INSURANCE CONTINUING EDUCATION

ETHICS: BEYOND RIGHT AND WRONG

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ETHICS: BEYOND RIGHT AND WRONG

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CHAPTER 1: UNDERSTANDING YOUR ETHICS

Although the purpose of this course is to promote contemplation about ethics in connection to your insurance career, it might be important for us to take a step back and consider what the term “ethics” means by itself. You can probably come up with your own suitable definition, such as “a moral compass that helps people determine right from wrong” or maybe “a set of rules or standards that determine how members of society should treat one another.”

In his book “How Good People Make Tough Choices,” ethicist Rushworth M. Kidder referenced a quote from English judge John Fletcher Moulton, who claimed that manners were essentially a type of “obedience to the unenforceable.” As Kidder noted, we can easily substitute the word “ethics” in place of “manners” and argue that ethics include the way we act when no one else is watching and the way we act when we have a real choice in how to act or how to behave. Although ethics and laws might be intertwined, our obedience to laws tends to be based on a desire to avoid punishment, whereas our obedience to ethics tends to be based more on a desire to follow our conscience and uphold our principles.

Who Cares About Ethics?

If we agree that being ethical involves more than just following the law and avoiding punishment, we are left to ponder the benefits or lack thereof of living an outwardly ethical life. Since making ethical choices can sometimes be a torturous process, why should we bother doing the allegedly “right thing” at all? Or to be a bit more blunt and direct about it, why should you take courses that ask you to meditate on your personal ethics and whether you are applying them appropriately when conducting your daily business?

Simply put, good ethics can help you build your business. The more outwardly ethical you are to your existing clients and the more trust you can build with them, the longer they are likely to remain in business with you. Similarly, the more your existing clients believe in your expertise and professionalism, the more likely they are to refer their friends and family members to you.

A solid record of ethical behavior might also provide some protection for you during difficult times. In instances where your business is struggling to compete on the basis of price, your reputation might attract at least a few consumers who would otherwise opt for one of your lower-cost competitors. Or in a more serious scenario, a clear history of proper behavior might lessen the fallout if you ever find yourself accused of an error, an omission or a regulatory violation.

If you stay in the insurance industry long enough, your degree of professionalism is likely to be noted by colleagues who might play a major role in keeping your clients satisfied. Consider, for instance, an underwriter with a large stack of insurance applications on her desk. In addition to reviewing relevant information about each applicant, she might note the insurance agent associated with the paperwork and ask herself, “Does this agent do his or her work in a careful and thorough manner?,” “Does this agent understand the types of risks that my company prefers?,” and “Can I trust this agent to give me honest and complete answers to any of my questions?” By building trustworthy relationships with others and showing good professional judgment, you might make it possible for applicants who are considered “borderline risks” to secure insurance in a reasonable amount of time and at a truly fair price.

Finally, your consistent attention to ethics can play a small part in improving the insurance community’s reputation. When pollsters such as Gallup have asked the public to rank various professions based on their level of perceived trustworthiness, insurance salespeople have tended to appear near the bottom of the list. Although we might question whether the public’s perception of insurance producers is even remotely fair, we shouldn’t deny that such opinions make it harder for us to do our jobs. Unless people understand how much we care about helping them, they will

view our recommendations to purchase a particular product or our suggestion to sit down and review the appropriateness of their existing coverage with tremendous skepticism and will wonder if our advice is based purely on our own self-interest. Meanwhile, unless carriers find the right balance between denying illegitimate insurance claims and providing significant financial relief to crisis-stricken policyholders, the general population will continue to view insurance as a purely profit-driven business that deserves no help in stopping preventable cases of consumer-driven fraud.

Getting the average person to see us and our industry as human beings and not as negative stereotypes won't happen overnight. But maintaining an obvious devotion to ethics can get us off to a good start.

Common Views on Ethics

Systems for determining right from wrong are numerous enough to fill the philosophy-focused curriculums at several major universities. We'll briefly mention three of the most common ethical systems or philosophies that continue to be studied and debated.

In general terms, "utilitarianism" is a brand of philosophy that asks, "What are the consequences for society as a whole?" Utilitarianism is commonly concerned with outcomes that produce the greatest amount of positive consequences for the greatest number of people. Concerns about how a minority of people will be impacted by those outcomes receive less attention under this ethical system.

"Kantianism" is a brand of philosophy that essentially asks, "What do the rules say about this situation?" Those rules might be written (such as in the form of a law) or might be communicated verbally from person to person and generation to generation. A fairly strict interpretation of Kantianism would claim that breaking a rule, regardless of the circumstance, is unethical, whereas abiding by a rule, regardless of the circumstance, is ethical.

Under the "Golden Rule," our views on what is right or wrong are determined by the question, "How would I want to be treated in this situation?" You may have also heard the Golden Rule as, "Do unto others as you would have them do unto you." The Golden Rule dates all the way back to the time of Confucius and has been incorporated into practically all of the major world religions. Its emphasis is on empathy and compassion.

You probably assume that you favor one of these value systems over the others. However, in practice, you are more likely to alternate between one or another depending on the specifics of the scenario and the people who are involved. As you read through some of the case studies found later in this course, consider taking a step back from them and analyzing how your personal code of ethics actually operates. For example, do you find yourself constantly thinking about rules in a manner similar to Kantianism? Are you typically putting more weight on the Golden Rule? Are your ethics as strict or as flexible as you've always assumed?

Shaping Our Ethics

If you notice yourself shifting from one ethical system to another when making decisions, the cause might relate to the fact that our ethics are shaped by so many different sources. Laws can influence our sense of right and wrong and seem to fit neatly into Kantianism's emphasis on rules. Our faith and our family can shape our ethics, too, but tend to do so in ways that emphasize a combination of rules and a call for empathy and kindness toward other human beings.

As we move into our careers, our ethics can undergo subtle changes based on guidance from professional organizations. For example, many insurance-focused professional organizations have their own codes of ethics. These codes can and often do ask members to follow rules that go

beyond the various insurance laws or rules that have been implemented by state or federal governments. If you are a member of this type of organization, consider taking a few minutes to locate and review the organization's code of ethics so that you can maintain compliance with them and remain in good standing with your fellow members. Depending on the professional organization, a formal code of ethics might require that you consider the following issues even if state laws don't directly address them:

- Your duty to disclose how much you will be paid as part of an insurance transaction (and whether payment will be in the form of a commission or a flat fee).
- The need to complete courses with an emphasis on certain topics that are important to the organization.
- The level of respect you should project in regard to your competitors.
- Your obligation to report suspected code violations to the organization's disciplinary board.

CHAPTER 2: APPLYING OUR PRINCIPLES AS PRODUCERS

Regardless of who or what shaped our ethics, there are common lessons about right and wrong that we've all been taught. For instance, we've all been taught to be honest, to treat others with respect and to avoid acting with too much self-interest.

Since the vast majority of us have already been taught these lessons, an ethics course like this is unlikely to turn an allegedly "bad" person into a better human being. But it might help you recognize instances in your professional life in which those very personal lessons about honesty, compassion and other virtues can be more specifically applied.

While you read the rest of this course, try to think of your ethics as a muscle. In order to keep a muscle strong and resilient, you must engage in at least a bit of periodic exercise. The case studies that you will examine later in this material are intended to serve as exercise for the ethics-related muscles that you already possess. The point of the exercises isn't necessarily to instill the "right" answers in you. (In fact, you might find that many of the case studies ask questions that have several "right" answers.) Instead, the examples presented here should give you some extra practice in processing ethical dilemmas and should make your personal set of principles clearer to you.

Unfortunately, many of our most important ethics-related decisions have to be made in the heat of the moment and often cannot be reversed. By meditating on the scenarios featured in this course and exercising your ethics as a muscle in other ways, you might find that you are capable of making quicker decisions without sacrificing any devotion to your values.

Staying Truthful With Clients

You've almost certainly heard that "honesty is the best policy." It should probably go without saying that lying to a consumer about the benefits or drawbacks of an insurance product is inappropriate. But is there a difference between saying something that is untrue and being completely quiet about a potentially important issue? Is it your duty to merely avoid telling lies, or are you required to go a step further and actively disclose all material facts to your clients, whether you're asked about them or not?

Consider this scenario:

- You are competing hard for a new account that could take your agency to the next level. You know that securing this business will greatly impress your boss and translate to advancement in your career. You also know that this prospect is more likely to be swayed by price than by anything else you might be able to provide. You are ready to send a quote

to the prospect and believe it is probably at least as low as the price being quoted by your closest competitor. However, you arrived at the quote by doing some creative math and applying certain discounts that are unlikely to remain in place beyond the initial policy period. You are fairly sure that your competition is calculating its quote in a similar fashion and is unlikely to mention the high probability of an eventual price increase to the prospect.

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- To whom do you owe the most loyalty? Your boss? The prospect? Yourself?
- If you present the low quote to the prospect, must you be completely honest and disclose the fact that the low price is likely to be temporary?
- Does your competition's behavior make you more or less likely to tell the full truth?
- When is it worth your time to educate a prospect about how insurance really works (including how rates and premiums are calculated)? Is it ever appropriate to avoid this type of educational opportunity?

Treating Everyone Equally

Unless there are legitimate actuarial reasons for treating applicants or policyholders differently, ethical insurance producers generally attempt to provide the same level of quality service to all of their prospects and all of their clients. But what does this attempt at nondiscrimination really mean within a business context? Does it merely mean that we should avoid treating people differently on the basis of such insignificant factors as race, religion and ethnicity? Or might it mean something more and mean that we should do our best to treat our smaller clients with as much care and attention as our larger ones?

Consider this scenario:

- You work as a commercial lines insurance broker and are approaching a 10-year business anniversary with your most important client. This client has stuck with you during difficult times even though some of your competitors have tried to lure the client away with promises of savings. You want to express your gratitude and decide to write a "thank you" note, but you still don't feel like you're doing enough. You revise the note by saying you will be making a donation in the client's name to his or her favorite charity. You feel good about showing your gratitude and helping a good cause. But did you do anything wrong?

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Does your state have any rules or restrictions on "rebating" (providing goods or services that aren't specified in the policy or insurance contract)?
- Even if rebating is allowed in your state, are there negative consequences for the insurance industry as a whole if agents and brokers engage in it?
- If you make this offer to your favorite client, do you have an ethical duty to extend the same offer to other clients?
- If you have reservations about making this type of offer to a client, are there other, more appropriate ways of showing your appreciation?

Demonstrating Your Competence

Despite inevitable frustrations related to our jobs, most of us probably want to believe that what we do has value and that there are correct and incorrect ways to conduct our business. Even though most consumers won't recognize how having pride in our profession can trickle down in a positive way to them, it often gives us a personal incentive to become more educated about our industry and, therefore, more adept at solving consumers' insurance problems.

A bit of networking can go a long way in terms of improving our competence and expanding our insurance knowledge. Producers who work almost exclusively in a sales capacity might benefit from stepping outside of their comfort zone every once in a while and inviting an underwriter, claims adjuster or compliance officer out to lunch. In the middle of enjoying the other person's company, the producer can learn a lot by asking the other person questions like, "What can I and the rest of my department do in order to make your job easier?" Conversely, the producer can educate the other person by explaining some of the hurdles that sales professionals often face when dealing with other divisions within an insurance organization. The more you know about how each piece of an organization works, the easier it will be to set clear expectations for clients when they ask about the status of an application or a claim.

Standing Up For Yourself

Whether the pressure comes from a consumer who has some control over our commission or a boss who has control over our employment, saying "no" to people who want us to engage in unethical behavior requires an admirable amount of courage. If the pressure is coming from an employer, we may need to consider the sad and stressful possibility that we should be working for a different company. After all, if a supervisor insists on having you do something that offends your principles, what are the odds that the same supervisor will support you during a professional crisis? Unfortunately in this scenario, the only person who is likely to be looking out for your long-term interests and your ability to maintain a positive relationship with your local insurance regulators is you.

If unacceptable pressures are coming from an applicant or client, you have a few other options and questions to answer. Consider this scenario:

- You're an insurance broker for a combative business owner. The owner is a long-time "problem customer" who is always uncooperative when you ask him for information. He says things like, "Why do you need to know things about my payroll? It's none of your business! Can't you just use your best guess and get this moving?" This time, the owner's comments are particularly personal and insulting. He has questioned your competency and called you a "typical insurance person, just caring about yourself and making money." The client has important coverage up for renewal in the next few weeks, and you're the only one who understands this account. You are tired of taking his abuse, but you still want to be professional. What do you do?

Now, carefully consider the all of the following questions, keeping in mind that there might be more than one "right" answer:

- Does your answer depend on whether you are running your own insurance business or are working for someone else?
- Would you respond differently depending on whether you are a new producer with few clients vs. an experienced producer with several clients?
- If you refuse to help the client anymore, is it appropriate to refer the client to one of your colleagues?

- Are you comfortable with the consequences for the client if you refuse to help him anymore and don't refer him to someone else?
- Are there steps you could've taken earlier in your relationship that would've prevented this problem from growing?
- Is it fair (to the client and yourself) to continue working with the client but only within certain limits?
- What is the likely cause of the client's hostility, and does it have anything to do with you?

CHAPTER 3: BUILDING ETHICAL RELATIONSHIPS WITH INSURANCE BUSINESSES

Without trivializing the importance of fairness toward consumers, licensed producers shouldn't forget about the various ethical duties they owe to the insurance agencies and carriers that they work with. Those duties tend to relate to disclosure of material facts about applicants and policyholders, the careful handling of premiums, and the upholding of any employment agreements between the individual producer and an insurance business. While reminding ourselves of those duties, we might also wonder whether those duties have limits and whether the companies we work for are being just as ethical toward us.

Consider this scenario:

- You have recently begun work as a captive agent for a major property and casualty firm that specializes in auto insurance. Your own auto insurance is from a different carrier and is up for renewal. You want to be loyal to your new company, but you also have concerns about buying from the same company you work for. For example, what if a claim isn't handled as expected, and things get awkward? Also, might you risk losing some privacy about your driving record or credit history? And what if a potential customer asks you where your own auto insurance is from?

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Do you owe any loyalty to the agent who issued your current auto insurance?
- If there is no way for anyone at your new company to know where your insurance is from, do you still feel obligated to switch?
- If you are uncomfortable about switching and choose not to, is it appropriate to disclose the reasons for your decision? Is it okay to lie if asked?
- If you and other drivers in your household are all covered by the same policy, how much involvement should those other drivers have in the decision to change carriers? Should your loyalty and respect for them outweigh your loyalty to your company in this case?

Insurance producers who act as agents are supposed to represent the insurance company and are thereby obligated to disclose relevant information that they learn from applicants or policyholders. Similarly, if an applicant or policyholder gives information to an insurance agent, the information is generally treated as if it were given directly to the insurance company. In other words, depending on state law, notice to the agent is considered notice to the carrier.

But with agents being made aware of so much information via their interactions with the public, is it ever practical, appropriate and ethical for an agent to withhold information from an insurer?

Consider this scenario:

- While giving a life insurance presentation at someone's home, you detect a strong odor of cigarette smoke. The applicant is sitting across from you and has indicated in writing that he doesn't smoke. You don't want to believe that the applicant is lying to you, so you consider other reasonable explanations. You ask if someone else lives at the home, but the applicant says he lives alone.

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Is it appropriate to dig deeper into the situation and ask more questions? If so, which questions would you ask?
- If you assume that the applicant is lying to you, should you raise the issue with the applicant?
- If you assume that the applicant is lying to you but don't raise the issue with him, what steps (if any) should you take after leaving the home? For example, should you note the situation in your records and share them with an underwriter? Is it acceptable to leave the situation alone and have faith that a paramedical exam will reveal the truth?
- If you assume that the applicant is lying to you, does this instance of dishonesty hint at other unethical behavior that he might commit in the future? Might this be a "problem customer" who should be let go as soon as possible?

Honoring Your Contract

Insurance producers are often asked by agencies and insurance carriers to sign non-compete agreements. These agreements limit the kinds of work that a producer can do if he or she ever leaves a current employer. For example, a non-compete agreement might say that a producer cannot do any of the following within one to five years after the end of his or her employment:

- Approach the agency's or carrier's clients with the intent of doing business with them.
- Sell insurance within a particular geographic area.
- Sell a particular type of insurance.
- Recruit former colleagues to work at the producer's new place of employment.

Legal experts have debated the legality of these agreements and generally agree that an agreement that imposes an unreasonable burden on a person's ability to earn a living is unenforceable. However, determining what is, in fact, an unreasonable burden is often unclear and might not be easily determined without the help of an experienced attorney or a ruling from a court. With this in mind, producers who are asked to sign this type of agreement might want to consult legal counsel before putting pen to paper.

If you run your own business and employ other producers, you might be faced with the decision of whether to require the signing of non-compete agreements and, perhaps, whether violations of those agreements should be countered with legal action.

Consider this scenario:

- You run an agency and have decided you must replace a struggling producer due to poor performance. The producer has been with you for two years after abandoning a successful career as a carpenter. You know the producer has a big family and a spouse with health problems, but you need to let the person go in order to stop losing money. The producer signed a one-year non-compete agreement with your agency. Three months after the producer's dismissal, you get a voicemail message from an important client. The client says

she's moving her business to a new agency owned by the dismissed producer. Before calling the client back, you think about the one-year agreement. Do you inquire about a potential breach of contract, or do you leave it alone?

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Does it matter that the producer didn't leave your agency by choice?
- Does it matter that he was successful as a carpenter and, therefore, seems capable of going back to that career.
- Assuming you employ other producers, are you concerned about how your response will be interpreted by them and whether they will lose respect for you?
- If you choose to call the client, is there anything to lose or gain by mentioning the producer's violation of the non-compete agreement?
- Is it ever appropriate to violate a signed agreement?
- Would you consider an alternative to legal action against the producer, such as an offer to rescind the agreement in exchange for financial compensation?

CHAPTER 4: SELLING THE "RIGHT" WAY

An ethical approach to selling insurance is likely to require a carefully self-monitored combination of disclosure, analytical skills and professionalism. Your success depends on your ability to explain complex products, determine how they apply to a prospect's goals and convince people that you, out of all insurance professionals, are the right person to buy from. Your chances of nurturing a positive relationship with a new client start upon your very first interaction with the person and continue as you learn more important information about the person's needs.

Before turning to the specifics of a particular product that might be worth purchasing, you have an obligation to clarify some basic facts for any prospect who you encounter. These basics include, but aren't necessarily limited to, the following items:

- Who you are.
- What you're selling.
- Which company or insurance entity you represent.

As a first step toward being clear about this information, think about what's printed on your business cards and email signatures. If you include any titles under your name that are meant to suggest a heightened level of insurance-related expertise, were they earned through successful completion of special courses or exams? If not, what is your rationale for including them? Although many people earn insurance designations in order to attract more business, unearned titles that are included for the sole purpose of luring new customers might confuse and ultimately alienate the very people you are hoping to attract.

If you have pride in your role as an insurance professional, you should have no problem clearly informing prospects that what you are selling is, indeed, a type of insurance rather than a mysterious-sounding financial tool. In the senior market, it is fairly common for producers to invite prospects to free seminars with the promise of a free meal and some tips about how to plan responsibly for retirement. In fact, many of these seminars are introductory sales presentations about annuities, yet the word "annuity" is often absent from the seminar organizer's advertising. Does the organizer leave out the word "annuity" because of a belief that recipients won't understand

the term? Or is the lack of clarity an intentional form of deception, done under the assumption that less people will attend if they know an insurance product (such as annuity) will be discussed? Even if you engage in this type of advertising for what you believe are valid, well-intentioned reasons, it might be worth considering how others—including your audience and regulators—are likely to perceive it.

Being clear about the companies or other insurance entities that you represent can be particularly important in the senior market because of the link between various senior-focused products and federal programs such as Medicare and Social Security. ;'As much as producers in this market might feel the need to emphasize the gaps in federal programs and the ways in which insurance can help fill those holes, your clients and prospects should never be allowed to think that you or your company is, in fact, affiliated with the state or federal government unless such affiliations are true.

Unfortunately, widespread misunderstandings about health insurance laws and government benefits have made it easy for scam artists to trick vulnerable citizens. For example, soon after passage of the Affordable Care Act in 2010, insurance regulators were already warning the public about real cases in which licensed producers falsely claimed to be from the government and conned people into purchasing bogus coverage. Such sad cases of deception help explain why states and federal departments tend to be very strict regarding the use of their names and their logos in advertising by private companies.

Disclosing Material Facts

Based on our own experiences when shopping for complex and relatively expensive products, we probably believe that consumers have a right to be informed of all material facts related to what we sell. But putting this belief into practice can be a challenge because the meaning of a "material fact" can differ from person to person, product to product and transaction to transaction. When deciding what must be disclosed to a potential purchaser, ask yourself, "What pieces of information are likely to have an impact on this person's decision to buy or not buy what I'm selling?"

More often than not, your answer will at least include the items on the following list:

- Price.
- Dollar limits.
- Major exclusions.
- Waiting periods or deductibles.
- Tax penalties or surrender charges (for insurance products with a cash value).
- Other issues that the applicant clearly cares about (based on your conversations with the person and your investigation of the person's stated goals).

Many insurance policies include a "free-look period," which allows a policyholder a set number of days (such as 10 or 30) to review an insurance contract after a purchase and cancel the coverage in return for a full refund of paid premiums. Although free-look periods are often mandated by law as a form of consumer protection, they should not be used as an excuse to avoid disclosure of material facts in advertising or in conversations with prospects. Since most insurance customers lack the time and the interest to actually read their policies, your role in educating your clients about the specifics of their insurance portfolio is immensely important.

Producers who advertise their products and services on social media platforms should be mindful of the ways in which these platforms can directly and indirectly put limits on the ability to disclose

all required information. For example, some social media sites force users to keep all of their communications below a certain length. Other social networks might not have rules about the length of posts, but producers might instinctively compose short items online because of the internet community's emphasis on shorthand communication.

Your commitment to disclosing material facts might be more obvious if you hold yourself to strict and consistent standards in all of your marketing campaigns, no matter if they are done via the mail, the phone or any corner of the internet. If a particular platform doesn't allow you to make the kinds of disclosures that would be important to your audience, you might want to reevaluate your advertising plans.

Watching Your Language

If you spend most of your day talking about insurance, it's very easy for the occasional vague word or unclear phrase to come out of your mouth. If you catch this happening to you, it might be appropriate to pause for a moment and then reframe the word or phrase so that your audience understands the content of your message. Since the average person knows so much less about insurance than a licensed producer, we might forget how easy it is for a consumer to misinterpret our language and how hard it can be for someone to put insurance information within the proper context.

Here are some words that, while not necessarily inappropriate, might deserve some clarification:

- "Unlimited." (A health insurance product might have an "unlimited" benefit cap but might limit the insured's choices in regard to networks of doctors.)
- "Comprehensive." (A product might be fairly "comprehensive" compared to similar products in the market but is still likely to have some important exclusions.)
- "Generous." (Who is to say what is "generous" and what isn't?)
- "All." (Insurance policies are complex legal documents. Words like "all" are often misleading because one broadly worded portion of a policy is often subject to exclusions found in another portion of the policy.)
- "Guaranteed." (This term can be particularly dangerous in regard to interest-sensitive life insurance policies. Whereas there might be a "guarantee" associated with a death benefit, there might not actually be a guarantee associated with cash values or dividends.)

Coping With Competitors

In an ideal world, you will have an extreme amount of confidence in your products and services and won't need to waste much time worrying about what your competitors are up to. Keeping quiet about other producers and other insurance companies in front of your clients can be both a sign of professionalism and a risk management tool that reduces your chances of making a libelous or slanderous statement. But, of course, we don't really live in that ideal world where everyone plays fairly.

Consider this scenario:

- You have invested a great deal of effort into a new prospect and are on your way to a meeting where you expect to finally win her business. When you arrive, the prospect apologizes and says she has decided to go with one of your competitors. You have a long history of losing business to this competitor, whom you believe is very quick to sign up new business but very slow to provide good service. Without being prompted to do so, the prospect reveals that she got a "great deal" from your competitor and tells you about

"promises" that the competitor allegedly made. Based on the prospect's words, it's clear to you that something is wrong. She either has a clear misunderstanding of how her desired insurance product really works or was given bad information by your competitor in order to close the deal. Now, you're not only annoyed that you lost this business but also fearful that the prospect has made a very serious and potentially harmful mistake.

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- How is the prospect likely to respond if you imply that the competitor's offer is too good to be true?
- Since you can't prove what really happened between the prospect and your competitor, is it wise to take no action at all?
- What might happen if you were to say nothing about your suspicions to the prospect but raise the issue in a private phone call with the competitor?
- How would you respond if a competitor contacted you and raised concerns about your own business practices?
- If you believe you need more information about the situation in order to proceed, how can you obtain it while also being mindful of privacy concerns?
- If this were the first time that you'd suspected the competitor of unprofessionalism or bad behavior, would you be more inclined to ignore the situation?

High-Pressure Scare Tactics

Fear plays a central role in insurance. In most cases, in fact, it is the very thing that gets people to purchase insurance in the first place. We purchase life insurance because we worry about the impact our death might have on our loved ones. We purchase property insurance because we worry about fires destroying our home and all of our belongings. We purchase health insurance because we worry about getting into a serious accident or being diagnosed with a serious illness.

Fear, in and of itself, can be a positive motivator because it can force us to find solutions to problems that we'd otherwise prefer to ignore. You might even argue that part of your duty as an insurance professional involves instilling a healthy dose of fear into your clients and making them confront the very real risks that exist in today's complicated world. But at what point do we risk crossing the line between providing people with a healthy dose of reality and scaring them in cruelly manipulative ways?

Consider this scenario:

- A middle-class married couple meet with a life insurance salesperson. They agree that term life insurance should be purchased for each spouse so that if either one dies, the surviving spouse and their two young children will be able to maintain their standard of living. The salesperson is willing to help them obtain their requested type of insurance but also asks them whether they would be interested in buying life insurance on their children. The couple declines, but the salesperson continues to pursue the possibility with them. "The right policy can help them save for college," he says. "Plus, you never know. They might be healthy now, but if one of your kids is ever diagnosed with a serious illness, they might never be eligible for good coverage later on. So now would be a great time to buy some." Again, the couple expresses no interest, and the salesperson makes another attempt to persuade them. "You have two kids. If an accident were to happen, have the two of you thought about

how you would pay for two funerals at the same time? I'm not trying to scare you. I just want to make sure that we're addressing all possible scenarios."

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Was it appropriate for the salesperson to bring up the issue of life insurance on the children at all?
- Was it appropriate for the salesperson to pursue the issue in any way after the couple first expressed no interest in it?
- Was it appropriate to mention the possibility of the children becoming disabled?
- Was it appropriate to mention the possibility of the children dying?
- Does your opinion of the salesperson change if you knew that life insurance on the children would've netted him a large commission? What about a small one?

Focusing on Suitability

One seemingly obvious but not always easy step toward maintaining good relationships with clients is to give them what they need. If you have been in the insurance business for practically any length of time, you probably have noticed that what someone needs is not always the same as what they ask for. Although consumers need to make the final, ultimate decisions about what to buy, your ethical (and, in some cases, legal) responsibilities include making the appropriate disclosures about requested products and taking the time to understand each person's unique situation.

Even if a prospect seems to have a clear goal regarding his or her financial future, that person might not be capable of articulating it in insurance-specific terms. For a simple example, consider a prospect who claims to want a life insurance policy for short-term needs but then says he wants to achieve that goal by purchasing a variable life insurance policy. In that case, your instincts should lead you to ask more questions and provide some basic education about the differences between term life insurance and the various types of permanent coverage, including variable life insurance. In short, the best way to help people get what they really need is to know your customers.

In order to increase the likelihood of pairing their clients with truly suitable products, many insurance professionals use a checklist of questions that are asked to each and every person before a transaction or recommendation is made. If you've worked in insurance for a long time, this checklist might be a matter of second nature to you and might be committed to memory. If you have less experience or are at all concerned that you will forget to ask an important question, you might rely on a printed copy that you keep in front of you at each of your appointments.

Though your checklist will depend on the type of business you're in, here are some basic issues that are worth considering as part of determining suitability for certain insurance products:

- For variable life insurance or variable annuities:
    - Age.
    - Investment objectives.
    - Financial situation.
    - Tax status.

  Note that there might be additional factors that must be considered and documented in accordance with state laws. Also, since variable products are generally considered to be

securities, producers selling these products should research their suitability obligations from FINRA.

- For any type of annuity (fixed, variable or indexed):
    - Age.
    - Income.
    - Financial situation.
    - Financial objectives.
    - Purpose of the annuity.
    - Existing assets.
    - Liquidity needs.
    - Liquid net worth.
    - Tax status.
    - Risk tolerance.

  Particularly over the past decade, insurance regulators have been concerned about types of annuities that are difficult to understand or that jeopardize senior citizens' financial stability through steep surrender charges and market risks. As annuities become more complicated and more customized to meet the demand of niche audiences, careful explanations of these products takes on even greater importance.

- For long-term care insurance:
    - Applicant's ability to afford coverage.
    - Goals and needs with respect to long-term care.
    - Values, benefits and costs of other applicable insurance.

  Affordability of long-term care insurance should be measured not only by current pricing and a prospect's current financial status but also by potential changes that could make coverage more expensive in later years. Despite the benefits of long-term care insurance for many people, insurers have struggled to price this product appropriately. Contrary to initial industry expectations, the amount of people who purchased some of the comparatively generous policies in the early days of the LTC market and cancelled their coverage before ever making a claim turned out to be fairly low. Then, due to shaky worldwide economic conditions in the early 21st century, LTC insurance carriers were unable to earn strong financial returns by investing their collected premiums. These and other factors caused many insurers to leave the LTC market entirely. Meanwhile, many of the companies that chose to stay in the market had little choice but to raise prices for new and even many existing policyholders. Therefore, if you are in a position to help someone choose a long-term care insurance carrier, you may want to conduct research regarding each carrier's financial stability and history of rate increases.

Suitability and Social Media

We touched on the topic of social media in regard to making necessary disclosures. This relatively new method of online marketing also deserves a mention in our discussion of suitability.

If a producer uses a social networking website in order to attract and communicate with a broad range of followers, any posts that a producer puts out on the social networking site should be written in ways that don't confuse readers into believing that a specific recommendation is being made.

Consider a producer who has 1,000 followers on a social media network and who posts a message to everyone that says, "Call me today to learn how universal life insurance can satisfy all of your estate planning needs." While it is certainly possible that some among the 1,000 followers are, indeed, good candidates for universal life insurance, the producer's post has the potential to mislead the rest of those followers and make them believe that universal life is a one-size-fits-all product.

Concerns about disclosure and suitability are at least partially responsible for the manner in which many of today's major insurance carriers conduct their social media marketing campaigns. Instead of emphasizing the benefits of specific products and using sales-heavy language, most carriers use social media to educate the general public about risk and to engage current and potential policyholders in fun, light-hearted conversations. For example, instead of posting about how everyone should purchase auto insurance from them, carriers might use social media to pass along car maintenance tips to drivers. Instead of pushing followers to make changes to their homeowners insurance, a property insurance carrier might offer advice about what to do before and after a storm so that damage can be minimized and claims can be paid quickly. Independent agencies might have more freedom to get personal on social media, which might involve posting about the local little-league team that the agency has sponsored or providing fun facts about the producers and office personnel who work there. Regardless of the specifics of a social media campaign, the emphasis tends to be on the subtle building of personal relationships rather than on selling.

Since most insurance advertising regulations were written prior to the widespread popularity of social media, the specific requirements for producers who market themselves on social media networks aren't always clear. Even if your state has not specifically addressed acceptable types of conduct on social media, here are some basic tips that can help you maintain a good ethical reputation online:

- When discussing a specific type of insurance, reserve some space for any important disclosures.
- Think before you type. Don't risk making controversial statements as a result of anger or carelessness.
- Plan ahead so that you can discuss any ethical or legal concerns about your campaign with an attorney, compliance officer, supervisor or carrier.
- Treat online communications as seriously as hard-copy communications. If you have a system in place that involves careful proofreading and editing of items sent through the mail, use the same process for anything posted online.
- Keep your social media posts general and educational rather than product-specific.

CHAPTER 5: UNFAIR CLAIMS PRACTICES

Completing an honest application and paying the first premium are only the beginning of the relationship between an insurance company and a new customer. Both parties, in accordance with the policy language, become tied to a contractual agreement, with the policyholder having the contractual obligation to pay premiums and with the insurer having the contractual obligation to cover the losses specified in the policy.

When a policyholder suffers a loss, the insurance company is supposed to follow the terms of the contractual agreement and should not attempt to engage the consumer in a new round of negotiation. In the event that a carrier fails to follow the terms of the policy, the consumer has the right to initiate legal action.

In addition to a lawsuit, the consumer's response to a seemingly inappropriate insurance settlement might include the filing of a complaint with state regulators. If the state's insurance department believes that the insurer's conduct is inappropriate and is part of a pattern of bad behavior, regulators might fine the carrier thousands of dollars for engaging in "unfair claims settlement practices."

Although a specific list of unfair claims settlement practices will differ from state to state, activities that are likely to raise ethical (if not legal) concerns are listed below, along with some hypothetical examples:

- **Denying a claim without conducting an appropriate investigation:** Following a combination of an earthquake and a fire at his home, Joe files a property insurance claim. Joe has coverage for fire losses but not earthquake losses. Instead of sending an adjuster to determine how much each peril contributed to the damage, his insurance company denies his entire claim outright.
- **Failing to settle a claim when the insurer's liability is reasonably clear:** Wayne and Mary are involved in a car accident in separate vehicles. Although Wayne freely admits the accident was his fault, his insurance company delays compensating Mary for her losses and instructs its legal team to find a loophole in the policy so it can deny all claims.
- **Intentionally offering to settle for an amount below what the claimant actually deserves:** Laurie's home was broken into by robbers, who stole most of her personal possessions. She has kept good records of what she owned and was sure to purchase coverage that was in line with what her belongings were actually worth. However, her insurance company views the settlement process as a negotiation and decides to offer her a much smaller amount. (This practice is sometimes referred to as "lowballing.")
- **Withholding money for a covered portion of a claim while disputing the rest of a claim:** Sarah's home was damaged by a hurricane. She and her insurer agree that at least a portion of her losses are covered. Coverage of her other losses are in dispute and depend on the wording of a flood exclusion. Rather than at least give her the money for the uncontested portion of her losses, her insurer decides to give her nothing until the flood-related dispute has been settled.
- **Requiring a deadline for providing proof of loss that isn't stated within the insurance policy:** Ben was listed as a beneficiary on his father's life insurance policy. The policy wasn't discovered until nine months after the father's death. Although the policy lists no deadline for providing proof of a death, the insurance company denies Ben's claim and says he should've provided a death certificate within six months of his father's passing.
- **Refusing to pay a claim because other sources of compensation may be possible:** George slips on a neighbor's steps and hurts his back. His health insurance company refuses to pay his medical bills because it holds the neighbor responsible for the accident. George's insurance policy makes no mention of this kind of situation, yet his insurer tells him he has no choice but to sue his neighbor.
- **Failing to make claimants aware of statutes of limitations:** Roberta has been fighting with her health insurance company over unpaid doctor bills for nearly two years. After those

two years, she will not be allowed to take legal action against the insurer. The insurance company knows her deadline is approaching but doesn't disclose it in a timely manner. The deadline passes, and Roberta is left without the ability to have the matter settled in court.

- **Reducing or eliminating policy benefits in order to facilitate a quicker settlement:** Jean's home requires major repairs after a fire. The amount offered by the insurer won't be enough to restore the home to its prior condition. In order to convince Jean to accept this amount, the insurance company stops paying for the apartment where she and her family are temporarily residing.

Most of us would probably agree that we should abide by the contracts that we sign. Similarly, many of us are probably in agreement that we should attempt to have compassion for others. However, some claims-related disputes can test our belief in these two matters of principle. We may want to honor certain claims as a matter of empathy and fairness yet ultimately conclude that paying those claims would technically be in conflict with the carefully worded coverage forms used by an insurance carrier.

Consider this scenario:

- A husband and wife are both named as "the insured" on a homeowners insurance policy. The policy specifically excludes "intentional acts of damage to the property that are committed by the insured." The husband and wife are in the middle of a messy separation. The wife still lives at the insured home, but the husband has moved into a nearby apartment. One day, the wife arrives home to find the husband vandalizing the garage door with spray paint. The wife contacts her insurance company and expects the damage to be covered by her policy. However, the insurance company says the damage was done intentionally by an insured and refuses to pay.

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Should the insurer be compassionate and pay the claim?
- Should the insurer stick to the language of the policy and deny the claim?
- Should the likely cost of the damage (which might not be large enough to satisfy a deductible) factor into your decision?
- Why do you think the exclusion mentioned in the scenario was included in the policy in the first place? Was it intended to exclude this specific kind of situation, or was it intended mainly as a fraud deterrent? Regardless, should the original reason for the exclusion factor into your decision?

Some insurance agents believe claims are mainly an issue for the insurance carrier and not a major concern for sales professionals. Those agents should keep in mind that even though they might not think of themselves as claims experts, they are the ones who usually have the closest relationship with consumers. Therefore, whether they like it or not, they are often the first ones who the claimant will call if a problem arises.

The impact of producer involvement in the claims process was quantified in a survey conducted in 2012 by J.D. Power and Associates. According to the survey, policyholders who have a negative claims experience are nine times more likely to switch insurance companies. The same survey found that greater involvement from agents translated to greater levels of satisfaction among claimants.

Clearly, claims are a significant influence on the insurance industry's relationship with the public. Since a negative claims experience can jeopardize your standing with a client, you might want to take advantage of any situation in which you can learn more about how claims are managed by a particular carrier. If you know any claims professionals, consider pulling them aside and asking what you can do to make their jobs easier. Then, upon getting an answer, provide feedback to them regarding how claims departments can help sales professionals manage expectations with consumers. The more you know about the process, the more you will be able to educate your clients.

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. The 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 the course completion process, you will be required to affirm that you have read this material from the California Department of Insurance.

CHAPTER 6: 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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