryland State Police. During the confession, Taylor said that he and Brooks arrived at the idea from "watching television." Brooks pled guilty to one count of conspiracy to commit insurance fraud, for which the court imposed a five-year suspended sentence and 18 months of probation.

When sentencing Brooks, Judge Michael J. Algeo said he has spent most of his working life as an attorney, prosecutor, and a judge and said, "this ranks as one of the dumbest things," he has seen anyone do. Judge John W. Debelius, III, of the Montgomery County Circuit Court, imposed a five-year suspended sentence, five years probation, and a judgment against Taylor in the amount of $250,000.

Automobile Insurance Fraud

In our study of bodily injury fraud, we learned how people stage fake automobile accidents in order to make such claims. But the same fake accidents can also result in large damage claims. How extensive is this problem? Statistics show that staged vehicle collisions are a major contributor to the $20 billion property-casualty insurance fraud problem. People who stage these collisions are inventive and thorough, even putting false witnesses on the scene to validate their story, and to contradict what the victim-driver says.

These people have favorite targets. They zero in on drivers with no passengers to dispute what they say, and go after luxury automobiles on the theory that the owners will carry a lot of coverage. And, they go to a great deal of trouble to establish false identities, renting post office boxes and even apartments to furnish a mailing address.

Staged accidents fall into several types. There is the ***Swoop and Squat***, in which the swoop automobile cuts in suddenly in front of the squat car, forcing it to stop quickly to avoid hitting the swoop car. But the car behind the squat vehicle usually can't stop, and hits the squat victim from the rear. ***Drive Down*** is yet another popular scheme. An innocent driver is trying to merge into traffic, and gets a signal from another driver that he or she will yield, and allows the victim of the scheme in. The innocent driver takes the signal as meant in good faith, and merges into traffic ahead of the signaler's car. That driver immediately smashes his or her car into that of the victim, and then denies that he or she ever signaled the innocent driver to merge.

Or a driver will drive a damaged car, and then claim it was damaged by someone who hit it and ran. Less effort is required by those who set up paper accidents: in these cases, a car owner whose vehicle is already damaged files an accident report with his or her insurer. The ***Drive Down*** is a scam that depends upon an opportunity presenting itself.- the driver wishing to set up an accident gets into a dual left turn lane at a high traffic intersection, and, if a driver in the inner lane drifts into the outer lane, the other driver sees to it that the two vehicles collide.

Defensive driving takes on additional meaning when drivers realize that not only are they vulnerable to legitimate accidents, but to those that are staged as well. In addition to the techniques suggested earlier for drivers to use to protect themselves against falling victim to staged accidents, here are others. Always look beyond the car in front of you to get a sense of how traffic is flowing. Keep at least one car length for every ten miles the speedometer shows. Keep careful watch when turning into a dual left turn lane. If an accident does occur, count how many passengers are in the other car, and get the names, phone numbers and addresses of all of them. Make sure the police are called. Get a copy of the police report.

When we consider the number of fraudulent claims, we realize that such warnings to drivers are seriously meant. For example, in 1994, investigations aided by the NICB discovered more than 4,200 actions by alleged insurance criminals that could be prosecuted. Among individual cases were those of 27 college students in two states who were charged with obtaining more than $500,000 in staged vehicle accident claims. In Virginia, in February of 1995, a ring of criminals who had allegedly gotten a quarter of a million dollars in false claims was found and its leaders were indicated. These leaders got people to fake accidents, and then sent them to medical clinics and law offices that were colluding in the scheme. In Texas, in that same year, two doctors and two lawyers, all practicing in Houston, along with 100 others, were charged with being part of a huge fraud operation which had gotten over one million dollars in false claims. In South Carolina fourteen people had received almost $600,000 through auto accident fraud. In Arizona, investigators looking at nearly 300 false claims amounting from $12 to $16 million found a ring that had doctors, lawyers, and chiropractic clinics involved.

The list goes on and on. There are simple cases, such as the following. A woman admitted to another driver that she had indeed backed into his car, but insisted there was no need to call the police. She gave the other driver her name, address, and phone number as well as the name of her insurer. The driver of the damaged car went home and waited for an adjuster to call. When no one did, he called the insurance agency, only to be told that the woman had reported the accident as being mutual fault, and had told her agent that the damage to her car was so slight that she would not file a claim. The man insisted that he had not been at fault, and described the type of damage to his car. The agent then called the client, who confessed that when she got home and told her husband about the accident, and said the police had not been called, he

suggested that she tell her insurance agent the story she in fact did tell.

This is an example of a person giving in to temptation, but it reflects an attitude toward insurers that helps create a climate in which people deliberately plan and carry out fraud.

People almost always think of insurance companies as having a great deal of money which is not connected to THEM: an insurance company can pay out enormous sums in claims, and still, society will not suffer.

This is, of course, absolutely wrong. An insurance company is nothing more than a pool of people who have merged a certain amount of resources in order to help cover losses of members of the pool. Insurance company employees have a duty to the entire pool to make certain that no monies are paid out that do not accurately reflect the kind of coverage the individual sustaining a loss had.

But there are several things that make this concept one that is easy for the public at large to forget. In the first place, when we spend money at other businesses, we come away with something concrete. But when we pay premiums, we receive only a paper policy, which few people read. Even when an agent dutifully goes over the entire policy, few policyholders pay attention. The policy gets put in a desk drawer, or a safety deposit box, and the only time the policyholder thinks about it is when it is time to pay another premium.

Also, most people have heard from friends and relatives stories of how when they did have a loss, the company did not pay them the amount they should have received. It is human nature to exaggerate mishaps: very few people complaining of being underpaid will state that they had forgotten their policy had a large deductible, or that their claim did not actually meet the requirements in the policy they bought. Instead, it becomes the insurer's fault that the claim does not really cover the loss.

And so few people derive from possession of insurance the comfort they should. They are required by law to have automobile insurance, and, if their property is mortgaged, they are required to have insurance for that. So in these cases, they do not even have the satisfaction that they are behaving responsibly by insuring themselves against possible loss.

Further, human nature being what it is, most people expect everyone else to suffer some loss, but not themselves. We can see why many people believe buying insurance is paying something for nothing, and why they shut their eyes to--or commit--insurance fraud.

It is not the purpose of this course to solve this particular problem, which definitely creates an atmosphere in which getting money out of an insurance company is not considered all that wrong. Communication between insurers and their clients does need to be improved, however, so that an understanding of how insurance works, and why it benefits society at large to make sure all claims are legitimate and real, becomes part of the way people think.

After all, there is the risk of more than just monetary loss to the insurer in a climate where insurance fraud can exist. Take the cases we have cited of staged auto accidents. Here, those staging the accidents certainly don't expect the innocent driver and possible passengers of the other car to sustain serious injury or harm. However, since the victims are randomly picked, it is not possible for those committing the fraud to know the physical, mental, and emotional

condition of the victims involved. A wreck might seem minor, but the shock of it might cause significant harm.

Of course, there are many more subtle cases surrounding auto fraud. Take the case of In Robert L. Whiteside who submitted a receipt to State Farm Fire and Casualty Company, claiming that his chrome rims and tires had been stolen from his residence during a burglary. The insurance company reimbursed the Kentucky resident a total of $3,965 for the parts, but when special investigators at the company began to review the receipt, Whiteside's story just wasn't adding up.

Not only was the change due back to Whiteside incorrect on the invoice, but the number listed on it matched a receipt given to another customer who bought other items from that store. Whiteside was also unable to verify that he did in fact own the tires and rims at any point, so the former Louisville corrections officer found himself in court.

In April 2009, Whiteside was found guilty of one felony count of insurance fraud, and was later sentenced to two years, probated for five years. Just as the years began to add up, so did the financial costs. Whiteside must pay court costs of $130, a $15 per month probation supervision fee, $3,695 in restitution to the insurance company, a fine of $7,930 as punishment for the fraudulent act, and $806 to the DOI Fraud Investigations Division for investigative expenses involved with the case. Interest will be charged on all expenses until the debts are paid on the more than $13,000 in fines.

Theft Insurance Fraud

Less risky to the general public, but still just as fraudulent where insurers are concerned is vehicle theft fraud, in which it appears that a vehicle has been stolen, but actually has not. Just as with staged auto accidents, vehicle theft fraud has a number of ways it can be achieved. In some of these, an owner "steals" his or her own vehicle, collecting the insurance money for a theft that never really occurred. In fact, a large number of fake auto thefts are committed by the owner of the vehicle involved, usually because he or she is in need of cash. Sometimes the motivating factor is that the owner can no longer keep up payments on the vehicle, or the insurance required. Sometimes the car needs major and expensive repairs. Sometimes a fake theft is a way to make money from a car without going through the process of selling it. But in all cases, it is the insurance company, and, ultimately, its policyholders, who pays.

There are several ways in which vehicle theft fraud is done. A popular method is to hide a vehicle and then report it stolen. When the claim is paid, often within 30 days time, the car turns up, as though it had been abandoned by the thieves. By this time, the owner has used the insurance money to buy a better car, and the insurance company is stuck with the "found" vehicle, which may be counted upon to need expensive repairs.

Yet another scam relies upon the overseas market for cars. Perpetrators rent luxury cars, make sure there is good coverage on them, and then report them stolen. The rental company gets reimbursed by the insurer, and the car joins other "stolen" vehicles aboard a ship bound for a lucrative market abroad.

Similar to the "paper accident" scam in faked auto accidents is the "***phantom vehicle***" scam. In this one, a person creates phony documents to prove ownership of a vehicle, often a luxury car,

or a classic antique. He or she then purchases insurance for the vehicle, and later, claims it has been stolen. One example of this scam involves a man who claimed that his entire collection--nine vehicles in all--had been stolen. The nine classic cars had been in a storage facility, or so he claimed. His insurer paid him $270,000 for the claim, and he then went on to make the same claim with a second insurer. Perhaps elated by his success, he over-stated his case, claiming this time that the tools had been stolen as well as the cars. But the receipts he submitted to prove the number and value of the tools were fake--upon closer investigation, the insurer determined that some of the information on the cars was also made up.

And there are cases where a person has committed a crime involving his or her vehicle, and has abandoned it and reported it stolen so as to avoid liability for whatever damage he or she caused. People involved in hit and runs, or who damage a parked car in a parking lot, are often guilty of this.

Yet another scam involves ***switching drivers***. This occurs when the person driving a vehicle involved in an accident either does not have a driver's license, or has a record of accidents. The legal (and premium) consequences of being responsible for an accident are worse for the true driver than for a passenger who has a driver's license and no record of accidents. Before the police arrive, the driver and passenger switch places. Even when there are witnesses, it is sometimes difficult for people to accurately remember who was driving when they are excited or upset by the accident itself. And, if the people involved in this fraud keep to their stories, it is unlikely that witnesses' reports will be believed.

How does this defraud insurers? Simply because the vehicle premium one pays is based, in part, on one's record as a driver. If a person who has been in many wrecks is able to conceal this from the insurer, he or she will not be paying a premium commensurate with the amount of risk he or she represents, and is thus cheating other members of the insurance pool.

Not all theft fraud involves automobiles. Travelers may claim to have been robbed on the street by an assailant who saw them changing money and waited for them to come out of the bank or exchange office. Or they may claim that certain items were stolen from their luggage in transit. Another popular scam is for a woman to wear a fake fur to a large party in a private home, and to call the hostess the next day claiming that when she went to retrieve her valuable mink, someone had taken it and left the fake fur in its place. Since the hostess can hardly be expected to remember exactly what each guest wore as she arrived, the hostess will not be able to prove that the guest did not in fact wear a valuable coat, and will file a claim for the lost coat's value. Meanwhile, the mink coat is safely in its owner's closet, along with the fake that makes the scam work.

These are examples of small frauds, but they add up. And worse, they add to the feeling that it is okay to cheat insurers, those companies with deep pockets full of money just waiting to be taken.

The use of schedules for jewelry, furs, and other objects of value make it more difficult for perpetrators of fraud to invent a "lost" object, but easier for them to establish value if they claim theft. And, in a time when muggings are frequent, and of such a large number that police forces can do little to either stop them or catch the muggers, it is easier for people to claim the loss of a valuable piece of jewelry to a person who robbed them on the street. Also, when a person has been robbed, he or she may take advantage of that to report stolen objects of greater value than

those actually taken.

Theoretically, all claims should be investigated so thoroughly that no possible lie would go undetected. But in reality, insurers can afford to spend just so much time investigating claims. For example, in the aftermath of Hurricane Opal, a real estate agent claimed loss of rent for a property that had been destroyed. Although the sale had not yet been closed, the property had been sold: closure took place some three days after the storm occurred. Because the agent had been the owner when the hurricane hit, she worked with the adjuster to determine the amount of loss. The monies involved would be paid to the new owner, who could then make repairs. When the new owner received a copy of the claim, she noticed that the real estate agent had included several thousand dollars in lost rent.

There were two things wrong with this claim. First, the property had not been rented, and second, even if it had, the monies would not belong to the former owner. The new owner called the insurer to tell them that this part of the claim, as well as the part that listed physical damages, were incorrect. The physical damages had been over-stated: all in all, the claim was fraudulent to the extent of about $3,000.

The insurer's response was to thank the new owner for reporting the fraud, but commented that with so many thousands of claims to settle, and so many suspected cases of much higher fraud, they could not spare people to investigate a claim of only a few thousand dollars. The real estate agent making the fraudulent claim may well have had enough experience with the pressure a disaster such as a hurricane puts on insurance adjusters and claims department, and felt confident that so small an amount would go untested. But add hundreds of other such "minor" frauds up, and the amount makes a significant contribution to the $20 billion annual bill for property and casualty fraud.

At the other end of the scale from such pedestrian frauds is a type which for most people would be pretty difficult to believe. This fraud involves the hired killing of expensive race horses who are literally worth more to their owners dead than alive.

Astonishing as it might seem, one man made a living for nearly ten years by killing animals their owners needed to get rid of in a way that would make the insurance on them pay.

His own favorite method was to electrocute horses, but at least one owner asked him to break a horse's leg so severely that the animal's veterinarian would order it killed. Nor is this killer an isolated example. Throughout the world of show horses, killing horses to get the insurance money is all part of the way things work. Such a scenario would seem to go against the public image of horse-owners having a devotion to their animals, a devotion familiar from movies sentimentalizing the relationship between owner and horse. But show horses are big business, and the animals cost a great deal of money, money that most owners cannot afford, or are not willing, to lose.

An owner might pay as much as $500,000 for a yearling of good blood-lines, with the expectation that the horse will earn back the investment and more winning prize money, and, later, with fees paid for stud services. But suppose the horse turns out not be a good runner, or to have a temperament making it impossible for it to be trained? Suppose it damages a leg, making it unfit to race? With no track record, it will not bring high fees as a stud. What is an owner to do? Some might turn the horse out to pasture, and take the loss. After all, horse

raising is a risk-filled business. But others see the amount of cash they can get if the horse dies--and before too long, it does.

Sometimes investigators can detect foul play in the death of such a horse. But often enough they have not, and some very large claims--one that totaled $36.5 MILLION--have been paid.

Fire Insurance Fraud

One of the most prevalent fraudulent activities, and one that costs insurers millions of dollars every year, is arson--the deliberate setting of a fire. Many of the acres destroyed in forest fires each year are the target of arsonists, and many buildings are destroyed by fires set by the people who own them.

There are usually ***two motives for arson***: one, the arsonist is trying to get back at the property owner. Some forest fires are set by people with grudges against large lumber companies, and businesses may be the victims of fires set by angry employees, rival businessmen, or customers with a beef.

These, though criminal, are not an act of insurance fraud. Fraud occurs when the insured sets, or has set, a fire to destroy a building that, like the expensive horse, is worth more ruined than in good shape.

There are all sorts of reasons for burning one's own property, but, like all other instances of fraud, a need for money lies at the bottom of such acts. And, the need for money arises from the fact that the property is not producing the income it once did, or has become a drain on the owner's resources.

For example, many cities across this country now have pockets of decay and decline where once-flourishing businesses have now closed. The buildings formerly occupied by stores and offices are empty, boarded up and vulnerable to vandals and the other results of disuse. In some cases, the land under a building is more valuable than the building itself.

Arson is seen as an easy--and profitable--method of getting rid of the building while raising some cash. Arson can usually be detected by the team investigating the cause of the fire: sophisticated lab techniques make it possible to detect the use of chemicals and other fire-starters that would have escaped notice when techniques were less refined. Still, creative arsonists can set fires in ways that make it difficult to determine just how the fire started, and also, even if arson is obvious, the blame can be put on someone else. Particularly in areas noted for vagrants, an unknown arsonist can be blamed.

But there are factors that, when present, indicate that the owner might be the one who set the fire. When a property is vacant over a period of time, or has not been well-maintained, or has been on the market for a long time, or has an absentee owner, or has had many changes in ownership, and then is destroyed by fire, investigators usually interrogate the owner carefully, and look more deeply into his or her affairs.

Other signs are owners who have questionable finances, who often have difficulty meeting tax and mortgage payments, or who have a number of losses by fire or theft in the past. There may

be co-owners who are in a seemingly unresolvable dispute as to how the building should be managed. Perhaps there is new business in the building, with an owner about which little is known. Or the owner might have other insurance on the building that has very high limits. Sometimes owners have criminal records. And even a simple thing like avoiding using U.S. mail could mean that the owner wants to avoid charges of using the mails to defraud--a federal offense.

These are all signals that the owner might be an arsonist, though they certainly do not constitute proof. There are also circumstances concerning the fire itself that warrant a closer look.

The fire department says that the fire has a suspicious origin. The fire policy is of recent date, or has recently been increased. The policy's face value is greater than the property's market value. The insured has had previous fire losses. The land would sell for a higher figure if there were no building on it. New building codes would force the owners to spend money for repairs and upgrading to code. The property has been condemned. Rent and payments of supplies and services, are delinquent. The business housed in the building was doing worse than the owner claims, or the owner removed the inventory before the fire. Financial records were destroyed by the fire. When the claim is audited, there is a discrepancy between claimed losses and the merchandise on hand. No remains of furniture or fixtures are found in the ruins. The method by which the fire began and spread is like that of other fires in the neighborhood.

One would think that building owners who set fire to their own buildings would know that the risk they take will probably not pay off: as fire departments and law enforcement agencies and insurers become more aware of the way these frauds work, and as computers make complex record-keeping possible, the possibility of getting away with arson, particularly of a building, gets less.

But people who risk committing fraud are gamblers, and they are playing with the aspect of insurance that is said to be like a gamble: the policyholder gambles that he or she will sustain a loss, and thus get something back for the premium paid, and the insurer gambles that he or she will not. It is thus comprehensible that some people would want to "fix the odds", just as crooked card players do.

Fire policies of course have to factor losses by arson into the premiums charged. In fact, the problem of arson became so bad in inner cities that insurers stopped writing such coverage in the years after riots such as those that occurred in the Los Angeles neighborhood of Watts. In a typical study, the Missouri Department of Insurance found that major insurance companies made it more costly--and in some cases impossible--for low-income, minority homeowners in urban areas to purchase policies. Even when policies were sold, they were far more likely to be limited fire insurance policies rather than the comprehensive homeowners' coverage available in other areas. Still, inner city policyholders paid more per $1,000 in coverage--due, of course, to the loss records when these neighborhoods first began to decline.

Insurers have to look at loss records when determining rates. When vandalism and arson caused severe property loss in certain areas, it is understandable that properties in these areas were defined as being high risk. And, like floods, riots and other criminal acts are not predictable: all one can do is look at the past record, and establish a probable incidence of property crime.

However, when insurance regulators in California found that nearly half the homes and businesses that had been damaged in the riots in Los Angeles were not insured, either because of prohibitively high rates or refusal of companies to issue policies in these areas, the situation began to change.

State Farm, which insures nearly one out of every four homes in the U.S., no longer considers the age and value of a home when issuing policies. Other large insurers have followed suit, making insurance for people living in inner cities available again. And, in an effort to educate homeowners as to what they can do to reduce incidents of arson and vandalism, some insurers are offering discounts to homeowners who attend a safety seminar and install security devices, much as automobile insurers reward safe drivers with lower premiums.

Still, insurers may experience higher loss rates in inner cities, making these policies less profitable. However, a vice president and senior lawyer for State Farm said, "The private sector cannot get away with purely economic considerations. You're certainly trying to make as much profit as you can. But the political and community pressure is on you to invest part of your assets and capital in less than promising markets. This is a major consideration."

When the owner of a property burns that property, the criminal act will have effects on others, but not as directly as when arson is committed during a riot. Here, the victims are often neighbors of the rioters, and are caught in a disaster to which they have contributed nothing. When insurers take steps to see to it that these victims still have access to insurance for their property, they are acting in a socially-responsible way.

Boat Insurance Fraud

One of the most creative types of fraud is maritime fraud--after all, a ship is a large object to hide! Indeed, one case is a hallmark of maritime fraud, involving as it did a supertanker named SALEM. Here is a quote from a story in the March 21, l993 edition of TIME magazine about this super-sized fraud.

"It took three years, but the South African public has finally learned. . . last week how its government lost $30.5 million in what has been called the biggest maritime fraud in history. The disclosures were made during a parliamentary debate. . . after which the government. . . tried to prevent both its critics and the press from discussing the matter any further. It's grounds: all information concerning South African purchase of oil, which are in contravention of world embargo to block such sales, is a state secret.

"The case involved the supertanker SALEM. . . which off loaded 180,000 metric tons of Kuwaiti oil at the South African port of Durban in late December l979. In Parliament last week, the South African government acknowledged that it had paid $45 million for the oil, The ship then sailed for Europe, but sank mysteriously in the Atlantic off the coast of Senegal on January l7, 1980. The trouble was that the cargo. . .left in Durban had actually been owned all along by the Shell International trading company, and the SALEM was supposed to have been carrying it to the Italian port of Genoa. As soon as it became known that the SALEM's cargo had in effect been sold twice, there were allegations that the tanker had been scuttled to hide that fact. The South African government revealed. . . that it has subsequently paid an additional $30.5 million to Shell in partial compensation for the loss. . . "

Such huge frauds are the exception, of course, but there are plenty of small operators who manage to cost marine insurers money with their inventive scams. There are three general classification of marine fraud--The Rust Bucket or Scuttling Fraud, Documentary Fraud, and Charter Boat Fraud.

In the first type of fraud, an older boat, perhaps one that is becoming "a hole that sits in the water and eats money," is loaded with cargo and sets out to deliver it to the cargo owner. Cargo and boat are both insured for amounts above actual value. Then, the ship sinks. Many times, weather conditions are fine, and offer no solution to what caused the ship to sink. Normally, the crew is able to leave the ship and get into life-boats so that there is no loss of life. Both of these circumstances are, of course, signals that the sinking may be a fraud. There are cases where the cargo was never loaded at all, and is sitting high and dry while the ship supposedly carrying it is scuttled, or abandoned in a place where it will not be found.

Documentary Fraud involves the use of forged or altered documents which cover the fact that a cargo has been stolen. One such example is a case in which 38,526 metric tons of crude oil with a value of $15 million dollars were siphoned off at sea and sold to another buyer. Forged documents covered the shortage. Another example is when marine crooks switched a $30 million cargo of coffee for sand, gravel and broken glass.

Charter Party Fraud uses a variation of Documentary Fraud. In this scam, a fraudulent operator charters a small tonnage vessel, paying the smallest amount necessary to hire it. He then sells the cargo space, and gets the freight charge from the shipper. Once the ship is loaded, and has left for its destination, he disappears. When the ship owner tries to collect the payments due for the use of the ship, he is left empty-handed. And, if the scam is detected before the cargo is delivered, the shipper may well have to pay freight charges again.

Registering boats that do not exist, insuring them and then reporting them stolen or lost at sea is a simple process. The Insurance Crime Prevention Institute has many such cases, including one involving one person who forged NINETEEN Manufacture's Statements of Origin for nineteen boats that existed only on paper. There is no requirement that boats be inspected before they are registered, so the "owner" of these ghost vessels was able to get insurance on them. Of course, all nineteen were eventually "stolen," and the owner reaped a small fortune in insurance claims.

But there are others who often share in the bounty from illegal claims, and these, unfortunately, are insurance adjusters themselves. Property-casualty insurance industry figures show that approximately TEN PERCENT of the $200 billion annual claim payments made are for false claims, and that the adjusters have colluded with property-owners to file them. We have already touched on this subject in prior sections; let us examine instances of adjuster fraud a little more closely here.

Water Damage Fraud

Certain types of fraudulent claims are popular with corrupt adjusters. Water damage claims are easy to stage: in one example, a public adjuster from New York had a plumber install a urinal in such a way that employees of the business could break the pipes connecting it to the water pipes. In another case, an adjuster suggested to a Florida company that it make a claim based on a ladder slipping in a warehouse, hitting and breaking and sprinkler head, and causing a $1.7

million inventory loss. Other scams involve "damaged goods" which are moved into a building for photographs to support the claim.

Public adjusters, who are usually paid 10% of whatever the insurer pays the claimant, obviously have a solid motive for fabricating or exaggerating claims--the more their client gets, the higher their fee. Of course, as in any industry, there are good and bad public adjusters. In the case of fraudulent claims, the some may charge up to 50% of the yield. Such corrupt adjusters rely on the fact that the claims-adjusting process is highly vulnerable to corruption. Because time and personnel are limited, most claims under $50,000 are settled with little oversight by the insurer. Furthermore, the distant insurer has to take the word of people on the scene--salvers, adjusters, accountants and so on--that the claim on paper accurately and truthfully reflects the claim in reality.

For the individual paying the premium, it probably seems inconceivable that so many fake claims get paid. But when we consider that an insurer with one million insureds may have only one hundred people servicing claims, it is easier to understand how fake claims slip through. And, were more personnel added, there would be higher administrative costs which would also show up in higher rates. That cut-off line of $50,000 represents the amount of loss insurers can absorb when measured against the costs of investigating claims under that limit. As we have seen, one way or another, insurance fraud is a costly business.

Agent fraud

A discussion about insurance fraud would not be complete without mentioning the misdeeds of agents. Consider the following types of agent fraud:

Misrepresentation of Value

An agent sold annuity policies to mostly retired clients where the average purchase was about $20,000. The agent typically represented that the principal was available at anytime and the accumulation value of the contracts were guaranteed to grow to certain levels. Both representations were so false so as to prove a fraudulent scheme for which the agent was liable.

Paid-Up Policies

An agent sold whole life policies under the assumption that coverage would be “fully paid” in six years. After six years it became apparent that the policies would not come close to being paid up. The courts determined that the agent’s actions constituted fraud.

False Statements by Agent

An agent sold disability policies to his clients on the basis that coverage could be extended for life for an additional premium, when in fact, the policy and rider required a higher level of disability occur before life benefits could be awarded. The court was clear to point out that any agent who does not understand the differences between two products he is selling is subject to liability for fraud.

Agent Mistatements on Application

An agent helped a client fill out an application for homeowner's coverage. The client supplied information that he had previous claims and was canceled by another carrier. A loss resulted and the insurance company refused the claim upon learning that the agent intentionally omitted the client's claim experience. The agent was accused of fraud.

Agent Back-Dating

An agent received an initial premium from a client three months prior to a fire that damaged the client's home. Upon learning of the fire, the agent scurried to obtain insurance he had neglected to purchase by altering his postage meter to give the appearance that he processed the application two days prior to the fire. The insurance company received the application three days after the fire and uncovered the fraud.

Signature Fraud

A policy was sold with $100,000 in uninsured motorist coverage. When the client submitted a claim, the insurance company produced a "Reduction Agreement" which reduced coverage down to only $25,000. The agreement purported to bear the signature of the client although he denied signing them. Eventually, the courts determined that the agent had signed the client's name thereby committing fraud.

Adjuster Fraud

The adjuster community has its own "bad seeds" . . . here are just a few:

Family Embezzlement Charges

A former claims adjuster allegedly stole more than $147,000 by issuing ***bogus settlement checks***. The family was arrested as the result of an investigation conducted by the California Department of Insurance (CDI) into alleged insurance fraud.

Melody Ann Mosqueda, a former insurance claims adjuster, was arrested as she appeared at the San Joaquin County Superior Court in Lodi, California on an unrelated criminal matter; she is charged with 13 counts of insurance fraud, money laundering, grand theft and burglary. Rachel Lee Anthony-Mosqueda was arrested last night by the Elk Grove Police Department; she is charged with nine counts of insurance fraud, money laundering and grand theft. Anthony Charles Mosqueda was arrested at his residence; he faces 10 counts of insurance fraud, money laundering and grand theft.

CDI's investigation was assisted by Zurich and Fireman's' Fund insurance companies. Bail for each family member was set at $250,000. The case is being prosecuted by the San Joaquin County District Attorney's Office.

CDI was alerted to the Mosqueda family's alleged scheme when workers from both Zurich and Fireman's Fund insurance companies independently discovered discrepancies in a claim Melody Ann Mosqueda had handled for their companies. Both companies conducted internal audits and discovered multiple discrepancies in multiple claims.

According to CDI detectives, Melody Ann Mosqueda perpetrated an embezzlement scheme while working for Zurich and Fireman's' Fund insurance companies as an insurance claims adjuster from 2003 to 2007 by allegedly inputting false information into legitimate insurance claims, then issuing payment for fictitious settlements and/or services. It is further alleged that these checks were issued to and cashed by Mosqueda and her family members. The Mosqueda family also apparently created several bogus companies to which Melody Ann would then issue insurance payments and subsequently cash those checks.

CDI uncovered that Mosqueda actually had created and diverted checks totaling more than $175,000, but some check remained not cashed.

Unlicensed Contractors Sentenced for Soliciting 2007 Wildfire Victims

Roger Paul Rajcic, 49, of San Diego, pled guilty to one felony violation of contracting without a license during the October 2007 Witch Creek Wildfires. Darrien Carl Webster, 40, of San Diego, also pled guilty to acting as an unlicensed public adjuster. Webster was sentenced to three years summary probation and ordered to pay $600 in fines and restitution.

"Unlicensed contractors and public adjusters routinely swarm wildfire zones to take advantage of disaster survivors," said Commissioner Poizner. "These individuals should beware - the Department of Insurance will find you and prosecute you if you attempt to dupe fire victims who have already endured too much hardship."

According to CDI investigators, a couple lost their home in the 2007 Witch Creek Fire in Ramona. The couple contracted with Rajcic and Webster, who, unbeknownst to the couple, were unlicensed. Rajcic was contracted to rebuild their home and Webster agreed to handle their insurance claim. When the couple discovered that both men were unlicensed, they contacted the Contractor's State License Board to file a complaint. The Department of Insurance was notified of the situation and jointly investigated the case with the Contractor's State License Board.

As a matter of practice, CDI routinely sends strike teams of enforcement officers to fire zones to conduct undercover operations to identify and help prosecute unlicensed contractors and public adjusters who attempted to scam wildfire victims.

Fugitive Extradited and Arrested After Scamming California Homeowners Out of Almost $100,000

A fugitive who fled California after he was convicted of swindling eight homeowners out of their insurance claims. Norman Hugh Baker, 52, failed to appear in the Torrance Courthouse for a June 7, 2007 sentencing hearing. A bench warrant was issued for his arrest following his failure to appear. California Department of Insurance (CDI) Investigation Division officials tracked down Baker in Lawrenceville, Georgia and transported him back to California on August 10, 2007. Baker faces a maximum of five years in state prison for a grand theft conviction and for his failure to appear in court.

CDI investigators discovered that Baker posed as a licensed public adjuster and conned eight homeowners out of almost $100,000. Baker convinced homeowners that he would help them with claims recoveries for rain damage. He obtained several insurance claims settlement checks

issued to him and the homeowners. After receiving the checks, homeowners were instructed to endorse them to Baker who claimed he would use the funds to conduct property repairs. Baker never arranged for any repairs, and instead pocketed $95,038.65 in claims checks.

In November, 2006, Baker pled no contest to one count of felony grand theft. He was ordered to return to court on January 4, 2007 for sentencing and to pay restitution to his victims. As part of his plea agreement, Baker paid half of the restitution he owed at his January 4, 2007 hearing, totaling $47,519.33. Baker was ordered to pay the balance of restitution on June 7, 2007. After failing to appear for his set court date, a warrant was issued and Baker was extradited from Georgia.

An Insurance Adjuster Pays Himself

Brandon Dial was an insurance adjuster who defrauded his employer by paying himself and others for invalid insurance claims. He contends that the district court erred by increasing his offense level under **U.S.S.G. § 3B1.3** for abusing a position of trust. He argues that he was merely a "run-of-the-mill" claims adjuster without significant professional or managerial responsibility.

The court said Dial had discretionary authority to settle and pay claims of up to $ 10,000 and *de facto* discretion to settle and pay up to $ 25,000 for some property claims. That authority placed him in a posture to commit the offense superior to that of the general public, thereby putting him in a position of trust that he abused.

Carrier Antics

Misbehavior is not limited to agents, adjusters and consumers. Many cases involve the carrier or insurer. Consider, for example the case of *McKay v. State Farm Mutual Automobile Insurance Co*. (1995).

In *McKay*, the plaintiff insured brought multiple causes of action against her automobile insurer that arose from its refusal to pay for damage to her car caused when an intoxicated pedestrian ran into the side of her Chevy Blazer on the freeway.

Although the driver of the Blazer had swerved in an attempt to avoid hitting the drunken darter, nonetheless the man and the vehicle collided. The man was subsequently run over by two other vehicles, and, unsurprisingly, suffered a far worse fate than the SUV. Still, the vehicle was significantly damaged and needed some major repairs.

The insured looked to her auto policy, which contained comprehensive property coverage only. She contended that because it was a man who ran into the side of the vehicle — instead of an object — it was not a collision under the definition of the policy. Therefore, she argued, the policy should unambiguously provide for coverage because it paid for direct and accidental loss to the damaged vehicle.

The defendant insurer disagreed, maintaining that under the terms of the policy and the law of the state, the insured did not have collision coverage; the accident was a collision; and thus the insured should have no coverage. In language very much the industry standard, collision was defined in the insured's policy as "the upset, or collision with another object of your covered

auto." With its own take on the meaning of the term, the state Supreme Court had adopted a definition of collision as "the meeting and mutual striking or clashing of two moving bodies or of a moving body with a stationary one."

Looking for coverage wherever it may be, the insured alternatively argued that there was coverage under the policy because the loss had been caused by "contact with a bird or animal," and thus it fell within the policy's comprehensive coverage. After all, argued the insured, if a deer ran into the side of her vehicle, then the loss would be covered. But why would it be any different with a human "animal"?

The court was not persuaded. Rather, it agreed with the insurer that a human being is, in fact, an "object." Relying on supporting case law precedent, the court refused to accept the insured's argument that this was not a collision because there was no object involved.

The court also pointed out that Black's Law Dictionary defines an animal as a "non-human, animate being that is endowed with the power of voluntary motion." Further, the court stated that the word "animal" had been defined in case law to mean "animal life other than man." Therefore, in the court's eyes, partying though he might have been, this pedestrian was no animal.

One cannot say this is fraud on the part of the insurer, but it is certainly a stretch when a collision has clearly occurred, regardless of the source, and a claim is denied.

The Cost of Fraud

Let us review the costs of fraud to insurers, to consumers, and to society. There is a dollar cost to insurers--$20 billion a year to the property-casualty industry alone.

That adds up to an enormous amount of money, all of it passed on to the consumer in the form of higher rates. As we have noted, it is estimated that insureds pay on the average $200 more per year in premiums to pay for insurance fraud. Nor does society as a whole escape the results of insurance fraud. An industry that has the purpose of protecting members of society from losses resulting from identifiable and quantifiable risks has to spend an inordinate amount of time and money investigating fake claims, or being more thorough when processing applications, leaving less time and money for fine-tuning the instruments it uses to protect policyholders. And, when cases of fraud become publicly known, a certain erosion in the faith of the public in insurers begins. Further, a climate in which people think it is all right to defraud insurance companies develops. After all, if the fellow down the block and the woman across the street got away with padding a claim, why shouldn't I?

It is this erosion of public trust that is perhaps the most serious consequence of insurance fraud. Trust is the essential element in the contract between insurer and insured. The insurer must be able to trust that the insured is accurate, thorough and truthful when applying for insurance and also when filing a claim, and the insured must be able to trust that the insurer is overseeing both applications and claims effectively so as to detect false statements and fake claims.

Penalties for Fraud

Unfortunately, for a long time, people attempting insurance fraud and failing were not prosecuted: the only cases that went to court were those that succeeded and were later found out. Now, federal statutes making it a crime to send documents intended to defraud through the U.S. mail are used to prosecute those who attempt insurance fraud, even when they do not succeed. An expanded ***mail fraud*** statute includes materials sent or delivered by any private or commercial interstate carrier, meaning that people who did not use the U.S. mails so as to avoid charges of mail fraud do not have that out. Also, sections of the federal crime bill apply directly to insurance fraud. These sections address false entries of a material (important) fact in the books, records, and statements of an insurer if the entry is meant to deceive interested parties about the solvency of the company; as well as making it a crime to use, or even attempt to use, force or threats to corruptly influence, impede or obstruct any insurance regulatory proceedings or any insurance regulator or examiner. Further, the bill defines most proceedings before state insurance regulators as official proceedings, a definition that protects witnesses who attend or testify at said proceedings. Another important section of the crime bill prohibits ex-convicts whose felony crimes involved dishonesty or breach of trust from being in the insurance business, unless written exceptions are made by the appropriate state official. Persons convicted of charges under this bill usually get up to 10 years in prison, although they can get as much as 15 years behind bars. And, civil actions and injunctions can also be used against those who violate these new criminal insurance fraud statutes. The maximum penalty in a civil action is either the amount the person received or offered for the prohibited conduct, or $50,000, whichever sum is higher. Admittedly, however, it is only the largest and most significant cases that get to court, the cost of litigation in both time and money militating against taking "minor" cases that far.

The staging of automobile accidents is specifically addressed in new legislation on the heels of victim motorists who have been injured and killed.

In California, under existing law, it is unlawful to knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim. Existing law imposes a up to a 5-year enhancement for each prior felony conviction for any person who violates this provision and who has a prior felony conviction for any specified offense against insured property or insurers.

Current laws on the books also impose penalties for the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer,
with an intent to defraud.

(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of a motor vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit which was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal or knowingly fail to disclose the occurrence of an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(4) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

Every person who violates the above rules is guilty of a felony punishable by imprisonment in the state prison for two, three, or five years, and by a fine not exceeding fifty thousand dollars ($50,000), unless the value of the fraud exceeds fifty thousand dollars ($50,000), in which event the fine may not exceed double of the value of the fraud.

There is another factor in insurance fraud which makes it increasingly difficult for insurers to determine how much risk is attached to each policy they write. That factor is the amount of money juries award when claimants sue an insurer on the grounds that the insurer did not fairly settle a claim. When a claimant takes an insurer to court in such a case, the insurer is vulnerable to two types of damages--tort damages and punitive damages. The tort damages will be awarded if the insurer is found guilty of not honoring the contract. Punitive damages may also be awarded. And these costs are impossible to predict.

For example, there is the case of a young woman who claimed that a burglar had taken all her jewelry, along with other valuable personal property. The adjuster learned, during the course of his investigation, that she had lost property in three previous burglaries. He also noticed that some of the property in her apartment seemed very like that on one of these previous claims. And when the young woman commented that she had received a certain object from a friend whose name seemed familiar, the adjuster went back and looked at the prior claims. One of them was in the name of the friend she had mentioned and this claim, for stolen jewelry, had ten items that exactly matched items on the young woman's present claim. In two cases, items were wristwatches with exactly the same serial numbers.

The adjuster went back and told the claimant what he had found, expecting her to retract what was clearly a false claim. Instead, she hired a lawyer, who threatened to sue the insurer if the claim were not paid. On its side, the insurer had written proof. On the lawyer's side was an attractive young woman with a decidedly innocent air. There are all too many such threats, and all too many cases in which insurers pay fraudulent claims rather than run the risk of high damage awards in court.

A more equitable way to deal with disputes between insurers and insureds is to apply contract damages only: that is, to require insurers only to pay the benefits defined in the contract should they lose a dispute with an insured.

Only the removal of the temptation to "strike it rich" with punitive damages will correct a situation in which people think of insurers as golden geese with an unlimited supply of golden eggs.

When individuals are convicted of insurance fraud, they are subject to both jail sentences and financial penalties. The severity of the sentences and the penalties depends, of course, on the severity of the crimes with which they are charged. Insurance fraud can bring charges of conspiracy, extortion, theft, violations of federal securities laws, obstruction of justice, and bank, wire and mail fraud. These are often known as "white collar" crimes, because they are committed by people of education and, usually, executive position. Although violence may not be involved, and no one is murdered during the commission of these crimes, still, when one considers the social cost of such crimes, it is clear that the individuals committing them deserve penalties as severe as the consequences of their acts.

Preventing Fraud

Insurance fraud is a problem of large proportions, and the insurance industry is constantly taking steps to solve it. Some of the steps can be taken by agents and adjusters. Others are being taken industry-wide. And others are being written into laws, as we have seen.

Let us look at some of the things individual agents and adjusters can do to stop insurance fraud.

First of all, agents should personally inspect any property covered by a policy they sell. In the case of valuable property, or in instances when there are multiple risk factors, photos are useful in later establishing the validity of claims. Proof of a property's value should also be asked for: there are varying factors which change a property's value, and these should be identified and known. Agents should also be wary of "walk-in" business that results in a large policy being sold. Most people who buy sizable insurance policies are in a position to have an agent on call;

this is one instance when one should definitely look the gift horse in the month. A more thorough than usual investigation of the potential client's background--credit reports, for example--might reveal information that would allow the policy to be declined. Agents should also talk about risk reduction to clients whose property is vulnerable to risk. Material relevant to their particular property and its safety should be made available. All too often, agents fail to educate clients in maintaining and protecting their property. Doing so might give the agent a feeling for the client's attitude toward the property--very often, it is intuition rather than concrete knowledge that points the way later to a suspicious claim.

Suspicious claim profiles help adjusters determine whether or not a particular claim should be closely investigated. Automobile insurance claims, for example, have a number of indicators that fraud may be present. The policy is relatively new, with a short time period between the time it was bought and the time the claim was filed; the policy was for comprehensive and collision only; the agent didn't know the applicant, and did not personally inspect the property/vehicle. The driver's license is new, is temporary, or is a duplicate. It is an out-of-state license. Does the age of the insured/spouse match the car? For example, a teen-aged couple driving an expensive car might be a tip-off to fraud. How long has the insured lived at his/her current address, and how long at the previous address? If the answer is six months or less, a warning flag goes up. PO Boxes and relative's addresses are also flags, as are transient residences, such as hotels, motels, trailer courts and the like. If the home telephone number is an answering service/device, or if a friend or relative's phone number is used, the claim is possibly fake. People who are self-employed, recently employed, or vaguely employed, should be looked at, particularly when the business isn't in the phone book or with information. If the car has been recently bought, if the seller's identity isn't provided, if it is an out-of-state vehicle, a gift, or had a really high or really low purchase price, if it was rebuilt from salvage, or has been upgraded with expensive accessories or equipment--all of these are signals of fraud. Also, if there are no receipts for additions to the vehicle, or if it was stolen before, or if the claimant is vague about financing or has recently refinanced the car, look out! Other signals are current financial problems, or a vehicle recently repossessed. If the claimant services the vehicle himself/herself, if the vehicle has recently been for sale, or if the insured was not the last driver of the vehicle before it was stolen--again, this may be a case of fraud.

More can be done to investigate the nature of entities. Let’s say for example an adjuster is working on a construction defect claim. He should consider whether any given claimant, when the property was purchased, may have himself been the beneficiary of a reduced price with an "as-is" provision in a contract of sale-offer and acceptance. If so, the claim has little or reduced value.

Furthermore, was there anything in the agreement could have required the seller to place a significant amount of money into an escrow account, e.g., a fund to replace known stucco cracks. Who held the trust account funds, when it was disbursed, to whom, and for what purpose?

If the claimant is found to be double dipping then she or he might then be guilty of insurance fraud that could subject her or him to felony charges and prison time. To get this information contact the closing attorney involved with the claimant’s purchase of the subject home. An alternative would be for defense counsel to subpoena all records from the real estate firm that handled the transaction.

Adjusters should also beware if the claimant can't provide the identity of a prior insurance carrier, or a prior policy number. When the premium is paid in cash, or when it has to be financed despite the fact that the insurance is on an expensive car, the claimant may be a fraud. Further, look at the report of the theft. If the handwriting is illegible, if the report is incomplete, if there is a delay, check further. The insured's story may differ from the police report, or perhaps the insured did not report the theft to the police. Sometimes fraud is indicated if an insured goes home to call the police rather than reporting the theft at the scene. The vehicle may not be registered with the Department of Vehicles for the current year, or it is registered or titled in a name not that of the insured, and the individual on the title can't be located. Sometimes fraudulent claimants are too cooperative and too knowledgeable, other times they are pushy and hostile, and may make references to "my attorney" when there is no reason to think they will need a lawyer. Again, when thefts happen far from home, and a friend or relative jut happens to be present, the claim may be a set-up. Sometimes the claimant doesn't seem concerned for the loss, and this may mean the loss is a fraud.

Many of these indicators that a claim may be fraudulent seem to describe people of low income, unstable employment, and transient life styles. This is not always the case. Frauds are just as likely to be staged by people who appear to be “perfectly respectable”. These are the homeowners' who lie about the value of contents lost when a beach was destroyed, or business people who arrange fires to cover business losses, or professionals such as doctors and lawyers who work with others to file false or exaggerated medical claims. Fraud knows no social class, no sex, no age. It is prevalent at all levels of society.

Fortunately, the insurance industry has responded to this situation with a number of powerful groups. One of these is the ***Insurance Committee for Arson Control (ICAC)***, founded in 1978 by major property and casualty insurers with various trade associations. Now its membership of 2,000 plus companies writes approximately 85 percent of property/casualty polices.

Because of an effort by ICAC, arson was elevated to permanent Part I status in the FBI's Uniform Crime Report with the passage of the Anti-Arson Act of l982. Further, ICAC worked with the NAIC to form a model reporting immunity law to encourage the exchange of information about suspected arson cases between insurers and law enforcement agencies. ICAC cooperates with local anti-arson committees, and offers information about arson control through brochures, a toll-free number, and a speakers program. With the Ford Foundation, it began a neighborhood program titled AIMS (Arson Information Management Systems) in five cities; the purpose of AIMS is to identify the presence of factors that might make arson likely. Such things as vacant buildings, violations of building codes and the like alert a neighborhood to the possibility of arson before it occurs.

Another industry-wide association preventing and detecting insurance fraud goes back to l912. This is the ***National Automobile Theft Bureau (NATB)***, which represents 580 property casualty companies which do about 95 percent of auto theft insurance nationally. Maintaining 188 million automobile manufacturer's assembly and shipping records through a sophisticated computer system, it also has a data system that can automatically check auto theft reports to see if there are records of pervious recovery and theft, salvage, impoundment, police inquiries, and, in the state of New York, derelict towing. NATB works with law enforcement agencies in detecting auto insurance fraud, and in preventing auto theft.

According to NATB, about 15 percent of all theft reports are false. Headway has been made in

reducing the number of auto thefts, but the figures for recovery have also gone down, largely because professional thieves know how to keep cars from being found, and because of a growing number of shops that take cars apart for their parts.

The ***Insurance Crime Prevention Institute (ICPI)*** is involved in criminal investigations of auto insurance claims that are suspect, and also other types of property casualty fraud. It is supported by about 400 insurers writing 80 percent of the property casualty insurance in this country. ICPI comes into an investigation when a member-insurer or a law enforcement agency requests that it do so. Any evidence of fraud it finds will be turned over to the proper law enforcement agency for further action.

The ***Coalition Against Insurance Fraud (CAIF)*** encompasses national and international organizations representing consumers, regulators, state legislators, prosecutors, attorneys general and insurance companies. Its purpose is to combat all forms of insurance fraud through public information and advocacy. The coalition has drafted model insurance fraud laws and works to enact them in state legislatures. The coalition also initiates public outreach programs to raise awareness about fraud and encourage consumers to support fraud-fighting efforts.

The ***Insurance Information Institute (III)*** has been one of the property-casualty's primary sources of information and analysis on insurance subjects, including insurance fraud.

The ***National Insurance Crime Bureau (NICB)*** is a public communication program supported y 1,000 insurers and self-insured private businesses. The NICB maintains a toll-free fraud hotline (1-800-TEL-NICB) and a Crime Net (on line resource offering statistics and news about insurance fraud).

The ***Property Insurance Loss Register (PILR)*** is concerned with residential property fraud; its computer base has 1.4 million property loss claims, including fire claims, and burglary and theft claims in excess of $1,000, entered by the 827 insurers who belong to the group.

These insurers represent 95 percent of the nation's property insurance premiums. When investigating a fire claim, PILR is able to look for undisclosed additional insurance; look for previous similar claims by an insured--and in this search, the computer pulls up phonetic spellings of surnames listed on the report so that an insured trying to disguise or conceal his or her identity can be found; look for the loss history of the location and at the insured's previous address; and last, look at reports for histories of similar name combinations, all through data in its computer system. When a claim is made for a theft or burglary, two searches, one the loss history of the individual, and the other a search for undisclosed other insurance, are made. Results are sent to insurers, who decide what action to take.

The ***Property Loss Research Bureau (PLRB)*** is a specialized resource organization for insurance companies, with regional anti-fraud programs on arson, theft, and the legal aspects of fraud defense one area of service. It also offers education, legal research, and consultation on property loss matters, as well as providing individualized guidance and practical advice on the proper handling of claims and avoidance of common pitfalls. Companies belonging to PLRB can send claims to it for help with questions about coverage, proceedings, and the availability of specialists who might be required.

PLRB has developed two Cause/Origin Research and Evaluation Kits which, with films, are

available to member companies. These kits and films show how to efficiently and effectively interview the insured, work with the fire department, inspect the scene, conduct a financial analysis, and examine any other factors that might be relevant to the loss, whether commercial or residential. Students also learn techniques which, when used in interviews and investigations, can help them tell legitimate claims from those which are not.
Also available from PLRB are a series of forms which individual insurers can send to policyholders who have filed a theft claim. The series has a notice of loss which both the insured and his/her spouse (if any) must sign, and also a form on which the stolen goods are listed, and their value put. If the stolen goods were gifts from another person, that person must sign an affidavit of donor which states that the goods were actually given, and that they do have the value claimed. A release of purchase information, when signed, permits the insurer to get in touch with merchants and credit card companies whose records can substantiate the client's claim.

Such forms not only gather accurate information, but they also put pressure on those making fraudulent claims. These forms, when used with the systematized claim handling procedures developed by PLRB, give insurers a much better chance of detecting fraud.

Industry-wide, insurers are adopting procedures like those of PLRB's, and they are using Special Investigative Units (SIUs) to reduce instances of fraud. An All-Industry Research Advisory Council survey showed that property casualty insurers using SUIs saved $7.39 for each dollar invested in these special teams. The SUIs cost $1.38 million industry wide, and produced a savings of approximately $10.2 million, the amount companies would have paid out in 1500 fraudulent claims including arson, bodily injury, collision, auto and property theft. The SUIs handled 2,358 claims for 19 companies, and were able to determine that 65 percent of these were fraudulent. In the other 35 percent classified as non-fraudulent, there were cases where fraud was suspected, but could not be conclusively proved.

The cases of fraudulent claims ranged from highly sophisticated professional rings down to the usually honest policyholder trying to get the best of a bad car deal. Insurers' claim personnel and also their underwriters work with SIUs in anti-fraud efforts. The ***Racketeer Influenced and Corrupt Practices Act (RICO)*** is now used in cases of insurance fraud. The act allows treble damages to be awarded, and also the forfeiture of a criminal's assets. Plus, the insurer may collect damages and take over the assets of ANYONE involved in the conspiracy to commit fraud, not only the named insured. For example, when 21 companies and individuals were convicted of conspiracy to commit fraud by falsifying auto accident and theft claims, a U.S. court awarded the insurer plaintiff $1.7 million in treble damages.

Other less dramatic means of combating fraud involve making sure that boats, like vehicles, are subject to a uniform identification system. Prior to the Federal Boat Safety Act of l971, boat registration and identification was haphazard. After the act passed, and enforced since August l, l972, each recreational boat built or brought into the U.S. is subject to its provisions.

The main sections that relate to insurance is that all recreational vessels must have a 12 character hull ID number, or HIN, which is permanently attached to the boat's hull. The number may be made up with the calendar year, or the model year method.

State Fraud Bureaus are also cropping up with a fury. These government organizations, with which insurance companies cooperate, complement the industry’s efforts to communicate the

ramifications of insurance fraud. The New York Fraud Bureau, for example, recently entered into an agreement with the NICB to produce a series of advertisements offering rewards to callers who report suspected fraud. The California Department of Insurance Fraud recently initiated an out-reach program to aggressively reach and train local law enforcement to become more aware of staged automobile collisions and the growing problem they are causing on street and highways. During the training, officers are taught to spot certain red flags which could indicate whether the accident they've responded to is staged, and they are also given pointers on how to proceed with their investigation once they believe they may have come across a staged collision. A positive effect of this program is how it has assisted officers in uncovering additional cases and suspects that have been tied into cases already under investigation.

Perhaps one of the fastest-growing areas in the fight to reduce insurance fraud is occurring among the commissioners who are the watchdogs for the industry. There is a connection between the threatened insolvency of an insurance company, and the possibility that its executives are committing fraud. And although companies that become insolvent are not always rife with fraud, in 41% of fraud allegations from l976 to l991, the insurers involved were inadequately pricing their products and overstating their assets--a sure road to insolvency, and very definitely--fraud.

The ***National Association of Insurance Commissioners (NAIC)*** not only pushed hard for the insurance provisions in the federal crime bill, but also has initiatives which help state regulators seek out insurance executive fraud. Further, the insurance industry has a Coalition Against Insurer Fraud (CAIF), one of whose activities was drawing up a model insurance fraud law addressing both claims fraud and insurer fraud. Such laws help stop fraudulent individuals by giving prosecutors and courts clear guidelines under which they may proceed.

Nor is there really such a thing as a "small" case of insurer fraud. When Louisiana regulators seized an insurance holding company in l991, it was $200 million in debt--and its executives had taken most of that sum. Yet another Louisiana insurer was seized in l989 with a $150 million debt--and the executives responsible for falsifying the records that kept that information hidden.

Because of the connection between insolvency and fraud, insurance commissioners such are stepping up efforts to keep informed about the financial condition of insurers doing business in their states.

Regulations in now require that financial reports from insurers be sent via US mail, keeping perpetrators of fraud from avoiding charges of mail fraud by hand-delivering their false documents. Other laws allow the prosecution of third parties who may have helped insurers conduct fraudulent operations. Rental assets are also outlawed. When a parent company transfers holdings from its books to an insurer's books, but lists only assets. Naturally, this makes the insurer's balance sheet look strong.

Efforts such as these are turning the tide against insurer fraud.

The Justice Department has a program titled National Level Insurance Fraud Working Group which uses FBI investigators as well as those from the Department of Labor and the Department of Treasury, the U S Postal Service and the Securities and Exchange Commission (SEC), to share information about instances of insurance fraud, and to get information from state regulators, as well as from insurers.

A top contender in the fight against insurance fraud is, as we have already stated, the federal crime bill. This bill makes it a federal crime to misappropriate funds from an insurer, file false financial reports, obstruct insurance regulation and attempt to deceive regulators about the insolvency of an insurer. Conviction under the bill carries sentences of up to 15 years in a federal prison, as well as penalties and fines.

All of these measures are helping and will continue to help reduce insurance fraud. Ultimately, however, it is the insurance industry itself which is in the best position to combat fraud. Over the years, insurance executives and employees have accumulated a great deal of experience and expertise that can not only help devise anti-fraud procedures, but can also lead to industry wide standards concerning the conduct of everyone in the field, and also the accountability of every executive and employee in maintaining a fraud-free operation. When used as expert witnesses in court cases, members of the insurance community can help judges and jurors understand the difference between what the industry as a whole accepts as standard practice, and the way the defendant behaved.

All anti-crime programs have several steps. Prevention comes first, and efforts like those of PRLB are helping make this step successful. As both consumers and those in the insurance field learn more about fraud, and about its costly effects, those who are neutral now will become advocates of anti-fraud campaigns. Detection is a second important step, and again, the systematized claims process and the series of forms issued by PRLB help insurers more accurately detect fraud. Prosecution is the next step, one made more effective by the presence of laws which more clearly define insurance fraud, and which make it possible for prosecutors to take everyone involved in a conspiracy to court.

Enforcement is the final step. This step, too, has becoming increasingly effective as even those whose frauds did not succeed are tried, convicted, and punished.

And, with the advanced computer systems the insurance industry now has, keeping track of a large amount of data, cross-referencing claims and other information, and doing sophisticated financial analyses is possible. All of these help detect fraud.

On a more personal level, it is essential that all policyholders become fully aware of how much fraud costs each of them. Agents must do a thorough job in educating their clients, helping them understand the precise nature of the policies they buy, and just what the policies will cover if a loss occurs.

As we stated at the beginning of this course, insurance is a social device which allows people to pool a certain amount of resources to cover a certain type and amount of risk. Loss reserves are calculated according to known risks, and there is no way an insurer can calculate fraud. ALL members of the pool should take responsibility for developing an active climate against insurance fraud. Only when the general public loses the vision of insurers as deep pockets who can pour out enormous sums and never feel it will the attitude that it is okay to defraud insurers change.

The Sub Rosa Investigation

For special fraud cases insurance companies will launch a *sub rosa investigation*.

According to the dictionary, ***sub rosa*** is an old Latin term meaning "under the rose," the rose being an ancient symbol of secrecy or privacy. In modern terms, it refers to the surreptitious filming or still photographing of a subject who is under investigation, what law enforcement calls ***surveillance video***.

A sub rosa investigation is potentially one of the most valuable tools a claims handler can employ. It is often true that "A picture is worth a thousand words." Film or video evidence can be very useful in criminal court. But there's also another saying: "Don't believe everything you hear--and only half of what you see." Sub rosa evidence, like all forms of evidence, may be open to interpretation. An effective sub rosa investigation takes time, planning, and preparation.

It is important to remember that not every suspected fraud case will be a good candidate for sub rosa investigation. Once again, the basic elements of fraud are: The lie; knowingly told; for the purpose of obtaining benefits not due; and the lie is material.

The Lie

The lie need not be either written or verbal--it can also be assertive behavior. For example, if a patient arrives at the doctor's office wearing a neck brace and using a walker, the doctor would assume the patient was using these devices because of an injury. But if it could be shown that the patient did not use these devices either before or after the office visit, there would be a strong suspicion that the patient was trying to fool the doctor. And trying to fool a doctor is a form of lying that can be prosecuted. Further, this is an instance where visual evidence could prove the lie.

On the other hand, there is a vast difference between a claimant saying "My back really hurts when I lift things" and "I can't lift things." You might suspect lying when you're told that the claimant's back hurts, but you won't be able to use sub rosa to prove the lie. Sub rosa is a visual tool, and can only be used to uncover lies that can be disproven visually.

Good sub rosa cases are where the claimant makes specific statement of things that can or cannot be done. Remember that the district attorney can't prosecute a claimant for not following the doctor's orders. If the doctor gives a work restriction and the patient does the activity anyway, you haven't necessarily established fraud. Video of the activity might help reduce the eventual permanent disability award, but it will be of no use in proving suspected fraud. The activity being filmed must be the subject of a statement (or assertive behavior) of the claimant, not someone else's opinion of what the claimant can or cannot do.

Also, consider whether the lie is material to the claim. Will disproving the statement change the benefits being provided to the claimant? People will sometimes lie in an attempt to obtain workers' comp benefits, but the lies are irrelevant to their eligibility and they would have had the same outcome if they'd told the truth. If that's the situation, the case is not a good candidate for a sub rosa, because unless you can establish that, by virtue of the lie told, the applicant gained some benefit that wouldn't have been obtained without that misrepresentation, you're not going to meet the element of materiality needed to establish a fraud case.

In some cases insurers might want to conduct an activity check before considering a sub rosa investigation. For example, an employer calls and says that the claimant is working at another

company while telling the doctor it's not possible to work. An activity check would be an inexpensive way of determining if that person is working and if the physical activity is different from what the person claims is impossible to do. Once this groundwork is completed, then they might consider running a sub rosa--if necessary.

Identifying the Subject

One of the most important elements of planning a sub rosa operation is obtaining good, solid identification of the subject. The best sub rosa in the world is useless if it's of the wrong person. A photograph of the claimant is the best identification, and there are several ways to obtain one:

- A claims handler or investigator should check with the employer to see if there is a photo in the personnel file that could be verified.

- Obtain a photocopy of the DMV photo from either the personnel file or the medical file. Doctors and clinics frequently keep a copy of this photo, as proof of who they saw.

- If there are no photos on file, the investigator might have to find the claimant, take a still photo, and show it to the employer to confirm identity. This might cost extra, but it would save time and money in the long run.

Another tactic is to arrange for the sub rosa to be done when a doctor's appointment is scheduled. The investigator can spot the claimant before the appointment, follow the claimant to the doctor's office, call the office to confirm that the patient is there, then follow the patient away from the office.

One of the excuses for refuting sub rosa evidence is to say that the suspect statement and the sub rosa were so far apart in time that the medical condition changed between the two events. If the claimant makes a statement, and then two months later there is a video taken that "disproves" the statement, can one prove that the medical factors or other conditions didn't change or improve in the intervening two months? Putting the sub rosa in context takes away one more excuse the claimant might try to use.

In many cases, the best possible time to conduct a sub rosa would just before and just after a medical appointment or deposition. These are the times when the claimant will make statements that you suspect of being false. Further, having the sub rosa done on the day of the office visit or deposition--as well as the day before and the day after--could make the sub rosa evidence so strong that it cannot be "excused away." If your film from before and after the deposition shows activity that is contrary to what the claimant said in deposition, then you have evidence that the claimant knowing lied under oath. It might sound like "trapping" the claimant, but it really isn't. We are asking questions and giving the claimant the opportunity to tell the truth. If the claimant lies, it is by choice.

The Time Element

A thorough sub rosa will include footage shot at all hours and on different days. Not everyone works or plays during the daytime. Not all jobs operate on a 9-to-5, Monday-Friday basis. Has the claimant ordinarily done the kind of work that is performed on a swing shift and/or graveyard

shift in addition to the day shift? Has the claimant been involved with sports groups or other activities that meet in the evening? On weekends? If your lead comes from an informant, such as the employer, you or the investigator might want to conduct an in-depth interview. The more information you have to begin with, the better the sub rosa will be.

Getting Maximum Coverage

One of the things most stressed in a sub rosa investigation is the need for sufficient video--enough footage to show context. A few seconds or a few minutes will not be sufficient. Insurers will want to show not only that the claimant performed the activity in question, but also that the person suffered no ill effects afterwards. You are looking to establish a pattern of activity, so you want film before the individual is actually engaged in the relevant activity; you want film during the activity; and you want lots of film afterwards.

Investigators should be cautioned about "turning on the camera only when the subject is doing something interesting." Footage like that allows the subject's attorney to argue that if the camera had not been turned off so quickly, you would have seen that the subject suffered pain and had to stop the activity. Take that argument away from the claimant by getting plenty of film before, during, and after the "something interesting."

The investigator needs to get as much film as possible over several days to show a pattern of behavior that is not a one-time event. It might sound like overkill, and it certainly can be expensive, but this is one situation where you definitely get what you pay for. Remember, the burden of proof is on the accuser, and the proof must be "beyond a reasonable doubt" in criminal cases. We must be able to remove any reasonable doubt that the subject is knowingly lying. Absent sufficient evidence, the district attorney might not be able to prosecute.

Also, experts in this area advise investigators to get good, clear, still photographs of the claimant at the time the sub rosa is taken. Stills have a sharper image than video and sometimes furnish better identity of the subject. Additionally, they can be enlarged for use in court and you can use them to capture a split second of time showing a particular activity or some other precise detail.

Evaluating the Sub Rosa

When insurers get the sub rosa material from the investigator, the first thing they try to do is to find reasonable explanations for the suspect behavior. Look at it the way the suspect's attorney will. Go over it with a fine-tooth comb. Are you sure the person in the film is the claimant? Is the activity different from what the claimant said could or couldn't be done? Are sure you it isn't exactly the same? Could the subject have suffered any ill effects from the activity that do not show up on film?

If you find any holes in the evidence, you must either plug them--with more sub rosa, witnesses, or some other strong evidence--or you might have to conclude that you haven't the necessary evidence for a fraud referral.

A Successful Sub Rosa

One of the best examples of a sub rosa that was done quite well was a case prosecuted in

Riverside County. Quite a bit of sub rosa tape had been taken of a particular claimant performing all sorts of chores at her church. She was sweeping, bending over, and picking up things. She was shaking out the vacuum cleaner bag and cleaning it out. She was even engaged in a few instances of horseplay with children in the parking lot. The day of the insurer's appointment, she was filmed lifting and lowering the hood of her truck and checking the water and oil. She did all of this despite having claimed that she had some neck problems, some back problems, and severely restricted movement. The interesting part of this video is that when she was driven to the doctor's office by her pastor, she got into the car unaided, then proceeded to put on her neck brace. When they arrived, the pastor handed her a pair of crutches, and she employed guarded motions and exhibited pain behavior as she walked into the doctor's office. She was found guilty of workers' comp fraud.

Sub rosa can be an effective fraud-fighting tool, but it is an expensive one. Cases need to be carefully chosen and planned to get maximum benefit.

Other Insurer Efforts to Fight Fraud

Insurance companies use a variety of means to fight fraud: sub-rosa investigations (see above) special investigative units, home office claims departments, and the National Insurance Crime Bureau are used most often to train employees in recognizing potential fraud. Overall, about 10 percent of insurers' total corporate training efforts are spent on means detecting insurance fraud.

Most insurers have also put automated claims index systems into place to uncover potential fraud. These systems are basically sophisticated data bases used to spot unscrupulous claimants and/or applicants. The NICB database, for example, is a huge, cross-referencing claims database providing access to some 400 million records. About three-fourths of insurers have put these systems into operation.

Great care is taken to insure that information supplied in this text is accurate and current. However, many of the general principles and conclusions are subject to interpretation and court case revisions. The reader is urged to consult legal counsel regarding points of law. This publication should not be used as a substitute for competent legal counsel.

REPORTING INSURANCE FRAUD

Who Should Report Fraud

California Insurance Code Section 1877.3(d) requires all insurance carriers, agents, self-insured employers, and all third-party administrators to ***report suspected fraud*** to the Fraud Division and the district attorney's office ***within 30 days*** after the duty arises. This means that if you, utilizing the various "red flags" and other warnings presented throughout this course, have come across some aspect of a fraudulent claim, and you believe it needs to be reported, and you are doing so without malice, then your duty is to make an initial report to your company's ***Special Investigative Unit***. If your company is not required to maintain an SIU function, then the report must be filed simultaneously with the Fraud Division and the office of the district attorney in whose jurisdiction the fraudulent act was committed. And these filing must be made within 30 days of knowledge. The Fraud Division and the district attorney hold a joint responsibility to take

your fraud report and act upon it accordingly. At this point it cannot hurt to put forth this reminder: The referral of a case to the Fraud Division or the district attorney's office does not mean a specific person or facility is guilty of fraud.

A preliminary evaluation by the Fraud Division will determine whether your particular case merits a criminal investigation and, ultimately, criminal prosecution. The cases that receive the highest priority are the most egregious in nature--the larger criminal conspiracies that are more likely to be prosecutable.

Don't PreJudge Fraud

When all the signs are there, it's easy to rush to judgment, e.g., a fire at a business in the dark of night; the insured admittedly at the property immediately beforehand, with no viable alibi at the time of the fire; and a financial outlook that was bleak at best. Seems like a foregone conclusion — until a week later when the electrical engineer concluded the fire was accidental, much to the surprise of everyone involved.

Experience gives agents and adjusters a useful feel for the issues and a sense of how best to approach a claim. The danger is when that experience leads to oversimplifying — or worse, to impulsively make decisions based upon suspicions rather than the evidence.

Rush decisions have their own consequences, often involving penalties and even punitive damages. And, while the facts are always important, in many legal venues, the real focus is on the decision-making process rather than the ultimate claim decision itself.

Take the *Gibson v. Allstate Insurance Company* case: The court had harsh words for what might be described as a "minimalist approach" to investigating a burglary claim. The insured reportedly returned home to discover someone had forced entry, ransacked a bedroom, and stolen various items of personal property. Even though the insurer initially assigned a local adjuster to the claim, the file was quickly transferred to an out-of state special investigator. The resultant independent investigation was limited to a telephone interview of the insured. Great weight was given to a police dispatcher's casual comment that the burglary was probably staged, despite the fact that the police did not examine the burglary. The claim was ultimately denied for failure to provide sufficient proof of ownership, although suspicions about the insured's role in staging the burglary actually motivated the decision.

The insured, however, successfully challenged the decision in court. The Court, while troubled about the lack of effort to thoroughly investigate the claim was more concerned that the insurer denied the claim before making an honest effort to determine its validity. In the court's view, the investigator had failed to act in good faith, spending "far more time and effort to defeat the claim than he ever did investigating the claim in the first place.

The lesson here is that as insurance professionals we must put our feelings and suspicions aside in favor of careful, deliberate decision-making until our investigation is complete. Wait until you have all the evidence before reporting a fraud..

Categories of Fraud in California

The California Insurance Fraud Division has grouped fraud into these categories. When

reporting a fraud, it is helpful to define the activity you are reporting using one of these categories.

Auto Collision

A staged auto collision is defined as a planned incident designed to fraudulently obtain monies from an insurance entity. A planned incident may take on various forms:

100 "Swoop" vehicle swerves in front of "squat" vehicle causing "squat" vehicle to slam on its brakes, which causes a rear-end collision with the victims vehicle.
110 "Squat" vehicle slows down to close gap between his vehicle and victim's vehicle, then brakes suddenly causing a rear-end collision with victim.
120 Victim's vehicle collides with suspect's vehicle while backing out of a driveway or while backing out of a parking space in a parking lot.
130 Pedestrian versus auto.
140 Suspect driver appears to give right-of-way to victim driver, usually in an intersection, causing vehicles to collide; suspect later claims no right-of-way was offered.
150 Solo vehicle crashes due to vehicle of unknown origin/description.
160 "Hit and run" vehicle strikes victim's car and leaves scene of the accident.
170 Parties conspire to create illusion of legitimate accident, using either pre-damaged vehicles or by intentionally and covertly inflicting damage on the suspect's vehicle(s). Generally, law enforcement is not called to the scene of the accident.
180 Collision orchestrated by organized criminal activity involving attorneys, doctors, other medical professionals, office administrators and/or cappers.
190 Medical provider inflates billing, knowingly submits bills with improper medical codes, and misrepresents facts.

Auto Property

200 Damages to vehicle exaggerated, non-existent, pre-existing, or vehicle damaged at a later point in time.
210 Damages inflated or exaggerated, non-existent or pre-existing; excessive billing of vehicle body parts or repair work.
220 Vehicle or motor home theft.
230 Vehicle or motor home arson.
240 Vehicle or motor home vandalism including such items as car rims, stereo equipment, and engine parts.
250 Policy backdated prior to loss date and/or theft of premium dollars intended for payment of coverage.
260 Embezzlement of funds.
270 Watercraft stolen or damaged while being transported on trailer.
280 Arson of a watercraft while transported on trailer.
290 Any other auto-related circumstance not listed above involving the presentation of false documents as proof of insurance.

Medical

300 Suspicious slip/fall claim.
310 Non-auto injury reported by insured and/or claimant; medical assistance was reported.

320 Inflated billing by any medical facility, doctor, chiropractor, laboratory, etc.
330 Disability claim submitted against disability insurance policy while claimant on permanent or temporary disability and receiving continual benefits and/or vocational benefits and/or claimant reported working or performing activities exceeding alleged physical limitations.
340 Foreign object found within food/drink products.
350 Pharmacist or pharmacy inflates bills or falsifies billing; person illegally obtains medical prescriptions and submits prescriptions for habitual need.
360 Dentist or dental office inflates bills or falsifies billing codes.
370 Embezzlement of funds.

Life

400 Questionable circumstances surrounding reported death; staged death/false identity.
410 Other life insurance claim-related fraud not described by other Life category code.
420 Suspicious or questionable actions by applicant or policyholder (insured's health misrepresented on application; suspicious timing of application in relation to insured's death); potential for monetary gain from life insurance policy. Include suspicious claims involving murder for profit and claims pertaining to viatical settlements.

Workers' Compensation

500 Suspicious employee applicant claim.
510 Employer committing illegal act against employee(s).
520 Legal provider inflates billing or materially misrepresents the facts.
530 Medical provider inflates billing, knowingly submits bills with improper medical codes, and misrepresents facts.
540 Pharmacy inflates bills or falsifies codes.
550 Any situation dealing with a Workers' Compensation claim that is not described by any other Workers' Compensation category code.
561 Misclassifying the type of workers to obtain workers' compensation coverage at a lower premium. (Example: classifying roofers as clerical, etc.)
562 Misrepresenting payroll to obtain workers' compensation coverage at a lower premium. (Example: Over-reporting wages as if employees are experienced journeyman with less likelihood of injury and thus allowing for lower premiums or under-reporting payroll to keep premiums lower.)
563 Misrepresenting claims history by not reporting reportable injuries or by creating shell companies to give the impression of a non or low claims history to obtain workers' compensation coverage at a lower premium.
570 Embezzlement of funds.
580 Uninsured Employers.

Other

600 Casualty, injury or theft that does not pertain to other fraud code definitions.
610 Suspicious loss or damage incurred to agricultural products and/or livestock not caused by acts of nature.

Fire

700 Suspicious commercial/business fire damage.
710 Suspected arson for hire.
720 Suspicious residential fire damage.
730 Inflated claims from fire loss.

Property

800 Suspicious residential theft.
810 Suspicious commercial business theft.
820 Insured reports baggage/cargo lost by commercial carrier (airline, bus, train, vessel).
830 Theft or damage to watercraft/aircraft while not on a trailer.
840 Arson of watercraft/aircraft while not on a trailer.
850 Property damage not included in other definitions.
860 Vandalism or malicious mischief to the interior or exterior of business or residence.
870 Suspicious theft of personal property while stored in a vehicle or motor home (commonly claimed under a homeowner's insurance policy).
880 Policy backdated prior to loss date and/or theft of premium dollars intended for payment of coverage.
890 Mold related.

Healthcare

001 Embezzlement of funds.
002 Using another's identity to secure health care benefits.
003 Medical provider knowingly submits false medical bills by billing for services not rendered, billing for wrong procedure codes, or billing for procedures of a medical necessity when procedures may have been elective or cosmetic in nature and not covered by health insurance.
004 Denotes cases where patients are recruited and given incentives to undergo medical procedures, whether those procedures were actually performed or not.
005 False billings by medical providers for immunizations that were not given.
006 Any other health care related circumstances not listed above or covered by another category code.

The Forms to Use

All suspected fraudulent activity is to be reported on CDI ***Form FD1*** (A sample can be viewed below) Suspected Fraudulent Claim (SFC) forms. Take care in providing accurate, detailed answers to all the questions. Keep copies of the FD1 for your records (either by SIU or in separate records). Be sure to indicate on the form whether additional follow-up will be completed. The originals are sent to the Fraud Division in Sacramento, and a copy is to be sent to the appropriate district attorney's office. Specify to which district attorney the case has been sent. The SIU is your conduit to the Fraud Division, and its regulations cover moving the referral through channels.

Retaining All Case Files

All the Fraud Division requires to begin its evaluation is the FD1. You will not be asked to submit your claims files unless the Fraud Division's evaluation shows that the case is a candidate for

further investigation. In the meantime, of course, it is important to keep the files updated if your investigation is ongoing.

The Immunity Provision

The Insurance Code provides you with immunity from civil suit when referring suspected fraud to the Fraud Division and the district attorney's office. This immunity covers not only the insurance carriers, the self-insured employers, and the third-party administrators, but also those agents, such as private investigators, retained by you to seek out additional information, and the government agencies involved in the investigation process. However, as broad as it is, the immunity protects you only ***as long as the fraud referral is done without malice*** and it is consistent, that is, it ***applies to everyone*** in the same manner. This means that a specific doctor or attorney cannot be targeted for investigation simply because they receive the lion's share of payouts on your claims processing.

After the FD1 Is Filed

Do not advise the suspect party that the claim has been referred to either the Fraud Division or the district attorney's office. The referral to the Fraud Division or the district attorney's office is handled separately from the proceedings.

If you have evidence to defeat a case within the jurisdiction, utilize it, regardless of the status of the Fraud Division or district attorney's case.

If a party is found guilty of fraud, restitution or incarceration can be imposed. A petition and Order of Restitution can also be filed.

Help

If you have questions about reporting requirements or need help completing an FD-1 referral form, please contact the CDI Fraud Division regional office which serves your county.

Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Lassen, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Joaquin, Shasta, Sierra, Siskiyou, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, Yuba – Call Sacramento (916) 854-5700

Alameda, Contra Costa, Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, San Francisco, San Mateo, Solano, Sonoma – Call Benicia (707) 751-2000

Monterey, San Benito, Santa Clara, Santa Cruz – Call Silicon Valley (408) 201-8800

Fresno, Inyo, Kern, Kings, Madera, Mariposa, Merced, San Luis Obispo, Tulare – Call Fresno (559) 440-5900

Southern Los Angeles and the City of Los Angeles Metropolitan Area – Call Southern Los Angeles County (323) 278-5000

Northern Los Angeles including the San Fernando Valley, Santa Barbara, Ventura – Call Valencia (661) 253-7400

Orange – Call Orange (714) 712-7600
Riverside, San Bernardino – Call Inland Empire (909) 919-2200

Imperial, San Diego – Call San Diego (619) 699-7100

The Agent / Adjuster As Witness

To the extent that you have heard the defendant say or do certain things, or to the extent that you are familiar with and are bringing to court or have presented to the court various documents, you may be called as a witness. You may be a source of information in that you can provide foundation for various documents.

Under previous law, only the custodian of the records could qualify business records. But to the extent that you have files that are under your control during the claims process, you may be the custodian of records for those files. You will be asked for information on how a claim file is prepared and how the documents are received and maintained, in order to satisfy the court that these records are reliable and should be admitted into evidence.

It is important that you know how your company's system works, because you will be called upon to not only describe the documents for what they are but also relate to the court the underlying system and show that the system is a reliable one.

Some Things to Remember as a Witness

- You are not an advocate in the criminal courts environment. You are there to tell what you know, what you recall, and to lay the foundation for the documents.

- Listen very carefully to the questions and answer only those questions. Don't give what you think the person should know, just give what has been asked.

- Don't guess. Don't draw conclusions unless you're asked to do so.

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CDI USE ONLY

Case #: _____ County Code: _____ SFC #: _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 1872.4 requires companies licensed to write insurance in California to submit this form WITHIN 60 DAYS after determining that a claim appears to be fraudulent. CIC § 1877.3 further requires reporting of suspected fraudulent Workers' Compensation claims to BOTH the CDI Fraud Division and the local District Attorney's Office WITHIN 30 DAYS.

SECTION I. REPORTING PARTY INFORMATION CODE

FRAUD TYPE CODE: 140 REPORTING PARTY CODE: 04 CHECK ONE: ☒ NEW REFERRAL ☐ AMENDED REFERRAL

REPORTING PARTY: Rest Assured Services (Company Name) _____ (California Company (CA) #) 11122 (Self-Insured/TPA#)

ADDRESS: 123 Assured Street, Suite 100 CITY: AnyCity STATE: CA ZIP: 11111

E-MAIL ADDRESS (IF APPLICABLE): _____

SECTION II. LOSS/INJURY INFORMATION

ALLEGED VICTIM: C&W Trucking Company (Company Name) _____ (California Company (CA) #) 5-2222-13-000 (Self-Insured/TPA#)

ADDRESS: 456 Safe Street, Suite 101 CITY: AnyCity STATE: CA ZIP: 22222

CLAIM #: AB1234567 POLICY #: X9876543 DATE OF LOSS/INJURY: 10/01/99

ADDRESS OR LOCATION WHERE LOSS / INJURY OCCURRED:

ADDRESS: First & Main Streets CITY: Everywhere STATE: CA ZIP: 33333

PREMIUM LOSS: _____ POTENTIAL LOSS: $47,000.00 ACTUAL PAID TO DATE: $8,500.00 SUSPECTED FRAUDULENT LOSS TO DATE: _____

SECTION III. SUSPECTED FRAUDULENT CLAIM ACTIVITY

SYNOPSIS: State the facts (who, what, when, where, how, why) that support your suspicion of fraudulent claim activity including any material misrepresentation(s). **Provide details regarding any prior history of fraudulent insurance claim activity by any of the parties. If known, include relevant claim numbers.** Attach additional summary sheets if needed.

Mike and Susie Smith alleged accident at First and Main Streets in Everywhere, California on October 1, 1999. They deny involvement in previous accidents, but index links them to five others at the same intersection. Treating chiropractor, Noel Jones, is refusing to provide treatment records.

History on index shows five other claims for other carriers and two potential aliases for suspect driver (copies attached).

You may include attachments documenting the suspected fraudulent activity. If a complete copy of the claim file has been submitted to the District Attorney's Office, please attach a complete copy to this Form FD-1. Otherwise, a complete copy of your claim file is not required.

DISASTER CLAIMS: If this suspicious activity is related to a major natural or non-natural disaster, check the box below that best describes the related event:

☐ EARTHQUAKE ☐ FLOOD ☐ FIRESTORM ☐ WIND ☐ OTHER NATURAL ☐ NON-NATURAL (MAN-MADE)

SECTION IV. REPORTS TO OTHER AGENCIES

☐ OTHER LAW ENFORCEMENT AGENCY (specify name): _____

☐ DISTRICT ATTORNEY'S OFFICE (specify name): _____

☐ NICB ☐ OTHER: _____

SECTION V. CONTACT INFORMATION

CONTACT (name/title): Able Seer PHONE: (111) 222-3333

FILE HANDLER (if different): Hal Helpful PHONE: (444) 555-6666 DATE FORM COMPLETED:

COMPLETED BY (if different): _____ PHONE: ( ) 10/09/99

California Department of Insurance **Fraud Division**

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury

CDI USE ONLY

Case #: _____ County Code: _____ SFC #: _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

Claim #: AB1234567 Policy #: X9876543 Date of Loss/Injury: 10/01/99

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)

PARTY A. ☒ INSURED ☐ EMPLOYER (CHECK ONE/If Workers' Compensation, must show employer here.)

Name: C & W Trucking Company (Last Name / First Name / MI) Phone #: (222) 222-2222

Address: 456 Safe Street, Suite 101 City: AnyCity State: CA Zip: 22222

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: CNWT1 State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY B. [30] (Enter party code in box)

Name: Smith, Mike (Last Name / First Name / MI) Phone #: (555) 555-5555

Address: 2000 Repeater Street City: Overland State: CA Zip: 55555

DOB/Age: June 30, 1966 SSN: 555-55-5555 Tax ID #: _____

DL #: B5555555 State: CA License Plate #: GOTU5 State: CA VIN #: _____

DBAs/Multiple Numbers/AKA's: Mike Green, Mike Johnson Party Claiming Injury: ☒ Yes ☐ No

PARTY C. [32] (Enter party code in box)

Name: Smith, Susie (Last Name / First Name / MI) Phone #: (666) 666-6666

Address: 2000 Repeater Street City: Overland State: CA Zip: 55555

DOB/Age: July 18, 1968 SSN: 666-66-6666 Tax ID #: _____

DL #: C6666666 State: CA License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☒ No

PARTY D. [06] (Enter party code in box)

Name: Jonee, Noel (Last Name / First Name / MI) Phone #: (777) 777-7777

Address: 15 Gangland Way City: Overland State: CA Zip: 77777

DOB/Age: July 18, 1968 SSN: 777-77-7777 Tax ID #: _____

DL #: A7777777 State: CA License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☒ No

PARTY E. [ ] (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: ( )

Address: _____ City: _____ State: _____ Zip: _____

DOB/Age: _____ SSN: _____ Tax ID #: _____

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury (continued)

CDI USE ONLY

Case #: ________ **County Code:** ______ **SFC #:** ________

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

Claim #: AB1234567 Policy #: X9876543 Date of Loss/Injury: 10/01/99

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY E. [02] **(Enter party code in box)**

Name: Sanford, Fred (Last Name / First Name / MI) Phone #: ( )
Address: ________ City: ________ State: ____ Zip: ____
DOB/Age: 6/20/66 SSN: 888-88-8888 Tax ID #: ____
DL #: ____ State: ____ License Plate #: ____ State: ____ VIN #: ____
DBAs/Multiple Numbers/AKA's: ________ Party Claiming Injury: ☐ Yes ☒ No

PARTY F. [31] **(Enter party code in box)**

Name: Innocent, Truly (Last Name / First Name / MI) Phone #: (444) 444-4444
Address: 2 Runover Lane City: Hitagin State: CA Zip: 44444
DOB/Age: February 20, 1959 SSN: 444-44-4444 Tax ID #: ____
DL #: A4444444 State: CA License Plate #: HITME2 State: CA VIN #: ____
DBAs/Multiple Numbers/AKA's: ________ Party Claiming Injury: ☐ Yes ☒ No

PARTY . [ ] **(Enter party code in box)**

Name: ________ (Last Name / First Name / MI) Phone #: ( )
Address: ________ City: ________ State: ____ Zip: ____
DOB/Age: ________ SSN: ________ Tax ID #: ____
DL #: ____ State: ____ License Plate #: ____ State: ____ VIN #: ____
DBAs/Multiple Numbers/AKA's: ________ Party Claiming Injury: ☐ Yes ☐ No

PARTY . [ ] **(Enter party code in box)**

Name: ________ (Last Name / First Name / MI) Phone #: ( )
Address: ________ City: ________ State: ____ Zip: ____
DOB/Age: ________ SSN: ________ Tax ID #: ____
DL #: ____ State: ____ License Plate #: ____ State: ____ VIN #: ____
DBAs/Multiple Numbers/AKA's: ________ Party Claiming Injury: ☐ Yes ☐ No

PARTY . [ ] **(Enter party code in box)**

Name: ________ (Last Name / First Name / MI) Phone #: ( )
Address: ________ City: ________ State: ____ Zip: ____
DOB/Age: ________ SSN: ________ Tax ID #: ____
DL #: ____ State: ____ License Plate #: ____ State: ____ VIN #: ____
DBAs/Multiple Numbers/AKA's: ________ Party Claiming Injury: ☐ Yes ☐ No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.

ETHICS & CLAIMS

Ethics & Adjusters

Do you think you're an ethical agent or adjuster? Could you prove it to a jury? What would your mother say about your practices? In the end, how will you judge your career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution.

The fact is, when large sums of money are involved, breaches in ethical and moral behavior are all too common and the industry of insurance claims adjusting is certainly no exception. There are many temptations for a claims adjuster since they have the ability to dictate the speed at which a claim is processed and the final settlement amount. That's a lot of power! Insureds have been known to offer a sum of cash in exchange for a quick claim resolution or desired claim amount. And, of course if one is paid based on the amount of the settled claim the temptation is even greater, but so is the potential penalty.

As a regulated "profession" a finding that an agent or adjuster has violated a particular ethical provision may lead to a reprimand, suspension, or even revocation of the adjusting license. Second, it is not uncommon for insureds and their attorneys to contend that an adjuster's violation of his code of ethics is imputable evidence of the insurer's "bad-faith" claims handling. Third, not to be familiar with such codes of ethics may result in awkward and embarrassing moments for that adjuster at deposition and trial, which, in turn, may lead to negative consequences for both the adjuster and the insurer. Notwithstanding the above, prosecuting attorneys have been known to say it is dangerously common for adjusters and other claims professionals to be wholly ignorant, let alone conversant about, any adjuster's code of ethics.

Do We Need A Moral Code?

Possessing a moral code is not all that is needed to set a professional apart from a layman. However, maintaining a Code of Ethics can inspire us to do better — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

Having ***high ethical standards***, or more simply being honest, can be more important than being right because honesty ***reflects character*** while being right reflects a ***level of ability***. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" production winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

Being ethical is indeed professional but the gesture goes beyond the mere compliance with law. It ***means*** being completely honest concerning ALL FACTS. It means more than merely NOT telling lies because an incomplete answer can be more deceptive than a lie. It means more than being silent when something needs to be said, because saying nothing can be the same as

a lie. For example, is it the duty of an adjuster to warn a first party insured of mold contamination and possibility of health risks discovered in a building under claim. While the legal issue gained steam in a famous ***Melinda v. Fire Insurance Exchange Case*** ($32 million – later appealed and settled for an undisclosed amount) most adjusters are coming to the realization that the duty of good faith and fair dealing obligate warnings be given to the insured. And, the adjuster should also include covered mold remediation in the scope of damages, including Additional Living Expenses necessary.

But, does the obligation stop at a simple warning? When handling water damage should the adjuster be pro-active concerning mold? What about third party claimants, e.g., other occupants near an infected unit? An adjusters responsibility is not only based on the sense of duty of one human being to another, it's accepted claims practice, professional and ethical, to take action. And, not doing so could be a breach of the Unfair Claims Practice regulations or a possible tort/criminal liability. The story doesn't end here either. Notification alone may not be enough because part of the training of an adjuster concerns the proper use of experts. An adjuster who may occasionally see or smell mold should know that it may also exist behind walls and other inaccessible locations. The presence of mold may also be indicated by unexplained illnesses, i.e., when the situation warrants, the adjuster has the obligation to seek out the liability exposures to properly evaluate the claim. Testing for mold by a professional could be required.

Adjusters and insurers may feel uncomfortable in disclosing potential health dangers where their client / claimant may suffer the wrath of potential new claims. However, failure to disclose such dangers to first or third parties could result in the building owner / policyholder being sued for damages in excess of the available policy limits. If that happen, who do you think the property owner might be looking to make up the difference? Policyholders might also have a bad faith claim against the insurer for failing to protect the property. In essence, as a practical matter, full disclosure may be cheaper in the long run.

Could lack of a health disclosure result in criminal charges? In the Melinda Case above, child endangerment criminal charges were filed against some insurance company personnel but later dropped in a settlement.

Instilling Ethics

Someday, it may be real important for a court and jury to hear that you have a history of serving claimants without consideration for how much you made or how busy you were, i.e., you are a person with good ethics.

Instilling ethics is a process that must start ***long before*** a person chooses insurance adjusting as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in a forum like this course of study may not be incentive enough to sway adjusters to stay on track. It may be easier to explain that honesty and fair play could mean greater sales and lessen the possibility of lawsuits.

Ethics Defined

Just what is ethics? A simplified definition of ethics is a ***set of values*** that constantly guides our values. These values are typically ***aligned*** with what society considers correct and positive behavior within legal boundaries. Ethics is also the ***balancing*** of an individual's good with the

good of the whole. Let's say you develop a seminar series on "mold detection". At the event, you have a person pass around a clipboard asking people if they would like to be informed of future seminars. The real purpose of this exercise, however, is to create a mailing list to market your adjuster services. Smart marketing? Or, breach of ethics? Are you really concerned with your clients education (the whole) or only what you will get out of their business (the one)?

Balancing the good of the one with the good of the whole is not as easy any more. The whole that we have to consider is everybody, not just a competing adjuster down the street or in the next town. Survival is important, but not at any cost. True survival requires long-term, successful relationships with customers and companies, as well a co-workers and competitors. When people do not understand their role in the "whole" and are completely self and survival oriented, it throws the ethical system we once knew out of whack.

How can you stay on track? Most important is that you know your personal core values and the values that your company stands for and then live and work congruently and consistently with those values. The people will know you as a person of integrity. And, with integrity comes trust.

The authentically ethical person in our seminar example would have simply disclosed the purpose of the clipboard or simply buy a mailing list from someone else. Respect for privacy would be honored and remembered.

Shades of Grey

One of the problems with ethics today is that we have so many different mores or values that guide our society. The values that guide each individual and/or company can vary tremendously, therefore an individual or company may be ***ethical*** according to their values and not to yours or the definition above. Several major shifts in right or wrong standards means that we are faced with more and more gray areas in our personal and professional lives. The shifts are occurring at such a pace that they may even hinder our ability to cope and process the changes.

Moral and Market Values

The American economy depends on ethical standards upheld by responsible business leaders. Unfortunately, this unwritten rule was violated in recent ethics scandals occurring in many corporate boardrooms. Respected companies lost credibility and innocent investors lost millions in the late 1990's and early 2000's. Cheating became rampant because it was the norm. It was no longer seen as wrong. In fact, at the peak of the problem, much of our economy resembled a giant pyramid scheme, taking in money from new suckers to pay those who invested earlier. A so-called ***bubble economy*** developed where businessmen willing to gamble with other people's money were rewarded handsomely. Stock prices were rising so fast that if you cut corners to meet projected numbers, you probably thought you were doing your shareholders a favor. And, there was always new money pouring in to make up the difference.

In insurance as well as the corporate world, people who rely on your word can be sucked in during times of sensitivity. Take the recent example of some less than ethical public adjusters who were contacting consumers late at night as they awaited treatment in a hospital emergency room following a disaster in their homes. An adjuster could easily take advantage of their tragedy.

Will tougher laws and even prison sentences be a deterrent. It can't hurt. But, the fact is bubbles burst quicker than a business climate can change. If a crooked practice doesn't pay off, a lot fewer people will take the risk of using them. So, the real challenge is to create a new business culture that matches the market. Think about a system that rewards and reinforces the honest and careful adjusters and businessmen just like the bubble economies made heroes out of the gamblers.

Moral Compass

During times of fundamental change, values that were previously taken for granted may be strongly questioned. These are the times when the attention to business ethics is critical. Leaders, workers and adjusters must sensitize their actions -- they must maintain a strong moral compass. John Kennedy Jr's last flight went wrong because he lost sight of land. In the growing dark around him, the horizon line became blurred and he became disoriented eventually flying his place right into the ocean. When nothing is stable or dependable, you also can lose your own sense of moral direction. When it happens, you start accepting ambiguity as real. You begin making up your own rules. You cut corners. This is exactly how things started going bad at Enron. Accountants simply made-up their own accounting standards. They lied, cheated and waffled because it was to their economic advantage. Over time, they began justifying their unethical behavior as acceptable.

How can you keep this from happening to you? You can have a strong, unfailing sense of what is right and stay focused on it at all times. It's called ***integrity***. When you have it, it allows others to trust you, even when things go bad. Kim Cameron, Professor of Organizational Behavior at the University of Michigan, says that it is not enough to simply encourage ethical behavior, honesty and integrity because these concepts in themselves imply an ***absence of harm***. A strong moral compass means that you strive for ***virtuousness*** where your actions rise to doing good, honoring others, taking a positive stance -- i.e., . . . "behaving in ways where ***self-interest is not the driving motivation***." Too soft and fuzzy for you? Well take note, Kim's research proved that businesses with high scores on virtuousness significantly outperformed those with low scores. ***It pays to have a strong moral compass!***

Truly honest and ethical people live by the choice to do what is right, even when it is not pleasurable. This is how reputations are built. And, regarding reputations, ***Alan Greenspan*** summed it up quite nicely . . "Your reputation is your stock and trade. If you do something to undermine that, then you very well may not have a company any more."

Moral Distress

Have you ever thought about why people make bad decisions? One reason is dissatisfaction with work or near impossible objections. When either one of these occurs, a person experiences growing pressure to engage in unethical behavior. You are left in a situation where every decision must weigh your own survival against the care and attention you give your client. The end results is that shortcuts will be taken or you become frustrated, resentful, angry or guilty about your bad decisions. What can you do?

Stakeholders: Experts suggest that, among other things, one should adopt a long-term stakeholder mentality, and, to be ethical under social justice theories you should be fair to all ***stakeholders***. What does this mean? A ***stakeholder*** is anybody that can be ***affected by your actions***. Your client is a stakeholder in that he depends on you and your insurance products to

protect is economic well-being. Your insurer is a stakeholder in you representing product fairly and within the scope of the law. The shareholders who have invested in the insurance company are also stakeholders and when it comes down to it, you are a stakeholder yourself. That's right! You owe it to yourself to survive in your chosen field. And, as we have already described, the best way to do this is long-term, with integrity and respect for others and all stakeholders. ***Remember***, customers ultimately pay your salary and commissions, and insurers enable you to make a living. That's something that should be important to you. So, how could you be a bystander and watch either of them be injured in any way by your actions?

Pace Yourself: Another way to reduce moral distress is to operate at a reasonable pace. We have already explained that when you cut corners it promotes unethical practices. For instance, if you fail to budget time to read a policy coverages, they go out without being reviewed raising ethical questions and moral distress. What about when you forgot to get a first party's signature. It's awful tempting to sign it yourself when you know they will approve it anyway rather than drive 30 miles back out to meet them a second time. Again, moral distress raises its ugly head. Of course, the solution is to allow more time the first time out. But, this will mean less production which creates economic stress. At times like this, you have to assure yourself that you are in this for the long-term. Being genuine and ethical means that you live by the choice to do what is right, even when it is not pleasurable.

A Tolerance For Problems: When you succeed at something, it's normally because you are doing something that other people do not want to do. In a sense, you have to "tune-up" your instincts to be ***satisfied*** at meeting objectives that others find hard to take or when people don't want you to succeed. What does this have to do with moral distress. A lot, because you can reduce your level of moral distress by increasing your tolerance for problems. Think about it. You can convince yourself that external forces are never-ending anyway, so there is no reasons to sweat it so much. The fact is, you're in the problem solving business and you're a pro! Just remember the immortal words of Saturday Night Live's Rosanna Rosanna Danna -- "It's always something!"

Professional Ethics Are Not Laws

Many adjusters and agents believe that professional ethics and the law are the same. It is important to realize that ***professional ethics are not laws***, ***yet they can be guided by laws***. Proof of this exists in the fact that you can be unethical yet still operate within limits of the law. A perfect example of this is the insurance client who fears he has physical problem because he is experiencing shortness of breath, yet he is allowed to withhold disclosing it on an application. He has no duty to disclose his "fears" of a medical condition. It's legal, but not too ethical. Laws in the United States are abundant, growing in numbers every day. The courts attempt to legislate protections from those without values or with values in opposition to what most of us would consider right and wrong. We have more laws than any one lawyer can ever know. And more and more lawyers seem to be necessary to handle the litigation that results from what seems to be a trend in "making others pay".

An Adjusters Code of Ethics

With all these concepts and consequences in mind, let's look at a sample code of ethics for adjusters on the next few pages. These suggestions are a compilation of present-day professional and coded standards for guiding adjusters in their everyday ethical decision-making.

AN ADJUSTER'S CODE OF ETHICS

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- An adjuster shall not directly or indirectly refer or steer any claimant needing repairs or other services in connection with a loss to any person with whom the adjuster has an undisclosed financial interest, or who will or is reasonably anticipated to provide the adjuster any direct or indirect compensation for the referral or for any resulting business.
- An adjuster shall treat all claimants equally.
- An adjuster shall not provide favored treatment to any claimant.
- An adjuster shall adjust all claims strictly in accordance with the insurance contract.
- An adjuster shall not approach investigations, adjustments, and settlements in a manner prejudicial to the insured.
- An adjuster shall make truthful and unbiased reports of the facts after making a complete investigation.
- An adjuster shall handle every adjustment and settlement with honesty and integrity, and allow a fair adjustment or settlement to all parties without any remuneration to himself except that to which he is legally entitled.
- An adjuster, upon undertaking the handling of a claim, shall act with dispatch and due
- diligence in achieving a proper disposition of the claim.
- An adjuster shall promptly report to the any conduct by any licensed insurance representative which violates any provision of the Insurance Code or Department rule or order.
- An adjuster shall exercise extraordinary care when dealing with elderly clients to assure that they are not disadvantaged in their claims transactions by failing memory or impaired cognitive processes.
- An adjuster shall not negotiate or effect settlement directly or indirectly with any third-party claimant represented by an attorney, if the adjuster has knowledge of such representation, except with the consent of the attorney. (The term "third-party claimant" does not include the insured or the insured's resident relatives).
- An adjuster is permitted to interview any witness, or prospective witness, without the consent of opposing counsel or party. In doing so, however, the adjuster shall scrupulously avoid any suggestion calculated to induce a witness to suppress or deviate from the truth, or in any degree affect the witness's appearance or testimony during deposition or at the trial. The witness shall be given a copy of the statement.
- An adjuster shall not advise a claimant to refrain from seeking legal advice, nor advise against the retention of counsel to protect the claimant's interest.

AN ADJUSTER'S CODE OF ETHICS (Cont)

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- An adjuster shall not attempt to negotiate with or obtain any statement from a claimant or witness at a time that the claimant or witness is, or would reasonably be expected to be, in shock or serious mental or emotional distress as a result of physical, mental, or emotional trauma associated with a loss.
- The adjuster shall not conclude a settlement when the settlement would be disadvantageous to, or to the detriment of a claimant who is in the traumatic or distressed state.
- An adjuster shall not knowingly fail to advise a claimant of the claimant's claim rights in accordance with the terms and conditions of the contract and of the applicable laws of this state.
- An adjuster shall exercise care not to engage in the unlicensed practice of law as prescribed by the California Bar.
- A company or independent adjuster shall not draft special releases called for by the unusual circumstances of any settlement or otherwise draft any form of release, unless advance written approval by the insurer can be demonstrated. A company or independent adjuster is permitted only to fill in the blanks in a release form approved by the insurer they represent.
- An adjuster shall not undertake the adjustment of any claim concerning which the adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the adjuster's current expertise.
- No person shall, as a public adjuster, represent any person or entity whose claim the adjuster has previously adjusted while acting as an adjuster representing any insurer or independent adjusting firm.
- No person shall, as a company or independent adjuster, represent him- or herself or any insurer or independent adjusting firm against any person or entity that the adjuster previously represented as a public adjuster.
- A public adjuster shall not represent or imply to any client or potential client that insurers, company adjusters, or independent adjusters routinely attempt to, or do in fact, deprive claimants of their full rights under an insurance policy.
- No insurer, independent adjuster, or company adjuster shall represent or imply to any claimant that public adjusters are unscrupulous, or that engaging a public adjuster will delay or have other adverse effect upon the settlement of a claim.
- No public adjuster, while so licensed, shall represent or act as a company adjuster, independent adjuster, or general lines agent.

AN ADJUSTER'S CODE OF ETHICS (Cont)

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- No independent adjuster or company adjuster, while so licensed shall represent or act as a public adjuster.
- A public adjuster shall advise the insured and claimant in advance of the insured or claimant's right of counsel, and choice thereof, to represent the insured or claimant, and that such choice is to be made solely by the insured or claimant.
- The public adjuster shall notify the insured or claimant in advance of the name and location of any proposed contractor, architect, engineer, or similar professional, before any bid or proposal by any of these persons may be used by the public adjuster in estimating the loss or negotiating settlement. The insured or claimant may exercise veto power of any of these persons, in which case that person shall not be used in estimating costs.
- The public adjuster shall ensure that if a contractor, architect, engineer, or other professional is used in formulating estimates or otherwise participates in the adjustment of the claim, the professional shall be licensed.
- A public adjuster shall not prevent, or attempt to dissuade or prevent, a claimant from speaking privately with the insurer, company or independent adjuster, attorney, or any other person, regarding the settlement of the claim.
- A public adjuster shall not acquire any interest in salvaged property, except with the written consent and permission of the insured.
- A public adjuster shall not accept referrals of business from any person with whom the public adjuster may conduct business where there is any form or manner of agreement to compensate the person, whether directly or indirectly, for referring business to the public adjuster.
- Except as between licensed public adjusters, no public adjuster shall compensate any person, whether directly or indirectly, for the principal purpose of referring business to the public adjuster.
- A public adjuster's contract with a client shall be revocable or cancellable by the insured or claimant, without penalty or obligation, for at least 3 business days after the contract is executed. The public adjuster shall disclose to the insured that the insured has the right to cancel with prompt notice within the revocation period. If the insured elects to cancel the contract, prompt notice shall be provided to the adjuster. Nothing in the provision shall be construed to prevent an insured from pursuing any civil remedy after the 3 day cancellation period.
- A public adjuster shall not enter into a contract or accept a power of attorney which vests in the public adjuster the effective authority to choose the persons who shall perform repair work.
- A public adjuster shall ensure that all contracts for the public adjuster's services are in writing and set forth all terms and conditions of the engagement.

Better Adjuster Practices

Ethical Decision-Making

Before the Enron fiasco, Arthur Anderson had a steadfast reputation. When big organizations wanted him to falsify their accounting he said . . . "No, we'll find other ways to make our money". The point is, to maintain ethical standards, you have to be able to think around problems, cultures and differences. Here are some ways to accomplish this:

Get The Facts: The Makkula Center for Applied Ethics suggests you find the relevant facts about a situation. This means identifying the individuals or groups who have an important stake in the outcome. Some may have a greater stake because they have special needs or because you have a special obligation to them.

An example might be elderly claimants. Due to their status or cognition, they may need to rely more on your advice than other claimants. Your ethical standards may have to be raised in matters that concern them.

Sizing Up The Problem: Michigan University Business Ethics Professor Tim Fort suggest you ask the following questions when faced with an ethical decision:

What's the moral issue?
Who has been harmed? Or who could be harmed?
In what ways?
What are the alternatives that exist?
What facts need to be known to make a reasoned decision?
What are the personal impacts on the person making the decision?

Working within a format like this helps bring the issues away from your own self-interests over the interests of others.

Pursuasion: If an ethical dilemma arises between you and a peer or claimant, why not solve the problem with your powers of persuasion. Be convincing. Have convictions. The influence you exert may very well change their mind.

Taking Risks: The more you are paid, the more complex the decisions you must make. Things are rarely "black and white" and a lot of your decisions will challenge your integrity. But, these are the risks you must be prepared to assume in a sometimes difficult world. You must constantly weigh ***short-term results*** with ***long-term consequences***.

Evaluate Alternative Actions: Which option will produce the ***most good*** and do the ***least harm***? Which option respects the rights and dignity of all stakeholders? Will everyone be treated fairly? Which option will promote the ***common good***. Which option will enable the deepening or development of the core values you share with your company? Your profession? Your personal commitment?

Reflect on Your Decision: Was you position defensible? Would you do it again? How did it turn out for all concerned? Was your decision successful for both you and your client?

Confronting Unethical Conduct

In a lot of ways, we have become a ***no-fault society***. Popular thinking dictates that as long as you don't own the problem you don't need to get involved. A crucial shift is needed to avoid this bystander mentality. People need to think of themselves as members of a community. And, their life in this community entails ***mutual obligations*** and ***interdependence***. In other words, be part of the solution, not part of the problem.

How can this be accomplished. Well, you can learn to help solve ethical dilemmas rather than walk away or simply ignore them. Here are a couple ways to do this:

State Your Position: Ask those who want you to perform an unethical task to ***state their position clearly***. This forces them to make an ethical choice. If your manager wants you to fudge a value, for example, pose the following question: Are you asking me to lie in this claim? It is probably a safe bet that he will back away from his unethical request.

Present A Case: Many ethical dilemmas result because someone has taken a short cut. You can sometimes turn their thinking around by presenting things statistically or in an organized manner. Take the manager who wants you to submit an inaccurate claim. If you use some of your CE materials or Google, you could probably find where an adjuster did a similar thing and faced a huge penalty and loss of license. When presented this way, it would be hard to ignore the correct path.

Don't Ratify Unethical Actions: One of the easiest ways to become entangled in the wrong deeds of someone else is to ratify their behavior. Not only is it unethical, but it can come back to haunt you in the form of rather large lawsuit. ***Ratification*** generally occurs where, under the particular circumstances, the employer demonstrates an intent to adopt or approve oppressive, fraudulent, or malicious behavior by an employee in the performance of his job duties. The issue commonly arises where the employer or its managing entity is charged with ***failing to intercede in a known pattern of workplace abuse***, or ***failing to investigate or discipline*** the errant employee once such misconduct became known. Corporate ratification in the punitive damages context requires actual knowledge of the conduct and its outrageous nature."

A Moral Company Climate

If you ***don't*** create an company culture that reinforces values and ethics, other adjusters and employees will only do what is right so many times and then they will either leave or give in to outside pressures to cut corners, lie, fudge, etc.

In order to reinforce this theme, you can't punish people for taking actions they need to take. You have to ***support*** good, moral decisions, even at the ***cost of production***.

What happens if no one else cooperates? You must continue to forge forward, even if you are the only one doing the right thing. Why? It's a fundamental choice you are making to be an ethical leader. And, it will pay off in time.

Privacy

Protecting a client's privacy is an ethical responsibility and an area of increasing liability. The concern by clients is that highly personal health and financial information you collect in the process of adjusting a claim will get in the hands of groups who might use this data to exploit them.

It may seem obvious and oversimplified, but the information in the adjuster's file is extremely confidential and all efforts to make it secure should be practiced. Remember, ***adjuster files are accessible by an insurance company and / or a plaintiff's attorney***. Then again, always check with your errors and omissions carrier before turning over any documents with client information.

Your attention to privacy issues is particularly important where electronic files are concerned. The problem is two-fold: You can unintentionally send records (e-mails, files, etc) to the wrong party -- E-mail users often hit the "enter" key which could send a message to a wrong party. Just as likely, you could "delete" something you do not want someone to know about your client and a plaintiff's attorney, with help from a programmer, could recover it from your computer.

Ways To Minimize Privacy Conflicts

The best approach to guard client information is to ***establish guidelines*** for handling files and communications (including e-mail). It also goes without saying that since others have access to your files, it would be wise to NEVER make a written derogatory comment or reveal some personal information about a client. Either could be damaging to you and your client. Extremely sensitive information on your computer may need to be encrypted to protect it from being accidentally transmitted. Software that uses passwords is always recommended. And, it is probably a law in your state, or soon to be, that your entire system be protected by a ***firewall*** to prevent unauthorized access.

Better Service

There are a thousand ways to make your service better. Here's a few of the more important ones you need to know:

- Always be positive. This means always trying to create a situation where your customer can be satisfied. If you don't handle a particular coverage, go the extra mile and find someone who will. Take the attitude that nothing is impossible and that no effort is too much.

- Keep your word. Don't make promises you can't keep.

- Don't argue. If a problem develops between you and your customer, always remember, the customer is "king". It doesn't make sense to debate an issue to death. Even if you are right, it doesn't matter. It is the customer's perception that you are wrong that counts. In his mind, you goofed. It is better to look at it as an opportunity to fix the problem and satisfy the customer. As we saw earlier, a dissatisfied customer can cost you a lot of money and time. And they're sure to complain to ten other people. Just give him some attention and assure him it will be fixed. Then make sure you do it!

- It's ok to acknowledge your mistakes. Unless a lawsuit is at risk, don't be too proud. Let the customer know that a mistake has been made. Apologize and set in place a solution to fix it.

Handling Tough Customers

No matter how you try, you will encounter tough customers who always believe they are right and you are wrong. Here are a number of ways to handle them:

- Negotiate. Always try and find a middle ground.
- Keep you cool. Make sure you and your employees understand that it is not personal. It's business. Keep a soft tone of voice and solve the problem.
- Listen to the customer. Since they usually think they are right and you are wrong, make sure you let them know that you are aware of the problem and you are concerned that it be solved as soon as possible. You can diffuse the situation somewhat by actually taking the customer's side and agreeing with them (to some extent).
- Set a policy. While there is never an excuse for poor behavior or lack of manners, you need to develop a policy for handling problem customers and stick to it. If you are too soft, then customers can easily pick up that you are an easy mark and they will always complain. Using a database or contact manager, you can document conversations with clients to ferret the chronic complainers. As long as you are fair, you can be firm with these customers. They may not win every time, but at least they may come to respect you.

Elements of Good Service

Following are the elements of good service.

- Reliability. Consistent service the customer can rely on.
- Quality performance. Make sure you do things well.
- Worthwhile outcome for the customer.
- Overall service. The ability to provide good service in ***all*** your dealing with clients.

Poor Service

You already know that poor service will drive your customers away. The trouble is that you may not even know about until it's too late. Why? Because a lot of people will never complain about poor service, they'll just move on to the next adjuster. Worst yet, when they have the chance, they'll complain to friends, family and others that your service was poor.

It is also important to realize that good service extends to everyone you deal with, not just paying customers. Providing poor service to people because they are not paying customers is a definite way to ensure that they will not want to do business with you in the future. Like others, they will also probably complain to their friends.

Best Practices

In any given industry, someone is compelled to document the strategies and tactics employed by highly admired companies. These companies are not particularly the "best-in-class" in every area -- such a company may not exist at all. Rather, due to their nature of competition and drive

for excellence, the ***practices*** they have implemented and honed place them among the most admired, the most profitable and the keenest competitors in the business.

In reality, best practices may not be revolutionary or new ideas; they are just ***good, sound business practices***. They may be things you already know, but having them broken down helps to bring attention and use them easier. Here are some adjuster best practices we found:

- **Acknowledgement:** An email notification will be sent to the assigning Client representative within 24 hours noting the assignment has been received. The acknowledgement will include the handling adjusters name and contact information.
- **Contact:** Contact will be made with the insured within the first 24 hours of receipt of assignment. If the adjuster is unable to reach the insured, a contact letter will be sent immediately. At time of contact, the adjuster will arrange inspection of the loss within five (5) business days, provided the insured is available. If not, the file will be noted accordingly.
- **Inspection:** The loss will be inspected within five (5) days of assignment and or contact with the insured.
- **Reporting:** The adjuster will prepare a full captioned report on all losses which will include: ***Reserve*** (on initial report) ***Coverage Analysis*** – Policy effective date, limits, deductible, any sub-limits, forms/endorsements that may pertain to the loss: (form number, title and edition date); any other information pertinent to the adjustment, i.e. loss location, schedule amounts, etc. ***Insurance to Value (ITV)*** Adequacy of limits will be commented on in the initial report. This caption is to include the type and percentage of applicable ITV clause. ***Title and encumbrances*** – Ownership/Insurable Interest, including Mortgagee, Lien Holder, Loss Payee. A records check can be provided at additional cost. ***Investigation/Adjustment Facts; Cause of Loss; Subrogation/Salvage; Recommendations***
- **Initial Reserve Report:** The initial reserve report will be within 15 days from date of assignment. If the reserve is anticipated to be in excess of $50,000 a phone call will be made to the Client within 24 hours of inspection, followed by an initial reserve report.
- **Interim Reports:** All interim reports will be within 30 days from the date of the initial reserve report and on 30 day intervals from that date forward, unless noted otherwise by the assigning adjuster.
- **Final Report:** The final report will be generated within 10 business days of the adjuster receiving all necessary documents to conclude the adjustment of the loss.
- **Estimates:** The adjuster will prepare a detailed estimate of all covered damages utilizing a computer estimating program, which will reflect line item depreciation for application ACV/RCV adjustment. The adjuster will not prepare an estimate for non-covered damages, unless specifically requested by client.
- **Diagrams:** Diagrams will be provided on all roof claims. Additional diagrams will be included as necessary with insurance to value calculations.
- **Statements:** Statements may be taken under the following circumstances: Late or delayed notice of loss; Property is discovered to be Vacant or Unoccupied ; The potential for subrogation exists ; Facts of loss are unclear ; Conflicting information is presented

; Important circumstances need to be documented ; Pertinent information may become lost or become "stale"

- **Photographs:** Photographs will be taken of all property alleged to be damaged, including: Photo of the front and back of every risk ; Photos of all damages seen or claimed ; If no damage is apparent to claimed property, photographic evidence will be provided
- **Insurance to Value (ITV):** Adequacy of limits will be commented on as indicated under the reporting section of this document. In the event the insured is underinsured, thus invoking the coinsurance clause or ACV clause under the policy, the adjuster will complete a detailed valuation of the insured property and include same with their report.
- **Experts:** Other than enlisting a salvor, the adjuster will contact the client for approval before making assignments to any experts. All assignments, once approved will only be made to experts on the clients approved vendor list.
- **Agreed Price:** The adjuster will always attempt to reach an agreed price with the insured or the contractor of their choosing.
- **Settlement:** The adjuster will not commit the client to any settlement without prior consent.
- **Denials:** All denials of coverage will be drafted by the client unless advised otherwise. The adjuster will also not prepare estimates for damages that are excluded under the policy unless specifically requested.
- **Proof of Loss:** A Proof of Loss will not be obtained unless specifically requested by the client.
- **Reservation of Rights:** All Reservation of Rights will be prepared by the client.
- **Non-Waiver Agreements:** Non-Waiver Agreements will be obtained upon request by client

Adjusters who follow best practices typically use them as a benchmark to see how they measure up with other adjusters -- where they excel and where they can improve. Benchmarking is a common practice among many industries. The mission is simple: observe, learn and copy practices that lead to success. As the old adage goes: ***Success breeds success***. Product or the type of agency (life, casualty, health, etc) is irrelevant. The bottom line is that these are tools and skills the adjuster can use to change or improve his practice.

Best Practices for Safety

While we are on the subject of better practices, let's not forget about being safe to sell or adjust another day. In addition to the normal words of advice on climbing roofs, crawling through attics and crawl spaces, avoiding "live" wires and treading lightly near structural issues we need to learn from one of the industry's worst disasters . . . the murder of young Katie Froeschle, a 25-year old adjuster in Florida.

The adjuster community has been stunned saddened by Katie's death . . . it also was a wake-up call, reminding us of job-related dangers that we seldom take into account when arriving at a property to conduct an inspection. Most of us think of falling off the roof as the greatest danger rather than an attack from the occupant of a home being inspected.

The occupant in this case was a tenant, a real bad guy who moved into the house just days before the inspection. According to police records, he had a criminal record for prior incidents of domestic violence and drug use and was actually growing 19 marijuana plants inside the home. It has also surfaced that the bad guy knew nothing about a Farm Bureau insurance adjuster coming to the home since the inspection for roof leak damage, the date and time had been arranged between the adjuster and the property owner. But, this is normal, an adjuster's initial point of contact is always the policyholder, not the tenant. But, as a mater of better practice, we must learn from the Froeschle murder that it is equally important to insist upon direct contact with the tenant regarding the inspection. Of course, investment property owners and/or property managers sometimes hesitate to give out tenant names and contact phone numbers. We now know how important this is.

The fact is, landlords, even when taking a rental application, really don't know the tenants occupying their properties. The application might say "no pets," but the adjuster encounters a pit bull on the property. Many landlords, especially in a tight, high-vacancy rental market, do not pull credit reports (much less run criminal background checks) which is why bad guys get approved. Perhaps the bad guy tenant was caught off guard by Katie's arrival. And that's all it takes for a routine inspection to go horribly wrong.

What we can learn from this is when scheduling an inspection of a rental property, explain to the landlord or property manager exactly why you need to speak directly with the tenant. When tenant contact is established, be specific about the inspection date, time, and possible procedures. If there is any possibility that you might need to gain access to the interior, make sure that the tenant is aware. Always ask if there are any pets on the property — not just dogs; either. Even if the tenants tell you they have no pets, advise them that, should there possibly be any animals present, they need to be contained during the inspection.

If there is a locked storage shed or room within the rental dwelling, do not insist that a tenant open and allow immediate access to the secured room. If room access is imperative to your damage evaluation (e.g. located directly underneath the area of primary roof damage or abutting a room that sustained interior water damage), ask the tenant if it would be possible to look inside the room at a later date and explain why access is being required. If the tenant hesitates or refuses, do not persist. Simply advise the landlord that there is an unconfirmed possibility of damage in that area, which may need to be addressed in the future, and that you are noting it in the file in order to protect their interests.

Engage with the tenant as little as possible during and after the inspection. Do not discuss what repairs you are authorizing and/or how much you are allowing the property owner for the repairs. Do not allow yourself to be drawn into any conversations regarding the landlord's upkeep of the property or the tenant's alleged rights. Above all, if there is any indication of violence or attack back off and leave immediately.

Safety Issues are not only for the agent/adjuster . . . what about the customer you are serving. For example, the use of salvaged air bags in a collision repair can have devastating results. Many auto repair and safety organizations recognize that they certainly reduce the cost of repairs but from a pure safety standpoint their use is discouraged. Do you go so far as to make sure the body shop purchases a new original equipment (OEM) airbag? Or, if a salvaged bag is being used is it certified and installed by someone with proper training?

Until there are enforced regulations that protect consumers and diminish the risk for small

businesspersons, salvage airbags should not be in the marketplace. Parts policy should not stop with airbags. There is a void in state and federal law that ensures replacement crash parts are safe and of the quality consumers deserve. A formal notice and consumer written consent regulatory structure is a first step toward a national replacement crash parts policy that works for consumers.

And, the case for best practices does not stop here. Understanding the type of material and its properties being used in vehicle construction is critical. This should be identified before starting an estimate — let alone the collision repair process — to avoid potential safety issues. Improper welding or even attaching pinch weld clamps without adequate knowledge of a vehicle's construction can irreparably damage the metallurgy or assembly integrity. This can lead to some startling consequences that estimators and repairers need to be aware of before the process begins. These welding techniques, which may seem commonplace, can actually weaken structures. They can also change the impact absorption and airbag deployment timing, in turn creating a potentially dangerous situation in the unfortunate event of another collision.

If you were to use pinch weld clamps to secure a Porsche Cayenne, for example, then you would compromise the adhesive bond between the inner and outer rocker panel assembly, thus weakening the structure. The only way to rectify the situation would be to completely replace the assembly, which would be quite expensive. Even if you don't repair Cayennes on a routine basis, other vehicle models will likely cross your path more than once, like the new Volkswagen Passat. This vehicle's center pillar is laser-welded and must be attached with adhesive bonding material if replaced in the collision repair environment. Volkswagen cautions that if the replacement panel is welded, then the structural integrity may be compromised. Again, this would potentially expose the driver to serious injury in the event of another collision.

Principles of Communication

Whatever mode of communication used by your or your clients, there are certain general principles you need to follow to make sure you are meeting client needs and eliminating potential confusion.

In a recent Claims Magazine article "Words Adjusters Should Not Use With Customers" , Kat Zeman said the goal is to avoid a battle "that could slow down or scuttle an otherwise legitimate insurance claim."

Zeman said that certain words often conjure up images of a claim that should be denied based strictly on semantics. Which five words were flagged? They were "Flood," "Experimental," "In my opinion," "Sorry," and "Whiplash."

Claims Magazine delved further into the issue with a a discussion group that produced the five most popular themes and phrases that claim professionals deemed inappropriate when handling losses.

Fraud. Several respondents noted that even suggesting fraud — let alone using the actual word — was fraught with perils. "Better prove it" before you use it was the advice of one respondent who works for an independent risk management firm.

You don't understand. This phrase implies condescension, especially to someone who is in

the midst of dealing with a loss. “By saying, ‘you don’t understand,’ you’re attacking the insured’s intelligence or ability to understand the situation,” said an owner of a third-party claim services provider. “It’s not unusual to disagree on something or have an insured not understand a policy condition.”

Junk. Using this word to describe a policyholder’s possessions insinuates that it has little value, said one claim consultant. Beyond that, observations and notes in a claim file can have repercussions down the road for both the adjuster and the insurer. “I agree with the comments [about] what should go in file notes, and I shake my head when I think back to some file notes I have seen throughout my career,” remarked one claim manager. The best rule to follow? Imagine your notes and observations being read aloud in a courtroom, and adjust them accordingly.

I don’t believe you. Expressing doubts about the legitimacy of a claim or the value of an item is a big no-no. If the facts and evidence do not support the assertion, then it’s best to keep your opinions to yourself — or put more effort into the investigation. “Saying, ‘I don’t believe you’ implies that you are questioning the insured’s integrity or lack thereof,” said an owner of a third-party claim services provider. “Not a good move, and it puts you in an adversarial position.”

Penalty. “My pet peeve has been the word ‘penalty,’ as used in the phrase ‘coinsurance penalty,’ which refers to an amount not recoverable on a claim due to the application of a coinsurance provision,” said the president of an advisory services firm. “The policy, including all of its endorsements, does not contain the word ‘penalty,’ but when cited by an adjuster, it seems to provoke a hostile response from the insured.”

What’s the solution? He taught his employees to reference the “response to recovery when applying the coinsurance provision.” It eliminated a negative word that fed the perception that the adjuster was harming the insured. It is also a healthy, proactive step in bad-faith states.

Clear communication is always your goal. For instance, when handling a ***client's instruction*** or request, it would be wise to ***repeat your understanding*** to the other person. Let's say that Mr. Dean called your office and advised you to adjust the settlement amount on a boat. You might respond by saying . . . "Mr. Dean, as I understand it, you want to adjust your settlement on your boat . . . "

If you are making a recommendation, you need to thoroughly explain the client's ***options and consequences***. For example . . . "Mr. Brighten, we recommend that you investigate other units in the complex for possible mold remediation. Even though you will being paying extra costs, your potential claims could be lower in the long run”.

Always confirm that you are ***meeting client needs***. "Mr. Smith, have I given you all the information you need to make a decision?" Does this policy make sense to you"? "Is there anything else I can answer for you to assure you that this is the right solution based on your needs?"

Be sure that your client always understand his ***current insurance coverage status***. "Mrs. Johnson, do you understand that mold is not covered in your policy?”

When you and your client are satisfied that you are BOTH communicating on the same wavelength you still need to ***document what was said, what was done and what needs to be***

done. For instance, it would be smart to follow-up a phone conversation with a letter outlining your understanding of the matter.

Telephones

For the not-too-distant-future, it is unlikely that the telephone will be totally replaced with alternative forms of communication. Instead of complicated e-mail, Internet or fax transmissions, a healthy portion of your clients will always prefer to simply dial you up with their problems and needs

One of the most important things to remember about phone calls is that they are not a permanent record of your communication with a client like letters, e-mail or faxes. There are lawsuits, and as many judgement awards against adjusters, where there were no "notes to the file" to verify the basis of a client/adjuster discussion. Your ***standard operating procedure*** should include a system to immediately document client phone calls, inbound and outbound, between you, clients and your staff. Every call should be logged into the client's file or, better yet, a ***contact management system*** to document what was said and the result of the conversation. Where needed, a follow-up letter documenting the basis of the phone call can be sent to the client.

As far as improving your phone calls consider the following advice:

- Call your company and ask for yourself or have someone do it for you. Try different times of the day and listen closely to the general demeanor of your employees. Are they courteous, helpful, enthusiastic, accurate?
- Call your company and pose as an existing customer or pose as a new one. Ask for different departments, voice a complaint or leave a message for a call back. Being passed from one wrong person to another can make a client feel unimportant and frustrated. Th initial contact should determine who best to handle the call and solve the problem.
- Make sure that all incoming calls are answered before the third ring. Always ASK if it is OK before you put someone on hold before you do. A good phone system will let you know if the caller has been on hold too long. Offer to call ask if necessary and find out when this will be convenient.
- Take complete and accurate messages. Incomplete phone messages or lost scraps of paper are not acceptable procedures.
- Return all messages within one business day or less. If you promise to call someone back by a certain time make sure you do . . . even if you still don't have an answer for his question. It is important to do what you say you are going to do every time.
- If your company has a menu of options, listen to it carefully. Does it make sense. Does it work?
- Try NOT to use a speaker phone unless you really need to because a caller may feel as though their conversations are less than private.
- Call new clients to make sure that their policy or information you sent them arrived.
- Call existing clients on a regular basis, just to say hello, or tell them about a new offering.
- If you leave a voice mail message for someone, speak slowly and clearly. Give the purpose for the call and a good time for them to call you back.
- If calls are taken at home, make sure family members understand the rules on message taking.

- Unlicensed people in your office need to know the proper procedures and what they can and can't say to clients.
- Hire customer service people who have insurance knowledge and a pleasant phone voice. Clients are more likely to trust a friendly, confident person on the other end of the line over one who is abrupt, uninterested or combative.

Cell Phones

Cellular phones are a modern-day marvel and a potential E&O tragedy. There are concerns about privacy and the basic inability to reach the intended party when needed. Equally important is the fact that calls are taking place outside the office where it is much more difficult to document the conversation.

Automated Messaging

Answering machines and voice mail systems are inexpensive methods to take calls in your absence. Newer systems are capable of documenting the time and date a call was received. However, all such systems are capable of breaking down when you most need them and/or distorting. Answering machines in an agency should not take messages. They should be limited to listing hours and an emergency number if needed. If you use one, your outgoing message should clearly state that your machine does not take messages. Claims and coverage issues must ONLY be handled during normal business hours with a "live" person.

Fax Messaging

Your fax machine is an incredibly useful part of your call center. One of the most important issues in handling faxes is to make sure they are delivered to the appropriate person and responded to in the same manner as a letter.

Here are some more things to keep in mind concerning faxes:

- Most states accept fax signatures and documents as good as the original. However, the paper on some fax machines (thermal paper) is know to fade over time. For this reason and others, it is always a good idea to not rely solely on faxes. Try and get the original in your file as soon as possible.
- Faxes are not a 100% reliable delivery system. For unknown reasons, they sometimes don't get to their destination even when your machine shows a confirmation that the message was received. For important documents, it is always wise to call and confirm delivery.
- Confidential information should not be faxed without the approval of the parties involved. It is best to call the intended receiver before the fax it sent.
- Faxes you receive should be date stamped and filed.

Online Communications

The Internet is a rich component for customer service. The challenge for adjusters is to bring the same level of excellence they have placed on traditional call center systems to their websites.

Online communications are evolving rapidly. Unfortunately, customer care is moving at a much slower pace. Recent studies, for example, have found that only a small percentage of

customers who sent an e-mail regarding an inquiry or purchase receive a follow-up e-mail. The same customer who telephoned their adjuster would be outraged to NOT receive a return call. To avoid this, your ***e-mails should be treated like a phone call.*** Check them often and return them promptly.

Online customers today are expecting more from e-commerce sites than just e-mail. Those who use the Internet often like the control it gives them. They can seek information, contact you and even complete transactions without ever speaking to a single person. If your site is primarily being used to advertise your services, it is recommended that you advise customers that they will have to call or write you to receive process claims.

E-Practices

*The passing of federal and state **e-signature laws** grant electronic signatures the same legal status as a handwritten signature for any legal document or transaction – including insurance. Combine this event with the electronic commerce explosion, and you will see why adjusters and insurers need to develop a digital strategy. One of the most significant elements of this strategy is a responsible approach to selling and servicing clients on the Internet – we call it **e-conduct** -- the responsibility you **chose to uphold** to make online insurance information or transactions better, more secure and usable for your clients.*

*At present, the insurance industry is not really **leading** the charge in the development and innovations in electronic commerce, in fact, some would say they are **lagging behind**.*

When it happens, the consumer will be the ultimate beneficiary with greater convenience, access and control. The Web will increase their knowledge, choices and product offerings. Positive side effects might be lower prices and improved service.

If we are indeed destined to be a significant Internet force, it is even more important to develop an ***e-conduct approach***.

E-Code

As of yet, there are no Internet police so it is up to you to abide by standards of ethics and reason when using the Internet for claims-related transactions or communication. An ***E-Code*** is a foundation of e-commerce procedures you may wish to adopt. The suggestions that appear on the following page are organized under three categories: ***Netiquette***. ***Compliance*** and the ***10 Commandments of Computer Ethics*** Keep in mind, ***new technologies*** and changing consumer views will require constant E-Code revisions.

Changes to your E-Code will also occur from the regulatory arena where new laws and the eventual codification of Internet insurance transactions will require new and different approaches to e-commerce compliance. For example, California passed a law requiring agents to include their license number on all ***printed materials***, including business cards, advertisements, premium quotes, etc. In coming years, look for the law to be modified to include all Internet advertising and websites. Or, look for so-called ***clean-up*** regulations like those passed in Arkansas where a new statute allows the Insurance Commissioner to interpret the words “print” or “printed” to include electronic printing. Additional legislation, like various state and federal ***electronic signature acts***, pave the way for legalizing online purchases,

including insurance, that formerly required hand-written signatures. Any of these events change your E-Code.

Compliance & Business Issues

There are at present many challenges to the sale of insurance on the Internet. Some of a business nature; some of a legal nature. Following is a discussion to help you understand the issues at hand.

Legality of Internet Transactions. Still unanswered is the question of whether insurance commerce conducted on the Internet is an insurance transaction regulated under the McCarran-Ferguson Act, or an interstate electronic transmission to be federally regulated under the Commerce Clause.

Lack of Commonality. Insurance industry participants in e-commerce will, for the moment, experience difficulty in sharing data and systems due to an absence of common technology or languages. Many data transfers within the industry, for example, are still done by mail or fax. In addition, electronic data interaction is still limited by the fact that only a few players have sufficient technology and transfer mechanisms. An example is the simple fact that many insurance agents are still not linked to insurance carriers. Likewise, other parts of the chain, such as insurer to reinsurer, have virtually no systematic links.

Consumer interpretations. A California adjuster's web site is just as likely to be read by a consumer in Florida. Insurance law between these two states is clearly different. Without a significant disclosure of same, consumers can all too easily request quotes or fill-in an application for coverage you cannot provide.

License Jurisdiction. In certain states, you may merely "trigger" an activity that requires licensing. For example, providing quotes or referring business may be considered actions requiring a producer license in some states. Adjusters wanting multi-state access to clients will need to review and ensure compliance with producer licensing in all states in which he intends to "farm" web interest.

Situs Problems. Since the Internet knows NO geographic boundaries, it is unclear as to the physical location where a sale or solicitation occurred. Did the transaction occur in the state where the adjuster is physically locate, or the state where the client visited the web site?

Signature Problems. Until electronic signatures become workable on a widespread basis, most state insurance laws require a "wet" signature accompany insurance transaction documents, including applications, added endorsements, release forms, changes in beneficiary or policy limits, product disclosures, etc. This is currently difficult to accomplish with "paperless" Internet transactions.

E-Conduct Code of Procedures

How do the issues above effect your e-conduct? Well, until your state adopts specific guidelines, the preferred practices you are about to read are highly recommended.

NETIQUETTE

(The following is courtesy of Arlene H. Rinaldi, The Net: User Guidelines and Netiquette, 1998)

- I will never assume that e-mail can be read by no one except me; others may be able to read or access my e-mail or the electronic messages sent by my clients.

- I will never send or keep any e-mail that I wouldn't mind seeing on the evening news.

- It is my responsibility when downloading programs, to check for copyright or licensing agreements. If the program is beneficial to my use, I will pay any authors registration fee. If there is any doubt, I won't copy it.

- I understand that under United States law, it is unlawful "to use any telephone facsimile machine, computer, or other device to send an unsolicited advertisement" to any "equipment which has the capacity (A) to transcribe text or images (or both) from an electronic signal received over a regular telephone line onto paper." The law allows individuals to sue the sender of such illegal "junk mail" for $500 per copy. Most states will permit such actions to be filed in Small Claims Court. This activity is termed "spamming" on the Internet and I refuse to do it

- I will never give my userID or password to another person except authorized system administrators that need to access your account for maintenance or to correct problems.

- I will keep paragraphs and messages short and to the point to help avoid confusion and inconvenience to the recipient of my e-mails.

- I will focus on one subject per message and always include a pertinent subject title for the message, that way the user can locate the message quickly.

- I will include my electronic signature (name, position, company, e-mail address and phone) at the bottom of Email messages when communicating with people who may not know me personally or when broadcasting to a dynamic group of subscribers.

- I will capitalize words only to highlight an important point or to distinguish a title or heading. Capitalizing whole words that are not titles is generally termed as SHOUTING! *Asterisks* surrounding a word can be used to make a stronger point. Use the underscore symbol before and after the title of a book, i.e. *The Wizard of Oz_.*

NETIQUETTE (Continued)

- I will limit line length to approximately 65-70 characters and avoid control characters.
- I will never ever send chain letters through the Internet. Sending them can cause the loss of my Internet Access.
- Because of the International nature of the Internet and the fact that most of the world uses the following format for listing dates, i.e. MM DD YY, I will be considerate and avoid misinterpretation of dates by listing dates including the spelled out month: Example: 24 JUN 96 or JUN 24 96
- I will follow chain of command procedures for corresponding with superiors. For example, I won't send a complaint via Email directly to the "top" just because I can.
- I will be professional and careful what I say about others: Email is easily forwarded.
- I will cite all quotes, references and sources and respect copyright and license agreements.
- I will not forward personal email to mailing lists without the original author's permission.
- Attaching return receipts to a message may be considered an invasion of privacy if the party I'm sending to is not expecting the message.
- I will be careful when using sarcasm and humor. Without face to face communications a joke may be viewed as criticism. When being humorous, use emoticons to express humor. (tilt your head to the left to see the emoticon smile) :-) = happy face for humor
- Acronyms can be used to abbreviate when possible, however messages that are filled with acronyms can be confusing and annoying to the reader.

  Examples: IMHO= in my humble/honest opinion
  FYI = for your information
  BTW = by the way
  Flame = antagonistic criticism

NETIQUETTE (Continued)

- I will not include very large graphic images in your html documents. It is preferable to have postage sized images that the user can click on to "enlarge" a picture. Some users with access to the Web are viewing documents using slow speed modems and downloading these images can take a great deal of time.

- While it is not usually a requirement to ask permission to link to another's site, out of respect for the individual and their efforts, I will send a simple email message stating that I have made a link to their site would be appropriate.

- When I include video or voice files, I will include next to the description a file size, i.e (10KB or 2MB), so the user has the option of knowing how long it will take to download the file.

- If I create a website it shall always include my email address and a date of last revision - so users linking to the site can know how up to date the information has been maintained.

- Infringement of copyright laws, obscene, harassing or threatening materials my website can be in violation of local, state, national or international laws and can be subject to litigation by the appropriate law enforcement agency.

COMPLIANCE & BUSINESS E-CODE

- To be the best adjuster possible, in my Internet communications and transactions I will comply with the same high standards of ethics and market conduct I practice in my everyday business.

- I understand that it is the ***burden of insurers and adjusters*** to meet all policy requirements, as mandated by the State, for any transaction, regardless of whether it is electronic or on paper.

- I realize that all forms of communication with my client, including the Internet, is considered ***advertising***, which is subject to intense and thorough state and federal regulations that may not distinguish the fact that communication is Internet-based versus other, more traditional mediums.

- I will comply with any and all state guidelines concerning ***signatures***, ***authenticity of signatures, delivery of policies, replacements, exchanges, etc.*** If my state does not except ***digital signatures*** it may mean that I must provide my client a combination of electronic forms and / or hard copies.

- I will follow any and all state guidelines regarding claim forms, disclosures, etc

- I will develop ***standard operating procedures*** to follow when handling inquiries, applications and other insurance-related transactions on the Internet to be sure my clients have been treated equally, fairly and with full disclosure.

- I will comply with any and all business and insurance laws regulating the collection of premiums from my clients through ***electronic funds transfer*** or other electronic medium, including verification of payment to meet ***proof of payment*** requirements under existing statutes.

- I will satisfy ***records retention requirements*** by being able to produce information or data which accurately represents a record of electronic client communications or electronic transactions.

COMPLIANCE & BUSINESS E-CODE (Cont)

- I will do whatever possible to protect my clients ***privacy*** by safeguarding outside access to any personal and financial information I have collected through the Internet by using a ***firewall*** or other acceptable device. Where security needs are at their highest, I will consider a system of ***encryption*** where only a specific sender and receiver of information is permitted access.

- I must also realize that computer crimes, such as embezzlement or planting of logic bombs, are normally committed by trusted personnel who have permission to use my computer system. Computer security, therefore, must also be concerned with the actions of trusted computer users.

- I will address consumer complaints through the Internet in the same efficient manner I would offline. Also, where it might be required, I will establish any ***hotlinks*** to allow a client direct access to the Department of Insurance consumer protection division for registering unresolved complaints or settlements.

- Since the Internet know no boundaries between states, I will make every effort to alert users of my website that my services and products are not available in states outside my licensing.

- Where products require special underwriting I will make everyattempt to present these additional requirements on my website so that consumers coming to my site are not mislead into believing there are no special requirements.

- I will respect the intellectual property of others by not posting unauthorized, copyrighted information on my website. To do so would infringe the owner's rights of public display.

- *I will investigate the wishes of my carrier to learn rules and regulations regarding their company name, logos, trademarks, forms and other proprietary information used on my web site or transmitted via electronic means.*

- *I will provide consumers of my e-commerce system complete knowledge about the services I offer. Doing so puts them in charge of the flow of information, the widest possible choice, convenience, accuracy and speed in order to make better-informed decisions.*

- To the extent possible, I will NOT restrict my consumer's ability to compare by limiting my e-commerce products. To this end, I will try to present a range of premium choices, a variety of carrier options and/or referrals in areas I cannot help.

THE 10 COMMANDMENTS OF COMPUTER ETHICS

By the Computer Ethics Institute

1) **Thou shalt not use a computer to harm other people:** If it is unethical to harm people by making a bomb, for example, it is equally bad to write a program that handles the timing of the bomb. Or, to put it more simply, if it is bad to steal and destroy other people's books and notebooks, it is equally bad to access and destroy their files.

2) **Thou shalt not interfere with other people's computer work:** Computer **viruses** are small programs that disrupt other people's computer work by destroying their files, taking huge amounts of computer time or memory, or by simply displaying annoying messages. Generating and consciously spreading computer viruses is unethical.

3) **Thou shalt not snoop around in other people's files:** Reading other people's e-mail messages is as bad as opening and reading their letters: This is invading their privacy. Obtaining other people's non-public files should be judged the same way as breaking into their rooms and stealing their documents. Text documents on the Internet may be protected by **encryption**.

4) **Thou shalt not use a computer to steal:** Using a computer to break into the accounts of a company or a bank and transferring money should be judged the same way as robbery. It is illegal and there are strict laws against it.

5) **Thou shalt not use a computer to bear false witness:** The Internet can spread untruth as fast as it can spread truth. Putting out false "information" to the world is bad. For instance, spreading false rumors about a person or false propaganda about historical events is wrong.

6) **Thou shalt not use or copy software for which you have not paid:** Software is an intellectual product. In that way, it is like a book: Obtaining illegal copies of copyrighted software is as bad as photocopying a copyrighted book. There are laws against both. Information about the copyright owner can be embedded by a process called **watermarking** into pictures in the digital format.

7) **Thou shalt not use other people's computer resources without authorization:** Multiuser systems use **user id's** and **passwords** to enforce their memory and time allocations, and to safeguard information. You should not try to bypass this authorization system. **Hacking** a system to break and bypass the authorization is unethical.

THE 10 COMMANDMENTS OF COMPUTER ETHICS (Cont)

8) **Thou shalt not appropriate other people's intellectual output:** For example, the programs you write for the projects assigned in this course are your own intellectual output. Copying somebody else's program without proper authorization is **software piracy** and is unethical. **Intellectual property** is a form of ownership, and may be protected by copyright laws.

9) **Thou shalt think about the social consequences of the program you write:** You have to think about computer issues in a more general social framework: Can the program you write be used in a way that is harmful to society? For example, if you are working for an animation house, and are producing animated films for children, you are responsible for their contents. Do the animations include scenes that can be harmful to children? In the United States, the **Communications Decency Act** was an attempt by lawmakers to ban certain types of content from Internet websites to protect young children from harmful material. That law was struck down because it violated the free speech principles in that country's constitution. The discussion, of course, is going on.

10) **Thou shalt use a computer in ways that show consideration and respect:** Just like public buses or banks, people using computer communications systems may find themselves in situations where there is some form of queuing and you have to wait for your turn and generally be nice to other people in the environment. The fact that you cannot see the people you are interacting with does not mean that you can be rude to them.

A Word On Unsolicited Online Advertising

Unsolicited advertising by e-mail, commonly referred to as ***spamming,*** is one of the web's most annoying problems. It is estimate that almost one-third of all in-box e-mails today is filled with spam. And it will approach 50% in a short time.

Despite today's sophisticated spam-killer programs, we are doomed to receive this unwanted e-mail. A recent North American survey of 1,000 consumers by Insight Express said 65 per cent of respondents spend more than 10 minutes a day dealing with spam. And 37 per cent of respondents get more than 100 spam e-mails a week.

Today, sophisticated spamming gets to many e-mail recipients by massive hit-and-miss deliveries, hitting popular online e-mail services first. Many Internet providers offer filtering services from their servers, but they can also block legitimate e-mail.

FAIR PRACTICE LAW

The Purpose of Fair Claims Legislation

The insurance industry is heavily regulated. The basic thrust and ***purpose*** of all such regulation is to maintain the solvency of insurers. A second goal is to promote the equitable, moral and legal interests of policyholders. This applies to both purchasing insurance and settlement claims. This portion of the course deals specifically with the handling of claims in California. However, there are certain reasons that claims legislation is enacted regardless of origin. They are:

Misrepresentation Issues

Under most Unfair Claims Settlement Practices Acts, an insurance company may not *knowingly* misrepresent material facts or relevant policy provisions in connection with a claim. It may not attempt to enforce policy provisions that were altered by the company without notice to a policyholder without knowledge or consent.

Undue Influence

Where fair claims legislation is enact, a company may not drag out the settlement of a claim under one portion of a policy where liability and the amount of the loss are reasonably clear, so as to influence settlements under a different portion of a policy. For example, auto insurer can't refuse to pay bills under the medical coverage in a policy so that the policyholder will settle an uninsured motorist claim.

Acknowledging Claims

An insurance company must acknowledge and act promptly in response to a communication about a policyholder's claim, i.e., the insurance company must respond within a certain time frame, such as 15 days.

Prompt Claims Processing

Insurers must implement standards for promptly investigating and processing claims. Otherwise, an unethical insurance company could endlessly stonewall by saying it is still investigating a claim.

Control Delays

An insurer may not delay an investigation or payment of claims by requiring unnecessary or repetitive reports and proof-of-loss forms.

Satisfaction Without Lawsuits

A company may not force a policyholder to go to court in order to recover amounts due under an insurance policy by offering substantially less than the money ultimately recovered. Otherwise, an insurance company with lots of lawyers on the payroll could just say, "Sue us!" and make claimants go to court. Obviously, that would discourage many individuals with small claims.

Lack of Appeal

An insurance company may not exploit the legal system by appealing almost all of the arbitration awards in favor of policyholders as a way to force a settlement or compromise of claims. The insurance company is allowed to appeal, but appeals can't be a standard business practice aimed at forcing policyholder's to take less than they're owed on a claim.

Unreasonable Delays

An insurance company may not refuse to pay claims or delay payment without a valid reason. It must promptly provide a reasonable explanation why a claim was denied or why a compromise settlement was offered. The insurer is required to make a good faith attempt to process a prompt, fair, and equitable settlement of claims in which liability is reasonably clear.

Claims Non-Compliance

Market Conduct & Claims

The claims end of insurance is probably one of the industry's biggest market conduct issues. Claim infractions subject insurers to frequent criticisms, with issues ranging from timely claim-handling issues to the remitting of the proper amount to the claimant. Providing required reasons for claim denials and specific notices, such as the bill of rights in an automobile claims process, also appear to be problematic for insurers. Apart from these timeframe and complete claim issues, insurers are also frequently cited for using unlicensed claim adjusters or appraisers.

Claims compliance violations result in internal resources being used to deal with examiner inquiries and corrective action plans, not to mention the direct out-of-pocket cost of assessed fines and per diem examiner fees.

Repercussions for noncompliance include potentially significant monetary fines and restitution orders designed to make claimants whole, with accompanying negative publicity when the repercussions are made public. Additionally, noncompliance findings during the exam can result in extended periods of time for the examiners to be on-site, resulting in higher overall exam costs, and increasing the probability of more frequent re-exams to determine if corrective actions were implemented.

California market conduct examiners will cite insurer violations in a manner such as this: "In 65 instances, the company failed to provide the insured with the Auto Body Repair Bill of Rights, either at the time of application for automobile insurance, at the time a policy was issued, or

following an accident. Specifically, in 40 of these instances, the Auto Body Repair Bill of Rights was not sent. In 15 instances, the Company sent an Auto Body Repair Bill of Rights letter containing incorrect language. The Department alleges these acts are in violation of CCR §2695.85."

Some companies are more sensitive to these market conduct “black eyes” than others. It’s bad for business. For these companies, adjusters probably do a little better job of evaluating the entire claim as opposed to just punching the information into the computer to see what spits out. And, their in-house attorneys may be a tad more reasonable in settling, especially where a bad faith action is at stake.

Non-Compliance With Fair Practice Law

The California case of ***Moradi-Shalal v. Firemen’s Fund*** (1988) virtually eliminated private lawsuits for violations of the fair practices act, overruling the ***Royal Globe Insurance vs Superior Court*** (1979). Thus, the enforcement of insurance codes has been with the insurance commissioner leading to legislation such as the present Fair Claims Practices.

In the ensuing years, insureds have attempted to circumvent the *Moradi-Shalal* ruling by bringing actions for unfair business practices. Another approach has been to pursue a common law bad faith claim based on evidence of violations of the Insurance Code and the Commissioner's regulations.

Jordan vs Allstate (2007) may change this. A precedent may have again been set whereby insureds may once again be able to collect on bad faith issues resulting in large punitive damages. In this case, the insured presented testimony from an expert on insurance industry claims settlement practices. The expert opined that Allstate's conduct violated provisions of Section 790.03(h). Among the alleged "violations" were ***failing to disclose all insurance policy benefits, failing to have a copy of the Commissioner's Regulations in the insurer's claim manual, and failing to provide the claimant with a statement listing all of the grounds for the denial of the claim***.

The trial court in the *Jordan* case ruled that the expert testimony was relevant and admissible. The Court of Appeal agreed. It held that the insured was not "seeking to recover on a claim based on a violation" of Section 790.03(h). Rather, the Court stated, "her claim was based on a claim of common law bad faith arising from Allstate's breach and the implied covenant of good faith and fair dealing, which she is entitled to pursue." The Court affirmed that it was proper for the insured to use the expert opinion as evidence to support the bad faith claim. The Court held that, "this is a *proper* use of evidence of an insurer's violations of the statute and the corresponding regulations."

The *Jordan* case raises a practical question: Is a claim based on evidence of violations of the statute and the regulations materially different from the old *Royal Globe* cause of action? Particularly in a jury trial, evidence of violations of the Fair Claims Handling Practices regulations can have a dramatic impact. Whereas the point of the *Moradi-Shalal* decision was to leave enforcement of the regulations to the Insurance Commissioner, not the courts, the Jordan decision arguably puts that enforcement back in the hands of a judge or jury.

For insurers, the *Jordan* decision highlights the importance of making a continuous effort to comply with claims regulations. Most of the regulations address matters that insurers would already follow as part of their regular practices. Yet, when placed in evidence in the trial of a bad faith case, an otherwise innocuous violation of a regulation may be the deciding factor in the outcome of the case. The admission of "expert" testimony to a jury about how the insurer does not "follow the rules" could be the difference between a defense verdict and a finding of bad faith.

Important Time Lines

A large part of claims compliance is following mandated timelines. Following is a chart to help claims professionals understand the timelines under the California Fair Claims Settlement Law.

TIME LIMIT	ACTION REQUIRED	CODE
Within 15 calendar days or sooner after receiving a notice of claim or legal action	Acknowledge receipt of the claim (unless paid) and begin any necessary investigations. Provide reasonable assistance and forms. Specify information claimant must provide for proof of claim.	2695.5
Within 15 calendar days or sooner of any client communication where a response is required	Reply to claimant (unless the claim is a notice of legal action).	2695.5
Within 21 calendar days or sooner of receipt of inquiry regarding a claim from the Dept of Insurance	Furnish DOI with a written response	2695.5
Every 30 days after a 30-day extension	Notify claimant of insurer's inability (if any) to make a determination regarding acceptance or settlement.	2695.7
Within 30 days or sooner after settlement and provision of release	Insurer must tender settlement payment after affirmation of coverage	2695.7
Within 40 calendar days or sooner after receipt of a proof of claim	Accept or reject the claim, in whole or in part and affirm or deny liability unless fraud is involved.	2695.5
At least 60 days before expiration of the statute of limitations applicable to the claim	Insurer must notify the claimant of the expiration of the statute of limitations in writing.	2695.7
Annually, before Sept 1	Certify under penalty of perjury that all adjusters have read and understand fair claims regs, keep a copy in the adjuster claims manual and have clear instructions on procedures for compliance.	2695.6

What Are Insurers Doing To Comply

Insurers are routinely examined by the California Department of Insurance to test compliance with their claims practices and procedures, including conformance with the Fair Claims Settlement Practices Act. Market conduct violations are often discovered and corrective action required to remedy any infractions. Following are actual cases where companies were found to be non-compliant and the procedures they enacted to comply with the law. The hope is this will be instructive to adjusters and others needing to better understand the law and the importance the Department of Insurance places on compliance.

1. A Company failed to properly document claim files. Specifically, a company failed to maintain claim data that was accessible, legible and retrievable for examination . . . a violation of CCR §2695.3(a).

Summary of Company Response: The Company acknowledges that it failed to document within the claim file that a policyholder was being provided an auto body repair bill of rights document. The Company states that the proper mailing of the consumer bill of rights document had been a clerical duty, but has modified its procedure such that the file examiner will mail the vehicle owner a copy of the auto body bill of rights with a notation placed within the claim file. The Company has submitted documentation to evidence this procedural modification for the Department's records.

2. A Company failed to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance. The Company failed to include a statement in their claim denial that should the claimant believe that the claim had been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. This is a violation of CCR §2695.7(b)(3).

Summary of Company Response: The Company acknowledges that all denials of coverage and/or benefits to policyholders and/or claimants must reference the California Department of Insurance, its address and telephone number. The Company modified its general form and specific denial correspondence to include the California Department of
Insurance reference, its address and telephone number to comply with the subject regulation. The Department reviewed this modified form to ensure compliance. Additionally, the modified procedure and forms have been added to the Company's training manual.

3. A Company failed to include, in the settlement, all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the comparable automobile. The Company failed to include in the settlement, all applicable taxes, license fees and any other fees incident to transfer of evidence of ownership of the comparable automobile. The Department alleges these acts to be in violation of CCR §2695.8(b)(1).

Summary of Company Response: The Company acknowledges that a new total loss notification procedure was needed to communicate all itemized deductions to policyholders and claimants. The Company implemented the following corrective procedures:

A. In the event of a determined total loss, a modified form will be sent to the insured regarding the return of, if appropriate, vehicle license fees or VLF fees. The name of the owner of the vehicle will be shown as the party to whom the return should be directed. When the signed form

is received from the owner, it will be sent to the DMV for them to return any monies due. A copy of the signed form will be placed in the claim file. Language confirming this procedure shall be included in the form correspondence to the vehicle owner. The Department reviewed this form for accuracy and to ensure that it is in compliance with the subject regulation.

B. Following this examination, the Company commenced a file by file review of all prior total loss settlements. On those files where the transfer or tag fee was allowed at $10.00, as opposed to $15.00, the difference has been returned to the vehicle owner. Any other variances inuring to the benefit of the vehicle owner have also been returned. Further, on any files not showing a VLF request form, the forms are being filled out and sent to the DMV for reimbursement. The accurate payment of sales tax had been reviewed and corrected prior to this examination by Company to ensure that sales tax was not paid twice and that the proper tax rate was utilized. Accordingly, Company is paying sales tax at 8.5% on all vehicular total losses. The Department reviewed the aforementioned forms for accuracy and to ensure that each is in compliance with the subject regulation.

4. A Company failed to provide a written basis for the denial of the claim. Here, the Company failed to provide a written basis for the denial of the claim. The Department alleges these acts to be in violation of CCR §2695.7(b)(1).

Summary of Company Response: The Company acknowledges that it failed to state, in writing, a factual basis for the denial. The Company has developed and implemented a modified form to be utilized by staff for all denials of coverage and/or benefits to policyholders and/or claimants. Further, the staff is being trained to provide a denial communication, in writing, which offers a clear and concise basis for the denial. In cases where specific policy language is applicable, a copy of the policy evidencing the subject language will be included in the denial.

5. A Company failed to begin investigation of the claim within fifteen calendar days.
A Company failed to begin investigation of the claim within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(3).

Summary of Company Response: The Company acknowledges that it failed to begin investigation in a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in2002 for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, during the first quarter of 2003, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

6. A Company failed to provide necessary forms, instructions and reasonable assistance within fifteen calendar days. The Company failed to provide the necessary forms, instructions and reasonable assistance within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(2).

Summary of Company Response: The Company acknowledges that it failed to provide the necessary forms, instruction and reasonable assistance to the claimant within a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received

California Fair Claims Settlement Practices Certification. Moreover, the Company hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California unfair claim practices document has been given to each examiner for their reference when handling a California claim.

7. A Company failed to acknowledge notice of claim within fifteen calendar days.
The Company failed to acknowledge notice of claim within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(e)(1).

Summary of Company Response: The Company acknowledges that it failed to acknowledge notice of claim within a timely manner. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

8. A Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims. The Company failed to issue notices or issue notices timely or issue notices that included all required benefit information. The Company failed to adhere to standard of prompt investigation and processing of claims. The Department alleges these acts to be in violation of CIC. §790.03(h)(3).

Summary of Company Response: The Company acknowledges that in the above-cited matters its investigation, processing and/or payment of an insured's claim was severely delinquent. Training and seminar sessions now include a greater emphasis on prompt investigations, processing and payments of claims. Regular file reviews by management is also designed to ensure claim handling quality and compliance.

9. A Company failed to accept or deny the claim within forty calendar days. The Company failed upon receiving proof of claim, to accept or deny the claim within forty calendar days. The Department alleges these acts to be in violation of CCR §2695.7(b).

Summary of Company Response: The Company acknowledges that it failed upon receipt of proof of claim to accept or deny the claim within forty calendar days. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

10. A Company failed to provide written notice of the need for additional time ever thirty calendar days. The Company failed to provide written notice of the need for additional time every thirty-calendar days. The Department alleges these acts to be in violation of CCR §2695.7(c)(1).

Summary of Company Response: The Company acknowledges that it failed to provide written notice to the claimant to request additional time to evaluate the matter. In an effort to ensurethat its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover,during the first quarter of 2003, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

11. A Company required the use of non-original equipment manufacture replacement crash parts. The Company required the use of non-original equipment manufacture replacement crash parts. The Department alleges these acts to be in violation of CCR §2695.8(g)(3).

Summary of Company Response: The Company acknowledges that it failed to warrant that non-original equipment manufacturer replacement crash parts were of like, kind, quality, safety, fit, and performance as original replacement crash parts. In an effort to ensure that its staff is in compliance with the subject regulation, it has forwarded correspondence to all licensed California independent appraisers who are currently being employed by the Company.
The subject correspondence mandates that all of the appraiser's estimate forms must list all part variances as required by the subject regulation. The Department has reviewed the Company's offered correspondence for accuracy and compliance with the subject regulation.

12. A Company persisted in seeking unnecessary information. The Company persisted in seeking information not reasonably required for or material to the resolution of a claim dispute. The Department alleges these acts to be in violation of CCR §2695.7(d).

Summary of Company Response: The Company acknowledges that it failed to request additional time, in writing, from the subject claimants to evaluate the matter. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

13. A Company failed to document the determination of value. The Company failed to document the determination of value. Any deductions from value, including deductions for salvage, must be discernible, measurable itemized, and specified as well as be appropriate in dollar amount. The Department alleges these acts to be in violation of CCR §2695.8(b)(1)(C).

Summary of Company Response: The Company acknowledges that a new total loss notification procedure was needed to communicate all itemized deductions to policyholders and claimants. The Company has implemented the following corrective procedures:

A. In the event of a determined total loss, a modified form will be sent to the insured regarding the return of, if appropriate, vehicle license fees or VLF fees. The name of the owner of the vehicle will be shown as the party to whom the return should be directed. When the signed form

is received from the owner, it will be sent to the DMV for them to return any monies due. A copy of the signed form will be placed in the claim file. Language confirming this procedure shall be included in the form correspondence to the vehicle owner. The Department has reviewed this form for accuracy and to ensure that it is in compliance with the subject regulation.

B. Following this examination, the Company commenced a file by file review of all prior total loss settlements. On those files where the transfer or tag fee was allowed at $10.00, as opposed to $15.00, the difference has been returned to the vehicle owner. Any other variances inuring to the benefit of the vehicle owner have also been returned. Further, on any files not showing a VLF request form, those forms are being filled out and sent to the DMV for reimbursement. The accurate payment of sales tax had been reviewed and corrected prior to this examination by the Company to ensure that sales tax was not paid twice and that the proper tax rate was utilized. Accordingly, the Company is 10 paying sales tax at 8.5% on all vehicular total losses. The Department has reviewed the aforementioned forms for accuracy and to ensure that it is in compliance with the subject regulation.

14. Upon acceptance of the claim the Company failed to tender payment within thirty calendar days. Upon acceptance of the claim the Company failed to tender payment within thirty calendar days. The Department alleges these acts to be in violation of CCR §2695.7(h).

Summary of Company Response: The Company acknowledges that it failed to tender payment to the claimant within thirty calendar days upon acceptance of the claim. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in November 2002 for its Georgia claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

15. A Company failed to respond to communications within fifteen calendar days. The Company failed to respond to communications within fifteen calendar days. The Department alleges these acts to be in violation of CCR §2695.5(b).

Summary of Company Response: The Company acknowledges that it failed to respond to communications from the claimant within fifteen calendar days. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Moreover, the Company has hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

16. A Company failed to provide written notification to first party claimant as to whether the insurer intends to pursue subrogation. The Company failed to provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. The Department alleges these acts to be in violation of CCR §2695.8(i).

Summary of Company Response: The Company acknowledges that it failed to provide written notification to a first party claimant that it would pursue the subrogation of the subject claim. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. The Company also hired new supervisors and examiners in addition to a new Senior Vice President of Claims. The Company has also established a new Special Investigations Unit (SIU). Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

17. A Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Company attempted to settle a claim by making settlement offer that was unreasonably low. The Department alleges this act to be in violation of CCR §2695.7(g).

Summary of Company Response: The Company acknowledges that it attempted to effectuate an unreasonably low settlement based on unsubstantiated deductions, which have been reimbursed to the insured. In an effort to ensure that its staff is more familiar with California regulations, the Company began a California specific training seminar in November 2002 for its claims staff. All participating staff received California Fair Claims Settlement Practices Certification. Finally, a copy of the California Fair Claims Settlement Practices document has been given to each examiner for their reference when handling a California claim.

Note: To meet the DOI required Annual Fair Claims Certification you must read and understand the rules below, keep a copy of these rules, with claims procedures from your carrier, in your adjuster manual. Part of our certification process involves answering specific questions (using the exam that came with this course) correctly.

The California Fair Claims Settlement Practices

CALIFORNIA CODE OF REGULATIONS, TITLE 10. CHAPTER 5
FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS

Table of Contents

Section 2695.1. Preamble

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

(1) To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

(2) To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

(3) To discourage and monitor the presentation to insurers of false or fraudulent claims; and,

(4) To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices**.** Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code Section 790.03(h) and/or California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790**,** except as specifically provided below:

(1) Workers' compensation insurance;

(2) Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);

(3) Self insured or self funded plans which are bona fide Employee Retirement Income Security Act ("ERISA") plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;

(4) Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds**.**

(d) These regulations apply to home protection contracts and home protection companies defined in California Insurance Code Section 12740.

(e) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter.

(f) Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations**.**

(g) The California Insurance Code provides the commissioner with access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine if such person is engaged in any unfair or deceptive act or practice. California Insurance Code Section 790.03(h) requires all persons engaged in the business of insurance to effectuate prompt, fair and equitable settlements of claims and to otherwise process claims in a fair and reasonable manner.

The Department considers the use of reliable information to be an essential element of the fair and equitable settlement of claims. The fact that information, data or statistical methods

used or relied upon by a licensee to process or establish the value of insurance claims is obtained through a third party source shall not absolve the licensee of its legal responsibility to comply with these regulations or to effectuate prompt, fair and equitable settlements of claims. Failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in non-compliance with these regulations or other applicable insurance code provisions. Any and all information received pursuant to the Department's request shall be given confidential treatment, as provided in California Insurance Code section 735.5 and California Government Code Section 11180 et seq. When processing or establishing the value of a claim, a licensee shall not be responsible for the accuracy of information provided by a governmental entity, unless the licensee has discovered or been notified of the inaccuracy and has continued to use the information.

NOTE: Authority cited: Sections 790.034, 790.10, 1871.1, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 790.03, 790.04, 735.5 and 12740 of the California Insurance Code, and Section 11180 et seq. of the California Government Code.

Section 2695.2. Definitions

As used in these regulations:

(a) "Beneficiary" means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insurer
or,

(2) for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "***Claims agent***" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

1) an attorney retained by an insurer to defend a claim brought against an insured; or,

2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "***First party claimant***" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "***Gross settlement amount***" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,

(2) the term "life agent" as used in section 32 of the California Insurance Code; or,

(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,

(4) an underwritten title company.

(i) "Insurer" means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term **"**insurer" for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term "insurer" shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) "Insurance policy" or "policy" means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include "surety bond" or "bond".

For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

(k) "Investigation" means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) "***Knowingly committed***" means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) "Licensee" means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner's consent is required before transacting business in the State of California or with California residents. The term "licensee" for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) "***Notice of claim***" means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer's obligations under that policy or bond may have arisen. For purposes of these regulations the term "notice of claim" shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.

(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "***Proof of claim***" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "***Remedial measures***" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;

(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "***Replacement crash part***" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "***Third party claimant***" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

NOTE: Authority cited: Sections 132(d), 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code**,** Section 995.130 of the Code of Civil Procedure and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082 of the California Insurance Code.

Section 2695.3. File and Record Documentation

(a) Every licensee's claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files ***shall contain all documents***, notes and work papers (including copies of all correspondence) ***which reasonably pertain to each claim*** in such detail that pertinent events and the dates of the events can be ***reconstructed*** and the licensee's actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:

(1) ***maintain claim data*** that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment**.** This data must be available for all open and closed files for the current year and the four preceding years**;**

(2) ***record in the file the date*** the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) ***maintain hard copy files*** or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee's ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

NOTE: Authority cited: Sections 790.04, 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.

Section 2695.4. Representation of Policy Provisions and Benefits

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured's policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer's additional liability.

(b) ***No insurer shall misrepresent or conceal benefits***, coverages, time limits or other provisions of the bond which may apply to the claim presented ***under a surety bond***.

(c) No insurer shall deny a claim on the basis of the claimant's failure to exhibit property, unless there is documentation in the file (1) of reasonable demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the ***subject matter*** which gave rise to the claim payment unless, prior to execution of the release**,** the legal effect of the release is ***disclosed and fully explained*** by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542, provided that**,** prior to execution of the release**,** the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in ***partial settlement of a loss or claim*** that contain or are accompanied by language ***releasing the insurer***, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a ***compromise settlement*** agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative proofs of claim where coverage may exist under more than one policy issued by that insurer.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(1), (3) and (4) of the California Insurance Code.

Section 2695.5. Duties upon Receipt of Communications

(a) Upon receiving any written or oral ***inquiry from the Department of Insurance*** concerning a claim, every licensee shall immediately, but in no event more than ***twenty one (21) calendar days of receipt*** of that inquiry, furnish the Department of Insurance with a ***complete written response*** based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

(b) Upon receiving any ***communication from a claimant***, regarding a claim, that ***reasonably suggests that a response*** is expected, every licensee shall immediately, but in no event more than ***fifteen (15) calendar days*** after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving ***notice of claim***, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen ***(15) calendar days later***, do the following unless the notice of claim received is a notice of legal action:

(1) ***acknowledge receipt*** of such notice to the claimant unless payment is made within that period of time. If the acknowledgment is not in writing, a notation of acknowledgment shall be made in the insurer's claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except

where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) ***provide to the claimant necessary forms***, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) ***begin*** any necessary ***investigation*** of the claim.

(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

NOTE: Authority cited: Sections 790.04, 790.10, 12340 - 12417, inclusive, 12921, 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 790.03(h)(2) and (3) of the California Insurance Code.

Section 2695.6 Training and Certification

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding these regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

A licensee shall demonstrate compliance with this subsection by the following methods:

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands these regulations and any and all amendments thereto;

(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee's claims adjusting manual contains a copy of these regulations and all amendments thereto; and,

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains insurance adjusters as defined in California Insurance Code Section 14021, the licensee must provide training to the insurance adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the insurance adjuster may annually certify in writing, under penalty of perjury, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6(b) (1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(3) of the California Insurance Code.

Section 2695.7. Standards for Prompt, Fair and Equitable Settlements

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age**,** race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) the extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in

subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a ***telephone conversation*** or personal interview with any source ***unless*** the telephone conversation or personal interview is ***documented in the claim file*** pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant's deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense.

This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.

NOTE: Authority cited: Sections 553, 554, 790.03(h)(5), 790.03(h)(12), 790.10, 1861.03(a), 10350.10, 10111.2, 11580.2(k), 12340 - 12417, inclusive, 12921 and 12926 of the

California Insurance Code and Sections 11342.2 and 11152 of the California Government Code**;** *Egan v. Mutual of Omaha Insurance Company* (1979) 24 Cal.3d 809 [169 Cal.Rptr. 691]; *KPFF, Inc. v. California Union Insurance Company* (1997) 56 Cal.App.4th 963 [66 Cal.Rptr.2d 36] (certified for partial publication); *Betts v. Allstate Ins. Co.* (1984) 154 Cal.App.3d 688 [201 Cal.Rptr. 528]. Reference: Section 790.03(h) (2), (3), (4), (5) (13) and (15), and 1872.4 of the California Insurance Code**,** Section 6149.5 of the California Business and Professions Code and California; and Penal Code Section 550.

Section 2695.8. Additional Standards Applicable to Automobile Insurance

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims.

(1) the words "automobile" and "vehicle" are used synonymously**.**

(b) In evaluating automobile total loss claims the following standards shallapply:

(1) The insurer may elect a cash settlement that shall be based upon the actual cost of a “comparable automobile” less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one-time fees incident to transfer of evidence of ownership of a comparable automobile**.** This amount shall also include the license fee and other annual fees to be computed based upon the remaining term of the loss vehicle’s current registration. This procedure shall apply whether or not a replacement automobile is purchased.

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant’s vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle’s future resale and/or insured value.

The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

(2) A “comparable automobile” is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with options and mileage similar to the insured vehicle. Newer model year automobiles may not be used as comparable automobiles unless there are not sufficient comparable automobiles of the same model year to make a determination as set forth in Section 2695.8(b)(3), below. In determining the cost of a comparable automobile, the insurer may use either the asking price or actual sale price of that automobile. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer

fairly adjusts for such differences. Any adjustments from the cost of a comparable automobile must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claim file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used. The actual cost of a comparable automobile shall not include any deduction for the condition of a loss vehicle unless the documented condition of the loss vehicle is below average for that particular year, make and model of vehicle. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. A comparable automobile must have been available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer. The comparable automobiles used to calculate the cost shall be identified by the vehicle identification number (VIN), the stock or order number of the vehicle from a licensed dealer, or the license plate number of that comparable vehicle if this information is available. The identification shall also include the telephone number (including area code) or street address of the seller of the comparable automobile.

(3) Notwithstanding subsection (2), above, upon approval by the Department of Insurance, an insurer may use private sales data from the Department of Motor Vehicles, or other approved sources, which does not contain the seller's telephone number or street address. Approval by the Department of Insurance shall be contingent on the Department's determination that reasonable steps have been taken to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles or other approved sources.

(4) The insurer shall take reasonable steps to verify that the ***determination of the cost of a comparable vehicle*** is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the ***average cost of two or more*** such comparable automobiles; or,

(B) when comparable automobiles are not available or were not available in the local market area in the last 90 days, the ***average of two or more quotations*** from two or more licensed dealers in the local market area; or,

(C) the cost of a comparable automobile as determined by a ***computerized automobile valuation service*** that produces statistically valid fair market values within the local market area; or

(D) if it is not possible to determine the cost of a comparable automobile by using one of the methods described in subsections (b)(3)(A)**,** (b)(3)(B) and (b)(3)(C) of this section, the cost of a comparable automobile shall otherwise be supported by documentation and fully explained to the claimant. Any adjustments to the cost of a comparable automobile shall be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used.

(5) In ***first party automobile total loss claims***, the insurer may elect to offer a ***replacement automobile*** which is a specified ***comparable automobile*** available to the insured with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer's claim file. A replacement automobile must be in as ***good or better*** overall condition than the insured vehicle and ***available for inspection*** within a reasonable distance of the insured's residence.

(6) Subsection 2695.8(b) applies to the evaluation of third party automobile total loss claims, but does not change existing law with respect to the obligations of an insurer in settling such claims with a third party.

(c) In first party automobile total loss claims, every insurer shall provide notice to the insured at the time the ***settlement payment*** is sent or final settlement offer is made that if notified by the insured within ***thirty-five (35) calendar days*** after the insured receives the claim payment or final settlement offer that he or she cannot purchase a comparable automobile for the gross settlement amount, the insurer will reopen its claim file**.** If subsequently notified by the insured the insurer shall reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(4). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,

(B) the stock or order number of the vehicle from a licensed dealer, or

(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the ***third party claimant*** make a claim ***under his or her own policy*** to avoid paying the claim under the policy issued by that insurer.

(e) ***No insurer*** shall:

(1) require that an automobile be repaired at a specific repair shop; or,

(2) ***suggest or recommend*** that an ***automobile be repaired at a specific repair shop***, unless all of the requirements set forth in California Insurance Code Section 758.5 have been met [***prominently disclose such requirement at time the insurance is applied for***].

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) If ***partial losses*** are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) ***pay the difference*** between the written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant**,** promptly ***provide the claimant*** with the name of ***at least one repair shop*** that will make the repairs for the amount of the insurer's written estimate. The insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by law. The insurer shall maintain documentation of all such communications; or,

(3) ***reasonably adjust*** any written estimates prepared by the repair shop of the claimant's choice and provide a copy of the adjusted estimate to the claimant.

(g) No insurer shall require the use of ***non-original equipment manufacture*** replacement crash parts in the repair of an automobile unless:

(1) the ***parts are at least equal*** to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non-original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to effect the repair; and,

(3) insurers specifying the use of non-original equipment manufacture replacement crash parts ***warrant that such parts are of like kind, quality, safety, fit, and performance*** as original equipment manufacturer replacement crash parts; and,

(4) all original and non-original manufacture ***replacement crash parts***, manufactured after the effective date of this subchapter, when supplied by repair shops ***shall carry sufficient permanent, non-removable identification*** so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation**;** and,

(5) the use of non-original equipment manufacturer replacement crash parts is disclosed in

accordance with section 9875 of the California Business and Professions Code.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) When the ***amount claimed*** is adjusted because of betterment or depreciation, all justification shall be ***contained in the claim file***. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment or depreciation. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. The ***basis for any adjustment shall be fully explained*** to the claimant in writing and shall:

(1) ***reflect a measurable difference*** in market value attributable to the condition and age of the vehicle, and

(2) ***apply only to parts*** normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(j) In a first party partial loss claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.

(k) After a covered loss under a policy of automobile collision coverage or automobile physical damage coverage as defined in California Insurance Code Section 660, where towing and storage are reasonably necessary to protect the vehicle from further loss, the insurer shall pay reasonable towing and storage charges incurred by the claimant. The insurer shall provide reasonable notice to the claimant before terminating payment for storage charges so that the claimant has time to remove the vehicle from storage. This subsection shall also apply to a third party claim filed under automobile liability coverage as defined in California Insurance Code section 660, however, payment to a third party claimant may be prorated based upon the comparative fault of the parties.

NOTE: Authority cited: Sections 790.10, 12921 and 12926 of the California Insurance Code, Section 3333 of the California Civil Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Sections 758.5, 790.03(c) and 790.03(h)(3) of the California Insurance Code and Section 9875 of the California Business and Professions Code.

Section 2695.85. Auto Body Repair Consumer Bill of Rights

(a) Every insurer that issues automobile liability or collision insurance policies shall provide the named insured(s) with an Auto Body Repair Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or loss that is reported to the insurer. If the insurer provides the insured with an electronic copy of a policy, the bill of rights may also be transmitted electronically. If the insurer provides the bill of rights following an accident or loss, the insurer shall also provide the bill of rights to the particular insured filing the insurance claim. If the insurer provides the bill of rights at the time of application or policy issuance, all named insureds that have not previously received the bill of rights shall be provided with a copy upon renewal of the policy.

(b) The requirements set forth in subsection 2695.85(a), above, shall apply to all automobile liability and collision insurance policies issued in California including commercial automobile,

private passenger automobile, and motorcycle insurance policies.

(c) The Auto Body Repair Consumer Bill of Rights shall be a separate standardized document and plainly printed in no less than ten-point type. An insurer may distribute the form using its own letterhead, but the language of the Auto Body Repair Consumer Bill of Rights shall be developed by the California Department of Insurance and shall read as follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.

4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR
Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210
California Department of Consumer Affairs
Bureau of Automotive Repair
10240 Systems Parkway
Sacramento, CA 95827

The Bureau of Automotive Repair can also accept complaints over its web site at:
www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER. Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921
California Department of Insurance
Consumer Services Division
300 South Spring Street
Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at: www.insurance.ca.gov

NOTE: Authority cited: Sections 790.10, 1874.85, 1874.87 of the California Insurance Code. Reference: Sections 790.03(c), 790.03(h)(3), and 1874.87 of the California Insurance Code; Sections 9884.8, 9884.9 of the California Business and Professions Code; and California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695.8(j).

Section 2695.9. Additional Standards Applicable to First Party Residential and Commercial Property Insurance Policies

(a) When a residential or ***commercial property insurance*** policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or ***replacement of an item or part [replacement cost]***, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The ***insured shall not have to pay for depreciation*** nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

(b) No insurer shall require that the insured have the property repaired by a specific individual or entity.

(c) ***No insurer*** shall ***suggest or recommend*** that the insured have the property repaired by a specific individual or entity unless:

(1) the ***referral is expressly requested*** by the claimant; or

(2) the claimant has been informed in writing of the right to select a repair individual or entity and, if the ***claimant accepts the suggestion or recommendation***, the insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(d) If losses are settled on the basis of a written scope and/or estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of each document upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between its written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair individual or entity that will make the repairs for the amount of the written estimate. The insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and which will allow for repairs in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations; or,

(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured's choice and provide a copy of the adjusted estimate to the claimant.

(e) Once the appraisal provision under an insurance policy is invoked, the appraisal process shall not include any legal proceeding or procedure not specified under California Insurance Code Section 2071. Nothing herein is intended to preclude separate legal proceedings on issues unrelated to the appraisal process.

(f) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. Any adjustment for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and replacement during the useful life of the property. The basis for any adjustment shall be fully explained to the claimant in writing.

(1) Under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051. Except for the intrinsic labor costs that are included in the cost of manufactured materials or goods, the expense of labor necessary to repair, rebuild or replace covered property is not a component of physical depreciation and shall not be subject to depreciation or betterment.

NOTE: Authority cited: Sections 790.10, 2051, 2051.5, 2071, 12921 and 12926 of the California Insurance Code**,** Section 7109 of the California Business and Professions Code and Sections 11342.2 and 11152 of the California Government Code**;** Reference: Sections 790.03(h)(3), (5) and (7) of the California Insurance Code.

Section 2695.10 Additional Standards Applicable to Surety Insurance

(a) No insurer shall base or vary its ***claims settlement practices***, or its standard of scrutiny and review, upon the claimant's**, *age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability***, or upon the territory of the property or person insured.

(b) As soon as possible, but in no event later than ***forty (40) calendar days*** after receipt by the insurer of ***proof of claim***, and provided the claim is not in litigation or arbitration, the insurer

shall ***accept or deny the claim***, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall provide to the claimant a written statement listing all bases for such rejection or denial, and the factual and legal bases for each reason given for each rejection or denial, which are within the insurer's knowledge. If an insurer's denial of a claim in whole or in part is based on a specific statute or specific bond provisions, the denial shall include reference thereto and provide an explanation of the application of the statute or bond provision to the claim. Written notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(1) A principal's absence, non-cooperation, or failure to meet the bonded obligation shall not excuse unreasonable delay by the insurer in determining whether a claim should be accepted or denied.

(2) While an insurer may consider all information provided by a principal**,** absent reasonable factual and/or legal bases for denying a claim, no insurer shall deny a claim based solely upon a principal's protest of a claim or denial of liability for a claim.

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such ***additional time [extension]*** within the time specified in subsection 2695.10(b). Such written notice shall specify the reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer's inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer's ability to comply, such written notice shall be provided within ***30 calendar days*** of the date of the initial notification, and ***every 30 calendar days*** thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

(f) Where the ***claim is to be settled*** by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within ***15 calendar days*** following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) ***within 15 calendar days*** following the insurer's ***receipt of a release*** properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer's liability, or impair the rights of other claimants under the bond.

(g) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.

(h) No insurer shall attempt to settle a claim by making a ***settlement offer*** that is ***unreasonably low***. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) ***the extent*** to which the insurer considered evidence submitted by the claimant to support the ***value of the claim***;

(2) the extent to which the insurer considered ***legal authority*** or evidence made known to it or reasonably available;

(3) the ***procedures*** used by the insurer in determining the dollar amount of damages;

(4) any other ***credible evidence*** presented to the Commissioner that demonstrates that the final amount offered by the insurer in settlement of a claim is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

NOTE: Authority cited: Sections 790.10, 12921, 12921.1 and 12926 of the California Insurance Code. Reference: Sections 790.03(h)(3), (4) and (15), 12921.3 of the California Insurance Code, and California Civil Code Section 2807.

Section 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting such the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error

shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires ***preauthorization of non-emergency medical services***, the preauthorization must be given immediately but in no event more than ***five (5) calendar days*** after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall ***explain the scope*** of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, ***the reason(s) for the denial shall be communicated in writing*** to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

NOTE: Authority cited: Sections 790.10, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h)(1), (2), (3), (5) and (13) and Section 10123.13 of the California Insurance Code.

Section 2695.12. Penalties

(a) In determining whether to assess penalties and, if so, the appropriate amount to be

assessed, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;

(2) whether the licensee has a good faith and reasonable basis to believe that the claim or claims are fraudulent or otherwise in violation of applicable law and the licensee has complied with the provisions of Section 1872.4 of the California Insurance Code;

(3) the complexity of the claims involved;

(4) gross exaggeration of the value of the property or severity of the injury, or amount of damages incurred;

(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged default of the principal;

(6) secreting of property which has been claimed as lost or destroyed.

(7) the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period;

(8) whether the licensee has taken remedial measures with respect to the noncomplying act(s);

(9) the existence or nonexistence of previous violations by the licensee;

(10) the degree of harm occasioned by the noncompliance;

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of this subchapter;

(12) the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter;

(13) whether the licensee's management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures; and

(14) the licensee’s reasonable mistakes or opinions as to valuation of property, losses or damages.

(b) This section shall not bar, obstruct or restrict any right to administrative due process an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and 790.07.

NOTE: Authority cited: Sections 790.035, 790.07, 790.08, 790.09, 790.10, 1872.4, 12340 - 12417, inclusive, 12921, 1065, 704, 780-784, 1011, 11690, 12926 and 12928.6 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h), 790.035 (a), 790.04, 790.05, 790.06, 790.08, 790.10 of the

California Insurance Code.

Section 2695.13. Severability

If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

NOTE: Authority cited: Sections 790.10, 12340 - 12417, inclusive, 12921 and 12926 of the California Insurance Code and Sections 11342.2 and 11152 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.
2695.14 Compliance Date

(a) Any amendments to these regulations shall be complied with within ninety (90) calendar days after they are filed with the Secretary of State.

(b) Prior to the ***compliance date*** of these regulations, ***licensees*** shall, pursuant to Section 2695.6, adopt and communicate to their claims ***agents standards*** for the prompt investigation and processing of claims, and provide ***training and instruction on these regulations***.

(c) These regulations shall apply to any claims handling that takes place on or after the compliance date set forth under subsection 2695.14(a).

NOTE: Authority Cited: Sections 790.10, 12921 and 12926 of the California Insurance Code and Section 11343.4 of the California Government Code. Reference: Section 790.03(h) of the California Insurance Code.

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