INSURANCE CONTINUING EDUCATION

ETHICAL SELLING AND FRAUD PREVENTION

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ETHICAL SELLING AND FRAUD PREVENTION

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All inquiries should be addressed to:

Bookmark Education
6203 W. Howard Street
Niles, IL 60714
(800) 716-4113
BookmarkEducation.com

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CHAPTER 1: THE IMPORTANCE OF ETHICAL SALES

Since ancient times, humans have looked carefully at ethics and have tried to determine what should or shouldn't be done in given situations. Our personal set of ethics is shaped by cultural influences as well as by the family members, peers and teachers who interact with us during our formative years. But as we grow older and more independent, the process of developing our ethics becomes increasingly a matter of personal responsibility. Without an authority figure looking over our shoulder and threatening to punish us for bad behavior, the choice to follow our internal code of ethics belongs to us. And without trustworthy elders at our disposal, we may need to think very carefully about how the black-and-white basics of good ethics (honesty, respect, compassion, etc.) fit into a world with so many gray areas.

Consistently applying solid ethics to our business can sometimes seem like a challenge. This is particularly true if we frame our understanding of ethics in a traditional way that has seemingly no room for self-interest. As idealistic as that view of ethics might be, it's probably best to admit that it isn't realistic. Though we may truly enjoy our jobs and aim to treat people fairly, it's probably safe to say that most of us do our work for the self-interested purpose of making money. In a world where money is practically necessary for survival, perhaps our business ethics should be focused not on the total elimination of self-interest, but on carefully monitoring that self-interest so that it doesn't harm the public.

Good ethics doesn't prevent you from having a profitable insurance career. In fact, adherence to a set of fair, well-meaning principles might contribute to your longevity in the business. Good ethics build strong relationships with consumers. Strong relationships, in turn, increase the chances of valued referrals.

Practicing good ethics can also keep those relationships strong when honest mistakes are made. Consider, for example, a scenario in which an insurance broker who specializes in commercial lines gives an otherwise excellent sales presentation to a long-time client but fails to adequately explain the intricacies of a major policy exclusion. After an accident at the client's place of business, the client is surprised to learn that the resulting loss will not be covered by insurance. Although the client is unhappy with the outcome, the broker has been helping to insure the business for many years and has otherwise proven to be very honest, knowledgeable, and service-oriented. The client and the broker have a conversation in which the broker expresses regret and compassion. Had this been a different broker, the client might have filed complaints with a regulator, threatened to sue or at least severed their relationship. But since the broker built up so much good will over the years by acting with supreme professionalism, the relationship is allowed to continue.

Good ethics, of course, don't guarantee happy endings like this one. But along with other facets of risk management, they can certainly reduce the likelihood of compliance problems and consumer complaints.

Right and Wrong in Insurance

Admittedly, even the world's best ethics curriculum is unlikely to stop a highly unethical person from committing harmful acts. However, studying ethics has the potential to help generally ethical people apply their well-intended principles in new ways. Throughout the remainder of this course, we'll make the reasonable assumption that you, the reader, are in that second group of people. You probably don't need someone to tell you the basics of right and wrong, but you might benefit from remembering what "doing the right thing" might mean in a number of seemingly ordinary business scenarios.

In order to demonstrate this point, let's take a few moments to consider two kinds of actions. First, make a brief list in your mind of what an ethical insurance sales professional SHOULD do when

representing carriers or consumers. Then, take the opposite approach and think of a few actions that an ethical insurance sales professional definitely SHOULD NOT do.

Without thinking too hard about it, your two mental lists might look something like these:

An Ethical Insurance Sales Professional Should:

- Respect confidentiality.
- Give necessary disclosures regarding costs and exclusions.
- Listen carefully to the needs of consumers.
- Provide honest and well-informed explanations to people's questions.
- Treat people fairly.
- Behave with integrity.

An Ethical Insurance Sales Professional Should Not:

- Make decisions for the consumer.
- Base product recommendations mainly on the amount of commission being received.
- Advertise and summarize products in ways that are deceptive.
- Make sales through the use of unnecessary fear.

Applying What You Already Believe

Coming up with those basic lists probably wasn't difficult. Recognizing how those basics can be brought to life, on the other hand, requires deeper contemplation. So, let's analyze a few of the listed items a bit more thoroughly.

Respecting Confidentiality

Respecting confidentiality in insurance doesn't just mean that you aren't using people's information for selfish reasons or engaging in gossip. It also means you are careful not to slip up and disclose private facts about people in seemingly harmless situations.

Suppose your client, Mary Jones, is interested in a life insurance policy with a rider that allows some of the death benefit to be used prematurely in order to pay for long-term care services. However, Mary has some health conditions that might jeopardize her eligibility for the rider. Your co-worker does more long-term care business than you and is well-versed in the underwriting criteria of various insurance providers, so you leave him a voicemail, asking for advice. Your co-worker returns your call while you are waiting to check-in at a crowded continuing education class. Since this is important business for you, you take the call while waiting in line and explain Mary's situation by providing her full name and the names of her medical conditions. Your co-worker agrees to review your notes about Mary, which are at your office, and hangs up.

You feel good about sharing Mary's information with a competent and respected colleague in order to get her what she needs. But did you respect her privacy as much as possible? Even if no one at the class is likely to know Mary or care about her medical issues, it was probably not a good idea to mention her specifics (especially her full name) in a public place. If nothing else, being careful to avoid disclosing personal information like this can be good practice for those situations in which accidental disclosure might be more harmful.

Providing Informed Explanations

Because your clients are unlikely to do so, you should remain informed by carefully reading the policies you sell. This ensures you will know the important facts that are likely to be important in the person's decision-making process, and it might even increase your chances of avoiding a regulatory complaint.

It may even be appropriate to provide unsolicited explanations of the insurance-buying process besides product selection and price. For example, you might consider explaining what happens after an application is submitted, how long approval might take and what kinds of issues might force a delay in the issuance of coverage. By knowing the intricacies of how a particular insurer processes and evaluates applicants' data, you can set reasonable expectations that will keep the applicant satisfied.

Treating People Fairly

A famous statement known as the "Golden Rule" instructs us to treat others as we would want to be treated. To an extent, this rule can be used to explain why we should consider offering the same level of service to all of our customers, but the realities of business might make this application at least partially impractical.

Put yourself in the position of a busy commercial insurance salesperson. You sell comprehensive property and casualty solutions to very large companies that mean a lot to your business's bottom line. You also have a few small businesses within your clientele that result in smaller returns. Both types of clients could use some time-consuming assistance from you as they navigate through their insurance options, but you only have so many hours in your day. So, does treating people fairly mean treating them equally?

Even well-meaning professionals are likely to admit that some clients are more valuable to them than others. Still, that doesn't mean the seemingly less important clients should be ignored. In these situations, it might be helpful to step back from the situation and categorize the service-related requests made by each party. Are there requests that should be addressed as soon as possible, even if the client isn't as integral to your business's success as everyone else? If there are requests that aren't as pressing, can the work be either passed along to another qualified person or scheduled for another reasonable time? At the very least, the client should be contacted and informed that his or her concerns will eventually be addressed.

Avoiding Fear

Insurance professionals need to carefully monitor their presentations so that they don't engage in unnecessary scare tactics. But since the fear of loss is at the core of any insurance transaction, the line between what's a scare tactic and what's simply a form of wise risk management is debatable.

Saying something like "You should consider life insurance in order to protect your family" appears harmless enough. But what if the statement becomes more specific and graphic? A slight modification like "You should consider life insurance in case something happens to you" adds a little more fear but might seem acceptable to many producers. A step further like "You should consider life insurance because your father died young" is riskier, not only because of fear but because it plays on the person's painful, personal memories and could offend the listener. In cases like this, the graphic details of a worst-case scenario are often already swirling around a prospect's mind and, therefore, don't need to be said.

Relationships With Carriers and Consumers

Regardless of whether they act as agents (and are generally considered to be representatives of the insurance company) or as brokers (and are generally considered to be representing the

consumer), all insurance professionals owe certain duties to insurers and the buying public. Without balancing those responsibilities, your working relationships with either side will undergo a great deal of strain. If you only look out for the interest of the insurance company at the expense of the consumer, very few buyers will want to know you. Conversely, if you conceal information from an insurance carrier in the hope of helping an applicant, your book of business will eventually be highly scrutinized by skeptical underwriters.

What Would You Do?

The conflicts that arise out of these dueling obligations are sometimes present during the application process. For instance, a disability insurance salesperson might be fully aware that an applicant has a potentially debilitating health condition, but the application provided by the carrier might be worded in a way that doesn't directly ask about this significant risk. At this point, the salesperson has a decision to make: Should the potentially problematic condition be disclosed to someone at the insurance company, or should the professional follow the exact wording of the application and only provide the requested information?

As challenging as this proposed dilemma might seem, doing research about various companies can often make the issue irrelevant. If you familiarize yourself with an insurer's views on various risks before approaching applicants, you might be more aware of which risk factors are really important to the company and which ones will have no impact on the pricing or availability of the company's products.

Handling Premiums

Both the consumer and the insurer might rely on the insurance salesperson to make sure that initial premiums are transferred to the appropriate party. Unethical handling of funds, such as putting premiums in an agency's general operating account, is a serious offense and has become one of the most strongly prosecuted insurance crimes. Although this form of wrongdoing is relatively uncommon in the life and health lines of insurance, it should be a major concern at most independent property and casualty agencies. Compared to life and health agents, independent property and casualty agents are at least more likely to receive checks that are made out to the agency rather than to the issuing insurance company.

In order to ensure proper compliance, insurance professionals who collect and make premium deposits should carefully review state rules regarding premium fund trust accounts. Important information about proper handling of money might also appear in the agency contract between you and the insurance carrier.

Building Relationships With the Public

Let's put relationships with insurers aside for a moment and focus on relationships with consumers. As you undoubtedly know, a lot of people outside of your profession have a negative opinion of the insurance industry. There are many possible reasons for this public relations problem, and a lot of those reasons are out of your personal control. But keep in mind that some people's negative perceptions of you are based on consumers' bad experiences with other insurance representatives. If you practice good ethics, you may be able to overcome some of the lingering negativity. Conversely, if you don't practice good ethics, you might make matters more difficult for the next insurance professional who deals with that person.

In order to ensure that your relationships with consumers remain strong, it is important to solicit and openly accept feedback from the public. By asking for feedback, you might be able to determine whether your explanations to a consumer were actually understood. If you are humble and willing

to accept criticism, feedback might also alert you to mistakes you are making and help you correct problems before they get out of hand.

Avoiding Complaints

Failing to acknowledge and address problems with consumers could lead you down a path toward unwanted lawsuits in civil or criminal court. If valid complaints are filed with your state's insurance department, you also risk losing your license and having to pay major fines.

Due in large part to internet technology, it has become increasingly easy for dissatisfied insurance buyers to file complaints against licensees. Instead of requiring paper-based complaints that can easily get lost amid the shuffling of documents at government offices, most states offer easy access to complaint forms at their insurance department's website. Since unsubstantiated complaints can still force a licensee to lose time and energy by submitting documentation and attending hearings, any hint of unethical conduct should be avoided whenever possible.

Examples of what to avoid are provided in the next several sections of this course.

Material Misrepresentations

Salespersons need to be careful to avoid material misrepresentations. A material misrepresentation is any false or misleading statement that is likely to influence someone's decision. Material misrepresentations might be made intentionally in order to influence a buyer, or they might be made accidentally by a licensee who is not being careful with his or her language.

Examples of material misrepresentations include misrepresenting the financial condition of an insurance company or misrepresenting the terms, conditions, benefits or exclusions of an insurance product. Insignificant mistakes, such as a spelling error that has no impact on the meaning of the word, are not material misrepresentations.

Misrepresentations can result from what is said and also by what is left unsaid. A misrepresentation that occurs because of what someone fails to mention is called an "omission." Omission is a problem if it involves something that, if known, would influence someone's decision.

Intimidation

Intimidation occurs when someone is forced to do something, such as purchase insurance, under the threat of harm. While you might never even think of engaging in intimidation in order to sell insurance, you should be on the lookout for this unacceptable behavior when meeting with the public. For example, when meeting with elderly clients and their families, watch out for hints of elder abuse from relatives who might not have the elderly person's best interests in mind.

If you sense that a family member is forcing an elderly person to purchase an insurance product (such as life insurance, long-term care insurance or an annuity), you should strongly consider divorcing yourself from the transaction. Contracts, including insurance products, are generally not enforceable if the purchaser enters into them against his or her will.

Lowballing

The term "lowballing" is often used in situations where insurance salespersons intentionally misrepresent the cost of an insurance product in order to steal business from potential competitors. It is also used on occasion to describe a claims-handling situation in which the settlement offered by the insurance company is lower than what should be offered under the policy. In either case, lowballing is sure to provoke anger from a trusting policyholder.

Defamation, Libel and Slander

Defamation occurs when someone makes a false statement that harms the reputation of someone else. In times of heated competition, insurance professionals must be careful to avoid inappropriate comments about other licensees or other insurance businesses. If statements about competing entities are harmful and false, charges of libel (written defamation) or slander (spoken defamation) might result. Due to the wide reach of the Internet, insurance professionals should be extra careful when making unflattering comments online.

Concerns about defamation can be managed by emphasizing the strengths of your own products and your own skills and by avoiding any unnecessary mentions of competitors.

Marketing and Terminology

When advertising insurance in the media or in an oral presentation, sales professionals should clearly identify the product being sold. An insurance product such as cash-value life insurance should be identified clearly and not disguised in terms like “family savings plan” or “emergency account.”

Advertisements must emphasize products that are actually available and shouldn’t involve “baiting and switching.” In a bait and switch, desirable deals are offered in order to initiate contact from a consumer. Upon inquiring about the seemingly great deal, the person is told that it isn’t available anymore but that there are other products available to suit his or her needs. Unlike an insurance licensee, the average person tends to know little about insurance and might be incapable of recognizing certain offers as “too good to be true.”

Twisting and Churning

“Twisting” or “churning” occurs when one insurance policy is replaced by another even though there is no clear benefit to the policyholder. Although these two terms are often used interchangeably, twisting generally refers to instances in which there is an unnecessary switch in insurance companies. Churning, on the other hand, generally involves exchanging policies that are issued by the same insurer.

Policy exchanges, in and of themselves, aren’t necessarily unethical. There might be clear differences in coverage that make a new policy a better fit for a buyer. Alternatively, a new policy might provide less coverage but cost significantly less than what the buyer is currently paying. However, agents should document the reason for exchanges and provide adequate disclosure of the potential consequences to the purchaser. For example, buyers should be made aware of any surrender charges or new exclusionary periods that might result from the swap. Also, the policy being replaced should remain in force until the new policy has gone into effect.

Tips for Ethical Insurance Professionals

We’ve addressed unethical behavior and some of the consequences for consumers. But let’s assume you’re a very ethical person who always tries to treat people well. What are some precautions you can take to avoid making a mistake or being accused of wrongdoing? The next few sections contain some simple pointers for you.

Analyzing Needs

To keep the consumer satisfied, you’ll want to ensure that the products presented to a potential purchaser are suitable. When you meet with a new customer, you should conduct a needs analysis in order to determine the suitability of specific products. To perform a proper needs analysis, you must ask several questions and listen carefully to the answers.

Helpful questions might include:

- What are your needs and goals?
- What kinds of property do you currently own?
- What do you do for a living?
- Do you own your own business?
- Do you have a family?

In spite of the important information that can be learned from those questions, you should consider alerting the consumer that the answers won't have an impact on their eligibility for insurance (as long as that's the case). Depending on the kind of insurance and the state where you do business, certain factors (such as marital status) cannot be used to charge someone more or to limit a product's availability.

The needs analysis is important because no two people are exactly alike. Even in a broader context, what you'd sell to a senior citizen is probably going to be different from what you'd sell to an 18-year-old. Similarly, what you'd sell to the 18-year-old is probably going to be different from what you'd sell to a 40-year old.

If you're working with a senior citizen, the main insurance concerns might be estate planning and paying for health care. An 18-year old might need renters insurance if he or she has an apartment. Auto insurance would be needed, too, if the person has a car.

At 40, there might be a bunch of needed insurance products because 40-year-olds are more likely to have dependents. Life, disability and homeowners insurance are all legitimate possibilities. So is extra liability insurance if the person has significant assets or has a pool or a trampoline in the backyard. The 40-year-old might also have a business, which opens up the door to a variety of commercial insurance products. The list of possibilities could go on and on.

Assisting Elderly Customers

You'll want to use special care when working with clients who are elderly or disabled because sometimes (not always) there can be a communication problem. The person might not be able to hear you or speak clearly. In situations like this, you might find it helpful to have one of the person's trusted family members in the room. But even then, you'll want to get a sense that the family member isn't the one making the decisions. Remember what we reviewed earlier about coercion and intimidation. Unfortunately, some caregivers don't always have people's best interest at heart.

Maintaining Documentation

No matter who you meet with or speak to, it's important to take and keep good notes. Taking detailed notes about all of your interactions with the public can decrease the likelihood of disagreements regarding what was said or not said in conversation or what kinds of financial advice were or were not provided. If you and an angry consumer continue to dispute the facts of a particular meeting or conversation, your notes can help defend you in the event of a regulatory complaint.

However, good notetaking shouldn't be an activity that is done only on occasion. In order to aid your credibility and for your notes to serve as an adequate piece of evidence, you may need to show that you take detailed notes in all similar circumstances.

The notes you take during client interactions should be contemporaneous rather than after the fact. The quicker you are to document something, the better chance you'll have at remembering all of the important details.

Some agents keep handwritten notes in client files. Others keep a continuous record in a computer software program. In either case, some sales professionals find it helpful to send an email to clients containing a summary of a conversation's key points. In addition to the summary, the email might ask the recipient, "Do you agree that this is what we discussed?" The client can then respond and clarify points where necessary.

To maintain a clear picture of your relationship with clients, and to protect yourself, here are some documents that you might keep in an organized, readily accessible fashion:

- Copies of completed applications.
- Copies of any written correspondence with clients.
- Copies of any written correspondence with insurance carriers.
- Notes from meetings.
- Notes from phone calls.
- Notes regarding all attempts to contact clients (for example, a note that you left a voicemail regarding an upcoming policy renewal).
- Notes regarding the timing of various mailings to clients or prospects.

A Note-Taking Case Study

In order to underline the importance of notes, let's go through an extended scenario, which was developed with the help of a former securities regulator. At the end of our story, you should also be able to see how consumer complaints of practically any kind can complicate matters for licensees.

Our story begins with a concerned daughter who has gone through her elderly mother's paperwork. After noting some suspicious documents, she discovers that her mother recently cancelled a decades-old life insurance policy and bought a new one. Since the annual premiums were the same for both policies, the daughter is unsure why the replacement took place. After talking with her mother, she convinces herself that a slick life insurance agent tricked her mother into switching insurance for no good reason.

The daughter contacts her state's insurance department and is told to send copies of any relevant documentation to the local regulators. With her mother's consent, she sends copies of the new policy and the cancelled policy, along with notes that the daughter took when the old policy was issued.

Upon receiving the documentation from the daughter, state regulators are able to identify the agent who sold the new life insurance policy and note that the agent has already had two similar complaints filed against him. Concerned that the latest complaint might represent a pattern, state regulators assign an investigator to the case.

At this point, the assigned investigator is concerned not only about the actions of the agent who sold a policy to the mother but also about the overall business practices at the agent's place of employment. In order to determine whether there is misconduct at the agency level, or perhaps a failure to supervise, the investigator writes to the agency's compliance officer and demands that all of the agency's records be readied for a visit. Because of the complaints against this one agent, ALL of the business's records (those related to the specific agent and those unrelated to him) will be subjected to scrutiny.

In response to the request by the investigator, managers at the agency start covering their tracks. They identify records proving that all agents have undergone ethics training, and they reprimand

the agent in writing. Unfortunately for the agent, the agency managers are more concerned about protecting themselves than about protecting him.

Meanwhile, the daughter has hired legal counsel and has announced that she and her mother plan to sue the agent for damages. Since his managers don't seem willing to support him, the agent decides to hire his own attorney. Luckily for him, the agent has made a habit of keeping detailed notes during all of his client interactions and of all company meetings. Through those notes, he is able to show not only that replacing the life insurance policy had a tangible benefit for the mother but also that his managers emphasized the money-making potential of life insurance replacements to all agents in the organization. Based on the various headaches caused by the entire experience and lack of support, the agent determines that he will be happier working someplace else.

We could take this scenario even further, but the story's two key points should already be clear to you:

- Regulatory complaints, even those in which no wrongdoing actually occurred, can be a big problem and should be avoided when possible.
- Maintaining detailed notes is an essential element of risk management for insurance professionals.

Keeping Yourself Informed

The evolution of the insurance industry doesn't stop once you pass your licensing exams. To serve the public well and remain on good terms with insurance regulators, sales professionals must take some initiative and keep up with what's happening around them.

While employees at large insurers might receive comprehensive training and frequent regulatory updates from a compliance department, licensees who work either alone or at small agencies must work a bit harder to remain up to date. Let's look at a few simple tasks that can help you keep up with important changes.

Looking Online

As part of keeping up with changes in state requirements, you might consider checking the website of your state's insurance department on a regular basis. Most departments will post important updates online, and some have completely stopped sending important news by regular mail. State websites are also likely to contain links to relevant insurance laws and administrative rules.

Regular Reading

Trade publications can help inactive licensees keep track of important trends in the insurance community. Many respected insurance publications offer free online newsletters that are delivered on a monthly, weekly or even daily basis. Others might be included as part of your membership in an insurance trade organization.

Reviewing Company Guidelines

Active licensees should periodically review any company handbooks or agency agreements that they receive as part of their employment with various agencies and insurance carriers. In many cases, the licensee will be representing an insurance company as part of a transaction and must conduct business in a manner prescribed by the company. It's possible that a company handbook or agency contract will put restrictions on a licensee's conduct that are more strict than local laws or state rules.

If you are in a supervisory position and do not have a handbook, you might want to consider creating one. Having sets of procedures all in writing and all in one place can make it easier for your workers

to respond to problems. Of course, you will want to ensure that everyone who receives the handbook actually read it.

Privacy Protection

As part of being a trusted insurance expert, you are likely to learn some very private facts about the people who do business with you. Whether they are about finances, health problems or planned business endeavors, we all have things about ourselves that we wouldn't want everyone to know. So even if you aren't required by law to keep something private, always try to be empathetic. Above all else, consider obtaining the person's written permission and signature before releasing any potentially sensitive information.

As in most things, privacy in the insurance business isn't absolute. You probably don't have to think very hard in order to come up with cases in which sharing someone's information is necessary to completing a legitimate business task. For example, a licensee might need to make copies or share the original version of a completed insurance application with an underwriting department. In general, this is considered an ethically acceptable practice as long as reasonable precautions are observed. (Even when sharing is necessary, information should not be left out in the open where it can be viewed for unnecessary purposes.) Similarly, most licensees are unlikely to have problems with sharing information when it is requested by a regulator or essential to their legal defense in a court of law.

Still, due to the amount of personal and financial information that they collect, insurance professionals should take reasonable steps to combat Identity theft. If identifying information about a client falls into the wrong hands, tremendous harm (including but not limited to the opening of fraudulent credit accounts) can be accomplished. Even theft that is quickly detected can take a great deal of time and effort to correct.

With prevention of identity theft in mind, consider all the items you carry around with you, such as a briefcase. Do you know what's contained in those items and where they are at all times? If the paper or electronic documents that you carry around were to ever to be lost or stolen, what might the consequences be for your clients? Obviously, proper privacy protection involves safeguarding physical forms of information and isn't just about improper oral disclosures.

Privacy Risk Management

Some rules and laws contain extensive requirements for sharing and storing personal information. Before going into greater detail about federal privacy laws, here are some simple actions that might help preserve people's privacy:

- Keep sensitive information locked or password-protected, and only give keys or passwords to responsible professionals who truly need the information.
- Maintain clear, documented procedures for maintaining clients' privacy in the workplace.
- Periodically review privacy procedures and update them as necessary.
- Restrict online activities so that all Web-based business is conducted through secure connections.
- Obtain written consent prior to disclosing anyone's personal information.

The Gramm-Leach-Bliley Act

One privacy-related law to be aware of is the Gramm-Leach-Bliley Act (GLBA). The GLBA was intended mainly as a deregulation measure that made it easier for banks, insurance companies and other financial institutions to become intertwined and consolidate. When companies become

affiliated with one another, the likelihood of information sharing is high. So, the law also called for some privacy measures. Those measures include the following kinds of requirements:

- Safeguard requirements.
- Privacy notice requirements.
- Opt-out requirements.

Many financial institutions follow GLBA rules that have been established by the Federal Trade Commission. But slightly different rules for insurance entities have been set by some state insurance departments. Due to the potential for variances in state requirements, you should conduct some legal research or speak with a qualified expert if GLBA compliance is part of your job. Depending on a company's procedures, GLBA-related tasks might be handled internally by the company or by the individual agent.

GLBA Safeguard Rules

As part of the Gramm-Leach-Bliley rules, insurers generally need to have written safeguards in place to protect their customers' information. Information must be safeguarded if it is "non-public personal financial information."

The requirements for implementing safeguards aren't particularly specific, maybe because the kinds of security risks are going to be different from person to person and company to company. But the safeguards should reasonably protect confidentiality and minimize security breaches. Basic examples of safeguards might include keeping paper files in locked cabinets and keeping data files password-protected.

When creating safeguards, companies need to consider the kinds of privacy or security risks that are likely to arise in their business and the best ways to address them. Workers at insurance companies should receive adequate training regarding how to keep information safeguarded.

Businesses also need to reevaluate their risks and their safeguards from time to time as their situations change. For example, a company that formerly worked with a significant amount of paper documents might need to reevaluate its safeguards as it moves toward greater use of electronic records.

GLBA Privacy/Opt-Out Notices

In addition to putting safeguards in place, insurance companies need to give people written privacy notices. A notice needs to say what information the company collects, what information the company gives out, and who receives the shared information. The notice must contain an opportunity for the person to opt out of having some of his or her information shared. In general, consumers can opt out of having their information shared with third parties who aren't affiliated with the insurance company.

The Health Insurance Portability and Accountability Act (HIPAA)

Along with making group health coverage easier to obtain for people with serious medical problems, the Health Insurance Portability and Accountability Act is one of the most significant federal laws pertaining to privacy. It dictates how our medical information can be shared and how people who have our information must protect it.

Licensees who are involved with health insurance obviously need to be aware of HIPAA so that they don't break the law. The rest of us probably don't need to worry about HIPAA from a compliance standpoint, but the law should still be important to us. After all, we all go to doctors,

most of us have health insurance, and we presumably all would prefer that our health information be kept as private as possible.

Knowing about HIPAA can be tremendously important in an emergency. If there's a medical emergency involving someone who isn't your spouse, some medical providers won't share important information with you because they don't understand the law. Or in another example, let's assume you're helping an elderly family member pay medical bills and you need information from a doctor or an insurance company. In these kinds of scenarios, it's helpful to know what your rights really are.

Protected Information

Specific HIPAA-related rules about keeping health information confidential are contained in the Department of Health and Human Services' extensive "Privacy Rule." However, the rule doesn't apply to all kinds of health information. In general, for information to be protected and covered by the rule, ALL three of the following statements must be true:

- The information was created by or given to a health care provider, health plan, health care clearinghouse or employer.
- The information relates to a person's medical condition, care provided to the person, or payment of care for the person.
- The information identifies the person or could reasonably be used to identify the person.

The last point about identification is very important. Your medical information isn't required to be protected under HIPAA if there's no reasonable way that it can used to identify you. In other words, a doctor saying something, like "I once treated a patient for tuberculosis" or an insurance company saying, "We've paid claims amounting to $20 million this year" might not be violating the law, but saying, "I once treated Jane Smith for tuberculosis," or "The policyholder at 123 Main Street has made a $5,000 claim" would almost certainly be a problem.

Keep in mind, though, that we're working with generalities here. HIPAA is a very complicated law, and the specifics of a given situation are integral to a proper compliance solution. If you are responsible for handling people's health information and have a concern, talk to an attorney or compliance officer who knows your situation and knows the rules. (Additional information about HIPAA compliance can be found in some of our other self-study courses.)

Keeping all of that in mind, here are some examples of information that are generally protected through HIPAA:

- Information discussed with a doctor or nurse.
- Information in medical files.
- Information about medical bills.
- Information about health insurance claims.
- Non-medical information (name, address, etc.) if it can reasonably be used to identify someone and uncover something about the person's health.

Note that it doesn't matter when the information was first given to a health provider or health plan. Even information that was provided prior to HIPAA's passage is protected. Information that people give about their relatives is protected, too (such as family medical histories that are shared with doctors).

The Agent's Role As "Business Associate"

HIPAA compliance is mainly a concern for health insurance companies, health care clearinghouses and health care providers, the three of which are collectively known as "covered entities." However, the Privacy Rule also needs to be followed by "business associates." Business associates are third parties who receive protected information on behalf of (or in order to perform services for) health care providers, health plans or health care clearinghouses. They aren't employees of covered entities, but they still do business for them or with them.

Some examples of business associates under the Privacy Rule are as follows:

- Lawyers and accountants for covered entities.
- Health insurance agents and brokers.
- Third-party administrators for health plans.

If you are a business associate, the covered entity that you're doing business with is required to have you sign a "business associate agreement." The agreement will state what you can and can't do with protected health information. The agreement can't allow you to do things under the Privacy Rule that a covered entity can't do. It can also put additional restrictions on the kinds of information you can receive and how you can share it. In other words, the agreement must be at least as strict as the Privacy Rule, but it can be stricter, too.

If a covered entity believes that a business associate is violating people's privacy (or if a business associate feels this way about an insurer), it must inform the potential violator and try to fix the problem. If the problem can't be fixed, the relationship must be terminated. If the relationship between a covered entity and a business associate ends, the business associate needs to return any health information, destroy it, or agree to keep it private. Circumstances and the format of the information will help determine the best of those three options.

CHAPTER 2: INTRODUCTION TO CONSUMER FRAUD

We've spent a lot of time talking about bad things that some people in the insurance industry might do. But of course, consumers are sometimes unethical, too. Many examples of their unethical behavior involve some degree of fraud committed against an insurance company.

Defining "Fraud"

When we use the word "fraud" in this course, we mean a form of deception committed against others for personal gain that is usually financial in nature. From an insurance standpoint, fraud that is financial in nature doesn't necessarily mean that the person is trying to illegally take money directly from the insurance company (such as by padding a claim or by faking a loss). It can also mean trying to save money from the beginning by lying on an application and thereby getting a better rate.

Within the context of this course, fraud doesn't include innocent mistakes, such as forgetting to mention a doctor's visit for a minor medical condition or being off by a few pounds when asked about your weight. Instead, our definition of fraud is focused on material representation. In other words, in order to constitute fraud by our definition, the untruth must be something that was intentional and also had an impact on the price of the insurance, the person's eligibility for the insurance, or the amount of money received from the insurance company.

Although it might seem silly at first to dissect our definition of fraud so carefully, it is important to note that other people might use a different definition that is looser or more strict. As we'll soon see, differences in definitions of fraud can create a disconnect between insurance professionals

and the public. This disconnect, when not acknowledged, often prevents fraud from being controlled.

What's the Problem With Fraud?

If left unaddressed, insurance fraud can produce a number of problems. Perhaps most significantly, money lost by insurers because of fraud tends to trickle down to the consumer in the form of higher premiums and in the form of coverage that is either insufficient or harder for everyone to find. Like any other business suffering losses, insurance companies might not be able to provide adequate products and still remain solvent.

There are even seemingly unintended consequences for the perpetrator of fraud. This is particularly true in cases where fraud involves a bogus or inflated insurance claim. Even if the person isn't caught, being compensated for fake or exaggerated losses will still make the person a bigger insurance risk. Future insurance might therefore be less affordable for the person or harder to find.

Sadly, fraudulent schemes can also cause physical harm or even death to innocent people if the criminal's plan goes wrong. Staged auto accidents, for example, might injure innocent drivers or pedestrians. Fires started for insurance money can easily spread to neighboring properties belonging to innocent victims.

To one extent or another, fraud affects all of us. In order to do our small part in spotting it, we need to know how it happens. Still, taking just one course about fraud during your career is unlikely to be adequate because skilled crooks know how to adapt. Once one type of scheme is exposed, they look for a new hole in the system and try to exploit it. If you truly want to play a part in stopping fraud, your attention to the issue must follow you through the years.

How Big Is the Problem?

The truth is, we don't really know how much insurance fraud actually takes place. The only time we learn about a case of fraud is when people get sloppy and are caught. So, who knows how many people are successful?

Still, a few industry groups have put together some numbers. The Coalition Against Insurance Fraud, which deals mainly with the property and casualty side of our industry, says $80 billion of insurance fraud occurs each year. Meanwhile the National Health Care Anti-Fraud Association says about $60 billion of just health care fraud takes place annually.

To put these numbers into perspective, insured losses amounted to $26 billion from Hurricane Andrew, $38 billion from the 9/11 attacks and $45 billion from Hurricane Katrina. Those of you who were in the property and casualty business at those times are probably well aware of the impact that those events had on insurers. If the estimated fraud figures from the aforementioned trade associations are accurate, we are essentially experiencing catastrophic losses every year just because of selfishness and lies.

Why Fraud Occurs

Fraud committed by consumers might be something that was always intentional (such as a policy that is purchased as part of a money laundering scheme). But it can also be something that a legitimate insurance applicant gets involved in later. For example, a driver might buy auto insurance because she really wants it and then decide years later to intentionally damage her vehicle while feeling some kind of financial pressure. Financial pressures might arise from high bills, a high amount of debt, personal financial losses or unexpected financial emergencies.

Some people are led toward fraud because they need to fund their vices. Vices include addictions to alcohol or other drugs, gambling or even extramarital affairs. If someone has an out-of-control lifestyle, he or she might turn to fraud to support it.

If fraud is being perpetrated by an insurance insider, work-related pressures might be part of the motivation. An agent or an insurance employee might feel underappreciated, underpaid or generally dissatisfied with a work situation. Concerns about job security might also cause employees to panic and do the wrong thing.

Feelings of entitlement aren't limited to insurance insiders. In fact, a consumer might have similar feelings and believe that fraud is one way to get back at an insurer that has continued to raise premiums even though the policyholder has made prompt payments without any losses. Similarly, a claimant who has a bad experience when trying to reach an insurance settlement might engage in fraud as a way to get even.

Finally, people might commit fraud under the assumption that what they're doing really isn't fraud at all. In an earlier portion of this course, we emphasized the need to clearly define fraud. In reality, consumers have a different definition of fraud than insurers.

To average consumers, fraud sounds like such a big thing, something that involves hundreds of thousands of dollars or more. With this mindset, padding a small property insurance claim or lying about where a car is garaged in order to get a slightly better rate doesn't seem so bad to them. Even if they agree that lying is wrong, they often don't think that all lying is fraud. Of course, people in the insurance business tend to feel differently.

Why Consumers Tolerate Fraud

In a survey conducted by the Coalition Against Insurance Fraud, less than a third of respondents said there is absolutely no excuse for insurance fraud. Everyone else said fraud was either justified in some cases or something that didn't bother them.

Those might seem like shocking statistics, but it's important for us to analyze the possible reasons behind them. Perhaps the low concern regarding insurance fraud is due to the fact that financial fraud isn't violent or graphic. It's usually not as scary to people as burglaries or murders. And like many other kinds of white-collar criminality, it often seems very impersonal. Even though it amounts to theft, the average person doesn't feel like they're losing anything from it. Although the insurance company being victimized is certainly losing money, that company doesn't have a face and, therefore, doesn't receive much sympathy.

Through those statistics, we might determine that the public doesn't expect the fight against insurance fraud to be a priority for law enforcement. If that's true, it might relate to what psychologist Abraham Maslow termed the "hierarchy of needs." Within the context of insurance fraud, Maslow's theory might say that if you live in a community that can be physically dangerous, your first priority is for law enforcement to keep you and your family physically safe. Until we are confident that our world is physically safe, we might not put as much pressure on government to prosecute other kinds of crimes, including financial ones. With financial scandals populating the news over the past few years, it's possible that the public is becoming more aware and less tolerant of white-collar crime. But only time will tell if this is really true.

A more likely reason why people tolerate fraud—let's be honest—is that they have a negative opinion of insurance companies. Similar to the public's favorable relationship with their own Congressional representative and their decidedly negative opinion of Congress, consumers usually like their insurance agent but don't like insurance companies.

The Agent's Role in Fraud Prevention

Regardless of their fairness or the reasons for them, society's views on insurance fraud won't change overnight. In the meantime, insurance professionals need to deal with the frauds that might already be occurring under their noses. Insurance agents and brokers, along with insurance carriers, must accept some of that responsibility.

It's easy to say that stopping fraud is someone else's job and leave it for a claims department, a special investigative unit or a claims-tracking software program. But is that an ethical approach to the problem?

We mentioned earlier how an agent or broker can owe ethical duties to both the insurer and the insured. No matter if you're representing the insurance company or the consumer in a transaction, you have an ethical obligation to bring parties together only in good faith. If you suspect that one of those parties is trying to deceive the other, you probably aren't doing your duty.

Relying on others to catch and stop fraud also tends to be impractical and inefficient. In most cases, the agent or broker has the closest insurance-related relationship with the consumer. The relative closeness of that relationship means that, out of everyone at an insurance company, the agent or broker is often the best judge of a consumer's character. The agent or broker might notice suspicious behavior that other insurance representatives might miss. Conversely, behavior that would otherwise seem suspicious might be excusable if the agent or broker can vouch strongly for the suspect's good intentions.

Despite the important role that sales professionals play in the fraud-fighting process, solutions to the problem shouldn't rest entirely on their shoulders. Insurance licensees are not police officers, and negative consequences can arise if they overstep their boundaries. If, for instance, an agent discourages a consumer from filing what turns out to be a legitimate claim, the resulting strain in the relationship might be irreparable.

Basic Kinds of Insurance Fraud

We can divide the kinds of insurance fraud into three broad categories:

- Application fraud (for example, a consumer who lies about tobacco use, how much he or she drives, or where he or she typically stores a vehicle).
- Claims fraud (in other words, lying about a loss).
- Producer/insider fraud (committed by agents, claims adjusters, marketers, company executives or others in the insurance field).

Since application fraud is perhaps the kind of fraud that is most likely to be detected by an agent or broker, let's summarize some of its warning signs.

Red Flags of Application Fraud

Some warning signs of potential fraud can pop up very early in a person's relationship with their insurance company. Something might seem strange on their application, or something they say might seem suspicious.

Red flags (or warning signs) of potential application fraud are listed below:

- The applicant seems nervous and fidgety.
- The applicant has a suspicious phone number or voicemail greeting.
- The applicant provides a suspicious identification card or has no identification.

- The applicant insists on buying more insurance than necessary.
- The applicant wants to pay large premiums in cash.
- The applicant has a suspicious credit history or a criminal background.
- The applicant becomes agitated when asked for necessary information.
- The applicant demands that a policy be issued as soon as possible.

Realize, of course, that the appearance of a red flag doesn't always mean that fraud is taking place. There might be several red flags, and your gut and brain will tell you that nothing bad is probably happening. Or there might only be one odd thing going on, and your gut might tell you that something's wrong. As you gain experience working with consumers, your judgment in these matters is likely to improve.

Note: The remainder of this ethics course includes text written by the California Department of Insurance as part of mandatory anti-fraud training for agents and brokers (beginning in early 2023). The body text is taken directly from a video transcript provided by the Department of Insurance and is required to appear here verbatim without changes to wording, grammar or punctuation. As a result, the style, voice and formatting may differ from the rest of this course.

As part of your course's exam procedures, you will be required to affirm that you have read this material from the California Department of Insurance.

CHAPTER 3: CALIFORNIA INSURANCE AGENTS AND BROKERS ANTI-FRAUD AWARENESS TRAINING

Hello and welcome to the required one hour anti-fraud awareness training.

You are participating in this training because you are either working toward obtaining your agent or broker license in the State of California, or you already have your license and are in need of this requirement to renew it.

In the next hour, you will hear from Commissioner Ricardo Lara and several Enforcement Branch personnel as we walk you through who we are, what we do and what your obligations are if you suspect potential insurance fraud may be occurring.

Message From Ricardo Luna: California Insurance Commissioner

Hello and welcome to the California Insurance Agents and Brokers Anti-Fraud Awareness Training.

I'm California Insurance Commissioner Ricardo Lara.

As insurance agents and brokers you provide an essential service and serve as an important resource for homeowners, renters, drivers and consumers across the state.

You also play a key role in anti-fraud effort for the insurance industry as you are in a unique position to detect suspicious insurance applications, potential fraudulent transactions, and claims, and stop them before the fraud is committed.

Because of the change in state law, beginning in 2023, agents and brokers now have a duty to report suspected fraud. The new requirement will assist investigators in our Department to do our job to protect consumers.

To help you comply with this law, our Department of Insurance has put together this training.

This training is really aimed at helping you identify red flags for potential fraud so you can meet your reporting duty. In doing so, you are helping prevent fraudulent insurance transactions and sending a strong deterrent message.

Our enforcement team is the largest branch in the Department, with more than 300 staff dedicated to protecting Californians and stopping fraud. Our team includes Detectives, Investigators, and support staff who work everyday to meet the Department's mission of insurance protection for all Californians.

Fraud hurts all of us, but by working together to fight fraudulent claims we can better serve our consumers.

Thank you, thank you for choosing a career in insurance and doing your part to keep California's insurance marketplace the strongest in the nation.

Thank you again, Muchas Gracias!

Insurance Fraud in the United States

The Coalition against insurance fraud is a group comprised of 281 member organizations that include both private and public groups. The Coalition was formed in 1993 and has dedicated nearly 30 years of work and research in the fight against insurance fraud.

The Coalition conducted a massive study that concluded with a report issued in 2022. The results of the study indicate there to be at a minimum $308 billion lost to insurance fraud each year. And it is estimated that about 10 percent of losses in property and casualty involve some element of fraud.

For agents and brokers, this is a significant number and can impact your profitability.

For more information about the Coalition Against Insurance Fraud, please visit their website at www.insurancefraud.org.

The California Department of Insurance: An Overview

Here are some highlights of the California Department of Insurance. If I may draw your attention to bullet points number 2 and number 4 here. The CDI has roughly 1,400 employees and 30 percent of those work in the Enforcement Branch. That is a lot of resources dedicated to the fight against insurance fraud. In fact, of the 11 branches within the California Department of Insurance, the Enforcement Branch is the largest. In a few moments, you will see why those resources are needed and some of the phenomenal work that our branch does.

Checkpoint

Here is a quick checkpoint question, and this is the first of many. The Departments goal is to provide training and form a partnership with you.

To effectively do that, we wanted to ensure that certain elements throughout this course were being retained. So, this checkpoint question is – How many operational branches exist in the California Department of Insurance?

And the answer is 11. Remember, there are 11 branches, with the Enforcement Branch being the largest.

The CDI Enforcement Branch

Before we get into numbers, figures and the particulars of what the Enforcement Branch does, please allow me to first outline our structure.

The Enforcement Branch has two divisions and an administrative support section.

Today, you will hear from both the Fraud Division and Investigation Division. But as a quick summary, the Fraud Division handles fraud committed against the insurance industry, such as claimant fraud, while the Investigation Division handles fraud and misconduct committed by agents, licensed and unlicensed, brokers and insurers.

Our divisions and the administrative support personnel occupy nine regional offices within California.

As mentioned earlier, we account for about 30 percent of CDI employees, equaling 424 positions. The rest of our resources are broken out here. You can see we operate with a significant budget as well as handle the administration of tens of millions to County District Attorney offices to assist in our fight against insurance fraud.

Insurance fraud in California impacts all of us and we are pleased to have these resources available to work toward helping California consumers.

For the next several minutes you are going to hear from one of our Investigator Supervisors and a seasoned Fraud Division Detective. They will provide some insight on recent cases and how the resources provided to our Department are used.

The Investigation Division

The mission of the investigation division is to protect California consumers by investigating suspected violations of laws and regulations pertaining to the business of insurance and seeking appropriate enforcement actions against violators.

Effective enforcement of the insurance laws help to safeguard consumers and insurers from economic loss and eliminate unethical conduct and criminal abuse in the insurance industry.

The investigation division is charged with enforcing applicable provisions of the California Insurance Code under authority granted by Section 12921. The Division pursues prosecution of offenders through both regulatory and criminal justice systems. The Investigation Division employs over approximately 90 investigative and support staff that are assigned to seven regional offices statewide to handle the large volume of complaints that are filed.

When appropriate, the Division will partner with a number of other state and federal agencies. Which include local law enforcement agencies, the Franchise Tax Board, the U. S. Postal Service and the FBI.

The Investigation Division Works These Kinds of Cases

The Insurance Commissioners priorities emphasize investigation and prosecution and in the following areas that concern the Investigation Division.

They include premium theft, senior citizen abuse, health insurance violators, illegal bail practices, unauthorized insurers and insurance transactions, deceptive sales and marketing practices, title insurance rebates, public adjuster violations, abusive acts committed by auto insurance agents and companies.

Investigation Division Case Work

In the last Fiscal Year, the Investigation Division opened 472 new cases, and working with the Departments Legal Division, obtained 236 administrative actions. The Investigation Division also made 20 criminal arrests while also carrying out the mission of protecting California consumers.

More Investigation Division Examples

Examples of case work done by the Investigation Division include agents forging documents and committing identity theft, premium theft, a broker or agent misappropriates premium payments and provides clients with phony documents as proof of coverage.

Material misrepresentations on life insurance and annuity policy applications in order to generate six figure commissions for the writing agent. Selling unregistered and non-existent investments to clients. Agents knowingly backdating an auto policy. Advance commission schemes and brokers and agents using unlicensed persons to issue quotes, bind policies and facilitate insurance policy transactions.

A Recent Investigation Division Case

Here is an example of an investigations case. Here we have a case that is joint between the California Department of Insurance and multiple federal and local law enforcement agencies against bail bondsman acting in bad faith and outside the law. These three defendants are charged with multiple felony counts of kidnapping with the use of a firearm, false imprisonment, residential burglary and misdemeanor counts of false arrest under color of authority, brandishing a firearm, acting as a fugitive recovery person as a convicted felon, acting as a fugitive recovery person while unlawfully carrying weapons and failing to notify law enforcement prior to arresting a bail fugitive.

Here is another recent example of investigative casework. In this case, a previously licensed agent stole identities of multiple individuals in a scheme to open a fraudulent insurance agency. His actions didn't stop there, he also used those stolen identities to attempt to open small business loans to fund his fraudulent insurance agency under the name of Cyber Access Insurance Agency.

Checkpoint

It's time for another checkpoint question.

This one asks, what is the focus of the Fraud Division within the Enforcement Branch?

Your options are fraud committed against the insurer, fraud committed against the consumer, fraud committed against elders/seniors, fraud committed by agents or brokers.

And the answer is A. Fraud committed against the insurer.

In looking at your other options here, fraud committed against the consumer do not meet the definition of insurance fraud. Fraud committed against elders or seniors also won't meet the definition unless the fraud includes an element of misrepresentation on an insurance policy where the insurance company is the victim. The final option, fraud committed by agents or brokers is not the responsibility of the Fraud Division, but rather the responsibility of the Investigative Division that you just heard about.

The Fraud Division

The Fraud Division is staffed by sworn personnel who conduct criminal investigations into various types of insurance fraud related violations. The Fraud Division is composed of four separate insurance fraud programs: Automobile Insurance Fraud, Workers' Compensation Fraud, Property/Life/Casualty Fraud, and Disability and Healthcare Fraud. Fraud Division detectives also provide assistance, as well as training for consumers, the insurance industry, and allied law enforcement agencies. The Fraud Division hosts several task forces with the mission to combat specific areas of insurance fraud, such as the Organized Automobile Fraud Activity Interdiction Program and regional worker's compensation anti-fraud consortiums. Fraud Division detectives may be assigned to various local law enforcement task forces such as auto theft, computer forensics, underground economy, pharmaceutical fraud, and disaster fraud. This pooling of

resources and expertise has identified strategies to aggressively investigate and deter fraudulent behavior. Fraud Division detectives are also tasked with identifying emerging trends in insurance fraud in order to protect California consumers.

The Fraud Division: Penal Statutes

Within the four Fraud Division programs, detectives investigate crimes related to sections 549 and 550 of the Penal Code, and 1871.4 of the Insurance Code.

Additionally, there are many other criminal violations associated with insurance fraud found in the Penal Code, Insurance Code, Labor Code, and Business and Professions Code.

Oftentimes, detectives uncover related crimes during their investigations, such as conspiracy, human trafficking, grand theft, automobile theft, arson, forgery, and embezzlement.

The Fraud Division: Penal Code Section 549

Penal Code 549 addresses illegal referrals and solicitation in connection with insurance fraud. This code is often associated with illegal activities concerning automobile insurance, however, the code applies to any type of fraud that falls within Penal Code 550 and Insurance Code 1871.4.

Any firm, corporation, partnership, or association, or any person acting in his or her individual capacity, or in his or her capacity as a public or private employee, who solicits, accepts, or refers any business to or from any individual or entity with the knowledge that, or with reckless disregard for whether, the individual or entity for or from whom the solicitation or referral is made, or the individual or entity who is solicited or referred, intends to violate Section 550 of this code or Section 1871.4 of the Insurance Code is guilty of a crime…

The Fraud Division: Penal Code Section 550(A)

Penal Code 550 (A) delineates the various unlawful acts regarding any false or fraudulent claim. Subsections 3 and 4 specifically mentions claims associated with vehicles, however subsections 1, 2, and 5 apply to any false or fraudulent claim.

Subsections 6 through 10 cover unlawful acts connected specifically with health care benefits.

It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of 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 that 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.(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers' compensation health benefits under the Labor Code.

The Fraud Division: Penal Code Section 550(B)

Penal Code Section 550(B) covers unlawful acts in connection with a claim or payment or other benefit pursuant to an insurance policy. This section can apply to an unlawful act committed in connection with a legitimate claim for a loss.

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.

Insurance Company Data

This chart shows a three year comparison of the total amount of insurance claims filed in California, the amount of claims referred to insurance carriers' Specialized Investigative Units, the amount of Suspected Fraudulent Claim referrals made to the Fraud Division, the amount of arrests made by the Fraud Division, and the amount of criminal convictions obtained by the various district attorney's throughout the state.

	2018	2019	2020
Claims in CA	209,800,209	68,197,096	103,976,124
Referrals to SIU	120,531	116,439	176,166
Fraud Referrals (SFCs)	23,341	23,723	20,203
Open Cases	1,341	1,828	1,817
Arrests	482	613	554
Convictions	430	386	400

A Recent Fraud Division Case

August 11, 2022 in San Bernadino, CA – Branden Heywood, 30, of Chino, was arraigned yesterday on 39 felony counts of insurance fraud after an investigation found he allegedly acted as the leader of a "paper collision" ring to collect over $80,000 in undeserved insurance payouts. In a "paper collision," the accidents never occurred and perpetrators use false documents to commit fraud.

This recent case involved an individual that functioned as a ringleader for a staged collision ring. The investigation revealed that the suspect was using his identity and others', including the identities of his minor children, to stage fake collisions by submitting fictitious medical records and altered California Highway Patrol collision reports to insurance companies in order to collect insurance payouts. The suspect recruited people on social media to say they had been passengers in the fake collisions. As a result, five additional suspects have been charged with felony insurance fraud.

A Recent Fraud Division Case

December 9, 2022 in Los Angeles, CA – Kenneth McDaniel, 32, was arrested yesterday on four felony counts of insurance fraud and assault with a deadly weapon after an investigation found he allegedly caused a vehicle collision in order to receive an undeserved insurance payout. The suspect cut in front of the victim and then abruptly stopped his vehicle for no reason. The entire accident was captured on dash cam.

The type of alleged scheme in this case is called a swoop and squat and is used to force a victim to remain in their lane so a collision cannot be avoided. These types of intentional collisions are extremely dangerous, not only for those involved, but for anyone on the road. The Fraud Division not only investigates these types of collisions, they also conduct training with local and state law enforcement agencies on how to identify and investigate these types of violent crimes.

More Recent Fraud Division Cases

This slide details several more recent investigations conducted by the Fraud Division. These examples demonstrate how insurance fraud can take a variety of forms, from concealing hit and run collisions to doctors submitting fraudulent bills pursuant to workers' compensation claims.

- A hit-and-run accident involved a driver excluded from a driver's insurance policy. Suspects in this case misrepresented who was driving.
- A suspect claimed that a vehicle was stolen when it was instead driven to Mexico and left there.

- A company owner under-reported payroll to reduce the amount of his workers compensation premiums. The premium loss was $4,000,000. He also operated a second company for which he failed to report any payroll or secure workers compensation insurance.
- A doctor was charged with multiple counts of medical insurance fraud, workers compensation fraud and grand theft after allegedly submitting over $500,000 of fraudulent medical services reimbursement claims. For five years, this doctor allegedly orchestrated a fraudulent scheme of billing medical services never provided and “upcoding” of bills to illegally obtain a greater payout from the insurer.

I hope you enjoyed hearing a little bit about what we do here at the Enforcement Branch.

Next, I am going to cover compliance requirements.

We will start with insurance company requirements and then get into the specifics of what you, as an agent or broker, are required to comply with.

Please keep in mind, the requirements we are reviewing today only pertain to anti-fraud operations. Other units within the California Department of Insurance may have additional requirements for the groups listed here. If you have questions about statutes and regulations that are outside of scope of anti-fraud operations, I encourage you to review our public website to determine the best resources for your questions.

Each Insurer Must Have an Special Investigative Unit

Insurance companies admitted to do business in the state of California are required to comply with the Insurance Frauds Prevention Act and the California SIU Regulations.

One of the initial requirements is to establish what is called a Special Investigative unit, or SIU for short. This unit is required to be available to investigative suspected insurance fraud on behalf of the insurance company. The unit can be comprised of internal or external employees. If an insurance company decides to go external for this function, they are subject to additional requirements, which we will go over shortly.

Insurer Anti-Fraud Requirements

The requirements within the IFPA and California SIU Regulations can be subdivided into these four sections.

Staffing and Operations. This begins with the existence of the SIU itself. The unit must also be comprised of staff that is knowledgeable in claims practices, investigative techniques and detecting fraud. As mentioned previously, if this unit is contracted to an external company, then contractual obligations also fall in this category. An external company must have a contract in place with the insurance company that contains very specific verbiage. The external SIU must also comply with all provisions of the IFPA and the California SIU regulations. If they fail to be compliant, the insurer they contract with could be assessed penalties. Operations also covers response requirements if a law enforcement agency, such as ours, reaches out to get documents or conduct an interview.

SIU Annual Report. The SIU Annual Report is a report filed each fall by approximately 1,200 insurance companies operating in California. This report contains statistical data, structural outlines and names and contact information for insurance company SIU personnel. This is a confidential report and the data is not released outside the Department. It is an insurers responsibility to know this filing is required. Notifications are mailed on the last business day each June; however, even if a notification does not reach its intended target, the filing obligation still stands. Since the filing

does contain several levels of data, you may get a request for information from an insurer you contract with seeking information. If this occurs, be sure you confirm who you are releasing information to and be certain you provide them with exactly what they ask for. Errors in data could result in penalties for them so it is important they be accurate.

Anti-Fraud Training. Training requirements for anti-fraud personnel comes in three levels. The first is training required to be given to newly hired personnel within 90 days of commencing their assigned duties. The training must cover specific criteria, some of which are the detection of fraud red flags or indicators and how to refer something to the SIU. The second level of training is an annual training for the integral anti-fraud personnel. This would be underwriters, claims adjusters, possibly premium auditors – basically anybody in a position to detect insurance fraud red flags. This training has similar topics to the new-hire training and is required to be given minimally once per calendar year. The third level of training is specific to the SIU personnel. SIU personnel are required to have five hours of continuing anti-fraud training annually and it must cover at least one of the topics of investigative techniques, communication with Fraud Division, legal and related issues, red flags or insurance fraud trends. Even though these training requirements do not apply to you as agents or brokers, be aware that some of this information is still needed for you to comply with reporting requirements. For example, in certain circumstances, you will need to know what the referral process to an insurance companies SIU is. So, even if you don't need the training, be sure you have the knowledge needed to effectively operate.

And finally, the detection, investigation and referral of suspected insurance fraud. This area covers a lot of requirements for both the integral anti-fraud personnel and the SIU personnel. It encompasses everything from how to detect red flags, how to refer those red flag files to the SIU, what investigative steps the SIU is minimally required to take, how to determine if and when a referral to the CDI Fraud Division is warranted and how to make that referral when it is required. Later in this training, we will talk more about when a referral is warranted to the CDI Fraud Division if you are an insurance company employee and if you are an agent or broker. While similar, there are key differences you'll need to know.

Recent Audit Finding: Communication With CDI

Within the area of staffing and operations, a common violation is failing to communicate with the CDI Fraud Division, California District Attorneys or other authorized governmental agencies within the timeframes specified by statute. Statute requires that insurers respond within 30 days to all lines other than workers' compensation and for workers' compensation insurers are allotted 60 days. Shown here is a recent violation that was written up by our SIU Compliance Unit. As you can see in column three, this company was significantly late on several communications. Violations such as this one hinders our ability to investigate and prosecute insurance fraud. As an agent or broker, you are also required to respond to file requests within these timeframes.

Agency	Line of Business	Number of Days Late
CDI	Workers Comp	84
District Attorney	Automobile	109
CDI	Automobile	96
CDI	Automobile	75
District Attorney	Workers Comp	100

The Law Applies to Everyone!

Too often people get into a mindset that they are either entitled to something or exempt from having to follow rules or laws. When it comes to insurance fraud, we don't care who you are, what your title is, or who you know. If you commit insurance fraud, we will be there to set you straight.

Recent Audit Finding: Anti-Fraud Training

Another recent violation written up by our SIU Compliance Unit. This one is in the area of training, specifically the new-hire training. As you can see here, our SIU compliance unit reviewed training records for a total of 1,120 new hires for this company. In that review, which reflected both the hire dates as well as the training dates, the compliance unit found that this company failed to train 3 percent of their new hires within the 90 day timeframe and failed to train 96 percent of the new hires at all. That amounts to a 99 percent noncompliance rate overall. The penalty assessed on this violation alone was well over six figures and the company also earned a fairly quick follow-up audit to make sure they implemented proper steps to rectify this issue going forward.

Insurer Anti-Fraud Requirements: Penalties

Speaking of penalties, California has two types of penalties for anti-fraud violations.

Violations are either considered to be willful or inadvertent.

Inadvertent penalties has a $5,000 maximum. If something is considered inadvertent, we also combine like violations that are similar.

Willful violations carry a $10,000 maximum. In cases of willful noncompliance, the Department does not combine like violations and so that $10,000 figure can be assessed for each act of noncompliance.

For example: in the previous slide, I showed you a finding that included over 1,000 people that were either trained late or not trained at all. If this were an inadvertent penalty, we would assess up to $5,000 for the entire violation. As a willful penalty, the company can be assessed a separate $10,000 for each individual that was not trained or trained late. Using that math, you can see how we got to a six figure penalty very quickly.

It is important to note, that to be considered willful, all the company needs to do is be aware the statute or regulation existing. It is very rare to have a violation be considered inadvertent for this reason.

This is not to say that for every violation we go after the maximum penalty allowed by law. Since we do consider fighting insurance fraud to be a partnership with the industry, we take into consideration several factors when determining what exactly a penalty will look like.

Some of those factors are, how quickly did an insurer come into compliance, what does their prior compliance record look like if we've examined them before and what kind of corrective action are they putting in place to avoid it in the future.

Some years are better than others when it comes to how much we assess in penalties. We noted our 2020 figure of $924,000 on this slide. We did that to illustrate that penalties are significant and insurance companies should not consider violations and penalties to be simply a cost of doing business.

Checkpoint

Insurance fraud committed by this group is not a violation of law.

- Politicians,
- Actors/actresses,
- CEO's,
- None of the above, insurance fraud is a crime regardless of status or title.

And the answer is D. Nobody is above the law.

Red Flags

- Not concerned about cost of coverage
- Asks detailed questions about types of claims that would be covered
- Asks questions about how long a policy has to be in force before coverage is effective
- Does not want a physical inspection of property or vehicle to be covered – offers pictures instead
- Pushing for immediate binding of the application
- U.S. P.O. Box only – refuses to provide a physical location
- Discrepancies in answering questions
- Paying cash for high premium policy
- Application completed in multiple visits with two or more people without a clear distinction of relationship
- Type of coverage (i.e. full coverage on a low value vehicle)
- No clear connection between insured and beneficiary
- Trying to buy a policy without interest in the object to be covered (house, auto, person)

Some of the most common red flags you may encounter are listed here.

They may include asking questions about specific types of losses that may be covered, asking about taking out a life insurance policy on a person they don't appear to have a direct connection to or attempting to purchase coverage on collateral they don't appear to have a connection to.

Any one of these, or combination, should be enough for you to pause and consider what your next steps should be.

Alright, picture this, a new customer calls and they want to insure a 1970 Pinto Station Wagon, and they want full coverage, meaning comprehensive and collision both included, they don't care what the policy is going to cost and they want to make sure the policy will be effective today. Sounds odd, right? I certainly hope so. While the scenario sounds somewhat entertaining, and perhaps you are even picturing this Pinto now, we would hope you stop, ask some additional questions and then decide if something is just isn't right.

That, of course, is an extreme example. What you will more likely encounter will just be someone who wants to take out a policy, doesn't want to have the collateral inspected or just seems to really want the policy to be effective immediately without really caring about cost.

Fraud Indicators

- Indirectly answering application questions
- Vague answers
- Hesitant to sign application
- Pushy behavior
- Walk-ins with no justification

Here are some of the more general indicators. Red flags tend to be specific, whereas indicators are not. If someone answers a question with hesitation, it could be a sign of potential insurance fraud, or it may just truly be a fuzzy memory.

For example: if I ask a potential client if they had a specific type of cancer in the last 20 years and they hesitate or respond in a non-committal way, it may not be someone trying to commit fraud, it might legitimately be someone who did have cancer but truly can't remember if they were considered cancer-free 19 years ago or 21 years ago.

Walk-ins with no justification we get asked about quite a bit. Cold calling an insurance company for quotes does happen, but usually it is spurred by something specific. A person might be shopping for lower rates or they may be unhappy with their current agent, broker or company. Perhaps they were referred to you by someone that you made extremely happy. Asking the question, how'd you here about us? Or, what caused you to reach out to us today? can be simple, valuable and effective ways to determine if a person has a reason to be calling you, or if they are simply calling every broker or agent in the area to see who they can trick. Again, not saying cold calls don't happen, but we'd recommend taking a closer look to see if additional flags or indicators are present if you do get a call with no reasons behind it.

Fraud Trends in 2022

Over the last few years we've seen some new trends come about in the industry, much of which is centered around claims and telehealth in a virtual reality. For underwriting and agency fraud, not much has changed. We do see an increasingly higher volume of policies purchased online or through phone apps, but we were seeing that before the pandemic as well. So, for 2022, we settled on these three trends to bring to your attention.

The intentional concealing of information, this could be something such as not listing all the drivers in the household.

The misrepresenting of collateral. This could be the number of something that is owned, such as how many pieces of artwork does somebody have or it could be the condition of something that is owned.

We also included an item that our Investigative Supervisor mentioned earlier in this training, and that is theft of premiums by agents or brokers. This can be the use of money provided to purchase a policy that is ultimately pocketed by an agent or broker and the poor policyholder has no idea until they have a loss and there is no coverage.

Next Checkpoint

Next checkpoint. This question is, which of the following is not considered an insurance fraud red flag?

Inconsistent answers, refusal to allow inspection of collateral, wanting liability coverage on an old vehicle, insisting coverage be bound immediately.

And the answer is C. Wanting liability coverage on an old vehicle. California law requires all vehicles have liability coverage if they are registered and so this is not an unusual request. Now, if the person is seeking to add comprehensive and collision coverage to an older vehicle, that should cause you to want to ask questions and have a deeper conversation.

Available Databases

Here are a couple of databases that exist to help you identify red flags as well.

Insurance Services Office, better known to the industry as ISO. If you have access to ISO, you will be able to see past claim history, potential fraud indicators that other companies may have noted. There's really, truly, a lot of great information available through ISO. If you don't have access, consider asking the companies you are working with if they can provide you access.

We also have the Arson database, this database is maintained by the Department of Justice is also a good resource if you are doing property policies. If someone has been convicted of arson, they should show up here, and that would be a pretty big indicator that perhaps you should stop, and consider whether or not you want to write a policy for them.

Fraud Warning Language

Alright, let's talk about the California fraud warning language.

This statement, "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison," must be provided to insureds.

As an agent or broker in California, you are going to see this wording a lot. Or at least, you should. This wording is required to be on forms used to apply for a policy, make a change to an existing policy or within the claims process. So, you may see it on applications, endorsement pages, basically on anything used to apply for or change a policy.

This requirement is actually amended as of 2023. Prior to January 1, 2023, you would find this wording only during the claim process. It was expanded because the Department saw a need to ensure consumers seeking to get coverage or change coverage were aware that honesty matters at all points of an insurance transaction.

SB 1242

Senate Bill, or SB 1242 is the reason you are all listening to this. In this bill, a few things happened, but those pertinent to you at this moment are: the creation of this 1 hour anti-fraud training that as I mentioned at the opening you are either getting now because you are seeking to obtain a license or you have one renewing. The bill also creates specific reporting requirements for agent and brokers. There are two reporting requirements depending on the status of the policy. If the policy is in the application stage and has NOT been placed with a specific carrier then the agent or broker

is required to report the red flag directly to the Fraud Division Consumer Portal. If the policy has already been placed, the agent or broker will report the red flag to the insurer's special investigative unit. Also on this slide, please note that an agent or broker is required to cooperate with the insurer's SIU or law enforcement. This is not actually new, but something that we wanted to point out as your interaction with us may increase with the implementation of these requirements.

It is important to know if you fall under these requirements.

An agent or broker is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5 1625.55, 1626 or 1758. 1. They are also not an employee of the insured.

For the purposes of the remainder of the of the California SIU Regulations, it is also important to know that the Enforcement Branch does not consider an agent or broker, as defined by these codes, as a contracted entity.

Lastly, but no less important, agents and brokers who refer to either a carrier or directly to the Fraud Division do have protections against civil liability as long as they were acting in good faith, without malice and reasonably believed that the action taken was warranted.

Checkpoint

And here is our next checkpoint. As it pertains to SB 1242, who is required to cooperate with law enforcement conducting a criminal investigation?

Brokers and agents, unlicensed agents, bail bondsmen, insurance company personnel.

And the answer is brokers and agents. The other listed individuals or groups here may have a duty to cooperate, but this question is specific to SB 1242, which applies to brokers and agents.

How Do I Fulfill My Obligation to Report Red Flags?

Over the next several minutes, I will walk you through how to access the consumer portal and what needs to be entered.

Keep in mind as we go through that this form is in the event of an unplaced policy. If you have placed the policy, refer the file to the insurance company SIU using whatever internal referral method they have created.

Getting to the Consumer Fraud Reporting Portal

We begin with the California Department of Insurance public website, which is located at www.insurance.ca.gov.

From the home page, you will find the word Fraud on the banner, this is located third from the right and we have it circled here in red.

When you hover over the word Fraud, it will produce a drop-down with several options.

Toward the bottom you will find an option that says "Report Fraud" and that is where you will click.

Clicking on Report Fraud will take you to this screen here, which has two options. The top option is for insurance company SIU personnel to report. As agents or brokers, you want to select the second option, which says Consumer Insurance Fraud Reporting Form.

Section 1: Person or Business Reporting Fraud

Clicking the link to open the Consumer Insurance Reporting Form will take you here and you will fill out the boxes as presented.

At the top, you will have a drop down giving you the options of individual, business or agent/broker. You will select agent/broker.

The next line down asks you if you wish to file anonymously. As agents or brokers you may not file anonymously. Statute does not allow for that. And the reason is, if the Fraud Division wants to open a case on this referral, we need to be able to reach out to you to get information or for the files.

The remainder of the form is fairly self-explanatory, please enter your name and contact information.

At the very bottom, you will indicate “yes” for being a victim of the alleged fraud. Even if you did not end up writing a policy because you detected the red flags and declined the business, you were still the victim of that fraudster trying to take advantage of you.

Section 2: Person or Business Reporting Fraud

The next section of the form is where you will enter the information of the person, or business, committing the fraud. More than likely in your case, it will be person.

To the right of the screen, circled in red here, you will find a button to create a suspect.

Clicking the create button will bring up a pop-up screen, so make sure pop-ups are enabled, and on that pop-up you will enter any data you have on the suspect.

Here is what that popup looks like.

At the top, it asks you who the person listed is. Your options here are going to be insured, claimant or other. Most likely, you will be selecting insured since you are not dealing with claimants under most circumstances and other would be reporting fraud perpetrated by providers, attorneys, medical personnel or similar individuals.

We do recognize that the term insured implies they are an insured of yours. In your case, this may not be wholly accurate. Reporting red flags through the consumer portal is for applicants who you have not placed business for and so they are not your insured at this point. That is ok, please select insured anyway. We will see that you are an agent or broker submitting and know that insured is potentially not a client of yours.

The remainder of the form, as you can see, will ask you for name, company name if applicable and address information.

When you save the information on that popup, you will see it populate under the line at the top of the screen shot where it now says “there are no records to display. ”

After entering the information, you will complete the rest of the section. For the location of the fraud, please be as specific as possible. This will help us ensure we get the referral to the right Regional Office for handling.

Section 3: Insurance Fraud Details

The next screen in the portal asks you write out what the suspected fraud details are. What you see here are the questions that appear on the form. Please do your best to answer these as thoroughly and accurately as possible.

The first question. Who are the persons committing the fraud?

When you answer this, be as specific as possible. What is their name? Full name preferably. Not just Sally. Also, not nicknames, provide the legal name. If someone goes by Bob, but their actual name is Robert, please enter Robert. If there is more than one person involved, enter them all. Don’t hold back, we need to know everyone who is part of the potential fraud.

The second question. When and where did the fraud occur? This one may be difficult to pinpoint. If someone called, you may not know exactly where they are calling from. If someone submitted something online, again, you won't know from where. The easiest way to handle this question if you don't have an exact location would be to use your office location. If a criminal case gets opened, our Detectives or Investigators will take on the task of confirming location for jurisdiction purposes.

The third question. What is the name of the insured, if different than the suspect? Now that is an interesting question, right? We do see a fair amount of fraud committed by someone other than the policyholder. Common examples include children taking out policies for parents. This could be property casualty policies and the parents don't speak English, and so the children are there facilitating. This could be medical or life insurance where the children are intentionally misrepresenting medical history of elderly parents in order to take advantage of something. There are other examples as well, could be significant others, could be other relatives that are not children. Unfortunately, the opportunity to commit insurance fraud when you are not the policyholder is just as prevalent as if the fraudster were the policyholder themselves.

Next question, include names of others who can corroborate this information. Ok, let's be honest, we could have written this easier. Simply put, what witnesses exist? The others that can be a potential witness range from family, friends, coworkers of the insured all the way to other employees within your agency. Did this person talk to more than one person in your office? If they did, list it here.

Last question. Is anyone in the insurance industry aware of what is occurring? When this is answered by a member of the general public, they provide us names of people from insurance companies, such as adjusters or agents and brokers. When you are answering this from the perspective of an agent or broker, you will not need to list yourself. We know you are aware, that is why you are reporting it. What you may want to add here is whether or not anyone with a company you contract with is aware? Perhaps you called an underwriter for advice, ultimately ended up not writing the business, and still need to report it. That underwriter should be listed here. Or, are you a member of an agent or broker association and the suspect has been the topic of discussion? Let us know that. It helps us determine the scope of the fraudulent activity if we know that this suspect is known to an entire agent or broker group.

Referral Form Synopsis

Alternatively, you can answer these questions. So, what you are seeing here are the questions that an insurer is required to answer when they submit referrals in our portal. As agents or brokers, you are not required to answer these questions; however, we have found that following these questions gives you greater success at conveying to our Detectives what the misrepresentation was and what information you have to support the allegation.

Please note: choosing to answer the questions on the preceding slide versus this slide is not a matter of compliance. It is a pure choice. What we ask is that either direction you go, you provide us with as much information as possible.

You also will not see these questions populate automatically when you are in the form because they are not your compliance requirement. If you are considering answering these questions, you will need to know what these are. You are welcome to take a screen shot of this, or you can reach out to the SIU Compliance Unit and they can email it to you. Their contact information is on the Departments public website.

- What facts caused the reporting party to believe insurance fraud occurred or may have occurred?

- What are the suspected misrepresentations and who allegedly made them?
- How are the alleged misrepresentations material and how did they affect the claim transaction?
- Who are the pertinent witnesses to the alleged misrepresentation, if there are pertinent witnesses?
- What documentation is there of the alleged misrepresentation, if documented?
- Provide a statement as to whether the or not the investigation is complete.

Section 4: Other Referrals

Section 4 of the form is next and the final section you will encounter when you complete the referral.

Remember, if you have already placed a policy, your reporting requirement is to the insurance company where that policy is placed. If, for some reason, you wish to also notify us directly, you are welcome to do that. In those cases, you will enter which insurance company you reported to in the top box.

If your case involves workers' compensation, we also strongly recommend you notify the applicable district attorneys office for the county of where the fraud took place. If you do this, please note on line three, what District Attorneys office you sent it to.

The purpose of this section is simply you notifying us if you have also reported the suspected fraud to anyone else. This allows us to know who else might be working the case or other companies or agencies we can seek information from.

Referral Form Summary Tips

Here are some tips for writing summaries.

First, do not include irrelevant information. If the sky that day was grey instead of blue, unless it matters to the suspected fraudulent activity, we really don't need to know.

Secondly, please do not copy and paste the same information under each question. We do read each and every referral and when you do that, we spend a lot of time re-reading the same information over and over just looking to see if something is different between them.

Last, when you answer the questions, and this is whether you are answering the ones prompted on the form or choosing to enter the questions as insurers, please make sure you are complete, thorough and accurate.

Checkpoint

And it's checkpoint time. From the CDI website, an agent or broker will report suspected insurance fraud via what portal?

Agent portal, company reporting portal, SIU annual report portal, consumer reporting portal.

And the answer is D. Consumer Reporting portal. At this time, a specific agent or broker portal does not exist. Statute specifies that an agent or broker will use the consumer reporting portal. The other options listed are the company reporting portal, which would be where insurance company personnel report and the SIU Annual Report portal, which if you recall much earlier in this training is an annual obligation of an insurance company operating in California.

Referral to CDI

So now that you know your two referral options and how to refer through our consumer portal, you may be wondering if the requirement comes with a timeframe in which you must refer. The answer is yes, you are required to refer within 60 days.

Insurers referring also have a 60 day requirement as noted here. But you will notice that the level of belief of the insurance fraud to refer is different. An insurance company has to establish what is called reasonable belief of insurance fraud, which means they've done some additional investigation to the red flags that you've notified them of.

Your referral obligations is at the point of detection of the red flag itself. And again, you're either going to refer that to an insurance company if the policy is placed or, you are going to refer it directly to us here at the Fraud Division for policies that are not placed. That is calendar days.

The sooner the better, just to ensure you are never outside that window.

Checkpoint

We have another checkpoint.

What is the timeframe that an agent or broker has to report suspected insurance fraud to the CDI Fraud Division?

14 days, 30 days, 60 days, or none of the above because there is no required timeframe in statute

And the answer is B. 60 days. Please be mindful of this. It is 60 calendar days and so that does include weekends and holidays. As a best practice, it is suggested that you refer as soon as possible. Waiting 60 days not only delays our ability to review the referral and make a determination on how to handle it, but it also allows you to potentially forget specific details that may be necessary for us to know.

Cooperation With Law Enforcement

Earlier in this training, I noted that you also have a duty to cooperate with an insurance company SIU and law enforcement agent.

So, what exactly does that mean?

If you receive a call or email from a law enforcement officer, whether that is one of our Fraud Division Detectives or perhaps a District Attorney Investigator does not matter, just please remember you have a duty to cooperate.

You are required to provide files and documents upon request. You are bound by the same time standards as insurance companies, as a reminder that is 30 days for all lines of business other than workers' compensation and 60 days for workers' compensation.

Please be sure to respond to all calls and emails asking for clarifications or additional information.

Also, please know that statute provides law enforcement the authority to interview you. You may not decline an interview. If you are asked to be present for an interview, either on the phone or in-person, work with the law enforcement officer to establish a time and place and be sure to be available and present.

Checkpoint

Checkpoint question.

What is the timeframe that an agent or broker has to provide file information on a workers' compensation file.

14 days, 30 days, 60 days or none of the above

And the answer is 60 days. Requests for workers' compensation allow 60 days to respond to authorized governmental agencies asking for the release or documents.

And, one final checkpoint.

What is the timeframe that an agent or broker has to provide file information on a file for lines other than workers' compensation.

14 days, 30 days, 60 days, none of the above

And the answer is 30 days. You only have 30 days in which to respond to requests for file information for all lines of business other than workers' compensation.

Thank You

Thank you for joining us for the last hour as we took you through several aspects of the anti-fraud requirements for agents and brokers in the State of California. We look forward to working with you. Should you ever need information from the California Department of Insurance, please visit our public website at www.insurance.ca.gov to locate contact information for our various units.

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