

Fraud in the Insurance Field

INSURANCE TRAINING
INSTITUTE, Inc.

ITI – A Family Owned Business
Providing Continuing Education
To New York Insurance Professionals
Since 1996

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Insurance Training Institute

FRAUD IN THE INSURANCE FIELD

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The Insurance Training Institute (ITI) is licensed by the NYS Insurance Department to provide Continuing Education Courses throughout New York State. Our students can be assured that the courses offered by ITI meet the requirements of the New York State Insurance Law and the guidelines established by the NYS Insurance Department. Our Courses also meet the reciprocity requirements of most other states for your Non-Resident Licenses.

ITI provides its students with a broad range of up-to-date courses to meet their individual professional education needs. ITI is firmly committed to the belief that a classroom setting, with instructors who are among the best trained and qualified insurance professionals in our industry today, provides individual students with the greatest opportunity to learn. A consistent schedule of statewide public classes is our promise to you. As a convenience to larger agencies and groups, private classes are also conducted by special arrangement.

While ITI's primary goal is to meet your individual training needs, we are a family owned business with a strong focus on improving the level of professionalism and the public image of the insurance industry as a whole. Each of our instructors brings with them their individual industry experiences for the benefit of their students. With more than 37 years of experience in the industry, I personally offer my experiences as a licensee and then an employee of the Executive Branch of the NYS Insurance Department, (assigned to the Licensing Bureau) for each student to call upon. Since opening in 1996, ITI has supported thousands of individuals and agencies with their licensing questions and problems. Today, ITI continues to provide the same level of individualized support that our students have come to rely on.

I, along with the dedicated staff at ITI look forward to the opportunity to once again be your provider of quality continuing education services in New York.

Thank you for your time and consideration:

Robert Secovnie, Director
Insurance Training Institute, Inc. (ITI)
A family owned and operated business

Pre-Licensing & Continuing Education for Life/Health Insurance Agents Continuing Education for P&C Agents, Brokers & Adjusters SBLI Certificates

INTRODUCTION

Why should Agents and Brokers learn about Insurance Fraud?

In your career as an insurance professional, you will come into contact with a client that is trying to defraud an insurance company. Insurance fraud costs Americans at least \$80 billion a year, or nearly \$950 for each family, according to the Coalition Against Insurance Fraud. Property/casualty insurance fraud cost insurers an estimated \$30 billion in both 2004 and 2005, according to the Insurance Information Institute as of January 2007.

Agents and Brokers have to be alert to the reasons, extent, and effect that fraud causes. They also need to become aware of how the war against this crime is being waged. It is the purpose of this course to do just that.

Fraud has been seen to occur at many different stages in the process of an insurance transaction. It can occur in the application process, when an individual is a policyholder, as well as by third-party participants. Professionals that provide services to claimants, also sometimes get into the fraud act. Some common frauds include misrepresenting information on the insurance application, inflating actual claims, staging accidents and claiming serious injury when only minor injury occurred.

By the late 1960's, fraud claims were soaring in the insurance field at a rate of about two billion dollars a year. With organized crime involved in automobile body shops, as well as dishonest doctors and lawyers getting extra fees from illegitimate claims, something had to be done.

One result of the rise of fraud claims was the loss of profit to insurance companies. Companies then were forced to raise rates to cover their losses. Once again, the consumer took a hit. As part of this cycle, it became fashionable for many policyholders to pad their claims, in an attempt to get more money from the insurance companies.

In the 1970's and 1980's many insurance companies and state governments knew help was needed in the insurance industry. Investigating fraudulent claims was difficult and time consuming. Individual efforts to solve the problem had not succeeded. Insurance fraud had become big business and organized effort would be the only choice to fight such crime.

With the rising price of insurance, it was the mid-80's that saw many insurers reexamining the issue. Stronger anti-fraud legislation and tougher enforcement began its rise at this time in many states. Consumers, who were being forced to pay higher premiums or fell victim to organized fraud groups, began to voice support. In addition, so were groups such as doctors and lawyers supportive, as unscrupulous members in those groups were tainting the reputations of those

professional fields.

Investigating suspicious claims is not a simple matter. Law enforcement agencies need special training to investigate and prosecute cases of insurance fraud. In addition, obviously it must be a concerted effort from many fronts to be successful. It is a war with many battles. It is also a delicate situation, as there is a fine line between investigating questionable claims and harassing legitimate insureds. The industry does not want to be labeled anti-consumer. Further, insurance companies are continually made aware of the fact that time factors are involved. In order to follow the fair claim practices set in many states, they need to decide on a claim in a timely fashion. This can occasionally put a strange hold on investigating suspicious claims.

Sometimes insurance companies also find it a problem with cost effectiveness. It is sometimes cheaper to pay a claim than investigate it. With that mentality, enforcement can become even more difficult. This may also encourage this type of crime to be repeated over and over.

Successful fraud prosecutions block certain fraud activities from continuing, plus they help in the publicity of fraud cases. This hopefully deters others from trying the same tactic. But once again, in order to be successful, an organized effort is necessary. If one state does a good job in fighting fraud, it might just force criminals into another state. Federal statutes are needed, as well as cooperation and communication between states.

We will investigate the extent of the problem, examine the processes to combat it and hopefully convince everyone that they too can be a part of the eradication of this serious problem.

Chapter 1

Defining Insurance Fraud

Section A What is it?

Insurance fraud occurs when people deceive an insurance company or agent to collect money to which they aren't entitled. Insurance fraud is not only being committed in the claims arena, but it is also prevalent in the process of obtaining and retaining policies.

In recent years, some states have enacted laws to make insurance fraud a felony. It is hoped that raising the level of this crime from a misdemeanor to a felony will provide the necessary deterrent to help combat the problem.

The unfortunate thing about insurance fraud is that it is paid for by the honest, law-abiding citizens, not only in higher premiums, but also in any increase in the price of goods bought by them. This higher cost comes as a result of corporations passing along their higher insurance premiums onto the consumers when they buy their products.

Section B The Scope of Insurance Fraud

Even though the insurance industry and other State and Federal Bureaus have been studying the fraud problem vigilantly for decades, no one really knows how to measure the exact extent of this epidemic. This white-collar crime is so widespread that it ranks a close second only to tax evasion. From 1987 to present time, fraudulent claims have doubled from 15 billion to 30 billion.

Section C The Extent of Insurance Fraud

Approximately 30% of all property claims are estimated to be fraudulent. Workers' Compensation claims are second at 25% and Auto claims are estimated to be fraudulent at a 20% rate. Many experts on the problem cite a weak economy for the rapid increase in this crime, as people who need money become desperate and feel bilking money from an insurance company is an easy fix to their problems. They try to justify it by considering how much they and their friends have paid into the system.

Insurance fraud is seen in other areas besides property claims, workers' compensation claims and auto claims. Fraudulent claims have also increased over 100% in the healthcare area since 1985.

Some medical providers and legal providers have aided in defrauding insurance companies by billing for treatment never performed or by fabricating personal injury claims.

Section D Public Opinion

One of the biggest problems in the fraud scenario is that the general public has consistently turned a blind eye and a deaf ear to those committing fraud. They rationalize that the supposed rich insurance companies can afford the losses. It is often not viewed as stealing or larceny. The same public would not usually hesitate to turn in a criminal who was in the process of robbing their neighbor's house. But would they hesitate to turn in a neighbor they knew padded their insurance claim? Research reveals that many individuals feel insurance companies overcharge, so they falsely believe securing a lower premium by giving false statements is not a big deal.

Most people would not condone an act of arson. However, these same people will usually turn a blind eye to their friend who has claimed "whiplash" or even to padding their homeowners claim to make up the deductible. Some believe that it is okay to lie on their application to reduce their premium. Or it may seem okay that their youthful operators suddenly "vanish" from their households. Others conveniently forget or fabricate the description of how their accident occurred so that the premiums don't go up. It has also become common practice for individuals to include old damage or missing parts when putting in claims for new damage from an auto accident.

Some go as far as staying home longer than necessary from their jobs (sometimes on the advice of their attorney) in order to get a higher settlement. Workers' Compensation adjusters are trained to look harder at "Monday Accidents" as many are really for injuries that happened at home on the weekend. All these and more are justified by people who believe that their dishonesty is a result of insurance carriers overcharging them. They somehow have come to believe that insurance companies make huge profits and have oodles of money just sitting around anyway.

A new reason for the emergence of more insurance fraud in the past 10 years is even scarier. The fact that so many other people do it gives them comfort in trying to get "their fair share." They push from their minds that it is a crime, even though the forms they receive from the company have statements on them saying, "Insurance Fraud is a Crime!"

There are even some agents who will "help" the insured report a loss to make sure that the policy will respond with payment for their client.

Section E The Effects of Insurance Fraud

Effects on the Company

As fraudulent claims rise, so does the company's costs. Just like other businesses, Insurance Companies have spent their money to combat this larceny. In the past 10 years, many companies have set up Special Investigative Units (SIU's) in their departments, whose role it is to train adjusters to deal with routine cases and to investigate and pursue fraudulent claims. These units cost the company additional money in their operating budgets and ultimately cost the consumer higher premiums.

Adjusters who face the problem on a daily basis often develop attitudes that the public as a whole is dishonest. They may tend to treat all customers and providers as adversaries and with suspicion, which only adds fuel to the fire, as consumers retaliate with negative attitudes toward the insurance carrier.

Effects on the Policyholder

The policyholder suffers by having to pay higher premiums. They also may have more exclusions in their policies, or carry limits on certain types of property.

Then Effects on Agents

Agents and Brokers can suffer from a loss of business, as people decide to reduce their coverage, or instead self-insure their exposure, because they can't afford the increased premium.

The Public is Affected

The public suffers in general as the cost of higher insurance premiums is passed on to them in higher costs of goods and services they purchase.

Individuals can also become victims, as arson sometimes will consequently kill innocent people. Insurance fraud is not always a "victimless" crime!

Section F Fighting Fraud

State and Federal Governments

The Health Insurance Portability & Accounting Act (1996) contains provisions aimed at combating fraud in the health care industry. Its primary thrust is to root out fraud in Federal Programs (such as Medicare). It is now a Federal crime to "knowingly and willfully" defraud any health care benefit program.

Interstate insurance fraud was addressed in the Violent Crime Control and Law Enforcement Act of 1994, by making it a felony.

States are now passing laws specifically defining the crime of insurance fraud. Other laws are being passed to make it a felony rather than a misdemeanor. Fraud agencies are being established on a state basis to identify and collect information on these crimes. Six states have auto inspection laws that help prevent “phantom” or damaged cars being added to policies.

Insurance Companies Fight Fraud

As stated previously, many companies now have “Specialized Investigative Units” (SIU’s) whose only function is to combat insurance fraud through the training of adjusters and providing extensive investigations into possible fraudulent claims.

Underwriters are taught how to study applications for potential fraud. The companies have a tough job in the investigation of these claims. They must tread carefully because of the “Unfair Claims Practices” legislation (Regulation 64 in N.Y.) or the threat of being sued for Bad Faith Claims handling. The SIU’s help in these areas as they conduct their investigation while the adjuster is handling the routine aspects of the claim itself.

How the Media and Internet Play a Role

Over the last few years, there has been a marked increase in television shows that contain investigative reporting, such as “60 Minutes” and “Dateline.” These shows have featured “sting” operations on doctors and others. There was even a show on a con artist who made a living on “slips and falls.” All of these help to raise the public’s awareness of these actions as crimes cost them money. A little education can go a long way to help prevent others from trying the same schemes.

To help combat Auto Fraud, The National Insurance Crime Bureau members have access to RICB, Online services that link over 6,000 insurance and law enforcement personnel with data on P&C Claims. Investigators use these to obtain leads on suspects. There is also AISG’s new All-Claims database that combines the Index System on BI Claims with the Property Insurance Loss Register (PILR).

Other Bureaus / Organizations

As mentioned, many states now have Insurance Fraud Bureaus. There are also Coalitions that have been formed to combat the problem. Along with these, there are also reporting bureaus that identify prior claimants and claims. Fraud is extensive and all of these groups and sources are needed to fight the battle.

Frequently Asked Questions About Fraud Prevention Plans And Special Investigations Units

- What Insurers Need to Know

Section 409 of the New York Insurance Law and the [Second Amendment to Regulation 95](#) require insurers to file with the Insurance Department a plan for the detection, investigation and prevention of insurance fraud. The Fraud Prevention Plan must include provisions for establishing a Special Investigations Unit (SIU), apart from any underwriting or claims units, to perform these functions. The following questions and answers are in bulleted form. These may be useful to insurers in implementing this mandate.

- **The Insurance Law permits insurers to use the services of an outside contractor to perform the functions of an SIU. What requirements must an insurer fulfill when using an outside contractor?**
 - An insurer that uses an outside contractor to perform SIU functions must include with its Fraud Prevention Plan a copy of the agreement between the insurer and the contractor. The agreement must include a statement that the contractor will cooperate with the Insurance Frauds Bureau. However, the law is clear that the insurer remains primarily responsible for the development and implementation of its Fraud Prevention Plan.
- **What is meant by an open budget line for an SIU?**
 - Each SIU should be established as a separate unit with its own budget line. The Department will review the source of each SIU's funding.
- **What details is an insurer required to provide regarding the staffing of a Special Investigations Unit?**
 - The Plan must include the name, title, job description and geographical location of each investigator in the SIU, in addition to the territory to which the investigator is assigned. This information must be updated annually and submitted as part of the annual report that insurers must file with the Department.
- **Is there a requirement for an SIU to include a minimum number of investigators?**
 - No. Each company has broad latitude in deciding how much of its resources will be dedicated to fraud prevention. However, companies must justify the adequacy of these resources.
- **SIU investigators hired after September 10, 1996 must be qualified by specific education and/or experience as outlined in the [Second Amendment to Regulation 95](#). One of these qualifications is a bachelor's degree in criminal justice or a related field. What are some related fields?**
 - Related fields include police science, forensic science, government/public administration, security management and pre-law. Other fields will be considered if they meet certain requirements.
- **What is meant by the vulnerability of an insurer?**
 - Vulnerability means the risk of potential loss from fraud, which varies from company to company. It is an important factor for insurers to consider when preparing a Fraud Prevention Plan. For example, strict underwriting guidelines coupled with thorough investigations of all policy applicants will decrease vulnerability.

- **Besides establishing an SIU, what other provisions must be included in Fraud Prevention Plans?**
 - Fraud Prevention Plans must also include provisions for in-service training programs for investigative, underwriting and claims staff in identifying and evaluating suspected insurance fraud; development of public awareness programs; and development of a Fraud Detection and Procedures Manual
- **Is an insurer required to provide the Department with a copy of its Fraud Detection and Procedures Manual?**
 - The Department has requested that Fraud Detection and Procedures Manuals be submitted with insurers' Fraud Prevention Plans.
- **Are an insurer's Fraud Prevention Plan or Fraud Detection and Procedures Manual subject to New York State's Freedom of Information Act?**
 - No. Section 409(e) of the New York Insurance Law states that "Any plan and the information contained therein is deemed to be a confidential communication and shall not be open for review or be subject to a subpoena except by court order or by request from any law enforcement agency or authority."
- **Section 409 of the Insurance Law and Regulation 95 require insurers to submit an annual report to the Department. When is the report due?**
 - An annual report must be submitted to the Department on January 15 each year beginning in the year 2000.
- **What information must the annual report contain?**
 - Insurers must report their experience, performance and cost effectiveness in implementing their Fraud Prevention Plans. This information will be analyzed and the results compared among all insurers. Following this comparison, some insurers may be required to amend their Plans.

New York State Insurance Department

ISSUED 01/10/2007

FOR IMMEDIATE RELEASE

ACTING SUPERINTENDENT PIETROLUONGO, DISTRICT ATTORNEY MUEHL ANNOUNCE ONEONTA MAN'S INSURANCE FRAUD GUILTY PLEA

Acting Superintendent of Insurance Louis W. Pietroluongo and Otsego County District Attorney John Muehl today announced that Jeffrey Gelbsman, a 38-year-old Oneonta, NY businessman, has pled guilty to fourth-degree insurance fraud related to a fire that occurred at Monser Brothers Tire Sales, Inc. in Oneonta, NY in August 2002. This announcement follows Gelbman's arrest in April 2006.

"Today's announcement is proof positive of not only the Insurance Department's success in combating insurance fraud around the state, but also the success of our new pilot program that brings government agencies together to prosecute insurance fraud," said Acting Superintendent Pietroluongo. "I commend all law enforcement and fire agencies that cooperated in this collaborative effort against insurance fraud"

Otsego County District Attorney John M. Muehl said, "This Office is dedicated to prosecuting all crimes committed within the county. With our staff and budget constraints we must prioritize street and violent crimes and make difficult decisions, even if they relate to a dangerous fire. Fortunately no one was hurt or killed and I am grateful the Insurance Department offered me the opportunity to utilize the Fraud Prosecutor Pilot Program. Without it this office may not have had the resources to prosecute this complex case. The program permitted me the opportunity to investigate the circumstances of the fire, the fire investigation, and related insurance fraud."

New York State Police Lieutenant Fabio R. Auffant, II said, "The State Police Computer Crimes Unit worked closely with the Insurance Department, federal and local investigative agencies, and assisted in this investigation by capturing digital evidence that culminated in an arrest and this guilty plea."

William G. McMahon, Special Agent in Charge, Bureau of Alcohol, Tobacco, Firearms and Explosives, New York Field Division said, "This case is a classic example of an individual's greed which ultimately resulted in victimizing the insurance company, creditors, the public investors and more seriously, the very firefighters who responded to the fire. The efforts of the New York State Insurance Department's initiative and the diligence of the Otsego County District Attorney's Office are to be commended. What appears to be a victimless crime has an impact on the wallet of law abiding citizens and ATF remains steadfast to work with our partners and aggressively pursue arsonists."

The Arson Bureau was requested by the Oneonta Fire department to act as the lead fire agency in investigating the fire at 15 Wall Street. Investigator James Ryan headed up a team of investigators that spent long hours both on scene and off. These investigators were successful in eliminating all accidental causes for the fire. These efforts and facts moved the investigation to other investigative agencies that continued to develop the case to the point it is today.

"It is through these combined efforts that keeps the crime of arson in check," stated Secretary of State Lorraine Cortez Vasquez. "On scene investigation is one of the services that the Office of Fire Prevention and Control provides to communities in the determination of the origin and cause of fires."

Jeffrey Gelbsman, of 24 East Street, Oneonta, NY, was the part-owner and full-time manager of the retail/wholesale tire store in question. Gelbsman's guilty plea stems from his alleged role in a fire that occurred at what was then the site of Monser Brothers Tire Sales, Inc. at 15 Wall Street, Oneonta, NY late in the evening of Aug. 16, 2002. The business has since moved to, and is currently situated at, 375 Chestnut Street, Oneonta, NY. Gelbsman's plea of guilty to fourth-degree insurance fraud is in exchange for a sentence of five years of probation and restitution of \$56,592.60. Gelbsman is due to be sentenced on April 2, 2007.

The investigation was the second conducted under a new pilot program initiated by the Insurance Department in 2006 and the second to end successfully with a conviction. Under this program, the State lends an experienced insurance fraud prosecutor to local counties to act as an Assistant District Attorney. In this case, the fraud prosecutor was charged with responsibility for investigating and evaluating the merits of the fire and corresponding insurance claim. William Andrews, an attorney with the Insurance Department's Office of General Counsel, served as a Special Assistant District Attorney to the Otsego County DA's office.

The Insurance Department's lead investigator on the case was Mark Howard.

Selective Insurance Company, the property/casualty insurer for Monser Brothers Tire Sales, Inc., paid claims to Monser totaling more than \$480,000 for the losses the business incurred in August 2002. With the insurance monies, Monser Brothers Tire Sales, Inc. constructed its existing outlet at 375 Chestnut Street, Oneonta, NY. The property on which Monser previously operated, and where the fire occurred, was subsequently sold to the city of Oneonta, NY and converted into a municipal parking lot.

Along with the Insurance Department's Frauds Bureau and the Otsego County DA's office, the investigation also benefited from the professional expertise and efforts of the Department of State's Office of Fire Prevention and Control's Arson Bureau, the federal Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), the New York State Police Computer Crimes Unit, as well as local and county fire investigators.

New York State Insurance Department

ISSUED 11/27/2006

FOR IMMEDIATE RELEASE

DECATUR MAN SENTENCED FOR FELONY INSURANCE FRAUD

Superintendent of Insurance Howard Mills and Otsego County District Attorney John Muehl today announced that Peter Mravlja of Decatur, N.Y., was officially sentenced subsequent to his plea of guilty to felony insurance fraud following a joint investigation into a suspicious fire at his dairy barn on April 20, 2003.

Mravlja's sentence consists of a \$50,000 fine to be paid by the end of next year, plus a \$5,000 surcharge; a \$150 DNA fee; a five-year felony probation term; 1,000 hours of community service over the next five years in five firehouses that responded to the blaze (Mravlja was a volunteer fireman); and an order to sell all of his guns.

"Today's announcement brings to a close a case that clearly demonstrates the success of our new pilot program," said Superintendent Mills. "Insurance fraud is a serious crime that can be exceptionally dangerous and costly to law-abiding New Yorkers. This administration is committed to fighting insurance fraud as vigorously as possible, and the conclusion of this case demonstrates our success."

The investigation was the first conducted under a new pilot program initiated by Superintendent Mills. Under this program, the State lends an experienced insurance fraud prosecutor to local counties to act as an Assistant District Attorney. In this case, the fraud prosecutor was charged with responsibility for investigating and evaluating the merits of the fire and corresponding insurance claim. William Andrews, an attorney with the Insurance Department's Office of General Counsel, served as a Special Assistant District Attorney to the Otsego County DA's office and presented the case to a grand jury that brought indictments for arson, insurance fraud and witness tampering against Mr. Mravlja.

Mr. Mravlja called 911 on Easter Sunday 2003, to report a fire in the dairy barn at Mravlja Farms, 315 County Highway 37, Worcester, N.Y., owned jointly by Mr. Mravlja and his father, George. Thereafter six local fire departments and 53 volunteer firemen responded and battled the barn fire for almost seven hours. During the course of the fire, one fireman was physically injured and 23 beef calves perished. The farm subsequently closed.

The fire's origins were listed at the time as "undetermined" because an electrical malfunction could not be ruled out as a potential cause. Otsego County Patrons Co-Operative Fire Relief Association of Schenevus, New York, their insurer, paid Mravlja Farms a total of \$143,555.81 to compensate the Mravlja family for the losses they incurred. Given a confidential

tip that the Mravlja Farms fire may not have been an accident, the Association subsequently asked the New York State Insurance Department's Frauds Bureau to revisit the case.

The Office of Fire Prevention and Control joined the investigation, assigning Investigator James Ryan to review the cause and origin of the fire.

Eight charged with fraud

Men accused of falsely registering cars upstate to save on insurance

By [MICHELE MORGAN BOLTON](#), Staff writer
Click byline for more stories by writer.
First published: Tuesday, December 19, 2006

ALBANY -- Eight downstate men were arrested and charged Monday with insurance fraud for allegedly using upstate addresses, including one in East Berne, to register a fleet of vehicles used exclusively in New York City.

The alleged scam resulted in the eight men being able to reduce their auto insurance premiums by nearly \$1.5 million by falsely registering their vehicles in counties where commercial insurance rates are relatively low.

"These cases hit everyone right in the pocketbook," said Albany County District Attorney David Soares in a statement. "Any time insurance companies are defrauded like this, law-abiding citizens pay the price."

Superintendent of Insurance Howard Mills said "aggressive fraud prosecution" has helped New Yorkers save half a billion dollars in insurance premiums this year.

Soares praised the interagency cooperation that led to the arrests, lauding the New York City Police Department, the state Departments of Motor Vehicles and Insurance as well as the New York Automobile Insurance Plan and prosecutors in his own financial crimes bureau.

Arrested Monday were Peter J. Albamo, 48, of Brooklyn; Richard Shavel, 44, of Monroe, Orange County; Harris J. Thorpe, 34, and Petar Bojilov, 30, both of the Bronx; Roben Allonce, 46, Zeev Lichtick, 53, and Roman Ashurov, 35, all of Brooklyn; and Winston A. McLean, 59, of Rosedale, Queens County.

In addition to insurance fraud, they also were charged with offering a false instrument. If convicted on all counts, each defendant faces up to seven years in state prison, except Albamo and Shavel, both of whom could serve up to 15 years behind bars because they face more counts of fraud and false filing.

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Man acquitted in house fire case

Homer Bosh, 47, had faced arson charge after his Albany home burned

By [MICHELE MORGAN BOLTON](#), Staff writer

Click byline for more stories by writer.

First published: Friday, November 10, 2006

ALBANY -- Businessman Homer Bosh raised both arms to heaven and screamed his thanks to God after an Albany County jury cleared him of charges he had burned down his own house last year.

"He burst out crying. He was ecstatic," said Bosh's lawyer, Gaspar Castillo. "I believed him from the beginning when he professed his innocence."

Bosh, 47, has denied any role in the April 29, 2005, fire that destroyed his 62 First St. home. The fire was memorable not only because it came amid a rash of city arson fires that spring, prompting the creation of a multi-agency task force to investigate, but also because Bosh stood and watched the place burn with an old friend, city Mayor Jerry Jennings.

Bosh, who owns and operates H. Bosh Moving of Troy, faced charges of third-degree arson, reckless endangerment and insurance fraud and could have spent years in state prison if convicted.

Instead, he was acquitted about 9:30 p.m. Wednesday after an almost three-week trial before acting state Supreme Court Justice Dan Lamont.

Jurors deliberated over two days, requested multiple read-backs of testimony and, at one point, admitted that they were at an impasse of 11-1, Castillo said. Lamont sent the jurors back behind closed doors to do more work, and they returned about three hours later with a unanimous decision, he said.

Fire investigators early in the case determined an accelerant was used at multiple spots on the back porch of 62 First St., igniting the 11 a.m. three-alarm fire.

But it just couldn't be proved that Bosh was the one who ignited it, said Albany County Assistant District Attorney David Gonzalez, who prosecuted the case. Gonzalez said he'd done his best with what he had after receiving the case two months ago from a colleague who has since left the office.

"I had a concern that this was a case where the evidence was enough to get probable cause for an arrest but maybe not enough to prove guilt beyond a reasonable doubt," Gonzalez said. "The investigation was very thorough. But the law is the law. Nobody saw anyone lighting a match."

Detecting Fraud

Workers' compensation fraud is a felony.

NYSIF investigates workers' compensation fraud only for NYSIF policies and claims. If you have information regarding any type of fraud against NYSIF, NYSIF makes it easy for you to [report fraud](#).

Because of the complexity of cases and tremendous losses associated with workers' compensation fraud, insurers have combated it by creating special investigation units to pursue fraud criminals. By industry estimates, each dollar spent on special units to fight fraud returns \$7 to \$10 in savings through deterrence or restitution.

NYSIF's special investigation unit, the Division of Confidential Investigations (DCI), has established itself as a local and national leader in arrests and prosecutions of felony fraud cases against policyholders, claimants and medical providers.

NYSIF continually educates its staff and businesses in New York to recognize potential fraud cases.

Mechanisms of Fraud

Be aware of the mechanisms of fraud used by the claimant or medical provider, including:

- Creating a fact pattern to fit a fictitious claim;
- Not reporting or under reporting work activities;
- Magnification or invention of physical symptoms;
- Filing a false document designed to obtain benefits;
- Billing for services not rendered;
- Other attempts to defraud, which can be as creative as they are numerous.

Recognizing Possible Fraud

As an industry leader in the fight against workers' compensation fraud, NYSIF encourages policyholders to be aware of common red flags that may signal potential claimant fraud. Red flags are not of equal importance or weight, nor do they, in and of themselves, prove anything. As a general rule, if you find clusters of red flags connected with a claim, the claim should be examined with care to determine if the claimant has lied about any material fact connected with the claim.

Common Red Flags Employment History

Injury reported after a serious problem on the job, such as disciplinary action, demotion, being passed over for a promotion, or notified of a layoff. Worker is a new hire, or has a prior history of multiple personal injury or workers' compensation claims.

Personal History

Injury reported soon after purchase of private disability insurance. Worker engages in high-risk leisure activities. Worker experiencing financial difficulties or domestic problems at time of injury.

Circumstances of Accident

Accident occurs early Monday or on the day of return from vacation, or was not immediately reported. Worker's description of accident has inconsistencies or is not believable. Accident is not witnessed, or witnesses' descriptions contradict injured worker's account. Injury is inconsistent with activity at the time of injury.

Claimant Behavior

Claimant difficult to contact during working hours, uses an answering machine to screen calls, or a post office box as a residential address.

The Division of Confidential Investigations

The primary mission of NYSIF's Division of Confidential Investigations (DCI) is to investigate cases of suspected fraud, including policyholder, provider and claimant fraud, against NYSIF and to refer completed investigations for criminal prosecution.

All fraud reporting is confidential

The Cost of Fraud

Workers' compensation fraud has a significant impact on the cost of workers' compensation. Insurance fraud imposes an enormous burden on our national economy. It has been estimated that the cost of insurance fraud against workers' compensation insurance carriers alone is over \$5 billion each year. Workers' compensation fraud carries a higher price tag than fraud in any other category of property/casualty insurance.

Not A Victimless Crime

Every dollar paid out because of insurance fraud must be made up by a dollar increase in premiums. Companies pass on the increases in premiums to their customers through higher prices for the goods and services they sell.

Moreover, the overall effect of fraud can be disastrous. Not only does the expense of fraud raise insurance premiums, it discourages business from expansion, can reduce productivity and threaten a company's survival. Other employees must pick up the slack of malingering co-workers, jobs go unfilled, and pay raises or profit sharing gains suffer as revenue is lost.

There are also hidden costs to fraud. The cost of workers' compensation coverage increases with every worker a business hires. The hidden cost of insurance fraud not only discourages businesses from expanding their operations, it also encourages schemes to hire workers "off the books" to keep costs down, minimizing the benefits and protections afforded these workers and allowing them to pocket salaries without paying their fair share of taxes.

One way or another, insurance fraud increases the cost of living while decreasing the quality of life for everyone. Help us keep the cost of living and the cost of your insurance down.

You can help [fight fraud by reporting](#) any type of suspected workers' compensation or disability insurance fraud against NYSIF.

Anti-Fraud Plan

NYSIF has filed a comprehensive anti-fraud plan with The New York State Insurance Department, prepared and submitted by NYSIF's Division of Confidential Investigations (DCI).

Major parts of the plan include:

- A comprehensive anti-fraud training program conducted by DCI for all NYSIF employees.
- A fraud recognition manual, created by DCI, for NYSIF employees.
- A Workers' Compensation Fraud Prosecution Manual, created by DCI, for district attorneys and other law enforcement agencies.
- An expanded anti-fraud public awareness campaign.
- Increased hiring of investigators, attorneys and support staff to expand DCI activities.
- Creation of a computer database to track and record fraud arrests, convictions and savings resulting from DCI investigations.
- Use of data mining software to develop enhanced capabilities for computerized searches, cross-checking of files and development of a historical database of fraudulent activities statewide.

Pick a profession, any profession



Medical providers, employees, business owners – anybody can be involved in workers' compensation fraud. NYSIF leads the fight against workers' comp. fraud. In the past eight years we have exposed fraud by 530 business owners, claimants and medical providers, saving over \$77.92 million.

TYPICAL WORKERS' COMP. FRAUDS:

- Overcharging for Medical Services
- Underreporting Payroll
- Filing False Compensation Claims
- Secretly Returning to Work

TO REPORT FRAUD CONTACT NYSIF AT:

- Div. of Confidential Investigations
PO Box 3395
Church Street Station
New York, NY 10007
- Toll-Free Fraud Hotline
1-877-WCNYSIF (926-9743)
- Online @ www.nysif.com



NYSIF *New York State Insurance Fund*

PREVENTING WORKERS' COMPENSATION FRAUD IS EVERY NEW YORKERS' RESPONSIBILITY

Chapter 2 Types of Insurance Fraud

Over Insurance

Companies need to underwrite coverages to make sure that a piece of property is not over insured. The agent needs to reevaluate and inspect his long-time customer's properties to determine if the property value was decreased over the years and policy limits should be lowered. This is especially true for inner-city properties. What may have been correct 15 years ago could very well be an over insured property today. The insured could never sell for the amount they are insuring it for, in such a case.

Arson for Profit

Even if a property is not over-insured, there are still circumstances when a fire could put the insured in a better financial condition and provide a profit he might now realize. High alimony, a decrease in business profits, seasonal risks, higher taxes, and other inner-city homes that are hard to sell, may all be suspect as reasons for arson.

Homeowners are a group that may resort to arson to collect insurance money. Some consider it because they are unable to sell their property, while others may watch as their neighborhood downgrades itself. They decide arson is their way out to make money. Some homeowner policies contain riders for expensive articles, like jewelry or artwork, also. If such articles are not found to be part of a fire's debris, fraud may be involved.

Small businesses have a higher tendency to consider arson as a way out of financial difficulties than large businesses. Often a large business has set aside a cushion or reserve to help them handle periods of economic depression. Small businesses, on the other hand, generally rely on their sales to cover their monthly expenses. As long as the business can make profits from its sales, its value as a business is greater than its insured value. But once expenses overtake income, a small business doesn't have the benefit of profit. Then the business value may drop below its insured value. This situation often tempts small businesses to consider torching their sites and collecting the insured value.

Statistics show that there is always a rise in small business fires during economic lows. Businesses facing bankruptcy sometime contemplate burning their stock and taking insurance money, rather than letting it get sold at auction or seized by creditors.

It has been estimated that the Insurance Industry loses approximately a half billion dollars a year to arson. Arson squads and firefighters have their work cut out for them in proving arson. It has become a specialized investigation with professional trained to detect arson. Arson specialists can often tell if a fire was set by examining the speed of the fire and its burn pattern. Sometimes they find proof of

accelerant use, too.

Prosecuting those who burn for profit is about the only deterrent. Those companies that are members report fire loss claims to the Fire Marshall Reporting Service (FMRS). This resource can be checked for previous fires. The Property Insurance Loss Register (PILR) has also been set up by the American Insurance Association. This data is computerized to inform companies of other claims with similar characteristics that may have been filed previously by the claimant.

Generally, the “torch” is the only one that gets convicted for arson. So some businesses will hire individuals to do the torching by paying them off. But those that hire the torch can be prosecuted for fraud under most state statutes.

Evidence to prove fraud can include altered proofs of loss, such as receipts, inventories and accounting books. If it is found that inventories are removed before the fire occurred, this information could also be important.

Auto Insurance Fraud

There are several types of fraud in this area”

Arson

Most car fires are electrical or stem from carburetor or fuel line or fuel pump. If a claim does not stem from these, there is a possibility of arson.

Arson is sometimes used to cover up fraud. A fire can be used to disguise the falsehood that other expensive articles were in the car at the time of the fire.

Theft

While there are many auto thefts, approximately 20% of all car thefts are cases of fraud, perpetrated by the insured. Some of these also involve arson, as the insured will report their vehicle stolen, but the car is recovered burned.

Many fraud claims involved theft from autos, which are easily perpetrated by breaking windows or prying the trunk open. Investigators often find forged or altered receipts for the supposed stolen items. Expensive items like jewelry and cameras are common items reported being stolen,

Stolen cars don't involve appraisals, so stolen car claims have become big business. Whether a car is new or old or non-existent, its claim of being stolen may render big money to its owner or crime ring. Such claims are common in cities, although they may be a scheme used anywhere.

Cars are sometimes purposely left or abandoned in high risk areas for theft. Once they are allowed to be stolen, a claim is put in for the hope of securing book value for their loss. In other cases, crime rings not only are involved claiming losses due

to theft of cars, but are also involved with stripping the cars and selling the parts at even bigger profits.

Staged Vehicle Collision Schemes

There are cases when an insured will deliberately hit a stationary object or roll it down a ravine, in order to collect on the collision portion of the policy.

Another common ploy has been to stop short in front of another car or back into another vehicle. Some professional criminals are even good at “accidentally” walking in front of moving vehicles and then claiming serious injury. It is also not rare to hear of cases where a perpetrator will climb into a vehicle after the accident occurred.

Fraud rings have also been known to stage accidents by bringing previously damaged vehicle to a location and setting up what looks like an accident. If rental or company cars are involved, financial claims are also made against those companies/agencies.

Auto BI & PD Liability Fraud – Staged Accidents

Approximately one-third of all bodily injury claims for auto accidents contain some amount of fraud, but only 3% are totally fraudulent claims that result from deliberate scams such as staged accidents.

Examples of this would include faking injuries and crashing cars on purpose. This information comes from 1996 Insurance Research Council (IRC) poll. It found that most of the 33 out of 100 BI Claims were from padding claims and exaggerated injuries. The IRC pointed out that this type of fraud has become convenient for dishonest doctors, lawyers, and individuals to take advantage of insurance companies.

Today's auto insurance includes coverage for those in the car that are injured, as well as to the occupants of the other car that is in the accident. No-fault insurance provides only personal injury protection, which has limits. With this fact in mind, sometimes comes the temptation by unscrupulous individuals to scheme. Some will fake injuries and try to beef up their medical expenses from an accident to claim money from insurance companies. Others have been caught faking an injury entirely. Injuries like whiplash, backache, and headache are common pretenses. They are often hard to prove, and some individuals try this ploy over and over again.

In terms of costs, it is estimated that the fraudulent part of these claims accounts for 17 to 20 cents of every payment dollar. This accumulates to about \$6.3 billion every year to the U.S.'s auto insurance policyholder's bills. Ninety percent of the dollars that would have been paid out would have come from opportunistic fraud and padded claims from real accidents, while ten percent arose from accidents that were set up.

This IRC study provided information and statistics from 15,000 injury claims from 9 states. It verified earlier findings concerning the variation in the amount and type of fraud different areas of the country. If compared fraud in urban, rural and suburban areas. As an example, fraud was twice as high in California as it was in Michigan. It found that in Los Angeles 67% of claims had some fraud, while 45% of the claims in the state as a whole had some fraud. Texas showed similar results where 36% of the state's claims had fraud involved. And the city of Houston showed fraudulent claims at a 54% rate. New York State and New York City, on the other hand showed only a 3% difference. The city showed a 33% rate to the State's 30% rate.

Staged auto accidents have become so common to be frightening. There are many different scams. Many of these are rear end type collisions, where the vehicle stops suddenly, causing the injured vehicle to rear end it. Hot targets for this type are luxury cars, as they offer the promise of high BI Liability Limits. Bogus witnesses are often used to support the criminal's story. These claimants many times team up with dishonest providers and attorney who inflate injuries. There are also professional pedestrians who make their living by pretending they were injured in the accident.

Inflated Claims

Inflated claims are probably the most frequent cases of fraud in the auto insurance area. Back injury is the hardest type of claim to disprove, and the most common claim by these criminals. They are also many times combined with dishonest providers and attorneys who inflate injuries.

Inflating the damage of a car accident is also very common. Dishonest body shops will do a variety of things to make extra money. One scam involves substituting damage. A damaged door can be placed on a friend's undamaged car, by temporarily removing the good door. A claim is put in for a supposed accident, which the friend and body shop will split the profit.

Another method of inflating damage comes from an auto body shop that fools an insurance company with the use of photographs it may keep on file for illegal uses. If it gets away with using photographs of another similar car with more damage than the car it really has in its shop, it can claim a bigger share from the insurance company.

With large amounts of money available for the taking, these types of crimes sometimes involve more than the body shop. Sometimes the car's owner is involved. Other times, unscrupulous insurance appraisers make deals with body shops. And we must not forget that doctors and lawyers often get involved, too.

Another tactic used to defraud insurance companies comes from the claim of auto accidents that don't even occur. A body shop may provide bills from repair it never did, yet get paid for it. With the use of a bribed appraiser, a written claim and a fed

photo of a damaged auto, the occasion is ripe for criminals to attempt stealing money from insurance companies.

It is even conceivable that a claim can be put in for a car that doesn't exist. A wrecked car is sometimes bought just for its title and VIN and then scrapped. Possessing the title and VIN, a car can be insured after being registered. From there the criminals can claim that an accident occurred, when in fact, the car never existed.

If a real accident, staged accident, or faked accident occurs late at night, or in a secluded place, it is possible that the police may not be on hand to make a report on the scene. A criminal may show up the next day and report the supposed accident at the police station. With the police report, completed accident forms, and damage estimates, it may not be long before another fraudulent case is on record.

Medical / Accident / Health Fraud

We have all read stories of doctors, dentists, etc. who have padded bills to defraud both Medicare and Medicaid Insurance. They present charges for treatment not provided to their patients or overcharge for services that they render.

Prosecutors are hard pressed to bring cases against doctors unless they have strong proof. Sometimes doctors even have teamed up with lawyers to work a scam. It may even start with a lawyer that contacts accident victims. They pressure victims to go to unscrupulous doctors who encourage long-term treatment, missed work, and a large claim for pain and suffering. Investigations on this type of fraud are tedious. Often the only way this fraud is discovered is through the testimony of the original claimant. Once the injured realize how much more money the doctor and lawyer are getting at their expense, they may have a tendency to give up information to an investigator.

Property / Homeowner Fraud

There is a variety of ways that insureds make fraudulent claims (other than arson) against these policies. Small fires are set to activate sprinkler systems for Water Damage Claims. Theft Claims are presented for property the insured never owned or that the insured had to sell in order to get money. Phony appraisals of antiques are secured to inflate a loss. Inflated estimates on damaged property are also common. This type of fraud can occur in homes as well as apartments.

Insurance companies sometimes hire contractors to repair or replace damaged homes or property. It has been discovered that some contractors have tried to charge for work not completed. Other times, they have charged for substandard materials that they used.

Workers' Compensation & DBL Fraud

The most common fraud in Workers' Compensation is for injuries not suffered on the job and faked or exaggerated injuries. Again, whiplash and muscle strains are the most common. Dishonest providers and lawyers are also involved with many of these claims. Employer premium fraud is also prevalent. Employers "misstate" their payroll to secure a lower premium payment to the insurance carrier. Working while collecting Workers' Compensation or DBL is also a common fraud case problem. Surveillance is often used if this is suspected.

White Collar Crime

Slip and Fall BI

This is one of the most widely perpetrated crimes. The claimant threatens to sue for a bogus injury because he slipped and fell on either a broken stair or slippery surface. The scam artist often uses this ploy to collect money from businesses and other buildings that collect enough insurance for him to drain. Stores, restaurants, public or government buildings are all common sites targeted. Witnesses are also often part of the fraud claim.

The Yank Down

Claimants pull display items down on top of themselves and then file a claim for an injury stemming from the "falling" object. This sometimes occurs at the individual's workplace.

Tripping

Usually a sidewalk situation, where it is broken or obstructed in some fashion, is a common fraud site. Curbs, stairs, or obstacles can all be used for a scam artist's props.

Product Liability

Lawsuits concerning products are balanced with liability insurance. Companies carry this insurance to cover injuries to cover injuries consumers may suffer from using their products. Unfortunately, individuals looking for quick cash have targeted liability insurance.

Scam artists claim finding bugs or other objects in their food they ate in a restaurant, illness caused by food they ate in a restaurant, or cuts and bruises or shocks from appliances or other products they bought.

Companies have had a tendency to settle quickly to avoid bad publicity over such issues. This may make them easy prey to the professional scam artist.

As you can see, there are numerous ways that insurance fraud can be perpetrated. We have highlighted the main categories, yet the list is endless and keeps growing.

New York State Insurance Department

ISSUED 11/07/2006

FOR IMMEDIATE RELEASE

TWO CHARGED IN RENTAL TRUCK INSURANCE SCAM

Superintendent of Insurance Howard Mills, Monroe County District Attorney Michael C. Green and Monroe County Sheriff Patrick O'Flynn today jointly announced the charging of two individuals with insurance fraud and other crimes related to staged accidents.

"I would like to commend and congratulate everyone involved in this joint investigation," said Superintendent Mills. "Without the coordination of these various government entities working in partnership, New York State would not be nearly as successful as we have been in rooting out insurance fraud. These are dangerous crimes that cost taxpayers a tremendous amount of money, and today's announcement is a clear demonstration that we will not tolerate these crimes in our communities."

Lt. William Saunders of the New York State Police Special Investigations Unit said, "This case is a prime example of the diversity and quality of the investigative scope of the task force. When most people think of auto crimes, they think of stolen cars. When they think of insurance fraud, they think of what we call 'owner give-ups' for the insurance money. And the latest scheme of fraudulently staging automobile accidents continues to be a growing concern. People should know that we have a very experienced and accomplished group of investigators in this task force who work very closely with other agencies, businesses, and citizens." Saunders added, "We also remind motorists that if they're ever in an accident, they should immediately call the police and make a report."

Monroe County District Attorney Michael C. Green said, "Cooperation among law enforcement agencies is vital in eradicating crimes such as these. The case before us today is a perfect example of the success that comes from working together. I would like to commend all the individuals from the various agencies that helped bring about this success."

Monroe County Sheriff Patrick O'Flynn said, "We are proud to work so closely with the New York State Insurance Department, Monroe County District Attorney's Office, NY State Police, the Rochester Police and the NYS Department of Motor Vehicles."

In March 2006, the Rochester office of the New York State Insurance Department Frauds Bureau received a suspected staged accident fraud referral from the Republic Western Insurance Company Special Investigations Unit concerning a suspicious motor vehicle accident that occurred on November 20, 2005 in the Town of Henrietta. Republic Western Insurance Company is the insurance carrier for UHaul rental trucks. Republic Western stated that on November 20, 2005, Thomas W. Boyde IV reported he was driving his vehicle in the Town of Henrietta when it was rear-ended by a UHaul truck being driven by Alexandra Rassis. Boyde and Rassis reported that they did not know one another, but Republic Western's investigation revealed that they had been romantically involved for many years.

Republic Western further reported that Boyde was involved in two other accidents involving UHaul trucks. One such accident occurred on June 6, 2002, during which he claimed that a UHaul truck struck two of his parked vehicles. In the second, on July 23, 2005, Boyde claimed that another UHaul truck struck and damaged to one of his vehicles.

Subsequent to the referral, the Insurance Frauds Bureau, Rochester office, under the supervision of Senior Investigator Gary S. Sullivan commenced a criminal investigation. The arrests and charges announced today are a result of a joint investigation conducted by the Monroe County Auto Crimes Task Force which is comprised of members of the New York State Insurance Frauds Bureau, Monroe County District Attorney's Office, Sheriff's Office, New York State Police Auto Theft Unit, Rochester Police Auto Theft Unit and NYS Department of Motor Vehicles Criminal Investigation Unit.

The investigation revealed that Boyde, of 742 Eastbrooke Lane, Rochester, New York, the operator of an escort service, acted as the ring-leader of small group of female associates, including Ms. Rassis, who would stage motor vehicle accidents in order to collect insurance money. The investigation centered around 13 fraudulent motor vehicle accident insurance claims that netted Boyde and Rassis more than \$50,000.00. In some cases, Boyde reported that while he was driving one of his vehicles it was struck by either a UHaul or Budget rental truck that was being driven by one of his associates. In other cases, he would be driving one of his vehicles and would suddenly slam on his brakes causing unsuspecting drivers behind him to crash into the rear of his car.

Charged were:

- ❖ Thomas W. Boyde IV, DOB: 02/25/62
742 Eastbrooke Lane, Rochester, New York
 - Charges: 22 felonies which include, insurance fraud, grand larceny, falsifying business records
 - Boyde was arrested on 10/23/06 and was arraigned before T/O Henrietta Justice Kopacki and committed to the Monroe County Jail without bail.
- ❖ Alexandra Rassis, DOB: 09/04/66
742 Eastbrooke Lane, Rochester, New York
 - Charges: 6 felonies which include insurance fraud and grand larceny
 - Rassis was arrested on 10/24/06 and was arraigned before T/O Henrietta Justice Kopacki and released on her own recognizance to reappear at a later date.

The carriers that were being defrauded were: Republic Western Insurance Company, Allstate, GMAC, GEICO, Budget Truck Rental, and the Robert Plan.

The case is being prosecuted by the Monroe County District Attorney's Office by Assistant District Attorneys Matthew Rich and Kelley Provo of the County Court Bureau, under the supervision of Special Assistant District Attorney Jennifer Whitman, Bureau Chief.

The investigation is ongoing.

Family due in court in insurance case

By **MICHELE MORGAN BOLTON**, Staff writer

Click [byline](#) for more stories by writer.

First published: Tuesday, November 7, 2006

ALBANY -- A Colonie family accused of staging car accidents over 15 years to collect as much as \$1 million in phony insurance payouts will return to court Wednesday for the first pretrial hearing in the case.

The group, which includes local welterweight boxer Frank Houghtaling, his brother, sister, mother, wife and sister-in-law will be missing one member.

Family patriarch Alfred "Big Al" Houghtaling, 59, who was accused with the others of insurance fraud, falsifying business records, grand larceny, conspiracy and enterprise corruption, has died. Houghtaling, a truck driver from Selkirk, died of cancer last month.

In June, he pleaded guilty to misdemeanor insurance fraud and was ordered to pay \$7,500 in restitution and a civil penalty to the state Insurance Department.

Defense lawyers have downplayed the indictments, which were announced in March. John J. Kelleher, who represents Joseph Houghtaling, 36, maintains that the case not only doesn't have a legal leg to stand on; he said it doesn't pass "the laugh test."

Kelleher said 31 of a total of 72 counts brought in a superseding, or corrected indictment, have been dismissed by Albany County Judge Stephen W. Herrick. That includes 28 of 66 charges faced by his client, and at least nine other counts faced by another defendant, he said.

"I would characterize that as a good start," Kelleher said.

"The district attorney has pasted a bunch of feathers to a football and now he wants us to believe it's a duck," said Frank Houghtaling's attorney, Terence L. Kindlon.

District Attorney David Soares said the case is proceeding well, and he is looking forward to the trial. He also said his office has filed a civil case against the defendants to ensure they don't sell property, including expensive watches and plasma televisions.

Also accused are Joseph Houghtaling's wife, Rhonda, 34. The two operate a plowing and landscaping business that also employs Rhonda's twin sister, Renee, who is Frank Houghtaling's wife.

In addition to being a boxer, Frank Houghtaling is a State Thruway employee, a member of the Air National Guard and an Army veteran.

Family matriarch Donna Houghtaling, 58, faces charges, as does her daughter Brenda Warner, 38, a nine-year Albany County Sheriff's Department paramedic who is currently suspended.

The only unrelated defendant is Willie Cook, 36, of 665 Clinton Ave., Albany, a longtime friend of the family.

The probe was launched in early 2004, when Albany detectives received a tip from a downstate insurance company about a series of suspicious claims from accidents involving rented U-Haul trucks.

During the investigation, Albany County Assistant District Attorney Brad Sherman and investigator Charlie Arsenault traveled to South Carolina, Kentucky, Vermont and across New York to examine claims the Houghtaling family submitted.

Sherman has said the defendants engaged in insurance fraud, with each playing a role -- whether as driver, passenger, owner, insurance holder or the one who submitted false claims.

They also allegedly solicited the help of others, who were paid to register vehicles in their names so that, on paper, the crashes would not appear to involve members of the Houghtaling family, authorities said.

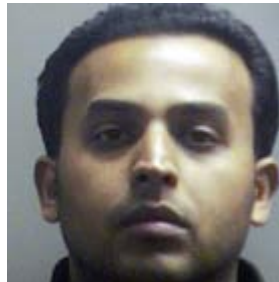
In March, when police raided four of the Houghtalings' residences and a business, they seized items that included computers, accident reports, day planners, wallets, checkbooks, computer disks and Rolodexes.

Inside Frank Houghtaling's home, authorities found a shirt with an Albany Police Department emblem, a police pendant and a gold commander's badge that was issued to Tony Bruno, who is now an assistant chief. Bruno was disciplined for giving away the badge as a gift to Houghtaling, apparently a close friend.

The legality of those searches as well as whether defendants voluntarily made statements implicating themselves to police, will be the subject of this week's court hearings. Bolton can be reached at 434-2403 or by e-mail at mbolton@timesunion.com.

Wife stands by husband charged in murder plot

BY SOPHIA CHANG



Newsday Staff Writer

January 12, 2007, 10:22 PM EST

Sitting quietly and calmly in a courtroom Friday, Tina Paul's only visible sign of distress was the balled-up tissue she clutched in one hand.

Once again, she and several relatives came to Nassau State Supreme Court to support her husband, Santhosh Paul, 31, despite charges he tried to hire a hit man to kill her for a \$1 million life insurance payout just before Christmas.

Judge Tammy Robbins denied bail a second time Friday, and Santhosh Paul returned to the Nassau County jail in East Meadow, where he has been held since his arrest Dec. 19.

Tina Paul, 30, insists she believes her husband is innocent and should be allowed to return to their Bellmore home while awaiting trial.

"I just want my husband home," Paul, a Cablevision accountant, said Friday.

Their 4-year-old son misses his father, she said. Prosecutors say Santhosh Paul brought the boy to some of his clandestine meetings with an undercover policeman posing as a hit man.

Assistant District Attorney Anne Donnelly said Santhosh Paul tried to call his wife several times from jail, in violation of an order of protection the court had issued.

But his attorney, Robert Gottlieb of Commack, said Tina Paul never sought an order of protection.

"His wife is here. She is supportive," Gottlieb said. "She does not fear for her safety."

Donnelly replied, "There are people who will stand behind loved ones."

Donnelly said Santhosh Paul, who owned a local mortgage insurance company, also is being investigated for his role in a mortgage fraud scheme, though details were not immediately clear.

Wife murdered for insurance cash

A New York man is facing a life sentence for shooting dead his British-born wife to cash in her \$500,000 life insurance policy.

Eric Rose, 46, was convicted on Tuesday at a court in Long Island of the second degree murder of his wife Wendy.

The jury rejected Rose's claim that his 52-year-old wife, originally from Kidsgrove, north Staffordshire, killed herself while hallucinating.

The insurance agent faces a full life term when he is sentenced in July.

Rose, a former student at Keele University in Staffordshire, moved to England as a child and returned to the US 19 years ago after the couple's wedding.

The jury at Suffolk County Court had heard how it was a "physical impossibility" that Mrs Rose killed herself as her husband claimed.

Wife warned friends

Assistant district attorney Kerriann Kelly told the court that the couple "fought like cat and dog".

Their house was about to be auctioned, their car had been repossessed and they had debts of \$16,700, Ms Kelly said.

The court heard how Mrs Rose had requested her life insurance policy be changed shortly before her death to make her son James and daughter Tracy equal beneficiaries.

She had also told friends they should suspect her husband "if anything ever happened to her".

Motivated by money

Ms Kelly described how Rose killed his wife with his .38-calibre Smith & Wesson revolver in the bedroom of their Long Island home.

"He killed her for the money and he killed her to be rid of her in one fell swoop," Ms Kelly told the court.

Mrs Rose died a day after the shooting when her life support machine was turned off.

Rose will be sentenced by Judge Gary Weber on 22 July.

Chapter 3 RECOGNIZING INSURANCE FRAUD

Section A Agent / Broker Responsibility

The agent has to be the first line of defense against insurance fraud. When writing a new account, he should inspect the building, property or auto to be insured. He should not ask a company to insure a risk that he feels uncomfortable with, just to make a sale. Agents should help to make sure that they are insuring a clean risk and that there are no physical or moral hazards involved. They should make sure that they have the applicant sign the application before they submit it to the company.

If, when taking the initial report of a claim, they have any reason to feel it may be fraudulent, the agent should relay this to the company claim department. Often, since the agent is usually in the same locality as the insured, he may also hear or receive information that the company adjuster wouldn't. Again, he should provide the company claim department with any information that he receives.

Section B Underwriter's Role

It is the company underwriter who has the final say as to whether an account can be written. The underwriter's role is to review the account before acceptance. ON property accounts, they can physically inspect the risk and secure prior claims history. They do this through the Automated Property Loss Underwriting System. ON Automobile Risks, they can secure prior claim history from CLUE or Motor Vehicle abstracts of driving records. ON applicants for Health or Disability Insurance, they can obtain information on the applicant from the Medical Information Bureau.

Section C Policy Warranties

A warranty is a pledge by the insured that certain facts are true, and will continue to be true, during the policy period. As they become part of the policy, if they aren't kept, the policy and coverage is voidable. An example would be the insured warrants that he will have night watchman on premises during the hours they are closed.

Section D Material Misrepresentation

A material misrepresentation is false statement given intentionally that had the underwriter know the truth he would have declined to write the policy.

Section E Concealment

Concealment is the deliberate withholding of “material” fact, that again, if the underwriter had this information previously, he would have declined to write the policy.

Insureds sometimes give false addresses to secure lower premiums. Others conceal the fact that they have teenage drivers, in order to secure lower auto premiums. Some state that they have alarm systems or guards, when in fact they don't, in order to reduce their premiums.

Section F Warning Signs of Fraud

There are many warning signs that agents and underwriters should be aware of to keep possible perpetrators of fraud from being their clients. They include walk-in customers, newly licensed drivers, and those that pay in cash. Some that use a post office address or others that don't have current coverage may be suspicious. Of course, not everyone that meets these criteria is fraudulent, but with the high incidence of fraud, these are some of the more suspicious situations to be checked out. We will examine signs for specific types of insurance.

We will now look at fraud indicators for a claim presented:

Financial Gain

If payment of the claim would make the insured “better off” financially, than he was prior to the loss occurring, there may be the possibility that the claim or parts of it are fraudulent. An adjuster needs to look at the financial history of the claimant, by securing the following background information

- a) Has the insured filed bankruptcy or continually had more expenses than income?
- b) Is the property in a low or hard sell area that would deter the insured from selling his home with a reasonable length of time?
- c) If a business, how long has it been running the “red”?
- d) If a seasonable business, is it peak-season or is it off-season?
- e) Is the insured an avid gambler?
- f) Is the insured recently divorced with high alimony or child support?

False Statements

An adjuster needs to be alert and take notes on recorded statements, as false statements are another fraud indicator. The adjuster needs to watch for contradictory statements made by the insured claimant. Adjusters are usually trained to ask the same basic questions several times, in different words. This occasionally can trip up an experienced fraud perpetrator. They should also be wary if the claimant and witness statements are identical, as this may have been rehearsed and they may be in collusion to defraud the company.

Inconsistencies / Secretiveness

There may be cause for suspicion on a claim for high priced articles, if the insured is living in a run down or low income housing area. One would not expect him to own the Mona Lisa or the Hope Diamond. Also, if the insured acts in a secretive manner (e.g. "You can't call me, I'll call you") this may be a fraud indicator. Vagueness and scanty information may also be a red flag for the adjuster.

Previous Claims

Once of the first things an adjuster should do is run a claims history on the insured or claimant. As mentioned before, there are various agencies that maintain claim history for almost all types of losses. An adjuster must not lose sight of the fact that there are professional claimants or insureds that make a lucrative living from collecting claims for insurance carriers.

Lack of Proof

The adjuster should always ask for proof that the insured owns the articles damaged or destroyed. They will ask for receipts, canceled checks, owners' manuals or credit records. For business claims, inventory records, insurance records, and accounts payable records are usually requested.

Lack of Witnesses

Primarily in Workers' Compensation and BI Claims, the lack of witnesses may be a fraud indicator. It is highly unlikely that in an office or plant there wouldn't be someone who saw an accident when one occurs. The adjuster should make an effort to find out who would normally be in the area where the claimant was injured.

Background Information on Individual / Job

The adjuster should also do a background check to determine

- a) The stability of employment (including any pending strikes or lay-off)
Unemployment for any length of time
- b) Income and occupation mismatch
- c) Address
- d) Migratory employment
- e) Telephone situation

Agents and Brokers may want to consider the following Fraud indicators related to applicants

- The applicant doesn't show proper identification
- The applicant doesn't work or live nearby
- The address he provides doesn't match his income/employment
- Applicant doesn't provide a telephone number or only gives a cellular number
- Applicant puts off meeting in person
- Applicant pays premium in cash
- Applicant not referred by previous customer
- Applicant's address if it is post office box or hotel

Fraud indicators related to application for auto policies

Name of previous insurer not provided
Proof of prior coverage not provided
Full coverage wanted for an older vehicle
Vehicle type / cost inconsistent with income
Vehicle unavailable for examination
No existing damage reported on older car
No purchase bill provided
High liability limit wanted

Fraud Indicators for Arson include:

- The fire company labels the fire suspicious
- The insured had one or more previous arson claims
- There are a number of similar suspicious fires in the area
- Family heirlooms or household articles were removed before the fire occurred
- Audit of business finances shows discrepancies when comparing losses with records
- The property was on the market for a long time or the market value has dropped
- The policy is fairly new or there was a recent increase in coverage

Fraud Indicators for Bodily Injury Claims include:

- Medical services way out of line with injury
- Injuries are of a type hard to detect or disprove (whiplash, backaches, headaches)
- Witnesses don't corroborate the claimant's story
- Claimant seems to take too long a period of time off from work for the type of injury

Fraud Indicators for Theft include:

- The robbery occurs shortly after the property gets insured
- There is no sign of forced entry
- An audit of finances shows discrepancies when comparing losses with inventories and values
- A check with neighbors reveals that objects or inventories were removed prior to the theft
- The only object stolen is the one insured

Fraud Indicators for Auto Claims include:

- The repair bills don't match the damage
- The VIN of the insured car doesn't match the damaged car
- The appraisal photos are questionable
- There were no witnesses
- There were questionable witnesses
- The garage that the car was taken to has a reputation for high damage claims
- There are no physical injuries, yet the car is damaged heavily
- A claim is filed soon after obtaining insurance

Chapter 4 Investigating Insurance Fraud

Section A Insurance Company Responsibilities

The company is responsible for providing prosecutors with information on people suspected of fraud. Evidence is assembled by the claim adjuster. But what is important to know is that in order for the prosecutor to have a chance at conviction, the evidence needs to show 3 things: **proof of fraud, proof of reliance, and proof of identity.**

Proof of Fraud

This is proof that there was a crime committed. This generally consists of a fake document that the claimant submits, along with a claim supported by testimony, showing the document to be false. If for example, the claimant forges a doctor's signature on the insurance form that the adjuster can prove is a true forgery, this key part of evidence will help in the conviction. Without this written statement, the case is in jeopardy.

Proof of Reliance

Generally, a fraudulent document is by itself not criminal, but it becomes criminal when the claimant tries to use it to cheat an insurance company. This is what we call reliance and proving it usually consists of the settlement draft with the claim adjuster's statement that the settlement was made based on the fraudulent document submitted with the claim.

Proof of Identity

After fraud and reliance are proved, the next part of ensuring a conviction is to prove that the correct person is being charged with the crime. This is not always so easy, as fake identification papers are not difficult to obtain. Claimants should be able to show identification like social security numbers, driver's license number, bank account numbers, photo id's, or job related identification. All of these can be verified.

It is also key that the claim adjuster not only obtains the evidence, but he must also protect it. We will discuss later what can be done to help protect the evidence.

Generally, fraud cases are prosecuted under state insurance fraud laws, fraud by false pretenses, or under the Federal Mail Fraud Statute. It should be noted that because most insurance claims are handled through the mail, insurance fraud is often handled in federal court under the mail fraud statute. The prosecutor needs to prove that the mails were used to further the fraud. A postmarked envelope with the document inside can be important evidence.

Section B Bureaus, Special Agencies, Newsletters

Companies need to be aware of all the reporting bureaus and submit information required (e.g. Central Index Bureau for Bodily Injury Claims). All claims personnel need to be trained to properly handle files so that fraud can be detected and get suspicious claims forwarded for prosecution directly with the required documentation.

Computers are central to business communication. Databases set up for insurance information can play a big role in the investigative process. The insurance industry has set up a database called Property Insurance Loss Registry (PIRL). PIRL keeps track of burglary, theft and fire claims. It is one of the most effective ways of finding suspicious and repeated patterns by individuals and crime rings. Most insurance companies are members of PIRL.

Some States require that companies set up Special Investigative Units (SIU's) to investigate suspicious claims.

Section C Government Responsibilities

The government has the responsibility for enacting legislation that helps bring the criminal to justice. The best example would be immunity laws that allow companies to report information without fear of criminal or civil prosecution. All states have immunity laws, but not all of them specifically cover insurance fraud, or limit the reporting to the Insurance department and not to law enforcement agencies.

Section D Claims Investigation

Collecting Evidence

Taking and Checking Statements

The claim file is the principal tool for compiling information to pursue prosecution for fraudulent claims. Many times the most important piece of evidence is the written or recorded statement of the insured, as he has attested to the validity of the truthfulness of the information. It is preferable to have a written statement, if possible, for proof that the claimant actually submitted it.

Bills / Receipts / Invoices

It is much easier to prove fraud if the claimant is made to submit an itemized bill rather than one that is just for services rendered. In an auto claim, each part and price for repair should be listed. In property claims, they should contain a list of all items damaged or stolen with the value of each item and its age. Again, original receipts for the articles damaged should be asked for and checked out with the store they were purchased at (for higher value items). Medical bills should contain dates of service and treatment rendered, along with a diagnosis from the provider.

In this area, it is also better to secure this information on a “Universal Claim Form” as it also asks why the treatment was performed, (e.g. Auto Accident, Workers’ Compensation Claim). The adjuster should inspect these documents for alterations in amounts. If altered with a pen, ink color or shade may vary. If typed, the size or style should be different.

Medical Exams and Evaluations

In many claims for Bodily Injury, the adjuster may want to have the claimant examined by a doctor to verify the treating doctor’s diagnosis and/or evaluation of the injury being claimed. These exams many times weed out the exaggerated claim or the malingerers. The treating physician sometimes will stretch out the period of disability for the claimant that they have known for a long time. The company exam can serve as a catalyst for stopping an exaggerated claim. The adjuster should have charts available to him to give the normal time frame for particular injuries or surgical procedures (e.g. Normal pregnancy disability is eight weeks). The adjuster can use the guides to determine if a medical exam should be set up on the claimant.

Inspection / Surveillance

For many claims, the adjuster should do a physical inspection to determine the extent or cause of claim. He should gather as much evidence as he can in an arson claim.

Most policies have clauses that give the company the right of inspection, and if the insured does not comply, it can negate the available coverage. There is also a clause in most proper policies that state that the insured, after a loss, must take reasonable steps to protect the property from loss. For instance, when a roof is blown off, the insured should have someone cover the hole until the company can inspect it. If the adjuster gets there 10 days later and it rained on the 8th day and damaged the personal property inside the house, the coverage for the personal property could be denied, as the insured did not comply with the policy provisions.

Surveillance is a tool to be used for weeding out fraudulent Bodily Injury Claims. Surveillance is used to determine the current activities of the claimant. The claimant is followed from a distance and during times when the individual may be doing things inconsistent with his injury. It is used to confirm that the claim is valid or prove it is a fraud case.

Video Tapes / Pictures

Someone once wrote, “A picture is worth a thousand words”. This is definitely true when the fraud perpetrator is caught on tape or a picture is taken of him performing activities that his injury would preclude him from doing (e.g. A person with a claim for a bad back injury is shown carrying a large, heavy chair into his home. Or imagine the individual that claims he can’t walk and is caught on tape dancing.

Witnesses

A witness report of an incident may be vital in providing proof that the claim is fraudulent. It is important that the adjuster conduct his interview of all witnesses as soon as possible after the occurrence, as time can dim the recollection of facts. It is important to determine if the witnesses have any connection to the claimant or are in cahoots with him. If not, the statement taken from the witness can carry a lot of weight in determining whether the facts, as reported by the claimant are valid.

Proof of Claim Loss

A fraudulent Proof of Loss is the document that a fraud case can hinge on. As stated before, by itself, signing a fraudulent document may not be a criminal act. It becomes so when the document is used to defraud an insurance company. The adjuster may have to testify that he based his settlement on statements attested to in the Proof of Loss forms.

Physical Evidence

Again, the adjuster should investigate the claim as soon as possible, as physical evidence may be destroyed or lost soon after the claim occurs. Some companies have the insureds take pictures of the scene immediately after the occurrence and ask them to save any evidence. It is easy for an individual to claim the stairs were broken 12 months down the road. However, if the insured or adjuster takes pictures and documents that they were fine at the time of the loss, a jury may be hard pressed to believe the claimant.

Documented Evidence

There is a myriad of evidence an adjuster may need to gather on a claim. Public records, ledgers, titles to properties, business records, ledgers, titles to properties, business records, and tax returns are just a few that can help substantiate either the claims or the fact that the claim is fraudulent.

Proof of Bodily Injury

CIB reports can give a history of injury and or claims presented. Independent Medical Exams (IME's), as discussed previously, can help a company disprove a Body Injury Claim.

Data and Document Collection

Again, the adjuster should collect all pertinent material to support the prosecution of fraud. The date a document is received should be logged in. The log should include the date documents are received, as well as how they were delivered and from whom they came. This way others involved in the scam may also get caught. For example, if a doctor delivers fraudulent bills for imaginary service, he too can be charged. Further, it is a good idea to use a notary public, if possible, when receiving a signed claim from a claimant.

Background Checks

An adjuster should do a variety of background checks to ascertain the demeanor of the claimant. He should, if possible, interview friends, neighbors, fellow employees and employers to determine the financial status or general character of the claimant.

Detection

Once fraud is detected, it should be the company's policy to get law enforcement agencies involved. Police personnel are stretched to the limit with their various responsibilities and often do not feel fraud is one of their big priorities. But this avenue is necessary even with the present limitations. Usually the insurer needs to finish his investigation before getting law enforcement into an active role. And it should be noted that the likelihood of a successful fraud conviction is based on the quality of that investigation.

Protecting the Evidence

Insurance companies need trained people to handle the documents and evidence. If they have set people taking in the evidence, making sure it is dated, logged in properly, and placed in a safe location, there will be a better chance that once law enforcement gets involved, the evidence will be intact and authentic. Video Taped, Taped conversation, and detailed minutes of interviews should be placed with the documentations for safekeeping until trial/prosecution.

Fraud case of the month

December 2006

Bad Time for Steak Thyme Subs

by James Quiggle

Musa Shteivi and his son Essa had a clear criminal vision for their Steak Thyme Subs eatery: They wanted to torch the West Chester, Ohio food outlet for insurance money. But they lacked a basic job skill: Nobody knew how to set a decent arson fire. Not even their hired arsonist.

After four botched attempts, Musa and Essa never saw a nickel of insurance money. They were dead from a gasoline explosion, and arsonist Joshua Hunter was in jail.

It's unclear why the Shteivis were so anxious for an insurance payout. But business owners sometimes resort to arson for an insurance bailout when they become debt-ridden or their business starts failing. Arson for profit also is an escape valve when the firm simply becomes a nuisance to operate.

Whatever the motives, smaller businesses are especially prone to insurance-driven arsons. They try to disguise the fire as an accident or an arson by a faceless criminal. But the owners are amateur arsonists, or hire amateurs who botch the job. The fire can spin out of control, killing or maiming innocents and damaging nearby buildings. Insurance investigators also can easily detect the red flags of arson, and quickly focus on the culpable owners.

Arsonist tries three times

Jordanian-born Musa and Essa had promised Hunter a \$60,000-dollar-a-year job if he'd burn down the place. Hunter agreed. The hapless torch tried to set three fires over the next six weeks in the summer of 2006, but never figured how to get a good blaze going.

One time he tossed a harmless Molotov cocktail through a window. Another time Hunter doused four chairs with a flammable liquid and set them on fire. The blaze quickly died and caused only minor damage.

Musa and Essa played dumb as word got out about the repeated fires. "I don't know who would do this," Musa told local 9News with a straight face. But they stuck with Hunter despite the screwups, and ordered a fourth blowout just 12 hours after Hunter's hapless assault on the chairs.

They decided to make the job so easy that even Hunter couldn't botch it: They went inside and spread gasoline around themselves. Hunter only had to come in later that night and start the fire.

But tragically, Musa and Essa had less arson talent than even Hunter: The pair took a smoking break—while standing in a pool of gasoline. They lit up their cigarettes, igniting an explosion that burned both men over 80 percent of their bodies and buckled a wall of the restaurant. They died within weeks. Hunter soon pleaded guilty to his part in the plot, and faces up to 10 years in prison when sentenced.

Owner torches hotel

A botched arson similar to the Shteiwis' also turned deadly in Hollywood, Calif. Anxious to avoid the large costs of upgrading his rickety tenement Palomar Hotel, owner Juan Ortiz torched the place for \$1 million in insurance money. But the gasoline exploded, sending a fireball roaring through the building.

A heat gust shoved resident Norma Galindo four stories to her death on the sidewalk below, just minutes after she handed her crying children to firefighters. Two other firefighters were seriously burned when flaming debris fell on them inside. Ortiz's own brother, who started the blaze, also died in the explosion. Ortiz was convicted of insurance fraud, and is being tried for other crimes.

In another arson that fortunately avoided tragedy, Barbara Colby Martin torched her rural Swiss Way Market for insurance money. The Scottsville, Va. woman was three months behind in rent, owed more than \$120,000 in state and federal back taxes, and was tired of running the store. Martin filed a \$250,000 claim with Hanover Insurance after the fire. She argued that a faulty staple that held electric wires might have caused the suspicious blaze. She received a mandatory minimum of 15 years.

Reputed mobster Sam Siligato earned 11 years in state prison for burning down his deteriorating building for \$200,000 in insurance money. Owing \$55,000 in property taxes, the Hammonton, N.J. man hired a migrant worker to burn down his building, which once was a deli. When his trial started, Siligato threatened a state witness with blood money—"three dollars with red stains on them."

Pizzeria burned down

Michael Augustine burned his Waterloo, Ill. pizza parlor for insurance money. He paid a crony \$470 to burn down the Pop N Pizza, only about two weeks after buying new coverage on the restaurant. Augustine provided a crony gasoline and containers to start the fire. He also threatened another potential witness, one of his accomplices in the blaze. Augustine pleaded guilty in federal court, and awaits sentencing.

Larger businesses are torched, as well as well. The top brass of a Long Island distributor of beauty products burned down their warehouse in a \$160-million investment and insurance scheme that ruined the company. The executives even bribed a fire official \$100,000 to list the fire's cause as accidental so they could collect insurance money and cover their own tracks. Herman and Jacob Jacobowitz await sentencing.

"Through a staggering series of willful and brazen schemes, these defendants looted a public company, defrauded thousands of investors, creditors and insurers out of more than \$100 million... all to fuel their greed and cover their tracks," U.S. Attorney Roslynn Mauskopf said. "This prosecution and please have successfully rooted out a massive corporate fraud and extinguished a culture of corruption and lawlessness that bred these crimes."

[James Quiggle](#) is director of communications for the Coalition Against Insurance Fraud, a national alliance of insurers, consumer organizations and government agencies combating all forms of insurance fraud. Visit www.InsuranceFraud.org, for more information. The author can be contacted at jamesq@InsuranceFraud.org.

Chapter 5 Anti-Fraud Laws, Rules and Regulations

Each state must pass laws individually to deter fraud. There is some federal legislation that will come into play, but it is as important that each state do its job to concentrate on making laws and regulations to fight fraud crimes. Right now, some states have some provisions that are stronger or better defined than others are. Enclosed at the end of this chapter is a comparison chart showing some differences between states.

Section A Key Aspects of each state

Insurance Fraud classified as a Crime

Insurance fraud is specified as unlawful in the state's penal code. A fraudulent act is committed if information in insurance applications is falsified in an attempt to lower premium rates, or to inflate the amount of loss in a claim. Defining the crime specifically helps educate law enforcers about insurance fraud and provides prosecutors with clear-cut cases. Raising the level of the crime from a misdemeanor to felony not only increases the penalties, but also acts as a deterrent to future crimes.

Where insurance fraud is not specifically mentioned in the penal code, more general provisions become applicable, most commonly theft by deception, which is on the books (in one of several forms) in 21 state. Seven other states have fraudulent schemes or practices laws which appear to cover insurance fraud. Nevada lists conspiracy to defraud another of property as a crime. Vermont appears to be the only state where the most applicable criminal statute is a grand larceny law. At least seven states have declared the making of false statements by anyone on an insurance application to be unfair trade practice and several states list insurance fraud as unprofessional conduct in statutes regulating doctors, lawyers and other professionals.

The use of Immunity Statutes

These types of laws provide protection for good faith exchange of immunity between insurers or others and state insurance departments or law enforcement agencies. Individuals or organizations are exempt from libel or unfair trade practice lawsuits, which could be brought against them for releasing information on prior claims. Some states have general statutes which apply to all kinds of insurance, while others pertain to cases of auto fraud.

Fraud Bureaus

Special Units have been set up in many states insurance departments to identify fraudulent acts, collect information on repeat offenders, and investigate cases. The main purpose of these bureaus is to set up documented criminal cases that can be readily prosecuted. Some bureaus have law enforcement powers.

Mandatory Insurer Fraud Plans

Many insurers are required by state laws to set up a specific program which identifies insurance fraud, and outlines remedial actions take to reduce it.

Section B Federal Laws

The Health Insurance Portability and Accountability Act” of 1996 contains Anti-Fraud Provisions. Its main thrust is to weed out fraud in the medical health care system in federal programs like Medicare. The Act also defines the crime of Health Care Fraud and provides prison sentences and fines for offenses.

The National Insurance Crime Bureau (NICB) provides online services that track insurance claims. This bureau is sponsored by insurance companies, law enforcement agencies, plus state and federal agencies. In 1995 the NICB, working with the FBI and local law enforcement agencies, helped to bring indictments on 121 individuals in 31 states involved in staged auto accidents. In 1996, it helped pass the Anti Car Theft Improvements Act.

Sectoin C State Regulations

We have attached copies of a chart showing the State Regulations. As you can see, many states have passed regulations to combat this growing epidemic. They have also set up fraud bureaus and made insurance fraud a felony.

The state charts also show that there are still states that do not have a hard line on insurance fraud. It may be simpler to have more federal legislation to help even out these discrepancies.

Section D Various Fraud Acts and Statutes

Arson Fraud

We are all aware that arson is a crime. In many states, it now includes vehicle arson.

Auto Fraud

The Comprehensive Crime Control Act, (Federal), makes it a federal offense to forge auto titles or registrations.

The Anti-Car Theft Act (also a Federal Act) makes car jacking a federal offense. It also requires repair shops to check Vehicle Identification Numbers (“VIN” numbers) for cars they are repairing with the FBI stolen vehicle list. It mandates that car manufacturers put “VIN” numbers on all new vehicles.

Auto manufacturers adopted a standard numbering system for identifying cars in 1954. The goal was to combat auto theft. Each car now has a VIN number. Each car has a different number to identify it from other cars. It is usually a 17+ digit strand of numbers and letters. Each number, letter, or set of numbers identifies different aspects of the car. This includes such facts as the car manufacturer, and car line. The number is printed in the Passenger Vehicle Identification Bureau each year.

Organized Crime Acts

The Federal Racketeer Influenced and Corrupt Organization Act (RICO) is regularly used to prosecute insurance fraud. It provides for the punishment of individuals directly or indirectly involved in insurance fraud. It provides that those convicted under this act pay triple damages.

Mail Fraud

The Federal Mail Fraud Statute prohibits the use of the mails to defraud or obtain money by false means or pretenses.

Property Fraud

Property losses that are of a suspicious nature are reported into the Property Insurance Loss Registry (PILR). It is maintained by member insurance companies to provide a source of information on fraudulent claims.

Workers Compensation Regulations

In some states that have set up fraud bureaus, one of the most common reasons for the set up was the eroding Workers' Compensation System. The National Insurance Crime Bureau estimates that Workers' Compensation fraud costs \$5 billion a year. The Coalition Against Insurance Fraud is pushing to make people convicted of Worker's Compensation Fraud provide restitution.

Issue	AL	AK	AZ	AR	CA	CO	CT	DE	DC	FL	GA	HI	ID	IL	IN	NY	NC	ND	OH	OK	OR	PA	RI	SC	SD	TN	TX	UT	VT	VA	WA	WV	WI	WY	
Fraud defined as a specific crime for:																																			
Claims fraud		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•			•			•	•
Underwriting fraud				•	•	•		•	•	•																•									
Insurer fraud				•		•		•	•																		•								
Fraud plan required				•	•	•			•	•						•			•			•					•					•			
SIU required				•	•	•			•	•						•											•								
Annual report requirement					•	•			•							•						•										•			
Auto pre-inspection										•						•						•													
Immunity		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Insurer-to-insurer				•	•	•		•	•	•					•	•			•					•		•							•	•	
Licensing board notification					•	•	•		•	•				•								•	•				•	•	•			•			
Fraud warning requirement		•	•	•	•	•		•		•				•	•	•			•	•		•	•				•		WC		•				

Immunity laws

State immunity laws listed below are specifically designed to allow insurers and others to share information related to insurance fraud investigations without fear of being sued for defamation. Other statutes may be in effect governing general immunity for good-faith reporting of all crimes. This information is provided for informational purposes only and should not replace competent legal counsel. For more information, contact [Howard Goldblatt](#), director of government affairs. This information also is available for [download](#) in pdf format

State	Insurer-to-Insurer Immunity	Specific immunity for reporting to:			
		Law Enforcement	Fraud Bureau	NAIC	NICB
Alaska		•	•	•	•
Arizona			•		
Arkansas	•	•	•		
California			•		
Colorado	•	•			
Connecticut		•			
Delaware	•	•	•	•	•
D.C.	•	•	•		
Florida	•	•	•	•	•
Georgia		•	•	•	
Hawaii	•	•	•	•	
Idaho	•	•	•	•	•
Illinois		•			
Indiana	•	•		•	
Iowa	•	•	•	•	•
Kansas	•	•	•		
Kentucky			•		
Louisiana			•	•	•
Maine		•			
Maryland		•	•		
Massachusetts	•	•	•		
Michigan		•		•	
Minnesota		•			
Missouri	•	•	•	•	•
Montana					
Nebraska	•	•	•	•	•
Nevada		•	•		

New Hampshire			•	•	
New Jersey			•	•	
New Mexico	•	•	•	•	
New York	•	•	•		
North Carolina	•	•	•		•
North Dakota		•		•	•
Ohio	•	•	•	•	•
Oklahoma		•	•		
Oregon					
Pennsylvania	•	•	•	•	•
Rhode Island	•	•			
South Carolina	•	•	•	•	•
South Dakota	•	•	•	•	•
Tennessee (wc)	•	•	•	•	•
Texas	•	•	•	•	
Utah		•	•		
Virginia	•	•	•	•	•
Washington					
West Virginia	•	•			
Wisconsin	•	•	•	•	
Federal immunity statute					

Immunity laws

New York

Section 406

In the absence of fraud or bad faith, no person shall be subject to civil liability, and no civil cause of action of any nature shall arise against such person (i) for any information relating to suspected fraudulent insurance transactions furnished to law enforcement officials, their agents and employees; and (ii) for any information relating to suspected fraudulent insurance transactions furnished to other persons subject to the provisions of this chapter; and (iii) for any such information furnished in reports to the insurance frauds bureau, its agents or employees or the workers' compensation fraud inspector general, its agents or employees. Nor shall the superintendent or any employee of the insurance frauds bureau, in the absence of fraud or bad faith, be subject to civil liability and no civil cause of action of any nature shall arise against them by virtue of the publication of any report or bulletin related to the official activities of the insurance frauds bureau. Nothing herein is intended to abrogate or modify in any way any common law privilege of immunity heretofore enjoyed by any person.

Chapter 6 Discipline / Enforcement

Section A Reporting Suspicious Claims

The adjuster who feels he has fraud indicators present in the claim to make him suspicious about the case, can do one of the following:

- The adjuster may review the claim with his manager, or a more senior adjuster, to see if they are in agreement with the suspicion.
- The Adjuster may want to inform the underwriter, just as they should on any material fact that would influence an underwriting decision, to stay on the risk. The underwriter can help the claim adjuster by supplying any information in the underwriting file that supports fraud indicators or that the investigation did not reveal, such as the claimant's history. If the fraud indicators are strong enough, the underwriter may cancel the policy.

Section B Determination of Fraud

If there is a suspicious claim, but not enough evidence to support a guaranteed prosecution, the company may do one of the following:

- Pay the claim
- Arbitrate the claim by offering a partial settlement
- Deny the claim

If the company denies the claim and the individual is not convicted, the company may be sued. This possibility is weighed based upon the facts of the case and if it would be winnable in court.

Section C SIU's

As mentioned before, many states have SIU's to handle the suspicious claims. These units have quickly become the focal point of fraud investigation. They have proved to be more effective in helping companies prove more fraud cases, as their entire handling of the claim is done with suspicion of fraud. The regular adjuster doesn't often have the time to do the extra work necessary in a suspicious claim. And some adjusters don't have the training to deal with fraud cases. The experience and expertise that has arisen in the SIU's has been a great tool in the fraud investigation.

Section D Independent Investigators

When fraud is suspected, the company may assign the claim to an independent investigator to do the additional work to support claim of fraud. They are often used to do surveillance work. They are also used to canvass the scene and secure additional witnesses.

New York State Insurance Department

ISSUED 10/20/2006

FOR IMMEDIATE RELEASE

NEW PROGRAM NABS DECATUR MAN FOR FELONY INSURANCE FRAUD

Superintendent of Insurance Howard Mills, Otsego County District Attorney John Muehl and State Fire Administrator James A. Burns of the Office of Fire Prevention and Control today jointly announced Peter Mravlja of Decatur, N.Y., has entered a plea of guilty to felony insurance fraud following a joint investigation into a suspicious fire at his dairy barn on April 20, 2003.

The investigation was the first conducted under a new pilot program initiated by Superintendent Mills. Under this program, the State lends an experienced insurance fraud prosecutor to local counties to act as an Assistant District Attorney. In this case, the fraud prosecutor was charged with responsibility for investigating and evaluating the merits of the fire and corresponding insurance claim. William Andrews, an attorney with the Insurance Department's Office of General Counsel, served as a Special Assistant District Attorney to the Otsego County DA's office and presented the case to a grand jury that brought indictments for arson, insurance fraud and witness tampering against Mr. Mravlja.

Superintendent Mills stated, "The Department is ready and willing to offer whatever resources it can to stop insurance fraud. This pilot program fills a gap between the ability and the desire to stop bogus claims. By offering our dedicated fraud fighters, we can assist the counties with the tools they need to stop the cheats. I am proud to announce the creation of this program and its rapid success. Through cooperation and partnerships we will continue to win the fight against insurance fraud."

District Attorney Muehl said, "I am very thankful to the Superintendent and the Insurance Department for extending their resources to this office. The special prosecutor pilot program is an excellent initiative that benefited the People of Otsego County. With our limited budget and resources we were able to prosecute an individual and bring him to justice in a complex case that otherwise would have been near impossible to pursue under our constraints. This program provides a dual benefit to both the residents of Otsego County and the State as we are able to prosecute insurance fraud cheats and obtain convictions in cases that otherwise may never have been prosecuted. In my view, this program not only brings additional people to justice, but of equal importance is one more deterrent against fraudulent claims and high premiums."

Mr. Mravlja called 911 on Easter Sunday 2003, to report a fire in the dairy barn at Mravlja Farms, 315 County Highway 37, Worcester, N.Y., owned jointly by Mr. Mravlja and his father, George. Thereafter six local fire departments and 53 volunteer firemen responded and battled the barn fire for almost seven hours. During the course of the fire, one fireman was physically injured and 23 beef calves perished. The farm subsequently closed.

The fire's origins were listed at the time as "undetermined" because an electrical malfunction could not be ruled out as a potential cause. Otsego County Patrons Co-Operative Fire Relief Association of Schenevus, New York, their insurer, paid Mravlja Farms a total of \$143,555.81 to compensate the

Mravlja family for the losses they incurred. Given a confidential tip that the Mravlja Farms fire may not have been an accident, the Association subsequently asked the New York State Insurance Department's Frauds Bureau to revisit the case.

The Office of Fire Prevention and Control joined the investigation, assigning Investigator James Ryan to review the cause and origin of the fire.

State Fire Administrator James A. Burns said, "The Office of Fire Prevention and Control is always available to assist in investigating fires. This particular prosecution was an excellent example of the partnerships and resources we can all bring together to successfully close a case. We applaud the Superintendent for the creation of this pilot program because arsons for-profit are inherently complicated. Not only is the determination of a fire's cause and origin investigation a difficult science, but when the fire was created for profit, there is the added complexity in sorting through the financial motive."

The joint investigation resulted in the three-count indictment, followed by the negotiated guilty plea to one count of felony insurance fraud. The terms of the plea agreement are that Mr. Mravlja repay the carrier the sum of \$50,000, perform a period of community service and serve an anticipated five-year felony probation period.

Mr. Mravlja remains free on \$5,000 bail pending his Nov. 3, 2006 sentencing.

LICENSEE	ADDRESS	PENALTY
Daniel M. Carmichael (Agent)		License Revoked
Respondent was convicted of grand larceny in the third degree for collecting commissions on insurance policies that he fraudulently procured. Respondent also collected cash premium payments from insureds and failed to remit the payments to the insurer. Respondent also failed to respond to Departmental investigatory letters. [Order issued September 21, 2006.]		

LICENSEE	ADDRESS	PENALTY
CSIR Enterprises, Inc. Judah Feinerman (Sublicensee)		Licenses Revoked
Respondent Feinerman pled guilty on or about November 22, 2004 to Conspiracy to Commit Wire and Mail Fraud. In making his plea, he admitted receiving fees in the mail and interstate wires from customers who were led to believe the fees would be applied toward the purchase of insurance policies. Respondent Feinerman collected millions of dollars in premiums for policies that were never obtained and issued certificates of liability and binders to clients from insurers that were not authorized to issue insurance coverage in this state for insurance coverage that had not actually been placed. [Order issued August 1, 2006.]		

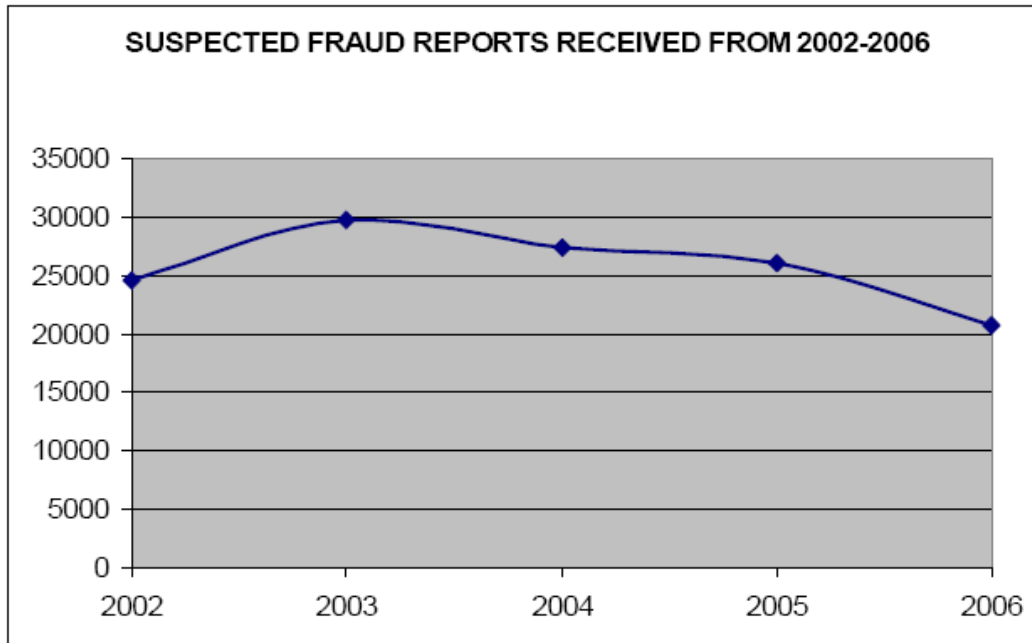
LICENSEE	ADDRESS	PENALTY
Donald J. Cummings (Agent)		License revoked
Respondent solicited and sold unauthorized annuity contracts to New York insureds; submitted fraudulent annuity contract applications to an insurer; conducted an insurance business using unlicensed names; and failed to notify the Department of a change in his business and/or residence address. [Order issued September 21, 2006.]		

LICENSEE	ADDRESS	PENALTY
John Hayden (Independent Adjuster)		License revoked
Respondent accepted money from a client for wrongfully enhancing the client's claim with an insurer by fraudulently inflating the extent of the property damage. As a result, Respondent was convicted of Insurance Fraud in the fifth degree. Respondent also failed to respond to Departmental investigatory letters. [Order issued November 5, 2004.]		

Insurance Frauds Prevention Act 2006 Annual Report

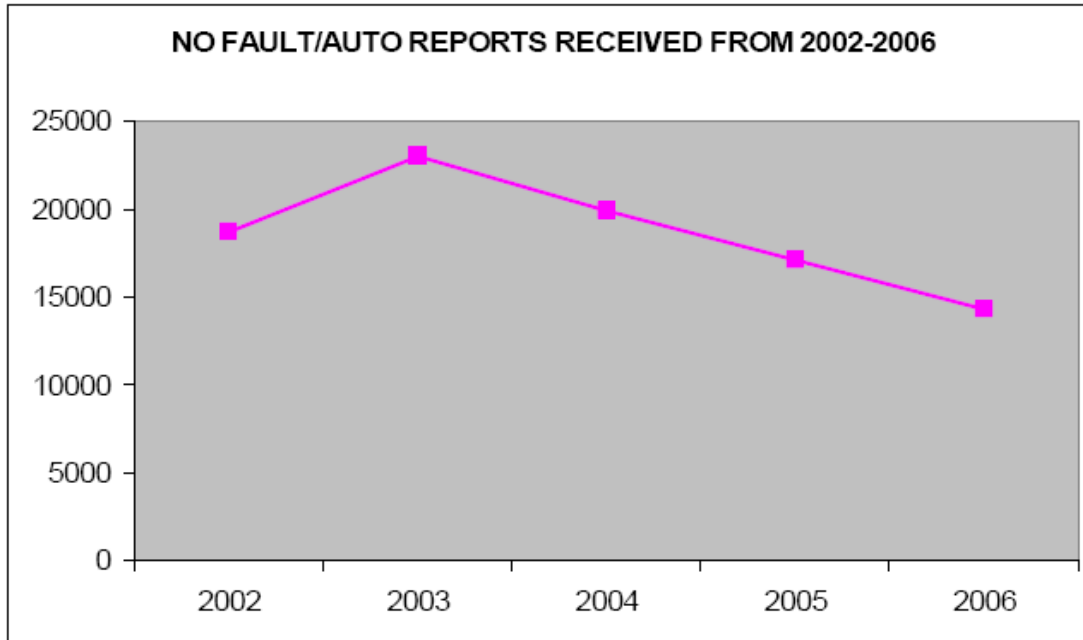
IFBs Received by Year	2001	2002	2003	2004	2005	2006
Auto Theft	2,085	1,694	1,927	1,778	1,082	1360
Theft From Auto	88	101	76	79	67	90
Auto Vandalism	260	235	385	297	263	326
Auto Collision Damage	1,129	775	1,819	1,614	1,071	1287
Auto Fraudulent Bills	58	32	35	33	19	39
Auto Misc.	724	707	1,213	1,451	1,335	1,125
No-Fault Auto Insurance	15,219	14,852	17,253	14,328	13,287	10117
Org./No-Fault/Auto Unit Totals	19,563	18,396	22,708	19,580	17,124	14,344
Workers' Compensation	1,733	1,086	1,121	1,027	1,118	1,034
Workers' Comp Unit Totals	1,733	1,086	1,121	1,027	1,118	1,034
Disability Insurance	93	102	73	65	96	129
Health Accident Insurance	1,572	1,518	1,791	2,236	2,183	1495
Medical Unit Totals	1,665	1,620	1,864	2,301	2,279	1,624
Auto Fire	374	267	315	400	309	310
Fire - Residential	159	127	114	135	154	157
Fire - Commercial	25	22	25	30	36	24
Arson Unit Totals	558	416	454	565	499	491
Auto I. D. Cards	591	536	191	130	214	73
Burglary - Residential	444	392	422	378	333	228
Burglary - Commercial	98	93	80	78	108	72
Homeowners	307	288	432	450	651	705
Larceny	25	45	43	58	48	56
Lost Property	112	108	182	263	339	256
Robbery	19	28	21	22	16	20
Bonds	0	6	6	5	5	1
Life Insurance	79	100	63	61	251	130
Ocean Marine Insurance	19	15	25	27	30	18
Reinsurance	2	0	1	0	0	0
Appraisers/Adjusters	12	5	30	7	4	3
Agents	42	65	50	52	42	41
Brokers	47	60	65	157	71	29
Ins. Company Employees	8	10	3	4	3	3
Insurance Companies	0	4	20	13	9	29
Unclassified	228	312	304	504	429	881
General Unit Totals	2,033	2,067	1,938	2,209	2,553	2,545

POSITIVE TREND



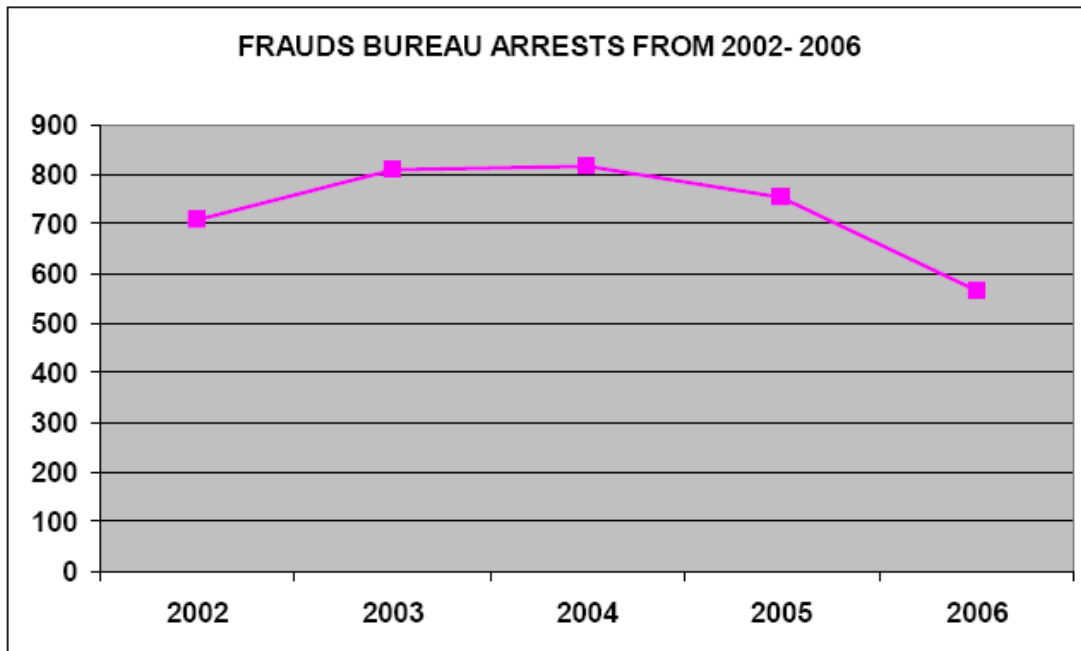
The Frauds Bureau has asked the industry to report not only clear incidents of insurance fraud but even those incidents with just the suspicion of fraud. Yet in the past three years, we have seen a decrease in the number of fraud reports submitted by the industry, a trend directly related to the combined efforts of the Frauds Bureau and prosecutors. Aggressive enforcement of the law leads to a reduction in crime.

RATE REDUCTIONS – SIGNIFICANT SAVINGS



- Reports of no-fault fraud have declined significantly in the past three years as major no-fault mill operators have been arrested and prosecuted. No-fault fraud is one of the costliest types of insurance fraud, driving up auto rates for all New York drivers.

HIGH-LEVEL, AGGRESSIVE ENFORCEMENT



- The Frauds Bureau and New York State prosecutors developed high-level, complex investigations that led to the arrest and prosecution of top-level organizers of fraudulent enterprises that cost consumers millions of dollars a year in higher insurance rates.

Regulators to Warn of Annuity Abuses

By Josh Friedman, LA Times Staff Writer

From: <http://www.latimes.com/business/la-fi-annuities9jun09,1,663545.story?coll=la-headlines-business>

Regulators will release a report today that says the variable annuity business is plagued by abusive sales tactics and will urge consumers to be cautious.

The report, by the Securities and Exchange Commission and the NASD, finds that annuities are frequently sold to people without regard to their financial circumstances, said a person familiar with the review.

The SEC's staff is expected to refer some of its findings to the agency's enforcement division for possible action, this person said.

The report's findings are expected to add pressure to the booming variable annuity business as regulators consider imposing new rules.

Variable annuities are retirement savings vehicles that aren't taxed until funds are withdrawn. The investor's money is typically placed in a stock or bond mutual fund that has the added protection of insurance that guarantees regular payments until death, which is known as an annuity.

Critics say annuities are often a bad deal in which consumers pay high fees for the benefits and brokers often don't disclose all the charges.

Variable annuity sales jumped tenfold during the 1990s, and last year assets in the industry increased 20% to about \$985 billion.

An SEC spokeswoman declined to comment on the report, except to confirm that it would be released today. With the report, the agency is expected to issue a consumer alert reminding investors that variable annuities are not suitable for everyone.

The report finds that annuities may be especially inappropriate for people who cannot tie up their money for a long time. That's because the contracts typically require investors to pay surrender charges if they withdraw more than 10% of their money in any of the first seven or so years, with exceptions for emergencies.

The report is expected to cite several examples of brokers making unsuitable recommendations to seniors and other investors. In some instances, investors had to mortgage their houses to afford the contracts, the source said. In other instances, consumers were not told about all the investment risks and expenses associated with the products, the report is expected to say.

Regulators and financial planners say that variable annuities can be useful as long-term investments but that consumers should be aware of their intricacies, including the surrender charges. In addition, ongoing expenses for the funds are usually higher than those for mutual funds.

Defenders of variable annuities note that the products offer far more features than mutual funds. In addition to guaranteed payments, annuities offer a "death benefit." When an annuity owner dies, his or her heirs are guaranteed to get at least the amount of the original investment.

For retirement savers, annuities also contain no investment caps — unlike individual retirement accounts, 401(k)s and similar vehicles that are also tax-deferred.

The NASD — the brokerage industry's self-regulatory organization formerly known as the National Assn. of Securities Dealers — recently proposed a sweeping set of rules governing the sales and marketing of variable annuities. The NASD's plan would require additional supervisory approval by any brokerage selling the products, as well as new training for brokers and "plain English" disclosure regarding the contract details at the point of sale.

In recent years, the NASD has brought approximately 80 enforcement actions against brokers alleging abusive practices in the sale of variable annuities. Among other abuses, brokers have been accused of "churning." Churning refers to the practice of getting investors to trade in old annuities for new ones to generate sales commissions.

In May, the NASD fined three securities firms and one broker a total of \$503,000 for violations involving variable annuity transactions. Two brokers were barred from the industry.

SEC Files Fraud Charges against Bilking Broker

It has filed a complaint against a Georgia broker for flat-out stealing maybe more than \$2.4 million from clients.

By Matthew Dublin

The SEC has filed a complaint against Georgia-based broker Dennis A. Martin charging three counts of securities fraud. Martin may have netted more than \$2.4 million through by misappropriating investor funds through forgery and gross misrepresentations. The Commission's charges coincided with a Georgia District Court order for a full accounting of all funds Martin received from his schemes, an expedited discovery process. It also prohibited destruction of documents, and ordered a freeze of Martin's assets.

According to the complaint, Martin was a registered rep with Linsco/Private Ledger Corp. from April 2004 through April 20, 2006. Martin worked as an independent contractor with LPL and operated out of his own office. At the same time, he conducted business as First Financial Group, a fictitious, unincorporated entity. The defendant allegedly stashed bilked customer funds in an account in the name of First Financial Group.

Starting in February, 2005, Martin allegedly advised between 5 and 29 customers to sell their current variable annuity contracts and purchase new contracts with higher principal investments. Martin told his customers that the new VAs would increase their minimum guaranteed death benefit.

After agreeing to the deal, the unwitting customers granted Martin authorization to sell securities in their accounts. At every step in the process, he told clients that he intended to invest their funds, according to the complaint. But instead, he redirected the money to his First Financial account, by forging customers' signatures on documents instructing the VA companies to close the annuity contracts and send the proceeds directly to him.

Martin then forged customers' names on the checks and deposited them into the First Financial account. He kept customer inquires regarding the location and status of their funds at bay through lies and falsified investment statements. He wasn't just ripping off strangers. One of Martin's supposed victims was his former father-in-law. On March 20, Martin advised his former relative to surrender his annuity contract through Pacific Life Insurance Company and purchase a higher principal annuity contract. He then allegedly forged the man's signature on an insurance company withdrawal request form directing the company to send him a \$198,077.57 check.

Martin then followed his usual modus operandi and forged the customer's name on the check for deposit into a First Financial account. When his former father-in-law inquired after the funds, Martin claimed he had invested the money in a "conduit IRA account," but would not disclose the account's location. He finally admitted to his ex-relative that he had "screwed up" after learning of LPL's investigation into the matter. He claimed that he had used the funds as collateral on a mortgage, but promised to repay the money within a few weeks. He also asked his former father in law to inform LPL that the funds had been repaid.

The SEC's complaint also describes an instance wherein Martin advised two clients to invest their annuity fund proceeds in a conduit IRA or "temporary IRA" through which he would invest on their behalf in a closed-end fund.

Martin assuaged the customers' concerns about penalty fees with a special First Financial "penalty waiver" offering. Martin later advised the customers to purchase a Lehman Brothers CD with a twenty-year maturity. Again, Martin deposited the customer's \$100,000 check intended for investment in the CD into a First Financial account.

In its complaint, the Commission is also seeking permanent injunctions against future violations, disgorgement of all ill-gotten gains, plus prejudgment interest and the imposition of civil penalties. LPL terminated Martin on April 20, 2006 for reasons related to this case.

Section 7 Insurance Fraud Summary, Facts and Opinions

Fraud is unquestionably a serious issue for the insurance industry. Fraud costs all sectors of the insurance industry \$80 billion a year. Property / Casualty fraud amount to \$30 billion a year.

Insurance fraud is any deliberate deception used as a means of obtaining money, goods and services against or by an insurance company or agent.

Fraud may be committed by many individuals, either singly or in groups/ rings. It can occur at different points in the insurance transaction: in the application process for insurance, while individuals are policyholders, as third-party claimants, and by professionals, such as doctors and lawyers, who provide service to a claimant.

The rise of fraud claims results in loss of profit to insurance companies. As a result, companies have been forced to raise rates to compensate. As part of the cycle, too many claimants have felt justified in padding their bills and stretching the truth on insurance application and claims.

There are no easy solutions to the problems of insurance fraud. Insurers, insurance departments, legislators, consumers and law enforcement agencies need to work together over the long haul against this crime.

The causes and factors behind insurance fraud are varied and often complex.

- Inconsistent and insufficient penalties
 - Drugs and violence are the top priorities with law enforcers. Insurance fraud and white-collar crimes need to be pushed as priorities, also. States still vary in penalizing fraud. More consistency is needed.
- Public Attitudes
 - Some mistakenly think insurance is a victimless crime. That is until they fall victim or until they are educated to see the value in fighting it.
- Insurance Company Practices
 - Some companies unwittingly promote fraud by paying off claims rather than fighting them. They believe it may be cheaper to do so, but they open themselves up for repetitions of the same.
- Medical Facilities
 - Some health providers and facilities have been tempted to inflate or fabricate claims of patients in order to gain bigger profits. They believe this is only fair to make up for the losses that have come to them as a result of cost cutting managed health care.

Efforts to portray fraud as a crime have found increasing success. Civil and criminal penalties for insurance fraud have been increased. This fact, with the increased publicity of insurance fraud on different fronts, has begun to help in the war against fraud. The media, newsletters and on-line computer have helped in this regard.

Special Investigation Units (SIU's) set up within insurance companies have been successful also. This has allowed for more successful prosecutions, as better trained and experienced investigators work on the fraud claims.

States will vary on the manner in which they handle and discipline fraud, but methods are becoming more consistent and effective. Continued communication should also help on this front. Federal legislation will also play a role.

The insurance industry fights fraud on two fronts: prevention and detection. The industry has started to pay more attention to the preventive aspect through education and publicity.

1. Agents, brokers and underwriters are the first line of defense. They can access on-line databases for information on policyholders and claims. They have also begun to do a better job meeting policyholders and claimants in person. The application process has become more systematized and exact. Inspection, identification checks, video taping and logging of information and documents has helped in the regard.
2. Public awareness/education is key to reducing the acceptability of insurance fraud. Media coverage, fraud newsletters, crime-stopper shows and computer information have made a dent in attitudes.
3. Staff education on fraud needs to occur in all businesses. Every employee and department needs to be informed and involved. Everyone needs to see the importance of becoming involved and active against fraud.
4. Detection and enforcement is the final step. With an organized and systemized investigation, fraud can be defeated. Whether through civil or criminal forums, fraud can be pursued and battled.

You may be outraged at the amount of money that is bilked from carriers by means of fraudulent claims. We hope that this course increased your awareness of the extent of insurance fraud. It continues to go on every second of every day. It is hoped that everyone, in and out of the insurance field, will seriously consider it their responsibility to play a role in the fight against this crime of fraud.

NEW YORK POST

CAR-INSURE \$WITCHEROO By TOM LIDDY

December 19, 2006 -- A group of con artists was nabbed yesterday for scamming car-insurance companies out of more than \$1 million, authorities said.

Eight taxi, limousine and school-bus company owners are accused of registering and insuring vehicles upstate and using them in the city, saving themselves \$1.5 million in premiums.

Police learned of the alleged fraud through insurance investigators who noticed "numerous [accident insurance] claims" in the city for vehicles registered out of the area.

FEDS CRACK CHIROPRACTOR 'FRAUD' AP

December 1, 2006 -- Two Wall Street chiropractors were busted yesterday on charges of defrauding insurance firms by charging for services that were never provided.

Christopher Green, of Wantagh, L.I., and Michael Horowitz, of Marlboro, N.J., even submitted bills for services they claimed to have provided while out of town, according to papers filed in Manhattan federal court.

The FBI began investigating after learning that Green had billed Oxford Health Plans for about \$172,000 - for allegedly treating Horowitz and Horowitz's wife.

11 CHEATED WORKER'S COMP: DA By IKIMULISA LIVINGSTON

October 19, 2006 -- Eleven people have been charged with scamming the worker's compensation system out of hundreds of thousands of dollars - including a man who kept cashing his deceased friend's check for 16 years.

Norman Berger is facing up to 15 years in prison for collecting nearly \$180,000 in benefits that were supposed to go to his housemate, who died more than a decade ago, said Queens District Attorney Richard Brown.

Berger, 60, of Manhattan, is charged with grand larceny, insurance fraud and other infractions.

The 10-month investigation caught 11 people reaping benefits they didn't deserve, authorities said.

Another suspect, Diane Brown, was hurt in 1984. But in 1998 she started working at a city hospital and allegedly continued to claim she was unemployed and due \$47,000.

December 30, 2006

City to Hire Investigators to Pursue Providers' Medicaid Fraud

By **TIMOTHY WILLIAMS**

New York City plans to hire 50 special investigators and auditors to pursue Medicaid fraud by hospitals, doctors and other health care providers as part of a new state pilot program, officials said yesterday.

The city will be the first municipality to participate in the Medicaid Fraud, Waste and Abuse Demonstration Project, which was enacted by the State Legislature last year and already involves 12 counties. Previously, local governments had lacked the authority to pursue fraud claims against Medicaid providers, though they were able to go after recipients suspected of Medicaid fraud.

Medicaid, a government health care program for the poor, has become one of the city's largest annual expenses in recent years as the number of people enrolled has risen to 2.7 million this year from 1.8 million in 2001. The federal government pays half of all Medicaid expenses, while the state and city split the cost of the remaining half.

The Medicaid program is projected to cost the city about \$4.8 billion this fiscal year, with the burden rising to \$5.2 billion in 2010, according to the city's Office of Management and Budget.

"We've been doing whatever we can to get control of the noncontrollable expenses," said Deputy Mayor Edward Skyler, referring to Medicaid, pension costs, debt service and fringe benefits that together consume more than half of the city's annual budget. "It is still a better deal for the city for a person to sign up for Medicaid and to go to a public hospital than it is for a person to go to a public hospital without insurance, because the city would foot the whole bill for that. If they have Medicaid, we are only paying one-fourth of the costs."

While it is unclear how much of the city's Medicaid costs are the result of fraud on the part of health care providers, Mr. Skyler -- who led the city's effort to become part of the program -- said that the city was hoping to recover at least several million dollars each year.

"I think it would be naïve to think there's no fraud in the system," Mr. Skyler said. "At the same time, predicting how much we can root out in the first year of the program is hard. We are being proactive because this is a mounting expense and the city has a vested interest in reducing fraud in the system."

The city intends to make the pilot project permanent, Mr. Skyler said.

The state has agreed to pay the city's \$6 million annual budget for the program, though the city will be required to reimburse the state if it recovers that much in Medicaid fraud and waste. Of monies above that amount, the city will be allowed to keep 25 percent of the resources it recovers, with 25 percent going to the state and 50 percent to the federal government. The counties that are already part of the program -- which include the ring of suburban counties around New York City, including Nassau, Suffolk and Westchester -- have not recovered significant amounts of money yet because the projects started so recently, said David Pietrusza, spokesman for the state Office of the Medicaid Inspector General.

Mr. Pietrusza however, said the state had recovered about \$673 million in Medicaid fraud in the 2006 fiscal year.

The city program, which will be administered by the city's Human Resources Administration, will begin work by mid-2007 after it has hired investigators, auditors, data analysts and other staff, and secured office space, officials said.

Since 2000, the H.R.A. has investigated Medicaid fraud carried out by recipients, mostly related to prescription medications. In all, the agency has recovered \$24 million, including \$3 million this year, officials said.

East News

Oneonta, N.Y. Business Owner Pleads Guilty to Insurance Fraud

January 11, 2007

Jeffrey Gelbsman, an Oneonta, N.Y. businessman, has pled guilty to fourth-degree insurance fraud related to a fire that occurred at Monser Brothers Tire Sales, Inc. in Oneonta in August 2002, according to Acting Superintendent of Insurance Louis W. Pietroluongo and Otsego County District Attorney John Muehl. This announcement follows Gelbman's arrest in April 2006.

Gelbsman's plea of guilty to fourth-degree insurance fraud is in exchange for a sentence of five years of probation and restitution of \$56,592.60. Gelbsman is due to be sentenced on April 2, 2007.

The investigation was the second conducted under a new pilot program initiated by the insurance department in 2006 and the second to end successfully with a conviction. Under this program, the state lends an experienced insurance fraud prosecutor to local counties to act as an assistant district attorney. In this case, the fraud prosecutor was charged with responsibility for investigating and evaluating the merits of the fire and corresponding insurance claim.

Selective Insurance Co., the property/casualty insurer for Monser Brothers Tire Sales, Inc., paid claims to Monser totaling more than \$480,000 for the losses the business incurred in August 2002. With the insurance monies, Monser Brothers Tire Sales, Inc. constructed its existing outlet at 375 Chestnut Street. The property on which Monser previously operated, and where the fire occurred, was subsequently sold to the city of Oneonta and converted into a municipal parking lot.

Source: New York State Insurance Department

1010 WINS - On-Air, Online, On Demand

Posted: Friday, 12 January 2007 6:40PM

Podiatrists Sentenced to 5 Years for Fraud

NEW YORK (AP) -- Two podiatrists who operated several clinics primarily serving indigent and elderly patients in New York were each sentenced to more than five years in prison Friday by a judge who noted that neither was remorseful for what prosecutors called a \$10 million fraud.

U.S. District Judge Kimba Wood imposed the sentence of five years and three months on Michael Brumer of Long Island and Lawrence Klein of Brooklyn and ordered the pair to pay a total of \$29,000 in fines.

"Medicare fraud is very harmful to the economy of the country," Wood said. "This is a very serious offense. It's the type of offense that harms society enormously."

Brumer and Klein, both 61, had pleaded guilty in 2003 to a Medicare and private insurance fraud that the government said cost the victims more than \$10 million.

The men, who both made pre-sentencing statements distancing themselves from their guilty pleas, were accused in an indictment of devising a system to defraud Medicare and private insurers while overseeing operations at foot-care clinics in New York City from 1986 to 2000. The indictment said they made claims for expensive procedures including surgery, anesthetic injections and X-rays when they actually had performed only routine foot care.

As she sentenced the men, Wood noted what she said was their lack of remorse and failure to take responsibility for the crime.

Assistant U.S. Attorney Marc Weinstein said the pair's actions had caused 15 others to be convicted of felonies in the case.

Producer Compliance

Continuing Education Requirements

New York State Insurance Department Licensees are required to complete 15 hours of approved continuing education during their licensing term. Changes to the education requirements are being implemented by the New York State Insurance Department to transition from date specific renewals for lines of authority to the date of birth for individual licensees.

Traditionally, individuals holding licenses for different lines of authority, such as Property Casualty Agent and Life Health & Accident Agent, are issued separate licenses with separate renewal dates (Life/Health agent renewals on 6/30 in odd years, Property/Casualty agent renewals on 6/30 in even years.) While individuals will continue to receive separate licenses for Life/Health and Property Casualty lines of authority, they will begin to renew all licenses together renewing on their date of birth and in the odd or even numbered year corresponding with their date of birth.

Transition to Birth Date Renewal

- Beginning in 2007 individual/tba Producer Licenses will begin the transition from a fixed date renewal to a renewal date based on their date of birth.
- An Individual with multiple licenses will end up with them all renewing on the same date.
- The licensing period will remain two years once the transition period has past.
- This will effect all individual/tba Producer licensees.

Date of Birth renewal

- Following Classes of licenses issued to individuals/tba will be effected by this change
 - Life, A/H
 - PC, Personal Lines
 - Life Broker
 - Consultants
 - Brokers/Excess Line Brokers
 - Reinsurance Intermediaries

General Rules

- The renewal period will not be less than two years
- The license renewal process will begin 120 days before its expiration date
- If a Producer licensed for LA, PC, LB, or BR does not submit a renewal application 60 days prior to the expiration date there will be an additional fee of \$10

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George E. Pataki
Governor



Insurance Department

Serving New York Since 1860



Howard Mills
Superintendent

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Online Renewal License Application

The application will be unavailable daily from 7:30am to 7:45am for regularly scheduled maintenance.

2006-08 Renewal Available for All Property/Casualty Agents

Additional note about using this Application: Please disable any "Pop-up Window" prevention software that you may be running before using this Application.

SYSTEM REQUIREMENTS

In order to renew your license online, you must use Internet Explorer version 5.5 or above OR Netscape Communicator version 4.7 or above. If you do not already have the required browser, please use one of the links below to access the Web site where you will be able to download the proper browser to use this online application.



In Addition:

Internet Explorer Users:

Internet Explorer Users must have a Cipher Strength of 128-bit encryption to use this application. To check

1. Select the Help Button
2. Select the About Internet Explorer option
3. Verify that the Cipher Strength is 128-bit
4. If it is, select the OK Button
5. If not, select Update Information and follow the instructions on www.microsoft.com

Important Note: After you have upgraded your web browser, restart your computer.

Netscape Users:



Enter License Number:(Numeric Portion Only) 537828

User ID:

Your user ID is the last 4 digits of your SSN, your 8-digit date of birth in (MMDDYYYY) format.
Example SSN 432-98-1234, DOB 08/26/46= 123408261946
Entities - user ID is the last 4 digits of the SSN and 8-digit date of birth in (MMDDYYYY)
format of a sublicensee/designated responsible person.

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Please select the class to be processed from the following list.

Your Licenses Pending Renewal

Select	Business Type	Class	License Number	Expiration Date	CE Required
<input checked="" type="radio"/>	TBA	PROPERTY & CASUALTY AGENT	537826	06/30/2006	NO

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NEW YORK STATE INSURANCE DEPARTMENT
WEB RENEWAL INSTRUCTIONS FOR PROPERTY & CASUALTY AGENT LICENSE FOR AN INDIVIDUAL/TBA
What must I submit to renew this license on the Web?

1. Completed Application.
2. Pay the required fee by Credit Card or Check. If paying by **CREDIT CARD**, the renewal license will be issued **within 2 business days**. See the [Fee Schedule](#). Separate payment is required for each application. **\$20.00** will be charged for each check dishonored by the bank.
3. If application reads: "**Continuing Education is required**" see the Continuing Education Note below.
4. **Submit online by 06/30/2006** or your license will expire.

Non-Resident - one who has declared a state OTHER than New York as their Home State. Home State is where you maintain a principal place of residence or business AND are licensed in good standing for the lines of authority being renewed in this application.

Resident - one who has declared New York as their Home State.

COMPUTATION OF TOTAL FEE

LICENSE FEE: If you declare New York as your home state, pay the license fee listed in the [Fee Schedule](#) for New York. If you declare a state OTHER than New York as your home state, pay the license fee listed in the [Fee Schedule](#) for the declared home state.

CONTINUING EDUCATION FILING FEE: Add \$10.00 if your application indicates that CE is required.

STATUTORY LATE FILING FEE: *If Applicable.

*If you are renewing your license with a prefix of LA, LB, PC, BR there will be a \$10.00 late fee if the renewal application is filed LESS than 60 days before expiration of the license.

TOTAL FEE: Add Continuing Filing Fee (if applicable) and Late Fee (if applicable) to License Fee listed in the [Fee Schedule](#). If license includes VARIABLE ANNUITIES, add additional VA fee to calculate total license fee if your home state charges extra for Variable Annuities.

CONTINUING EDUCATION NOTE

2006 Renewal: 15 credit hours of Continuing Education are required if the application indicates "CE REQUIRED." Do NOT submit Continuing Education documentation. Credits must be accumulated during the biennial licensing period and before submitting this application.

Non-residents who have met the Continuing Education requirements of their Home State need not take New York Continuing Education Courses.

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STATE OF NEW YORK INSURANCE DEPARTMENT
TBA PROPERTY & CASUALTY AGENT APPLICATION

07/01/2006 TO 06/30/2008

LICENSEE REILLY | JOHN | B | 537826
 *LAST NAME | *FIRST NAME | MIDDLE NAME | SUFFIX | LICENSE NUMBER

TBA NAME REILLY AGENCY

1. SOCIAL SECURITY# ***_**_**** 2. DATE OF BIRTH **_**_**** 3. GENDER M F
4. INSURANCE BUSINESS ADDRESS (**MUST BE COMPLETED, NUMBER AND STREET REQUIRED**) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

(IF YOUR COUNTRY IS NOT LISTED IN THE STATE /COUNTRY DROPDOWN BOX THEN YOUR APPLICATION CANNOT BE SUBMITTED VIA THE WEB)

1344 ROUTE 9

* ADDRESS LINE 1

ADDRESS LINE 2

PO BOX- GANSEVOORT SARATOGA COUNTY (FOR NY STATE ONLY)
 PO BOX / DROP BOX / OTHER *CITY
 New York 12831 (518) . 265 . 9637
 *STATE / COUNTRY *ZIP TELEPHONE #

5. INSURANCE RESIDENCE ADDRESS (**MUST BE COMPLETED, NUMBER AND STREET REQUIRED**) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

(IF YOUR COUNTRY IS NOT LISTED IN THE STATE /COUNTRY DROPDOWN BOX THEN YOUR APPLICATION CANNOT BE SUBMITTED VIA THE WEB)

58 BURNT HILLS DRIVE

* ADDRESS LINE 1

ADDRESS LINE 2

PO BOX- QUEENSBURY SARATOGA COUNTY (FOR NY STATE ONLY)
 PO BOX / DROP BOX / OTHER *CITY
 New York 12804 (518) . 265 . 9637
 *STATE / COUNTRY *ZIP TELEPHONE #

6. INSURANCE MAILING ADDRESS (**MUST BE COMPLETED, NUMBER AND STREET REQUIRED**) DO YOU WANT TO MODIFY THIS ADDRESS? Yes No

(IF YOUR COUNTRY IS NOT LISTED IN THE STATE /COUNTRY DROPDOWN BOX THEN YOUR APPLICATION CANNOT BE SUBMITTED VIA THE WEB)

Mailing Address: Same as Residence Business

56 BURNT HILLS DRIVE

ADDRESS LINE 1

ADDRESS LINE 2

PO BOX- []

PO BOX / DROP BOX / OTHER

QUEENSBURY

*CITY

SARATOGA []

COUNTY (FOR NY STATE ONLY)

New York []

*STATE / COUNTRY

12804 - []

*ZIP

(518) - 265 - 9637

TELEPHONE #

6a. []
*HOME STATE

7. I CERTIFY THAT I AM CURRENTLY LICENSED AND IN GOOD STANDING IN MY STATE OF DOMICILE FOR THE LICENSE APPLIED FOR IN THIS APPLICATION (Non-resident must complete this question in lieu of submitting a hardcopy home state certification.) Yes No

8. FOR FUTURE CORRESPONDENCE PROVIDE THE FOLLOWING : (Optional)

Primary E-mail : JOHN@REILLYCONSULTING.COM

Confirm Primary E-mail : JOHN@REILLYCONSULTING.COM

Secondary E-mail :

9. WEB SITE ADDRESS (optional) :

10. SUBMITTED BY (If not applicant):

Name:

Company:

Telephone #:

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Background Qualifications

The Applicant must read the following very carefully and answer every question:

1. Are you under obligation to pay child support? Yes No

- If Yes: a) Are you not in arrears or less than 4 months in arrears? Yes No
- b) Are you paying by Income Execution Plan agreed to by courts or parties? Yes No
- c) Is the obligation the subject of pending court proceeding? Yes No
- d) Are you receiving public assistance or supplemental security income? Yes No

2. Since execution and filing of your last application, other than traffic violations, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been convicted of, or are you currently charged with, committing a crime, whether or not adjudication was withheld? Yes No

"Crime" includes a misdemeanor, felony, or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.

"Convicted" includes, but is not limited to, having been found guilty by verdict of a judge or jury, having entered a plea of guilty or nolo contendere, or having been given probation, a suspended sentence or a fine.

3. Since execution and filing of your last application, other than traffic violations, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been involved in an administrative proceeding regarding any professional or occupational license? Yes No

"Involved" means having a license censured, suspended, revoked, canceled, or terminated; or being assessed a fine, placed on probation or surrendering a license to resolve an administrative action.

"Involved" also means being named as a party to an administrative or arbitration proceeding which is related to a professional or occupational license.

"Involved" also means having a license application denied or the act of withdrawing an application to avoid a denial. You may exclude terminations due solely to non-compliance with continuing education requirements or failure to pay a renewal fee.

4. Since execution and filing of your last application, has any demand been made or judgment rendered against you, OR any business in which you are or were an owner, partner, officer or director, during your connection therewith, for overdue monies by an insurer, insured or producer, or Yes No

have you been subject to a bankruptcy proceeding? (Only include bankruptcies that involve funds held on behalf of others.)

5. Since execution and filing of your last application, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, been notified by any jurisdiction to which you are applying of any delinquent tax obligation that is not the subject of a repayment agreement? (Any obligation that has been repaid or was a part of a bankruptcy proceeding may be excluded.) Yes No

6. Are you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, currently a party to, or have you or any business in which you are or were an owner, partner, officer, or director, during your connection therewith, been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, misappropriation or conversion of funds, or misrepresentation or breach of fiduciary duty? Yes No

7. Since execution and filing of your last application, have you, or any business in which you are or were an owner, partner, officer or director, during your connection therewith, had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct? Yes No

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STATE OF NEW YORK INSURANCE DEPARTMENT
WEB RENEWAL AGREEMENT FORM

THE APPLICANT MUST READ THE FOLLOWING VERY CAREFULLY:

I HEREBY CERTIFY THAT, UNDER PENALTY OF PERJURY, ALL OF THE INFORMATION SUBMITTED IN THIS ON-LINE APPLICATION IS TRUE AND COMPLETE. I AM AWARE THAT SUBMITTING FALSE INFORMATION OR OMITTING PERTINENT OR MATERIAL INFORMATION IN CONNECTION WITH THIS APPLICATION IS GROUNDS FOR LICENSE REVOCATION OR DENIAL OF THE LICENSE AND MAY SUBJECT ME TO CIVIL OR CRIMINAL PENALTIES.

WHERE REQUIRED BY LAW, I HEREBY DESIGNATE THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY IN EACH JURISDICTION FOR WHICH THIS APPLICATION IS MADE TO BE MY AGENT FOR SERVICE OF PROCESS REGARDING ALL INSURANCE MATTERS IN THE RESPECTIVE JURISDICTION AND AGREE THAT SERVICE UPON THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY OF THAT JURISDICTION IS OF THE SAME LEGAL FORCE AND VALIDITY AS PERSONAL SERVICE UPON MYSELF.

I FURTHER CERTIFY THAT I GRANT PERMISSION TO THE COMMISSIONER, DIRECTOR OR SUPERINTENDENT OF INSURANCE, OR OTHER APPROPRIATE PARTY IN EACH JURISDICTION FOR WHICH THIS APPLICATION IS MADE TO VERIFY INFORMATION WITH ANY FEDERAL, STATE OR LOCAL GOVERNMENT AGENCY, CURRENT OR FORMER EMPLOYER, OR INSURANCE COMPANY.

I FURTHER CERTIFY THAT, UNDER PENALTY OF PERJURY, EITHER a) I HAVE NO CHILD-SUPPORT OBLIGATION, OR b) I HAVE A CHILD-SUPPORT OBLIGATION AND I AM CURRENTLY IN COMPLIANCE WITH THAT OBLIGATION.

I AUTHORIZE THE JURISDICTIONS TO GIVE ANY INFORMATION CONCERNING ME, AS PERMITTED BY LAW, TO ANY FEDERAL, STATE OR MUNICIPAL AGENCY, OR ANY OTHER ORGANIZATION AS REFERENCED IN SECTION 110 OF THE NEW YORK STATE INSURANCE LAW AND I RELEASE THE JURISDICTIONS AND ANY PERSON ACTING ON THEIR BEHALF FROM ANY AND ALL LIABILITY OF WHATEVER NATURE BY REASON OF FURNISHING SUCH INFORMATION.

I ACKNOWLEDGE THAT I UNDERSTAND AND WILL COMPLY WITH THE INSURANCE LAWS AND REGULATIONS OF THE JURISDICTIONS TO WHICH I AM APPLYING FOR LICENSURE.

FOR **NON-RESIDENT LICENSE APPLICANTS**, I CERTIFY THAT I HAVE BEEN LICENSED WITHIN THE LAST NINETY (90) DAYS AND IN GOOD STANDING IN MY HOME STATE/RESIDENT STATE FOR THE LINES OF AUTHORITY REQUESTED FROM THE NON-RESIDENT STATE.

NOTIFICATION:

PERSONS FOUR MONTHS IN ARREARS IN CHILD SUPPORT OR WHO HAVE FAILED TO COMPLY WITH A SUMMONS, SUBPOENA OR WARRANT RELATING TO PATERNITY OR CHILD SUPPORT PROCEEDING MAY BE SUBJECT TO SUSPENSION OF THEIR BUSINESS, PROFESSIONAL DRIVER AND/OR RECREATIONAL LICENSE AND PERMITS INCLUDING BUT NOT LIMITED TO LICENSES ISSUED PURSUANT TO §11-0713 OF THE ENVIRONMENTAL CONSERVATION LAW.

INTENTIONAL SUBMISSION OF FALSE STATEMENTS FOR PURPOSES OF FRUSTRATING/DEFEATING LAWFUL ENFORCEMENT OF SUPPORT OBLIGATIONS IS PUNISHABLE UNDER §175.35 OF THE PENAL LAW.

PRIVACY NOTIFICATION:

PURSUANT TO ART. 1 SEC. 5 OF THE NYS TAX LAW, IT IS MANDATORY THAT YOU REPORT YOUR SOCIAL SECURITY NO. AND/OR EMPLOYER IDENTIFICATION NO. YOUR FAILURE TO RESPOND MAY BE REPORTED TO THE DEPT. OF TAXATION AND FINANCE. THESE TAX IDENTIFICATION NUMBERS ARE



CONTINUING EDUCATION QUESTION

15 credit hours of Continuing Education are required. Do not submit Continuing Education Documents. Credits must be accumulated during the biennial licensing period.

If you are a non-resident, you must have met the Continuing Education requirements of your State of Domicile. Section A OR Section B must be completed. You will be charged an additional \$10.00 to renew this license.

(A) New York Approved Continuing Education.

I ATTEST THAT I HAVE COMPLETED STATUTORY CONTINUING EDUCATION AS INDICATED BELOW AND MAINTAIN CERTIFICATES EVIDENCING THIS

Yes No

IT WILL BE NECESSARY FOR YOU TO ENTER THE DETAILS BELOW FOR THE CONTINUING EDUCATION COURSES THAT YOU HAVE TAKEN FOR THIS RENEWAL.

Table with 6 columns: COURSE, CREDITS, COURSE COMPLETED DATE (MM/DD/YYYY), COURSE, CREDITS, COURSE COMPLETED DATE (MM/DD/YYYY). It contains 8 rows of input fields for course details.

OR

If you answered (A) above and provided New York Course information, DO NOT answer (B). You can now proceed by selecting 'Next.'

(B) Non-Resident Continuing Education Certification Attestation:

I HEREBY CERTIFY THAT I HAVE MET THE CONTINUING EDUCATION CRITERIA OF THE STATE SELECTED IN THE BOX BELOW.

Yes No

MY STATE IS: [dropdown menu]

Next Reset



Fee Details

Renewal License Fee	\$	\$80.00
Continuing Education Fee	\$	\$0.00
Additional Variable Annuity Fee	\$	\$0.00
Statutory Late filing Fee	\$	\$0.00

Check Payable in US Dollars **\$ 80.00**

If paying by credit card, your application will be processed and your license issued within two business days.
If paying by check, your application will remain pending until the above check(s) made payable to the Superintendent of Insurance is/are received and processed by the Department's Renewal Unit.

Pay By Check	Cancel	Pay By Credit Card
------------------------------	------------------------	------------------------------------



Pay License By Credit Card

Credit cards accepted    

WARNING: PLEASE VERIFY THAT YOUR CREDIT CARD INFORMATION IS CORRECT. IF THE INFORMATION IS NOT CORRECT, YOU WILL BE REQUIRED TO LOG-IN AND ENTER THE INFORMATION ON THE APPLICATION AGAIN.

Credit Card Number		Card Type	Mastercard	<input type="checkbox"/>
Card Holder Name	JOHN REILLY	Zip	12831 -	
Credit Card Amount	80.00	Expiration Date(mm/yy)	02	09
		<input type="button" value="Process"/>	<input type="button" value="Cancel"/>	

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Glossary

Many of the coverage terms used in this course are familiar to all insurance producers. However, certain terminology does not carry across the P&C / L&H boundary. The following terms define the major areas covered throughout this course.

Accident

An unforeseen, unintended, unexpected event, mishap, or casualty. (HL GL-1)

Actual cash value

An amount equivalent to the replacement cost of lost or damaged property at the time of the loss, less depreciation

AD&D

Accidental Death and Dismemberment

Additional PIP

Additional First Party Benefits paid for extended loss on account of personal injuries sustained by an eligible injured person. Coverage applies to named insured's and other persons sustaining injuries.

Additional Disability Coverages

Wage loss benefits exceeding state minimums typically opted for by high income earners.

Admitted Company

An insurance company authorized and licensed to do business in a give state

Agent

One who solicits, negotiates, or effects contracts of insurance on behalf of an insurer.

Arbitration clause

The provision in a property insurance contract which states that if the insurer and insured cannot agree on an appropriate claim settlement, each will appoints an appraiser, and these will select a neutral umpire.

Assignment

Transfer by the policy owner of legal rights or interest in the policy contract to a third party

Auto liability

Covers against bodily injury and property damage for which the insured may become liable

BI – Bodily Injury

Bodily Injury means bodily harm, sickness or disease, including required care, loss of services and death that result. BI coverage is provided to a named insured under auto coverage policies.

Binder

A temporary contract or agreement executed by an agent or insurer putting the insurance into force before the contract has been written or the premium paid

Broker

One who represents an insured in the solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions.

Cancellation

When a portion of the premium is returned by insured and coverage has ended. Possible reasons for cancellation include fraud and non-payment of premiums

Coinsurance clause for property

A clause under which the insured shares in losses to the extent that he is underinsured at the time of loss.

Coinsurance clause for health

A provision stating that the insured and the insurer will share all losses covered by the policy in a proportion agreed upon in advance.

Collision –

Sudden damage to a vehicle caused by it coming in contact with another object. This definition is usually modified by terms and conditions in an automobile insurance policy.

Community Rating

A rating system in which the charge from insurance to all insured's depends on the medical and hospital costs in the community or area to be covered. Individual characteristics of the insured's are not considered at all

Comprehensive

This is the broadest form of coverage and will provide for any loss except for collision or overturn of the vehicle.

Conditions

These are provisions of an insurance policy which state either the rights and duties of the insured or the rights and duties of the insurer

Declaration

A term used in insurance other than life or health to denote that portion of the contract in which is stated such information as the name and address of the insured, the property insured, its location and description, the policy period, the amount of insurance coverage, applicable premiums, and supplemental representations by the insured

Disability Income (DBL)

Standard disability income insurance provides wage earners with temporary cash payment/benefits to partially replace wages lost for disabilities due to non-occupational injury or illness. The New York Disability Benefits Law (DBL) provides for payment of 50% of the average weekly wage to a maximum of \$170 per week for maximum of 26 weeks within a consecutive 52 week period and commences on the eight day of disability.

Direct Loss

A loss which is a direct consequence of a particular peril. Fire damage to a refrigerator would be a direct loss.

Dividend Options

The insured is given the option to apply dividends as follows: receive the dividend in cash, apply the dividend toward the payment of any premium due on the policy, apply the dividend to the purchase of paid-up insurance, or leave the dividend with the insurance company to accumulate at interest. Some companies have additional options.

Ethics

Honesty, integrity i.e. Insurance professionals should give full disclosure of information used for underwriting decisions

Felony

A charge in criminal conduct. The stricter of a crime from committing insurance fraud

Fidelity Bond

Protects insured regarding money and securities. Protects retirement plans against loss resulting from acts of fraud and dishonesty on the part of the fiduciary either directly or in collusion with others

Fiduciary

A person holding the funds or property of another in a position of trust.

Fraud

Deliberate deception used as a means of obtaining money, goods, and/ or services

Hazard

A specific situation that increases the probability of the occurrence of loss arising from a peril, or that may influence the extent of the loss

Health Insurance

A broad term covering the various forms of insurance relating to the health of persons. It includes such coverage as accident, sickness, disability, and hospital and medical expense. This term is used instead of sickness and accident insurance.

Health Maintenance Organization (HMO)

An organization that provides for a wide range of comprehensive health care services for a specified group in consideration of fixed periodic premium payments. An HMO may be sponsored by a medical school, hospital, employer, labor union, consumer group, insurance company, hospital medical plan, or the government.

Home Owners policy

A multi-line policy for owner occupied residences. Homeowner's policies provide property and liability coverage over dwelling, other structures and personal property.

Indirect Loss

Loss resulting from a peril but not caused directly and immediately by that peril

Insurance Fraud

Deliberate deception used as a means of obtaining money, goods, and/ or services in the insurance industry. Common types include arson, theft, staging vehicle accidents

Insurance Law

Statutory laws made by the assembly, senate and governor violation of these laws may also be imposed by the superintendent of insurance in addition to civil and criminal penalties

Insurance Scheme

A plot to receive money from unsuspecting customers looking to buy insurance. Insured's should be suspicious of the price of insurance seems to good to be true. They should contact the NYS Insurance department in order to make sure the agent and company are licensed as well as always check the bills closely for accuracy

Insurance Services Office (ISO)

An organization of the property and liability insurance business designed to gather statistics promulgate rates, and develop policy forms.

Insurance Services Organization

They print and distribute manuals, provide rules and forms. They also collect and compile data

Insuring agreement

That proportion of an insurance contract which states the perils insured against, the persons and/or property covered, their locations, and the period of the contract

Life Insurance

Insurance upon the lives of human beings that creates an immediate and guaranteed estate at the death of an insured and which may also provide living benefits through cash value. (LI GL-11)

Litigation

To contest in legal proceedings. Legal actions are typically employed by an injured individual against an insurance company to gain policy benefits to stated maximums. Litigation based on liability of an insured may also be used as a measure to obtain additional money to provide for additional losses.

Long Term Care

Long term care is the type of care that you may need if you can no longer perform "[activities of daily living](#)" by yourself, such as eating, bathing or getting dressed. It also includes the kind of care you would need if you had a [severe cognitive impairment](#) like Alzheimer's disease. Care can be received in a variety of settings, including your own home, assisted living facilities, adult day care centers or hospice facilities.

Long term care can be covered completely or in part by long term care insurance. Most plans let you choose the amount of the coverage you want, as well as how and where you want to use your benefits. A comprehensive plan includes benefits for all levels of care, custodial to skilled.

Material Misrepresentation

The most serious type of misrepresentation; i.e. a fraudulent statement made by the application of an insurance policy (also see Misrepresentation)

Medical Payments (Med Pay)

Medical Payments paid as reimbursement for medical and funeral expenses because of bodily injury, paid on a per-person, per-accident basis. Benefits are paid only to third parties under homeowner's policies and to first and third parties under auto coverage. Claims generally must be made within 3 years.

Medicare

A program of health insurance and medical care for persons who are 65 years of age or over, and certain other disabled persons under age 65, operated under the provisions of the Social Security Act. Medicare has two parts: Part A (Hospital Insurance), and Part B (Medicare Insurance, helps cover doctors' services, outpatient hospital care, and some other medical services that Part A does not cover).

Medigap policies

Issued to supplement Medicare benefits (paying for deductibles, coinsurance and even charges not covered by Medicare). In 1991, Congress established 10 standardized Medigap policies.

Miscellaneous Expenses

Hospital charges other than room-and-board; i.e. X-rays, drugs, laboratory fees, etc. (in connection with hospital insurance).

Misdemeanor

Criminal conduct i.e. filing an insurance claim which contains a fraudulent statement

Misrepresentation

A false statement, which the prospective insured makes in an application for a policy. A misrepresentation is material if the insurance company, having known the true facts, would have refused to issue the policy or taken other underwriting action such as charge an additional premium or requiring the or requiring the attachment of an impairment waiver. Statements are considered representations and not warranties. If an insurance company discovers an insured's misrepresentation on a policy they may cancel any coverage not required by law, giving the named insured 20 days notice.

Moral Hazard

A condition of morals or habits that increases the probability of loss from a peril.

Morale Hazard

Hazard arising out of an insured's indifference to loss because of the existence of insurance.

Motives for Insurance Fraud

Reasons why people file false claims and commit insurance crimes. They include loss of a large account, desire to change locations, gambling debts, economic loss, facing bankruptcy, inability to fill contracts, etc

Non Admitted Insurer (unauthorized or unlicensed insurer)

An insurer not licensed to do business in the jurisdiction in question.

Non-Owned Auto Coverage

Covers bodily injury and property damage for your company while vehicles are used by employees for your business use.

Non Renewal

When an insurance company does not renew a policy. In auto and home owners insurance the note of non-renewal is sent to the insured and must include the reason for non renewal

NYS Fraud Bureau

The investigative unit that are assigned to insurance fraud cases. They often work with law enforcement agencies as well as the insurance company's special investigative unit. They require insurance companies to develop thorough plans for prevention and detection of insurance fraud

OBEL – Optional Basic Economic Loss

Basic Economic Loss consists of medical expense, work loss, other expense and death benefit not to exceed \$50,000. Basic Economic Loss coverage is provided under statutory PIP. Optional Basic Economic Loss provides an additional \$25,000 of coverage that may be applied as directed by the recipient, subject to policy language.

Open Enrollment Period

A period of time during which people, who would otherwise have to submit evidence of insurability, can apply for group insurance or HMO coverage, without such evidence.

Peril

The cause of a possible loss

Physical Hazard

Any hazard arising from the material, structural, or operational features of the risk itself apart from the persons owning or managing it.

PIP - No Fault

Personal Injury Protection coverage provides reimbursement for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident. Benefits include Basic Economic Loss, Medical Expense, Death Benefit and Other Expenses defined by in a policy. Benefits are limited by the insuring agreement.

Pro Rata

Distribution of the amount of insurance under one policy among several objects or places covered in proportion to their value or the amounts shown

Regulation 60

The New York State Insurance Department Regulation governing the replacement of life insurance policies and annuity contracts in New York State.

Rental Car Coverage

Includes coverage to rent a vehicle in the event of a covered loss.

Replacement Cost

The cost of replacing property without a reduction for depreciation

Representation

A statement in legal terms, made on an application for insurance that the applicant represents as correct to the best of his knowledge and belief

Self Insurance

Making financial preparations to meet pure risks by appropriating sufficient funds in advance to meet estimated losses, including enough to cover possible losses in excess of those estimated.

Small Business Fraud

A small business committing insurance fraud; they have a higher tendency to consider arson and other crimes as a way out of financial difficulties. Statistics show a rise in small business fires when facing economic loss and/or bankruptcy

Social Security

Any government program which provides economic security for portions of the public.

Soft Fraud

When a normally honest person tells little white lies to their insurance company i.e. a homeowner inflating the value of their stereo stolen during a robbery

Special Investigative Unit (SIU)

An insurance company's fraud investigation department. They investigate fraudulent practices

State Fund

A fund set up by a state government to finance a mandatory insurance system such as Workers Compensation and Non occupational disability benefits.

Subrogation

The right of one who has taken over another's loss to also take over his right to pursue remedies against a third party

Superintendent of Insurance

The person in charge of the NYS Insurance department i.e. commissioner. He may revoke a license for any violation of the NYS Insurance law. Punishments include possible fines and imprisonment for up to one year plus suspension or revocation of all licenses

Supplemental Spousal Liability

Supplemental Spousal Liability Insurance means coverage against liability of an insured because of death or injuries to his or her spouse up to the liability insurance limits provided under the policy even where the injured spouse, to be entitled to recover, must prove the culpable conduct of the insured spouse.

Towing

Covers cost to tow an insured vehicle

Uninsured and Underinsured Motorist

Pays damages for bodily injury caused by drivers of uninsured vehicles, when such drivers are legally liable for injury to the insured and/or passengers.

Workers Compensation

Benefits paid for an injury (or disease contracted) arising out of and in the course of employment. The amount of the benefits and the conditions, under which employees are eligible, are determined by the workers' compensation law. In Most states, the insurance providing these benefits may be purchased from private insurance companies. In a few states, only a monopolistic state workers' compensation fund is permitted to issue such insurance. In some states, the coverage may be obtained from either a state fund or from a private insurance company. (HI GL-16)

Viaticals

Viatical, or a life settlement, is the sale of a [life insurance](#) policy by the [beneficiary](#) of the policy, before the policy matures. Such a sale, at a price discounted from the face amount of the policy but usually in excess of the current cash surrender value, provides the seller an immediate cash settlement. Generally, viatical settlements involve insured individuals with a life expectancy of less than two years. The life settlement market is currently focused on individuals with life expectancies of three to ten years. A life settlement can be an innovative wealth and estate planning tool, especially when the policy holder encounters changed circumstances, such as bankruptcy, divorce, unaffordable premiums, change in tax laws, or a serious or life threatening illness. From the perspective of the investor, purchasing a life settlement is similar to buying a bond with a negative coupon and an uncertain redemption date.

New York State Insurance Department License Renewal Process

New York State Insurance Department

Licensing Law Changes

(Posted 1/22/04)

New York has recently passed the Producer Licensing Model Act

The enactment of this legislation has caused substantial changes in Licensing procedures and requirements.

These changes appear in the following areas:

- Appointments
- Lines of Authority
- Terminations For Cause
- 90 Day Certification
- Resident/Nonresident
- Nonresident Excess Lines
- Exemptions from Licensing
- Licensee Reporting
- Commission Eligibility

Appointments

- Previously an appointment was required as part of an application for an original agents license.
- Now an agent's license may be issued without an appointment. However...
- An appointment must be made 15 days from either the date an agency contract is executed with the insurance company or the first insurance application is submitted.

Terminations for Cause

- Previously only Insurance Companies terminated agents/producers "For Cause"
- Now that responsibility has been expanded to include any of the following relationships:
- Employment
- Contract
- Other insurance business relationship
- This means that Producers as well as companies and others with an insurance business relationship with a Producer, must submit a written notice of Termination for Cause to the Department if they are terminating a producer for any of the reasons stated in the newly revised Section 2110 of the Insurance Law.

Responsibilities with Terminations For Cause

- Within 30 days of terminating a producer the party terminating must submit a statement to the Superintendent stating the facts relative to the termination for cause.
- Within 15 days after filing notification with the Superintendent, the party filing the termination for cause must provide a copy of that statement to the producer being terminated.
- Any supplemental information must be promptly submitted to the Superintendent and then to the producer.

Revised Section 2110

- Provides more detailed reasons for revoking or suspending a Producer license, including failure to pay state income taxes.
- It also extends the Superintendent's authority over producers whose licenses have expired, been surrendered or have lapsed by operation of law.

Resident/Nonresident

- Previously if a licensee had a business or resident address in New York they had to be licensed as a resident.
- Now a producer names their home state.
- The authorities they have in that State will determine how they may be licensed in New York.
- A producer may have a New York address and still be licensed as a nonresident.

Exemptions to licensing [revised section 2101(a)]

- A great deal of detail has been provided with regard to the duties that may be performed without being licensed as a Producer.
- This will make it easier to determine whether or not a license is required.

Commission Eligibility

If a Producer is licensed at the time of the sale, solicitation, or negotiation of an insurance policy he/she may receive renewal or deferred commissions even if he/she is no longer licensed. This is true for all lines of authority.

Line of Authority

- The major lines of authority are now:
- Life
- Accident and Health or Sickness

- Property
- Casualty
- Variable Life/Variable Annuity
- Personal Lines - property and casualty (this line now requires only 40 hours of pre-licensing education)

Certification for Nonresident Licensing

- A Producer may now apply for licensing based upon a certificate, which indicates that he/she was licensed in good standing within the last 90 days.
- It is not required that they be currently licensed.

Licensing Nonresident Excess Lines Brokers

- New York will now license nonresident Excess Lines Brokers for business other than just Purchasing Groups.
- Provided that the applicant's home state will license New York licensees in the same manner.

Licensees Reporting Requirements

- A licensee must notify the Superintendent of a change of address within 30 days of the change.
- If a licensee changes his/her home state they must provide certification from the new home state within 30 days.
- Licensees must report any administrative action taken against them in any other jurisdiction or by another governmental agency within 30 days.
- A licensee must report any criminal prosecution taken against him/her within 30 days of the initial pretrial hearing date.

Frequently Asked Questions



Must Producers now notify the Insurance Department when they terminate a business relationship with another Producer?

Ans: Only if that termination is for a "For Cause" reason as shown in Section 2110 of the insurance law.



Are there any liability protections for the terminating party?

Ans: In the absence of fraud, bad faith or gross negligence, a producer shall not be subject to civil liability. Refer to Section 2112(g)(1) of the New York Insurance Law for complete text.

? May nonresidents still apply through NIPR if they do not have an appointment?

Ans: Yes. Both the NIPR and New York Resident online application process have changed to accommodate applicants for agent licensing without appointments.

? Is there an online process for submitting a Termination for Cause Notice?

Ans: At this time the online appointment and termination process is only available for insurance companies. If a producer is filing a Termination for Cause Notice they may do so in writing to the:

New York State Department of Insurance
Consumer Services Bureau
One Commerce Plaza
Albany New York 12257

? Will Personal Lines Producers have to do 15 credits of Continuing Education?

Ans: Yes. The only change is for the Pre-licensing Education, which is 40 hours instead of 90.

? Is there a specific exam for Personal Lines?

Ans: Yes. Our exam vendor Experior Assessments will administer these exams. They may be contacted at <http://www.experioronline.com/>

? Will there still be Agents and Broker Licenses?


Ans: Yes. "Producers" are defined as, Agents, Brokers Reinsurance Intermediaries and Excess lines Brokers. Licenses will indicate you are a Producer licensed as an Agent, Broker, Reinsurance Intermediary or Excess Lines Broker.

? Will this change licensing for Excess Lines?


Ans: Yes. Previously New York would only license Nonresident Excess Lines Brokers for dealing with Purchasing Groups. Now they will be licensed to do the same business residents may. Providing their home state will license New York residents in the same manner.

? What will happen if a producer fails to file a "termination for cause" report to the Superintendent?


Ans: Any violation of the Insurance Law is a matter for investigation, and may result in disciplinary action.

 Would the Department take action against a Licensee for outstanding New York State Income taxes?

Ans: Any violation of the Insurance Law is a matter for investigation, and may result in disciplinary action.

 Other states have gone to a single Producer license, allowing the licensee to operate as either an Agent or Broker. Is this the same for New York?


Ans: New York has maintained the distinction between an Agent and Broker. The term "Producer" is an all-inclusive term, covering Agents, Brokers, Excess Line Brokers and Reinsurance Intermediaries.

 Will New York still have sublicensees for entities?


Ans: Yes. There will be at least one qualified person as the designated responsible party for any entity.

 How many Home States may a Producer have?

Ans: Only one. However a Producer may change their Home State with proper notification.

 Do I need an appointment to get an original agent's license?

Ans: You do not need an appointment to become licensed as an agent. You must however have an appointment 15 days after an agency contract is executed or the first insurance application is submitted.

 What are the additional reporting requirements and what will happen if a Producer fails to comply?

Ans: Producers must report a change of address, change of home state, any administrative action taken against them, as well as criminal prosecution. If they fail to report any of the above the matter will be investigated and may result in disciplinary action.

STEP BY STEP INSTRUCTIONS FOR NEW YORK STATE ONLINE INDIVIDUAL/TBA LICENSE RENEWALS “CORPORATIONS & PARTNERSHIPS MUST BE MAILED IN”

- 1 Point your web browser to www.ins.state.ny.us/enrenew1.htm
- 2 Read the Instruction Page CAREFULLY!
- 3 Click the “Renew Your Individual/TBA License” button at the bottom of the Instruction Page screen
 4. A) Enter the Numeric Portion of your license number in the first box B) Enter your Password in the second box
 - a. Note: Your password is the last 4 digits of your social security number, plus your full date of birth.
 - b. Note: If you receive an error message while attempting to login, you should contact the New York State Insurance Department for assistance. It is strongly suggested that you send an “Email Message” with your license number, date of birth, last 4 digits of your social security number and your complete name, with a description of the error you are receiving. The Department answers most inquiries within several hours.
 - 4 Select the license to be renewed
 - 5 Read the “Web Renewal Instructions...” and click “Next” to continue
 7. A) Complete the Application
 - a. Note: The “Web Renewal” allows you to correct certain information. Please review the application carefully and make any necessary changes.
 - b. Note: If you answer yes to question 8 and/or 9 and do not have the “case number” available, you should exit the application until you have the required data. You may contact the Department for assistance. It is suggested that you contact the Department by email at coned@ins.state.ny.us.
 - B) Enter your CE Course Completion numbers in question 10 (a)
 - c. Note: Please contact your Continuing Education Providers if you are unable to locate your Course Completion Numbers. The Department is unable to provide course completion numbers!
 - d. Note: DO NOT ANSWER QUESTION 10B – unless you are a non-resident licensee in New York C) Click Next
 8. A) Read the “Pop Up” window. B) Click the “I Agree...” button to continue C) Note: It is strongly recommended that you elect to pay by credit card. You may pay by check, however, this will delay the issuance of your license. If you pay by credit card your license renewal will be processed within 48 hours. D) Click Process
 - 2 Print a copy of your invoice. This is your receipt of your license processing.

Congratulation on the successful completion of your Online Renewal!

Sample Questions:

- 1) Insurance Fraud affects:
 - A. Insurance Companies
 - B. Policy Holders
 - C. Agents and Brokers
 - D. All of the Above

- 2) Small Businesses have more of a tendency to consider arson as a way out of a financial difficulty than would a large operation.
 - A. True
 - B. False

- 3) Indicator(s) of Medical Fraud / Claim Inflation would be:
 - A. Minor Accident produces major medical costs
 - B. All of the injuries are of a subjective nature, headache, whiplash, etc.
 - C. Both
 - D. Neither

- 4) Toll-Free 800 numbers are being set up by some states to combat fraud:
 - A. True
 - B. False

- 5) An employer could be suspect of Workers Compensation insurance fraud if:
 - A. Payroll for certain classifications do not match with number of employees for a job title, ex. 25 office clerical personnel and 2 factory line workers
 - B. Claims for benefits are paid directly to the insured from the Workers Compensation Insurance Carrier

Answers: 1, D 2, A 3, C 4, A 5, A