

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW
YORK
TITLE 11. INSURANCE DEPARTMENT
CHAPTER IV. FINANCIAL CONDITION OF INSURER AND REPORTS TO SUPERINTENDENT
SUBCHAPTER A. RULES OF GENERAL APPLICATION
PART 86. REPORTS OF SUSPECTED INSURANCE FRAUDS TO INSURANCE FRAUDS BUREAU;
REQUIRED WARNING STATEMENTS

Section 86.1 Introduction.

This Part is hereby promulgated to establish procedures to effectuate the purposes of the Insurance Frauds Prevention Act (L. 1981, ch. 720), as amended

Section 86.2 Definitions.

The following shall govern the construction of the terms used in this Part:

- (a) "Claimant" means any person who attempts to obtain a benefit from an insurer or self-insurer.
- (b) "Commercial insurance" means insurance other than personal insurance.
- (c) "Insurance policy" has the meaning assigned to insurance contract by section 1101 of the Insurance Law, except it shall also include reinsurance contracts, purported insurance policies, self-insurance plans and purported reinsurance contracts.
- (d) "Insured" means the named insured, as defined in the policy, or an applicant for insurance.
- (e) Insurer means an insurer authorized to do an insurance business in this State, including any organization exempted from compliance with the licensing requirements by the Insurance Law which is engaged in the business of insurance in this State. For the purposes of this Part, all health maintenance organizations, the Motor Vehicle Accident Indemnification Corporation, the New York Automobile Insurance Plan, the New York Property Insurance Underwriting Association, and the Medical Malpractice Insurance Plan shall be deemed insurers.
- (f) Person includes any individual, firm, association or corporation.
- (g) Personal insurance means a policy of insurance insuring a natural person against any of the following contingencies:
 - (1) loss of or damage to real property used predominantly for residential purposes and which consists of not more than four dwelling units, other than hotels, motels and rooming houses;

- (2) loss of or damage to personal property which is not used in the conduct of a business;
- (3) losses or liabilities arising out of the ownership, operation or use of a motor vehicle, predominantly used for non business purposes;
- (4) other liabilities for loss of, damage to or injury to persons or property, not arising from the conduct of a business; and
- (5) death, including death by personal injury, or the continuation of life, or personal injury by accident, or sickness, disease or ailment, (excluding) including insurance providing disability benefits pursuant to article 9 of the Workers' Compensation Law.

A policy of insurance which insures any of the contingencies listed in paragraphs (1) through (5) of this subdivision as well as other contingencies shall be personal insurance if that portion of the annual premium attributable to the listed contingencies, exceeds that portion attributable to other contingencies.

(h) Statement includes, but is not limited to, any notice, proof of loss, bill of lading, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or medical provider records, X-ray, test result and other evidence of loss, injury or expenses.

(i) Claim form includes any document supplied by an insurer or self-insurer, directly or indirectly, to a claimant which the claimant is required to complete or submit in support of a claim for benefits.

Section 86.3 Applicability.

The provisions of this Part shall apply to all kinds of insurance authorized by section 1113(a) of the Insurance Law.

Section 86.4 Warning statements.

(a) Except with respect to automobile insurance, all claim forms for insurance, and all applications for commercial insurance and accident and health insurance, provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State, shall contain the following statement:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

(b) All applications and claim forms for automobile insurance provided to any person residing or located in this State in connection with insurance policies for issuance or issuance for delivery in this State shall contain the following statement:

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for commercial insurance or a statement of claim for any commercial or personal insurance benefits containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who, in connection with such application or claim, knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation."

(c) Self-insurers may adopt one or both of the required warning statements set forth in (a) and (b), above on their claim forms.

(d) Location of warning statements and type size. The warning statements required by subdivisions (a), (b) and (e) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size. On claim forms which require execution by a person other than the claimant, or in addition to the claimant, the warning statements required by subdivisions (a), (b) and (e) of this section shall be placed at the top of the first page of the claim form or on the page containing instructions, either in print, by stamp or by attachment and shall be in type size which will produce a warning statement of conspicuous size.

(e) Notwithstanding the provisions of subdivisions (a) and (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.

Section 86.5 Reports of fraudulent acts.

Any person licensed pursuant to the provisions of the Insurance Law who determines that an insurance transaction or purported insurance transaction appears to be fraudulent or suspect shall submit a report thereon to the Insurance Frauds Bureau. Reports shall be submitted on the prescribed reporting form issued by the Insurance Frauds Bureau or upon any other form approved by order of the superintendent. Reporting may also be done by means of any medium or system approved by order of the superintendent.

Section 86.6 Fraud prevention plans and special investigation units.

(a) Every insurer writing private or commercial automobile insurance, workers' compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, which writes 3,000 or more of such policies in any given year, and every entity licensed pursuant to article forty-four of the

public health law, except those entities with an enrolled population of less than 60,000 persons in the aggregate and except those entities certified pursuant to sections 4403-a, 4403-c, 4403-d, 4403-f, and 4408-a of the public health law, shall develop and file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this State and those fraudulent insurance activities affecting policies issued or issued for delivery in this State. Notwithstanding the foregoing, insurers writing only reinsurance contracts shall not be required to comply with the provisions of this section.

(b) The plan shall include the following provisions:

(1) Establishment of a full time Special Investigations Unit separate from the underwriting or claims functions of the insurer, which shall be responsible for investigation of cases of suspected fraudulent activity and for implementation of the insurer's fraud prevention and reduction activities under the Fraud Prevention Plan. In the alternative the insurer may contract with a provider of services to perform all or part of this function, but shall remain primarily responsible for the development and implementation of its Fraud Prevention Plan. The agreement under which such services are provided shall be filed with the Insurance Frauds Bureau as part of the Fraud Prevention Plan, and must provide for specified levels of staffing devoted to the investigation of suspected fraudulent claims. In the event that investigators employed by a provider of services will be working for more than one insurer or on cases in states other than New York, the plan must apportion the percentage of the investigator's efforts which will be devoted to working for the insurer on its New York cases. The agreement shall also require that the provider of services cooperate fully with the Department of Insurance in any examination of the implementation of the Fraud Prevention Plan, and provide any and all assistance requested by the Insurance Frauds Bureau, any other law enforcement agency or any prosecutorial agency in the investigation and prosecution of insurance fraud and related crimes.

(2) A description of the organization of the Special Investigations Unit, including the titles and job descriptions of the various investigators and investigative supervisors, the minimum qualifications for employment in these positions in addition to those required by this regulation, the geographical location and assigned territory of each investigator and investigative supervisor, the support staff and other physical resources, including database access available to the Unit and the supervisory and reporting structure within the Unit and between the Unit and the general management of the insurer. If investigators employed by the Unit will be responsible for investigating cases in more than one State, the plan must apportion that percentage of the investigators' efforts which will be devoted to New York cases.

(3) The rationale for the level of staffing and resources being provided for the Special Investigations Unit which may include, but is not limited to, the following objective criteria such as number of policies written and individuals insured in New York, number of claims received with respect to New York insureds on an annual basis, volume of suspected fraudulent New York claims currently being detected, other factors relating to

the vulnerability of the insurer to fraud, and an assessment of optimal caseload which can be handled by an investigator on an annual basis.

(4) A description of the relationship between the Special Investigations Unit and the claims and underwriting functions of the insurer, including procedures for detecting possible fraud, criteria for referral of a case to the Unit for evaluation, and the designation of the individuals authorized to make such a referral; and a description of the relationship between the Unit and the Insurance Frauds Bureau, other law enforcement agencies and prosecutors, including procedures for case investigation, detection of patterns of repetitive fraud involving one or more insurers, criteria for referral of a case to the Insurance Frauds Bureau, designation of the individuals authorized to make such referrals, and a policy to avoid duplication of effort due to concurrent referrals by the Unit to more than one law enforcement agency.

(5) Provision for the reporting of fraud data to a data collection form to be designated by the superintendent.

(6) Provision for in-service training programs for investigative, underwriting and claims personnel in identifying and evaluating instances of suspected insurance fraud, including an introductory training session and periodic refresher sessions. This description shall include course descriptions, the approximate number of hours to be devoted to these sessions and their frequency.

(7) Provision for coordination with other units of the insurer to further fraud investigations, including a periodic review of claims and underwriting procedures and forms for the purpose of enhancing the ability of the insurer to detect fraud and to increase the likelihood of its successful prosecution, and for initiation of civil actions where appropriate.

(8) Development of a public awareness program focused on the cost and frequency of insurance fraud, and methods by which the public can prevent it.

(9) Development of a fraud detection and procedures manual for use by underwriting, claims and investigative personnel.

(10) Timetable for the implementation of the Fraud Prevention Plan, provided however, that the period of implementation shall not exceed six months from the date the Plan is approved.

(c) Persons employed by Special Investigations Units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education and/or experience which shall include:

(1) an associate's or bachelor's degree in criminal justice or a related field; or

(2) five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies; or

(3) seven years of professional investigation experience involving economic or insurance related matters; or

(4) an authorized medical professional to evaluate medical related claims.

Notwithstanding these minimum requirements, anyone employed as an investigator in a special investigation unit or by a provider of investigative services under contract to an insurer as of the effective date of this amendment and who was also so employed on or before September 10, 1996 may continue in such employment provided the insurer identifies such person in writing to the superintendent giving the date such employment began and a description of the person's qualifications, employment history and current job duties.

(d) Every insurer required to file a fraud prevention plan shall file an annual report with the Insurance Frauds Bureau no later than January 15 of each year on a form approved by the superintendent, describing the insurer's experience, performance and cost effectiveness in implementing the plan and its proposals for modifications to the plan to amend its operations, to improve performance or to remedy observed deficiencies. The report shall be reviewed and signed by an executive officer of the insurer responsible for the operations of the Special Investigations Unit.

Section 86.7 Separability provision.

If any provisions of this Part or the application thereof to any person or circumstance is held unauthorized by law, the remainder of this Part and application of such provision to other persons or circumstances shall not be affected thereby.