INSURANCE FRAUD AWARENESS TRAINING

NEW AGCS ACT. LEAD. SUCCEED.

NOTICE

This training is for informational purposes only and is not intended to or creates a contract of employment between you and Allianz Global Corporate & Specialty.

Please follow your company guidelines or speak to your manager regarding how to address the topics presented herein.

LEARNING OBJECTIVES

This Insurance Fraud Awareness Training provides an overview of insurance fraud, including how to recognize and refer suspicious activity during the sales and application process.

By the end of the course, learners will be able to:

- Describe insurance fraud, including both claims and underwriting fraud
- Understand the Allianz Anti-Fraud Policy
- Identify insurance fraud red flags
- Describe the Special Investigations Unit ("SIU") and its role in combating fraud
- Know how to report potentially fraudulent activities

OVERVIEW

- Insurance fraud refers to the commission of any act with the intent to obtain an outcome that is favorable, but fraudulent during an insurance claim.
- Insurance fraud may entail a person filing a false insurance claim altogether, or exaggerating their damages, injuries, or other losses in order to receive benefits.
- Fraud may be committed by multiple parties including: policyholders, claimants, brokers, or vendors.

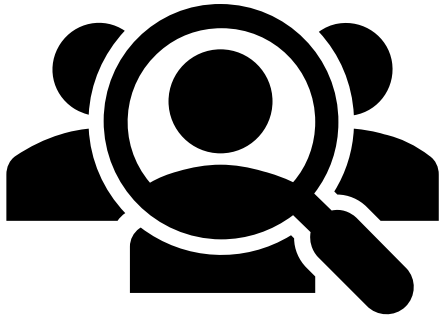
OVERVIEW

- According to the Maryland Insurance Administration*, a variety of different methods can be used to commit insurance fraud, including:
  - Providing false information
  - Overstating a claim
  - Completing false documents such as policies or certificates
  - Pocketing a premium
  - Selling unauthorized insurance
- Commission of insurance fraud leads to high costs for everyone. The Coalition Against Insurance Fraud estimates that fraud steals $80 billion a year across all lines of business.

*Maryland Insurance Administration, Insurance Fraud for the Consumer, Insurance Fraud for the Consumer (maryland.gov)

WHY INDIVIDUALS COMMIT FRAUD

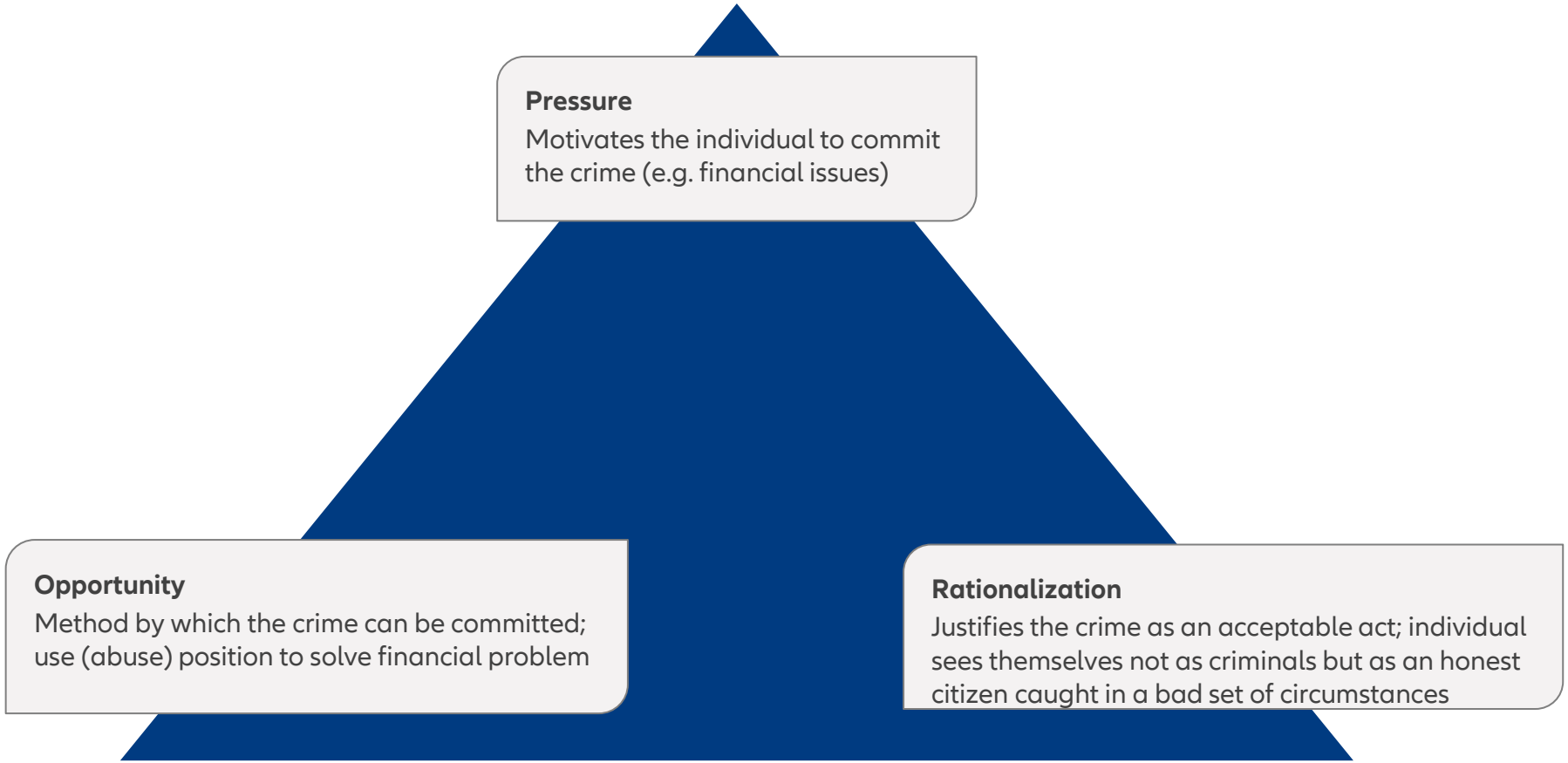
- The primary reason individuals commit insurance fraud is to obtain financial gain.
- Individuals who maintain an insurance policy year-over-year come to believe that since they have paid insurance premiums for so long, they deserve to be compensated in the form of an insurance claim.
- Even individuals with legitimate claims may engage in fraudulent behavior and will try to increase the amount of compensation owed by claiming more severe injuries or greater losses than what actually occurred.



WHY INDIVIDUALS COMMIT FRAUD

The reason individuals commit fraud may be explained using the following behavioral model (Fraud Triangle).

Under this theory, there are three (3) factors that must be present at the same time in order for an ordinary person to commit fraud.



TYPES OF INSURANCE FRAUD

- There are many types of insurance fraud, but the judicial system often categorizes them as either hard or soft fraud.

- Both hard and soft fraud can lead to significant harm and must be reported immediately.

TYPES OF INSURANCE FRAUD

Hard Fraud

- Hard fraud occurs when someone deliberately fakes an accident, injury, theft, arson or other loss to collect money illegally from insurance companies.
- Hard fraud cases typically lead to felony charges.
- Example of hard fraud:
  - An individual has been unemployed for several months when their car breaks down. Desperate for money to fix the car, the individual stages a robbery at their home. The individual then files a police report claiming several expensive items were stolen.

TYPES OF INSURANCE FRAUD

Soft Fraud

- Soft fraud occurs when normally honest people tell “little white lies” to their insurance company.
- Many individuals think its just “harmless fudging.”
- Example of soft fraud:
  - An individual experiences appliance damage due to a small kitchen fire. When the individual files an insurance claim, they report the cost to replace the appliance as much higher than the cost of the original purchase. Although the claim is legitimate, the attempt to receive a larger amount in damages is considered soft fraud.

INSURANCE FRAUD TRENDS

- Industry studies report the following trends around insurance fraud:
  - Fraud comprises about ten percent (10%) of property-casualty insurance losses and loss adjustment expenses each year.
  - Twenty-four percent (24%) of U.S. consumers believe it is acceptable to pad an insurance claim to make up for the deductible.
  - Ten percent (10%) of Americans believe insurance fraud does not hurt anyone.
  - Sixty-eight percent (68%) of consumers believe insurance fraud occurs because people believe they can get away with it.
  - Seventy-six percent (76%) of individuals are more likely to commit insurance fraud during an economic downturn than during normal times.

STATE FRAUD LAWS & REGULATIONS

- According to the National Association of Insurance Commissioners ("NAIC"),* "[i]nsurance fraud for at least some lines of insurance is a crime in every state and the District of Columbia. Thirty states make insurer fraud a specific insurance crime. To address specific issues involving criminal activity, 42 states, plus the District of Columbia, have insurance fraud bureaus that investigate claims of illegal insurance activities."

- In Maryland, the Maryland Insurance Administration ("MIA")^ "...is an independent state agency that regulates Maryland's insurance marketplace and protects consumers...." "The [MIA] also is responsible for investigating and resolving complaints and questions concerning insurers that conduct business in Maryland."

  - Consumers may report insurance fraud to the MIA's Fraud Division.

*National Association of Insurance Commissioners, Insurance Fraud, Insurance Fraud (naic.org)
^A Consumer Guide to Insurance Fraud, Maryland Insurance Administration, consumerguidetoinsurancefraud.pdf (maryland.gov)

INSURANCE FRAUD PENALTIES

- Penalties for committing insurance fraud will vary depending on several factors including the extent of the fraud and type of fraud.
- Penalties may include:
  - Criminal penalties (fines and jail time)
  - Civil penalties
  - Other remedies as may be rendered (e.g. restitution)

CONSEQUENCES OF INSURANCE FRAUD

- According to the Maryland Insurance Administration,* insurance fraud has additional consequences aside from criminal and civil penalties.
  - Insurance fraud leads to higher premiums for policyholders.
  - Businesses that are forced to pay higher premiums may transfer these amounts to customers by increasing prices.
  - Customers, in turn, may look elsewhere rather than paying the increased cost which can cause demand for the goods and services to fall, leading to potential job losses.

*A Consumer Guide to Insurance Fraud, Maryland Insurance Administration, consumerguidetoinsurancefraud.pdf (maryland.gov)

COSTS OF INSURANCE FRAUD

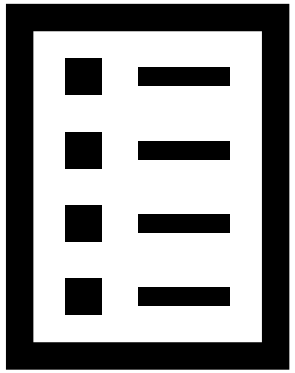
- An example of the substantial losses caused by insurance fraud is exhibited by the aftermath from Hurricane Katrina.

- According to the FBI,* "[a]pproximately 1.6 million insurance claims were filed, totaling $34.4 billion in insured losses. Of the $80 billion in government funding appropriated for reconstruction, it is estimated that Insurance Fraud may have accounted for as much as **$6 billion**."

*Federal Bureau of Investigation, Reports and Publications, Insurance Fraud, Insurance Fraud — FBI

ALLIANZ ANTI-FRAUD REQUIREMENTS

- Allianz Global Corporate & Specialty (“AGCS”), in accordance with the Allianz Anti-Fraud Policy, maintains zero tolerance for fraud and corruption.
- To support this objective, a global anti-fraud program is maintained.
- Each employee is responsible for maintaining vigilance toward preventing and detecting fraud and mitigating fraud risks.



RECOGNITION OF INSURANCE FRAUD

- It is important to detect fraud indicators as early as possible in order to most effectively mitigate any harmful effects.

- Key elements in fraud recognition include:

  - Easy Targets
    - ❑ Certain companies and/or professionals are known by offenders to be less likely to question their claims.

  - Small & Routine
    - ❑ Fraud is typically more common in smaller, routine matters.

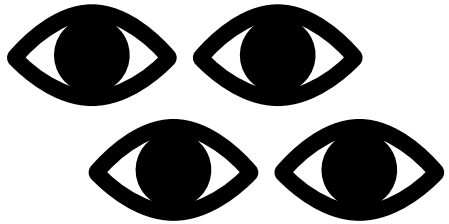
  - Early Recognition
    - ❑ Critical to a strong, fundamental claim handling process.

  - Deterrence
    - ❑ Starts with claims and underwriting professionals and is further supported by internal and external investigative agencies.

RECOGNITION OF INSURANCE FRAUD

- To help prevent or detect internal fraud, AGCS utilizes the four-eyes-principle.

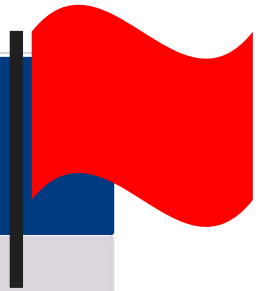
- There are several forms to establish a four-eyes-principle, such as:
  - Review/sign-off by a second person, e.g. referrals
  - Segregation of duties
  - Approval and/or authorization
  - Performance of reconciliations
  - Management review
  - Committees



CLAIMS RED FLAGS

- General fraud indicators (red flags), as well as those associated with certain claims lines, include:
  - General (applicable to all business areas)
  - Workers' Compensation
  - General Liability
  - Auto
  - Medical
  - Property
  - Property - Fire

CLAIMS RED FLAGS

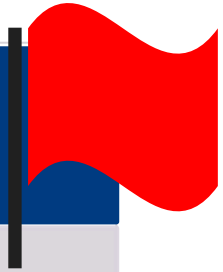


General Claims Fraud Indicators (for all business areas)

- History of prior claims
- Aggressive customers or claimants
- Rapid escalation of demands
- Early representation by counsel
- Poor or illegible policy or claims documentation
- Limited address or contact information
- Refusal to discuss or provide details
- Losses occurring close to policy inception dates

CLAIMS RED FLAGS

Claims Fraud Indicators for Workers' Compensation



- Accident not reported to supervisor
- Canceled medical appointments
- No witnesses to corroborate facts associated with the incident
- Uncooperative employee who will not provide details
- Pending termination or layoff

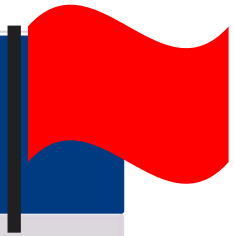
CLAIMS RED FLAGS

Claims Fraud Indicators for General Liability

- History of prior claims
- Lack of evidence to support a claim
- Overly cooperative or knowledgeable witnesses
- No witnesses to confirm details of injury could point to a “faked” injury
- Inconceivable explanation of the injury

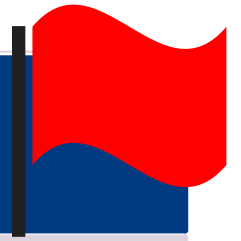
CLAIMS RED FLAGS

Claims Fraud Indicators for Auto



- Serious injuries claimed after a minor accident
- Multiple claimants alleging injury with immediate legal representation
- Multiple vehicles repaired at the same body shop
- No documentation of the accident by law enforcement
- Immediate attorney representation
- Rental vehicle involved in an accident

CLAIMS RED FLAGS



Claims Fraud Indicators for Medical

- Identical medical treatment for each claimant
- All claimants treated by the same medical provider
- Obtaining treatment on Saturdays or Sundays which is not usual
- Low impact accidents with soft tissue injuries requiring excessive treatment
- Method claimant used to find a doctor

CLAIMS RED FLAGS

Claims Fraud Indicators for Property

- Excessive history of prior claims
- Loss occurs immediately after policy inception, policy limit increase, or policy expiration
- Recent separation or divorce may provide a motive
- Large cash losses can be an inflation of the loss
- Numerous appraised items or scheduled property
- Loss inventory by claimant which differs from police report
- Vacant premises at time of property loss

CLAIMS RED FLAGS

Claims Fraud Indicators for Burglary / Theft

- Losses are questionable (e.g. fur coat stolen on trip to Hawaii)
- Losses include numerous appraised items and/or items of scheduled property
- Losses include numerous family heirlooms
- Losses include total contents of business/home, including items of little to no value

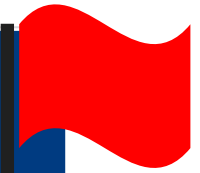
CLAIMS RED FLAGS

Claims Fraud Indicators for Property – Fire – Arson for Profit or Fire-Related Fraud

- Building and/or business was recently purchased
- Building and/or contents were up for sale at time of loss
- Business or insured is experiencing financial difficulties
- Fire site is claimed by multiple mortgages
- A smaller loss occurred at the same site within the preceding year
- Suspicious absence of family pet at time of fire

CLAIMS RED FLAGS

Claims Fraud Indicators for Property – Fire – Fire Loss/Incident



- Commercial fire occurs on holiday / weekend or when business is closed
- Fire alarm and/or sprinkler failed to work
- Fire department reports the fire cause is suspicious or unknown
- Fire occurs late at night

CLAIMS RED FLAGS

Claims Fraud Indicators for Property – Fire – Fire Scene

- Burned building is in deteriorating condition
- Absence of items of sentimental value
- Absence of remains of expensive items used to justify an increase over normal 50% contents coverage
- Absence of remains of non-combustible items of scheduled property
- Property / contents were heavily over-insured

UNDERWRITING FRAUD

- Underwriting fraud occurs where an insurance application or supporting documentation contains a material misrepresentation or omission of facts bearing on the extent of the risk for which coverage is sought.

- If not caught, underwriters may rely upon the misrepresentation and issue coverage or certain terms that otherwise would not have been issued had the true facts been known.

- Premium fraud is related to underwriting fraud and occurs when an insured and/or broker misrepresents facts related to the “exposure” upon which the underwriter has quoted and/or adjusted the premium in order to obtain a lower premium.

UNDERWRITING FRAUD

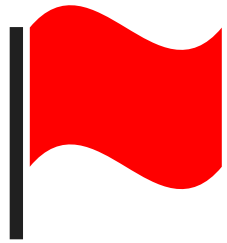
- AGCS maintains a Standard on Anti-Fraud which outlines the company's zero tolerance of fraud.
- The AGCS Standard on Anti-Fraud establishes requirements related to reduction of underwriting fraud.
- At AGCS, underwriting fraud is typically reviewed by the AGCS Global Underwriting External Fraud manager.
- Suspected incidents of underwriting fraud may be reported via the Ethics Helpline at 1-888-788-0023.

PREMIUM DIVERSION

- The most common type of insurance fraud is premium diversion which occurs when an individual embezzles insurance premiums.*
- Premium diversion typically occurs when the insurance agent keeps the premium payments made by the insured instead of sending them to the underwriter.
- The insured is completely unaware that the payments are not going to the underwriter.
- In most instances, the insured only realizes their payments were never received by the underwriter when they go to file a claim and they find out they do not have any coverage as the policy was canceled for lack of payment.

*FindLaw, What Is Premium Diversion? - FindLaw

UNDERWRITING FRAUD RED FLAGS



- Common fraud indicators for underwriting fraud are broken down into the following categories:
  - General
  - Misstatement
  - Premium

UNDERWRITING FRAUD RED FLAGS

General

- Lack of a full description of operations on the application
- No supplemental application received where required
- Application shows a lapse in coverage over the past several years
- Number and size of all losses on the application are small compared to size and complexity of the risk to be insured
- Information from Dun and Bradstreet shows differing operations and locations compared to what is provided on the application

UNDERWRITING FRAUD RED FLAGS

Misstatement

- Name of previous carrier or proof of prior coverage cannot be provided
- Questions about prior claims left unanswered
- Insured is uncooperative, missing records, or has suspect records
- Applicant suggests price is no object
- Applicant seeking new business coverage but has not been in this or any type of business in the past
- Insured represents employees as independent contractors to exclude them for premium purposes
- Applicant is reluctant to use mail or electronic communication; only meets in person

UNDERWRITING FRAUD RED FLAGS

Premium

- Application prior history section shows much larger premium paid for the previous year's policies than is being quoted for the new prospect risk
- Application showing that vehicles are stored in a rural community as opposed to a high density urban community location where insured's business is located
- Application for liability insurance understates the sales exposure for products manufactured and sold by insured differ from public records or insured website
- Insured mispresents the amount of its current payroll or misclassifies its payroll and/or job functions based on information on Experience Rating documents
- Number of drivers are understated relative to number of vehicles
- Insured repeatedly delays, reschedules, and/or attempts to avoid the premium audit

CHECKS AND BALANCES

- AGCS maintains several methods to help underwriters catch a potential red flag resulting from fraudulent information, including:
  - Dun and Bradstreet
  - Inspection Reports
  - Premium Audit Reports
  - Motor Vehicle Reports
  - Claims Handlers Reports
  - Internet Searches

TECHNOLOGY AND INSURANCE FRAUD

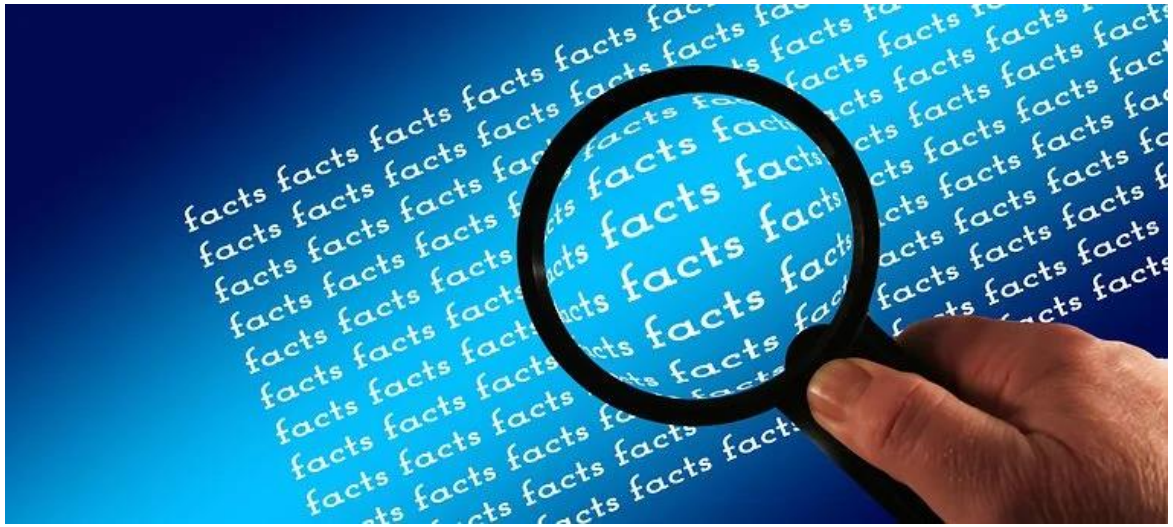
- According to a white paper from the Coalition Against Insurance Fraud entitled *The State of Insurance Fraud Technology*, anti-fraud technology is increasingly playing a bigger role in the fight against insurance fraud.*
  - "Detecting claims fraud continues to be the reason most anti-fraud technology is deployed."
  - "Insurers rely much less on traditional technologies such as business rules and red flags, and more on predictive modeling, link analysis, and exception reporting."
  - "41% say their tech budgets for 2019 will be larger, signaling even greater expansion for the future. Predictive modeling and link analysis/social network analysis are the two top areas where new money will be spent."

**The State of Insurance Fraud Technology*, Coalition Against Insurance Fraud, coalition-against-insurance-fraud-the-state-of-insurance-fraud-technology-105976.pdf (sas.com)

SPECIAL INVESTIGATIONS UNIT

- AGCS created the Special Investigations Unit ("SIU") to prevent and deter insurance fraud through education and inter-department cooperation, and to aggressively defend against, pursue, and prosecute those who defraud the company.

- Key functions include:
  - Investigation of Suspicious Claims
  - Awareness & Detection of Insurance Fraud
  - Claim Fraud Analytics
  - State SIU Annual Reporting



SPECIAL INVESTIGATIONS UNIT

- Investigation of Suspicious Claims
  - Conduct investigations into alleged fraudulent claims
  - Identify and report substantiated frauds both internally and to governmental entities
  - Identification of fraud trends to provide potential fraud deterrence

- Awareness and Detection of Fraud
  - Training in fraud identification
  - Updates regarding industry fraud trends and initiatives, fraud fighting tools, and results

SPECIAL INVESTIGATIONS UNIT

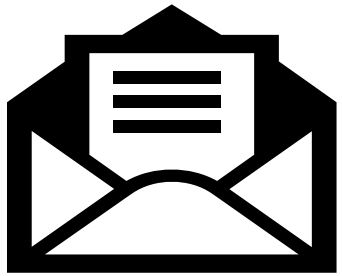
- Claim Fraud Analytics
  - Use data analytic tools to identify fraudulent claims
  - Field investigations, data mining and on-line investigations are conducted

- State SIU Annual Reporting
  - Annual reporting on external fraud programs
  - Collaborate with other departments

SPECIAL INVESTIGATIONS UNIT

- If you suspect claims fraud has been committed by third parties such as policyholders, claimants, brokers, or vendors, you must report it immediately

- Options to report potential insurance fraud include:
  - Email SIUReferral@agcs.allianz.com to refer a claim to the SIU
  - Call the Fraud Hotline at 1-800-317-8781; callers may remain anonymous
  - Call the Ethics Hotline at 1-888-788-0023; reports are confidential and can be anonymous



CASE STUDIES

Case Study #1

From the Michigan Department of Attorney General*

- An individual was charged with crimes relating to the sale of counterfeit insurance documents.
- It was alleged that the individual sold car insurance policies that appeared to be through an insurance company.
- The insurance company, however, determined the documents were fraudulent.

*AG - Guilty Plea Obtained in Detroit Insurance Fraud Case (michigan.gov)

CASE STUDIES

Case Study #1

- In addition, it was revealed that the individual was not licensed by the State of Michigan to sell insurance.

- The individual pled guilty to one count of using a computer to commit a crime which is a seven-year felony and one count of insurance fraudulent acts which is a four-year felony.

CASE STUDIES

Case Study #2

From the United States Department of Justice, Office of Public Affairs*

- A Maryland couple was charged with conspiracy to commit insurance fraud, as well as related charges, including money laundering and identity theft.

- The couple is accused of allegedly conspiring to defraud insurance companies by obtaining over 30 life insurance policies for applicants by misrepresenting their health, wealth, and existing life insurance coverage.

- The total death benefits from these policies was approximately $20 million.

*Maryland Couple Indicted in $20 Million Insurance Fraud Scheme | OPA | Department of Justice

CASE STUDIES

Case Study #2

- The couple is also charged with defrauding investors to obtain funds that the couple then used to pay premiums on policies.

- In addition, the couple allegedly did not report approximately $5.7 million and $2 million they received in life insurance proceeds on their tax returns.

- If convicted, the couple faces a maximum penalty of 20 years in prison for each count of conspiracy, wire fraud, mail fraud, and money laundering and three years in prison for each count of filing a false tax return.

CASE STUDIES

Case Study #3

From the Illinois Attorney General*

- An Illinois former customer claims representative pleaded guilty to submitting approximately 43 fraudulent insurance claims and stealing more than $180,000 dollars.
- Additionally, 12 individuals associated with the claims representative were also charged as part of the scheme.
- The former employee was charged with being the organizer of aggravated insurance fraud, one count of aggravated insurance fraud, one count of theft, three counts of insurance fraud, one count of conspiracy to commit aggravated insurance fraud, and one count of mail fraud.
- The individual pled guilty to aggravated insurance fraud and theft and was sentenced to four years in prison.

*Illinois Attorney General - ATTORNEY GENERAL RAOUL: CUSTOMER CLAIMS REPRESENTATIVE PLEADS GUILTY IN INSURANCE FRAUD CASE (state.il.us)

CASE STUDIES

Case Study #3

- According to the Illinois Attorney General's office, as a senior customer claims representative at an insurance company, the individual would either add a claimant, such as a friend or family member, to a claim that had already been closed or create a new claim against an insured.

- The individual would then split the proceeds with her family and friends who participated in the scheme once they received the insurance checks.

- The scheme was uncovered during an audit that was opened after a customer filed a police report indicating she was notified of a pending accident claim in her insurance file which she was not aware.

CASE STUDIES

Case Study #4

From the United States Attorney's Office Eastern District of Texas*

- A Houston man pled guilty to interstate transportation of money by fraud.
- According to information presented in court, the individual submitted an insurance claim related to water damage to his house he said was caused by a defective water heater.
- As part of the claim, the individual submitted fraudulent documentation for out-of-pocket expenses incurred for the replacement of personal property that was destroyed by the leak.

*Houston Man Pleads Guilty to Federal Charges Stemming From Insurance Fraud Scheme | USAO-EDTX | Department of Justice

CASE STUDIES

Case Study #4

- Due to the fraudulent claims, the insurance company issued a series of checks, including one for more than $136,000.
- As part of the plea, the individual must repay the $136,000 to the insurance company.
- Under federal law, the individual faces up to 10 years in prison.

CASE STUDIES

Case Study #5

From the Kansas Attorney General*

- An individual was convicted of insurance fraud and related charges stemming from numerous crimes committed while working as an insurance agent.

- The individual was accused of:
  - Filing fraudulent and false insurance claims against her customer's insurance policies and keeping the payments.
  - Receiving insurance premium payments from customers and keeping the money while never obtaining an insurance policy for the customer.
  - Forging signatures to obtain loans in her customers' names and then using the loan proceeds to pay their insurance premiums.

- The individual was ordered to pay a $3,000 fine and serve 36 months probation.

*Smith Center woman convicted of insurance fraud, related charges (ks.gov)

CASE STUDIES

Case Study #6

From the Iowa Insurance Division*

- The Iowa Insurance Division's Fraud Bureau conducted an investigation on an individual who provided false information to an insurer after a single-car accident where he was the driver.
- The man made false representations regarding the nature of the loss by claiming his vehicle was stolen to obtain the benefits of the insurance policy.
- The individual pled guilty to one count of Presenting False Information (a class "D" Felony) and received a five year prison sentence.

*Waterloo Man Pleads Guilty to Insurance Fraud (iid.iowa.gov)

ADDITIONAL RESOURCES

Additional resources on insurance fraud include:

- Fraud Bureaus – maintained by states to investigate insurance fraud
- Coalition Against Insurance Fraud – www.insurancefraud.org – organization formed to prevent fraud, includes research and information on how to report fraud
- National Association of Insurance Commissioners – www.naic.org – provides expertise and analysis to help set standards and regulate the insurance industry