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I. CIVIL INVESTIGATIVE AND ENFORCEMENT ACTIVITIES

The FFCPD's Civil Investigation Unit includes a team of attorneys who, utilizing the investigative and enforcement powers granted by the Financial Services Law, investigate civil financial fraud, consumer law, banking law and insurance law violations. Some of the Unit's investigations, activities and initiatives since the FFCPD began its work on October 3, 2011, the effective date of the merger, are discussed below.

Mortgage Servicing Reform

Consumers as well as housing and legal services advocates have expressed concern to DFS about the mortgage foreclosure process. Consumer groups have voiced concerns that the industry is not following the law and negotiating in good faith and is not actively exploring options other than foreclosure. The industry has voiced concerns over the length of the modification and foreclosure processes and the need for increased efficiency as many cases now experience long delays in the court system. The Department recognizes that problems with the mortgage foreclosure and modification processes adversely affect New York's economy, homeowners, tenants, and the lending industry, and the Department has been actively working with consumer groups and the mortgage industry to find ways to improve various aspects of the processes.

Through the efforts of the Financial Frauds and Consumer Protection Division, the Department has achieved much needed reforms in the mortgage servicing industry. In fall 2011, the FFCPD secured agreements from eight mortgage servicers to reform their servicing and foreclosure processes. Ocwen Financial, Morgan Stanley, Saxon, American Home Mortgage Servicing, Vericrest Financial, Goldman Sachs Bank, Litton Loan Servicing, and Specialized Loan Servicing signed Mortgage Servicing Practices agreements with the Department.

The Mortgage Servicing Practices agreements signed by the eight servicers make important changes in the mortgage servicing industry which, as a whole, has been plagued by troublesome and unlawful practices. The agreements require the servicers to:

- End robosigning and implement staffing and training requirements to prevent robosigning;
- Withdraw any pending foreclosure actions in which filed affidavits were robosigned or otherwise not accurate;
- Provide a dedicated Single Point of Contact representative for all borrowers seeking loss mitigation or in foreclosure;
- End dual tracking, so that borrowers pursuing loan modifications or other loss mitigation options are not referred to foreclosure;
- Ensure that any force-placed insurance be reasonably priced in relation to claims incurred; provide timely notifications prior to placing new insurance; terminate force-placed insurance and refund unearned premiums upon receiving evidence of a borrower's

- if the beneficiary does not elect how payment should be disbursed, the insurer should send the beneficiary a single check; and

- the insurer may not place the proceeds of the policy into a retained asset account unless the beneficiary affirmatively chooses to have the benefits deposited in such an account after receiving specific disclosures. In short, the new standard is that the beneficiary receives a full lump-sum payment unless expressly opting for a retained asset account.

By October 1, 2012, insurers are required to provide written notice to beneficiaries of existing retained asset accounts that they may receive a lump-sum payment of the remaining proceeds. By that same date, insurers must provide existing retained asset accountholders with certain disclosures, including advance notice of an interest rate change and notice of inactive funds being subject to the New York Abandoned Property Law.

Foreclosure Relief Unit

At the Governor's direction, and to assist homeowners facing foreclosure or the risk of foreclosure, DFS created a Foreclosure Relief Unit within the Department's Real Estate Finance Division. FFCPD has been involved in launching the Unit.

Disciplinary Unit and Producer Investigations

In addition to the newly formed civil investigation team of attorneys, the Civil Investigations Unit also consists of disciplinary attorneys and examiners who oversee the activities of licensed individuals and entities who conduct insurance business in New York State. The goals of the Unit are to protect the public and ensure that licensees act in accordance with applicable insurance laws and Department regulations. There are currently more than 265,000 licensees in New York. Licensees include producers (agents and brokers), independent and public adjusters, reinsurance intermediaries, bail bond agents, viatical settlement brokers, and limited lines producers.

The Civil Investigations Unit monitors the insurance marketplace to determine if unlicensed activity is occurring and, if necessary, take steps to ensure that individuals or entities either achieve compliance or cease activities. The Unit reviews original and renewal licensing applications when irregularities are identified.

The Omnibus Crime Bill of 1994 disqualifies from employment in the insurance industry anyone convicted of a criminal felony involving dishonesty or a breach of trust. This ban, however, may be removed if approval for written consent to engage in the business of insurance pursuant to 18 U.S.C. §§ 1033 and 1034 is given by the Superintendent. The Civil Investigations Unit also reviews all such applications for written consent.

When a violation of the Insurance Law is proven, an administrative sanction may be imposed resulting in license revocation or suspension, the denial of pending applications, or monetary penalties imposed with corrective actions to address violations.

Noteworthy 2011 Disciplinary Actions and Statistics

1. Cross Border Sales Investigation

This investigation, which grew to involve more than 130 agents, began as an investigation of one agent. The investigation resulted in the issuance of Circular Letter No. 6 dated April 13, 2011 and disciplinary action against numerous agents. Several complaints indicated that insureds were purchasing annuity/variable life contracts without realizing they came with a 15-20 year holding period and surrender schedule. Some complaints indicated that the applicant was in New York when the contract was signed, however, the application states it was signed in New Jersey. Other complainants questioned why New York would allow the sale of insurance contracts that tied up money for such long periods and included such high surrender charges. The investigation revealed that the contracts were sold for companies that are not authorized to conduct business in New York. The complaints led to the revocation of the agent's license and uncovered the possibility of similar improper sales by over 130 agents.

The investigation is ongoing and is targeting insurance agents who sold annuities issued by unlicensed insurers to New York residents by claiming that the transactions occurred outside of New York. As a result of the investigation, disciplinary action to date is as follows:

- 11 agents signed stipulations agreeing to surrender their licenses with the effect of revocation
- 3 agents had their licenses revoked after hearings
- 2 citations were issued and hearings have been scheduled
- 38 agents signed stipulations agreeing to pay almost $1.7 million in fines
- 5 agents agreed to sign stipulations to pay fines totaling $85,000

The Department anticipates additional disciplinary action in 2012 as a result of this investigation.

More than $350,000 has been collected from respondents that conducted and/or allowed certain employees/individuals to conduct business in New York without being properly licensed, appointed or registered.

II. THE CRIMINAL INVESTIGATIONS UNIT ("CIU")

As part of the merger of the former Banking and Insurance Departments into DFS as of October 3, 2011, the Criminal Investigations Bureau of the Banking Department and the Insurance Frauds Bureau of the Insurance Department combined to form the Criminal Investigations Unit of the Financial Frauds & Consumer Protection Division.

A. The Criminal Investigations Bureau ("CIB")

Highlights of 2011

- CIB conducted 112 investigations which resulted in 33 convictions.
- 83 new cases were opened for investigation.
- The Mortgage Fraud Unit's investigations resulted in 23 arrests involving more than $33 million in losses to victimized homeowners and financial institutions.
- The United States Department of Justice recognized two investigators of CIB by awarding them the Director's Award for their significant contribution to the litigative team which successfully prosecuted a $98 million mortgage fraud case in the Eastern District of New York.

Background

The Criminal Investigation Bureau of the former Banking Department was formed in 1992 with the passage of Chapter 321 of the Laws of 1992. The Financial Frauds Prevention Act of 1992 established a criminal investigations bureau within the Banking Department. The Act granted powers to the Superintendent of Banks and, in turn, to CIB to investigate all possible violations of the New York Banking Law and certain enumerated misdemeanors and/or felonies of the New York Penal Code and to take appropriate action after such investigation.

CIB's areas of responsibility grew in recent years. Since 2001 when the Superintendent of Banks began to issue anti-money laundering regulations to ensure compliance by licensees with applicable federal anti-money laundering laws and related regulations promulgated by the United States Department of the Treasury and the Office of Foreign Asset Control ("OFAC"), CIB has investigated violations of these laws and regulations. Similarly, as a result of the financial crisis, the New York Penal Code was amended in 2008 to address new crimes relating to residential mortgage fraud and CIB was granted authority to investigate possible violations relating to residential mortgage fraud activities. A Mortgage Fraud Unit ("MFU") was created within CIB to provide investigative expertise to various federal, state, county and local investigative agencies. In 2009, the State legislature passed various measures relating to the licensure of mortgage loan originators who originate mortgage loans on residential real property and conformed state law to the federal law provisions of Title V of The Housing and Economic Recovery Act of 2008 ("SAFE Act") and related regulations. CIB was delegated the responsibility to review applicants' criminal histories to assist the Mortgage Banking and Legal

Divisions in their determinations of whether applicants meet the statutory requirements to be licensed or registered by DFS.

Current Activities

As currently constituted, CIB conducts specialized investigations into criminal conduct involving the financial services industry and works cooperatively with law enforcement and regulatory agencies at the federal, state, county and local levels. Among CIB's major focuses are the following areas:

1. Bank Secrecy Act and Anti-Money Laundering Investigations

CIB conducts criminal investigations into possible violations of the federal Bank Secrecy Act, federal and state anti-money laundering laws and related regulations, and possible violations of the federal OFAC laws and related regulations. Members of CIB have assisted federal, state and county prosecutors in numerous investigations relating to violations of both federal and state laws. In recent years CIB assisted the New York County District Attorney's Office and the United States Department of Justice in their investigations of foreign financial institutions' violations of OFAC sanctions. Specifically, these investigations involved whether the banking institutions in question knowingly conducted illegal monetary transactions on behalf of sanctioned entities and individuals and caused the falsification of the records of the banks' New York offices while enabling certain banking clients to access the United States banking system. As a result of these multi-year, multi-agency investigations, three foreign banking institutions entered into deferred prosecution agreements and paid penalties in excess of $1.2 billion.

2. Investigations of Money Services Businesses

CIB works closely with numerous federal, state, county and local regulatory and law enforcement agencies to ensure compliance with federal and state statutes and related regulations pertaining to money services businesses, including licensed cashers of checks and money transmitters. CIB works closely with the New York/New Jersey High Intensity Crime Area and with the federal Financial Crimes Enforcement Network on matters designed to detect and eliminate the illegal transmission of money within New York State as well as to eliminate illegal money laundering. CIB also works closely with both federal and state tax officials to identify and prosecute individuals and companies for tax avoidance activities.

3. Mortgage Fraud Investigations

CIB participates in numerous federal, state, county and local mortgage fraud investigations. The MFU within CIB was created to combat mortgage fraud by providing investigative expertise and support to regulatory and law enforcement agencies. The MFU's three-fold mission is to investigate mortgage fraud cases throughout the State; to assist local, State and federal regulatory and law enforcement agencies in the investigation and prosecution of such cases; and to educate law enforcement and the financial sector in identifying, investigating and prosecuting mortgage fraud. The MFU is a member of several federal mortgage fraud task forces and its staff has provided expert testimony at trial and in grand jury proceedings. Since its inception in April

2007, the MFU has participated in investigations which have culminated in charges against more than 160 individuals and involved in excess of $ 369 million. In 2011, mortgage fraud investigations resulted in 23 arrests in cases involving more than $33 million in losses to victimized homeowners and financial institutions. In 2011, cases that went to trial resulted in 32 convictions.

4. MFU Professional and Training Activities

In furtherance of its mission, the MFU hosts a monthly Mortgage Fraud Working Group, created a Mortgage Fraud Training Course to train individuals in the investigation and prosecution of cases, and developed the Mortgage Fraud Forum to provide a platform for prosecutors across the state to explore trends and exchange ideas on methods to combat the epidemic of mortgage fraud.

Mortgage Fraud Working Group: The MFU hosts monthly meetings of the Mortgage Fraud Working Group during which members of federal, State and local law enforcement and regulatory agencies meet to discuss recent trends in mortgage fraud. Representatives from more than twenty-five agencies regularly attend the meetings. In 2011, members of the FBI, Housing and Urban Development's Office of Inspector General, Financial Crimes Enforcement Network, United States Attorney's Office for the Southern District of New York, Queens District Attorney's Office, Freddie Mac, Office of the Attorney General, and Federal Housing Finance Agency's Office of Inspector General and Legal Services have made presentations on issues pertaining to the mortgage crisis and fraudulent activity within the mortgage industry.

Mortgage Fraud Forum: In conjunction with the New York Prosecutors Training Institute, CIB has presented an annual continuing legal education course relating to mortgage fraud issues. The forum brings together state and federal prosecutors from across New York State to discuss mortgage fraud cases in respective jurisdictions. The course is presented at both upstate and downstate locations. 2011 represented the fourth year of the Forum, which was attended by representatives from over 50 agencies, including the District Attorney's Offices of Albany, Fulton, Monroe, Orange, Rensselaer, Ulster, Bronx, Kings, Nassau, New York and Richmond Counties, Internal Revenue Service - Criminal Investigations, New York State Attorney General's Office, New York State Department of State, New York City Department of Corrections, the U.S. Attorney's Offices for the Northern, Southern, and Eastern Districts of New York, HUD-Office of the Inspector General, FBI, New York City Department of Investigation, New York City Tax Commission, New York State Grievance Committee, New York State Office of the Inspector General, U.S. Secret Service, and U.S. Department of Homeland Security.

Mortgage Fraud Training: In conjunction with the New York State Division of Criminal Justice Services ("DCJS"), CIB has made presentations at the Mortgage Fraud Investigation Course offered by DCJS, and the MFU regularly conducts training sessions throughout the state in the detection, investigation and prosecution of mortgage fraud. DCJS offers a wide variety of training services to criminal justice agencies and

individuals. Recent training sessions have been attended by representatives from over 50 agencies, including the District Attorney's Offices of Albany, Fulton, Monroe, Orange, Rensselaer, Ulster, Bronx, Kings, Nassau, New York and Richmond Counties, Internal Revenue Service - Criminal Investigations, New York State Attorney General's Office, New York State Department of State, New York City Department of Corrections, the U.S. Attorney's Offices for the Northern, Southern, and Eastern Districts of New York, HUD-Office of the Inspector General, FBI, New York City Department of Investigation, New York City Tax Commission, New York State Grievance Committee, New York State Office of the Inspector General, U.S. Secret Service, and U.S. Department of Homeland Security.

Major Investigations and Prosecutions During 2011

- Guilty Plea in TARP-Related Bank Fraud Case

In January 2011, Carlos Peralta pled guilty to wire fraud in federal district court for the Southern District of New York. Peralta had participated in a fraudulent investment scheme through which he caused the pastors of a church in Coral Springs, Florida to wire $103,940 from a Florida-based bank to an account at The Park Avenue Bank in Manhattan. Shortly thereafter, in March 2010, The Park Avenue Bank was closed by the former Banking Department and the Federal Deposit Insurance Corporation ("FDIC") was named as Receiver. Charles Antonucci, the former President of The Park Avenue Bank, previously had been charged with self-dealing, bank bribery, embezzlement of bank funds and fraud, the first time that a defendant was charged with attempting to defraud the Troubled Asset Relief Program ("TARP"). This ongoing investigation is being conducted by the SIGTARP in partnership with the Federal Bureau of Investigation ("FBI"), Immigration and Customs Enforcement ("ICE"), CIB and the Office of the Inspector General of the FDIC ("FDIC-OIG").

- Operation Bad Deeds - Takedown of Largest Mortgage Fraud Ring in the History of the Southern District of New York

In January, Queens attorney Cheddi Goberdhan pled guilty in Manhattan federal court to a seven count indictment charging him with conspiracy to commit bank and wire fraud and with six counts of bank fraud in connection with a scheme that defrauded banks out of more than $23 million in home mortgage loans. In June, Goberdhan was sentenced to five years in federal prison for his role. The judge also imposed a restitution order on Goberdhan in the amount of $4.7 million. Goberdhan reaped hundreds of thousands of dollars in illicit profits from the scheme, in which he worked closely with corrupt mortgage loan officers of GuyAmerican Funding, a Queens mortgage brokerage firm. Goberdhan, who acted as the closing attorney and the attorney for the straw buyers on numerous mortgage loans originated through GuyAmerican Funding, was the ninth defendant who was convicted of or pled guilty to this mortgage fraud scheme. In February, David Ramnauth, the former President of GuyAmerican Funding, was sentenced to 30 months in federal prison for his role in the scheme after pleading guilty in 2010. The case was brought in coordination with President Obama's Financial Fraud Enforcement Task Force.

The GuyAmerican Funding case was part of a larger joint federal, state and local law enforcement operation - Operation Bad Deeds - which was announced on October 15, 2009 and in which 41 defendants were charged in various mortgage fraud scams in New York, Pennsylvania, Ohio and North Carolina. Operation Bad Deeds was the largest joint law enforcement operation involving mortgage fraud in the history of the Southern District of New York, involving an estimated $64 million in fraudulent home mortgages related to more than 100 residential properties in New York State. CIB worked jointly with the FBI, Office of the Inspector General ("HUD-OIG") of Housing and Urban Development ("HUD"), United States Secret Service ("Secret Service"), United States Postal Service Inspector General ("USPSIG") and the FDIC-OIG on this investigation.

- Operation Sweet Deal - Takedown of Largest Mortgage Fraud and Identity Theft Scheme in Nassau County History

After a two year investigation, the Nassau County District Attorney announced in March that her office had filed four indictments charging 17 people with more than 108 crimes for their roles in mortgage fraud and identity theft schemes that stole more than $20 million from homeowners, banks and the Nassau County government. The indictments represented the largest takedown of mortgage fraud in Nassau County history. Fourteen of the seventeen defendants were charged with enterprise corruption under the New York Organized Crime Control Act and with related crimes, including grand larceny, scheme to defraud and falsification of business records. Among those arrested were lawyers, mortgage brokers, real estate brokers, bank employees, a real estate appraiser, a financial consultant and a U.S. States Postal Service employee. In October, the ringleader of the theft ring, James Sweet, pleaded guilty to one count of enterprise corruption, two counts of grand larceny in the first degree, money laundering in the first degree, thirty-two counts of grand larceny in the second degree, seven counts of money laundering in the second degree, five counts of identity theft in the first degree, money laundering in the fourth degree, scheme to defraud in the first degree, conspiracy in the fourth degree and thirty counts of falsifying business records in the first degree. Sweet also was ordered to pay more than $1.2 million in restitution to lending institutions and, in December, was sentenced to 4 to 12 years in state prison for his role in leading the corrupt enterprise. CIB provided investigative expertise and assistance on the investigation to the Crimes Against Real Estate Unit of the Nassau County District Attorney's Office.

- Manager of Mortgage Brokerage Firm Sentenced to 60 Months in Prison for Participating in Multi-Million Dollar Sub-prime Mortgage Scheme

In August, the U.S. Attorney for the Southern District of New York announced that Micah Meyers, the manager of a mortgage brokerage firm, had been sentenced to 60 months in federal prison for his role in a sub-prime mortgage fraud scheme involving dozens of residential mortgages totaling more than $10 million. Meyers pled guilty in 2010 to one count of conspiracy to commit bank and wire fraud. He defrauded lenders by preparing and submitting false and misleading loan documentation and recruiting straw buyers to purchase targeted properties. Members of CIB worked with the FBI, the Secret Service, the FDIC-OIG and the USPS-OIG on this multi-year, multi-agency investigation.

- Ringleader of Mortgage Rescue Scams that Targeted Distressed Homeowners Sentenced to State Prison

On August 17, 2011, Roger Huggins, a ringleader of a massive mortgage rescue scam that defrauded legitimate homeowners and various lending institutions, was sentenced to 4 to 12 years in state prison. Seventeen individuals, including Huggins, had been charged in 2010 with defrauding legitimate homeowners and various lending institutions out of more than $3 million in equity that had been stripped from 26 refinanced residential properties valued at $13 million. Later that year, Huggins pled guilty to a charge of grand larceny for duping desperate homeowners into turning over title to their homes so he could take out inflated mortgages and pocket the proceeds. This investigation was conducted jointly by the Office of the Queens District Attorney, the CIB, the New York State Police and ICE.

- Ringleader of $98 Million Mortgage Fraud Sentenced to 108 Months in Prison

In October, Thomas Kontogiannis, a New York real estate developer who led a mortgage fraud conspiracy that resulted in losses of more than $98 million, was sentenced to 108 months in federal prison for conspiracy to commit bank fraud. The sentence was imposed pursuant to his October 2010 guilty plea. Seven co-defendants previously pled guilty on related charges in the largest mortgage fraud case in the history of the Eastern District of New York. Kontogiannis defrauded Washington Mutual Bank ("WaMu") and DLJ Mortgage Inc. ("DLJ") in connection with his development of two tracts of land in Brooklyn and Queens. He staged sales of properties financed by mortgage loans to straw buyers, prepared false loan files, and created fraudulent appraisals and title abstract reports. After the loans closed, Kontogiannis ensured that the mortgages and deeds were not recorded, thereby permitting him to "sell" the same property repeatedly. Eventually, Kontogiannis sold the loans to WaMu and DLJ. The case was brought in coordination with President Obama's Financial Fraud Enforcement Task Force. Members of CIB worked jointly with the FBI and the FDIC-OIG on this matter. In December 2011, CIB investigators Robert Tarwacki and Delroy Levy received special recognition by the U.S. Department of Justice for their role as members of the team that successfully prosecuted the case. The seven person team was selected to receive the Director's Award for Superior Performance by a Litigative Team.

- Five Individuals Sentenced to Prison for Their Roles in Multi-State Mortgage Fraud Scams

In December, New York State Attorney General Eric Schneiderman announced that five individuals formerly affiliated with Rivertown Financial Services of Albany had been sentenced in State Supreme Court for their roles in a multimillion dollar mortgage fraud scheme that defrauded mortgage lending institutions and owners of residential real estate. The defendants solicited homeowners who were in financial distress to sell their homes to Rivertown, which homeowners were told would lease the homes back to them and apply their net equity as down payments on their eventual repurchases of the properties. In some cases, the homes were never sold back and some customers were evicted. In other cases, customers who repurchased homes were forced to spend thousands of dollars beyond their initial agreements. The scheme was accomplished through the use of straw buyers who provided inflated income and asset

information to obtain loans to buy properties in the Capital Region and in the Hudson Valley. The sentences for the various individuals ranged from one year in state prison and restitution totaling $908,000 to four to twelve years and restitution totaling $5.6 million. The Office of the State Attorney General, CIB, and the Insurance Frauds Bureau worked jointly on the investigation, which was started by then Attorney General Cuomo.

Program Support Activities

1. ATM Program

The New York Banking Law authorizes DFS to enforce provisions of the ATM Safety Act (the "Act") as well as the security requirements set forth in New York City Local Law 70, which predated the Act. The primary purpose of the Act is to ensure the safety and convenience of ATM users by establishing minimum security measures at ATM locations. The ATM Inspection Unit within CIB ensures compliance with the Act by conducting inspections of bank-owned ATM facilities throughout the State and monitoring submissions provided to DFS as required under the Act. The Superintendent has authority to assess fines for violations of the Act and to approve variances or exemptions to required security measures. The relevant article of the Banking Law applies to all federal and state chartered banking institutions, whether headquartered in or outside New York State, provided that the institution operates one or more ATMs within the State. As of year-end 2011, there were 4,908 ATMs under the ownership of a banking institution and, thus, subject to the security provisions of the Act.
On January 11, 2011, DFS adopted amendments to the Superintendent's Regulations relating to security measures that must be employed at ATM facilities. The amendments require that a banking institution file an annual report of compliance with the Superintendent certifying that the institution is in compliance with the Act. The amendments clarify the filing deadlines and require that the report be made under penalties of perjury. The amendments also require banking institutions found to be in violation of the required security measures to file with DFS a report attesting that corrective action has been taken to remediate the violation(s). This new reporting requirement facilitates the enforcement of the New York Banking Law which provides that the Superintendent may, after due notice and a hearing, impose a civil penalty on a banking institution that fails to correct a violation of the Banking Law.

During 2011, the ATM Inspection Unit of CIB conducted 8,075 inspections. Of the 8,075 inspections, 1,328 resulted in the issuance of notices of violations.

2. Mortgage Loan Originator Licensing Support

CIB provides critical support to the Mortgage Banking Division's efforts to comply with the provisions of New York Banking Law Article 12-E. Article 12-E, which became effective July 11, 2009, establishes provisions to facilitate New York State's compliance with the federal SAFE Act. Under the SAFE Act, states were encouraged to increase uniformity, enhance consumer protection and reduce mortgage fraud through establishment of a national mortgage licensing system ("NMLS"). The NMLS, as established, is designed to provide minimum licensing standards and uniform applications for state-licensed mortgage loan originators, to provide a comprehensive licensing and supervisory database covering all fifty

states, to enhance consumer protections and support anti-fraud measures, and to facilitate responsible individual behavior in the sub-prime mortgage marketplace. One of the key tools in the SAFE Act is the requirement of a criminal background check of each mortgage loan originator applicant. During 2011, investigators within CIB reviewed 579 criminal history reports related to mortgage loan originator applications filed with the State.

Task Force/Working Group Participation

CIB is an active participant in numerous task forces and working groups designed to foster collaboration and cooperation among the many agencies involved in fighting financial fraud. Among the task force groups of which CIB is a member are the following:

Crime Proceeds Strike Force
FBI C-3 Mortgage Task Force
HIFCA- El Dorado Task Force
MAGLOGLEN
Mortgage Fraud Working Group
National White Collar Crime Center
New York External Fraud Committee
Long Island External Fraud Committee

Continuing Education

CIB staff routinely attends career development seminars, conferences and training programs to stay abreast of emerging industry developments, to maintain proficiency in various investigative techniques and to maintain industry contacts. During 2011, members of CIB staff attended the following courses:

- Mortgage Fraud Investigation Training, offered by DCJS;
- Interview and Interrogation Course, offered by DCJS;
- New York State Banking Department Consumer Compliance Update;
- New York State Banking Department Intermediate Fair Lending;
- American Association of Residential Mortgage Regulator's Mortgage Fraud School;
- MAGLOGLEN Annual Business Meeting and Law Enforcement Conference;
- Introduction to Capital Markets and Topics in Capital Markets, offered by New York State Banking Department;
- Cyber Investigation 100- Identifying and Seizing Electronic Evidence, offered by the National White Collar Crime Center;
- Cyber Investigation 101- Secure Techniques for On-Site Preview, offered by the National White Collar Crime Center;
- Financial Crimes and Cybersecurity, offered by the National White Collar Crime Center;
- Financial Regulation and Enforcement Symposium, offered by Sheppard Mullin Richter & Hampton LLP;
- Policing, Regulating and Prosecuting Corruption, offered by New York University School of Law.

Focuses for 2012

A primary focus of the CIB for 2012 will be to enhance its investigations by leveraging the additional expertise of the investigators in the Insurance Frauds Bureau. For example, using the Bureau's expertise at undercover operations, including use of wiretaps, and their investigators' training as armed peace officers, the CIB will have greater opportunities to infiltrate organized crime networks and develop more complex financial fraud investigations on its own without early referral to other prosecutors. Through the pooling of investigative resources and the ability to exploit additional intelligence-gathering databases and networks, the CIB will more effectively and efficiently target those individuals and entities perpetrating financial crimes against New York's financial markets, including health care fraud, insurance fraud, money laundering, tax fraud and terrorist financing, at the expense of New Yorkers.

B. The Insurance Frauds Bureau (the "Bureau")

Highlights of 2011

- Investigations conducted by Insurance Frauds Bureau staff resulted in 703 arrests during 2011.
- A total of 1,667 new cases were opened for investigation.
- By year-end 2011, prosecutors had obtained 401 convictions in cases involving the Insurance Frauds Bureau.
- Court-ordered restitution totaled $34 million as a result of Insurance Frauds Bureau criminal investigations.
- Bureau efforts to crack down on workers' compensation fraud resulted in 32 arrests in two major sweeps in 2011. There were 148 arrests for workers' compensation fraud, an increase of 24 percent over 2010.
- There were 210 arrests for health care fraud in 2011, an increase of 32 percent over 2010.
- Bureau staff provided training for 2,388 participants from 31 law enforcement, insurance industry and community groups during 2011.

Background

Article 4 of the New York Insurance Law created the Insurance Frauds Bureau in 1981. The Insurance Frauds Bureau has a longstanding commitment to combating insurance fraud. That commitment has continued as the Bureau took its place in the new FFCPD within the new DFS.

The Insurance Frauds Bureau is part of the FFCPD's Criminal Investigations Unit. It is responsible for the detection and investigation of insurance and financial fraud and the referral

for prosecution of persons or groups that commit these frauds. The Bureau is headquartered in New York City, with six additional offices across the State in Mineola, Albany, Syracuse, Oneonta, Rochester and Buffalo.

The Bureau's specialized units are Major Case, Arson, General, Auto, Workers' Compensation, Medical, No-Fault, Mortgage and Title, and Upstate. The Bureau provides in-service training for its staff and conducts training for law enforcement, the insurance industry and community groups. The Bureau also has a unit of insurance examiners who are responsible for insurer compliance with Article 4 of the New York Insurance Law and Department Regulation 95. The examiner staff may also perform market conduct examinations of insurer Special Investigations Units.

Operations and Activities

1. Suspected Fraud Reports/Investigations

The Bureau received 23,422 reports of suspected fraud in 2011. The vast majority of those reports –22,635 – were received from licensees required to submit such reports to the Department and 787 were received from other sources, such as consumers and anonymous tips. The Bureau opened 1,667 new cases for investigation during the past year. Tables showing the number of fraud reports received, investigations opened, and arrests by type of fraud appear in the Appendices.

During 2011, the Bureau referred 402 cases to prosecutorial agencies for criminal prosecution. Prosecutors obtained 401 convictions in Bureau cases.

The Bureau has a fraud hotline and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 21 per week in 2011.

2. Arrests

Insurance Frauds Bureau investigations led to 703 arrests for insurance fraud and related crimes during 2011, up from 668 in 2010. Some of the notable arrests are discussed in detail below.

3. Civil Enforcement, Restitution and Forfeitures

Section 403 of the New York Insurance Law authorizes the Department to levy civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. Under Section 2133 of the Insurance Law, the Department is also permitted to levy a civil fine of up to $1,000 for possession of a fraudulent automobile insurance identification card and up to $5,000 for each additional card possessed.

Insurance Frauds Bureau criminal investigations resulted in $34 million in court-ordered restitution in 2011, or more than five times the $6.6 million ordered in 2010. Insurers realized savings of $366,000 due to fraudulent claims investigated by the Bureau.

4. Multi-Agency Investigations

The Bureau conducted numerous multi-agency investigations during 2011. In the Department's continued effort to save money for businesses and employers in New York by cracking down on workers' compensation fraud, the Bureau led investigations joined by the Office of the Fraud Inspector General of the Workers' Compensation Board, the State Insurance Fund and other insurers. As a result of these efforts, the number of arrests for workers' compensation fraud increased by 24.4 % in 2011. The Bureau also teamed up with the NYPD's Fraudulent Accident Investigation Squad and Auto Crime Division, as well as local law enforcement agencies throughout the State, in the investigation of many no-fault and other auto-related fraud cases. The Bureau's Arson Unit investigators collaborated with the Bureau of Alcohol, Tobacco, Firearms and Explosives, the FDNY's Bureau of Fire Investigations and the NYPD's Arson Explosion Squad.

The Bureau collaborates with numerous other agencies in the investigation of all types of insurance fraud. Among these agencies are local District Attorney's Offices, the U.S. Attorney's Offices, the New York State Attorney General's Office, the New York State Department of Motor Vehicles, the U.S. Postal Inspection Service, and many task forces and working groups of which the Bureau is a member.

Cases in which the Bureau pooled resources with fraud-fighting partners are summarized below in this Report.

Task Force/Working Group Participation

The Insurance Frauds Bureau is an active participant in numerous task forces and working groups designed to foster cooperation among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing of investigative skills. Among the groups in which Bureau staff participated during the past year are the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- Monroe County Auto Crime Task Force
- FBI/U.S. Attorney Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force
- New York Anti-Car Theft and Fraud Association
- National Insurance Crime Bureau Working Groups
- Motor Vehicle Theft and Insurance Fraud Prevention Board (Department of Criminal Justice Services)
- High Intensity Drug Trafficking Area (HIDTA)
- High Intensity Financial Crimes Area (HIFCA)
- New York State Banking Department Mortgage Fraud Working Group
- Medicare Fraud Strike Force
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney's Office Insurance Crime Bureau

The Bureau has been a member of the Albany-based Drug Enforcement Administration Tactical Diversion Task Force since February 2011 and a Bureau investigator has been assigned full time to the Task Force since then. An investigation conducted by Task Force members resulted in the arrest in December of three suspects charged with possession of forged prescriptions for oxycodone. The successful investigation of 18 Task Force cases in 2011 led to 47 arrests. The Task Force investigates organized drug diversion schemes, "doctor shopping" and forgery of controlled-substance prescriptions. Several other investigations conducted by the Drug Enforcement Administration Task Force are summarized below.

Training

Investigators participate in the Bureau's In-Service Training Program. Newly hired investigators also participate in an Entry-Level Training Program. Both programs were developed by the Bureau's Training Officer and comply with the standards and curriculum established for professional police officers by the Bureau of Municipal Police of the New York State Division of Criminal Justice Services (DCJS). Bureau investigators are seasoned professionals with broad law enforcement experience and often exceed the high standards set by DCJS.

The Bureau conducted four training sessions at the New York City Police Academy during 2011, attended by 1,440 recruits. Three additional sessions were conducted for 114 recruits at the Westchester County Police Academy. Police Officers are often the first responders to auto accidents and other emergency situations and their ability to recognize insurance fraud can be critical to an investigation. Consequently, the Bureau places great emphasis on the training of police recruits.

The Bureau also provided training to members of the insurance industry and local police and fire departments throughout the State. Investigators also made presentations to a number of community groups during 2011 as part of the Department's outreach and community affairs initiatives, services and programs on issues affecting a broad spectrum of consumers, including the senior population.

In 2011, the Bureau provided training for 31 groups comprising 2,388 participants. A complete list of the groups for which the Bureau provided training during 2011 appears in the Appendices.

Continuing Education

Investigators, examiners and support staff routinely attend career development seminars and training programs to increase their proficiency in investigative procedures, use of Department/industry/law enforcement databases as investigative tools and problem-solving techniques to stay current with emerging developments in the area of insurance fraud.

During 2011, Bureau staff took advantage of many of the educational opportunities offered by the New York Anti-Car Theft and Fraud Association, the New York Prosecutors Training Institute and the New York State Division of Criminal Justice Services, among others. An annual course in driver safety is also available to all Department staff and is required every three years for the investigative staff.

Fraud Prevention Plans

Section 409(a) of the Insurance Law and Department Regulation 95 require all insurers that meet the criteria delineated in the Law to submit to the Department a Fraud Prevention Plan ("Plan") that includes establishing a Special Investigations Unit ("SIU") separate from claims and underwriting. The SIU is responsible for investigating cases of suspected fraud and for implementation of fraud prevention and reduction activities.

Affiliated insurers may submit one Plan covering the entire group of insurers. Additionally, some insurance carriers submit multiple separate Plans, each of which addresses different lines of business or different markets. At year-end 2011, there were 143 approved plans on file. A complete list of insurers' Plans on file as of year-end 2011 appears in the Appendices.

According to Section 409(g) of the Insurance Law, an insurer with a Plan on file must also file an Annual Report describing the insurer's SIU's experience, performance and cost effectiveness in implementing the Plan by March 15 of each year. Reports are submitted electronically through a secure portal environment accessed from the Department's Web site.

Four plans submitted by newly licensed life settlement providers were approved by the Insurance Frauds Bureau in 2011. Plans are required to be submitted with each life settlement provider's application for licensing.

Life Settlements

A life settlement is the sale of a life insurance policy to a third party – the life settlement provider. The owner of the life insurance policy sells the policy for an immediate cash benefit. The life settlement provider becomes the new owner of the life insurance policy, pays future premiums and collects the death benefit when the insured dies.

The Life Settlement Act, signed into law in 2009, marks the first time the life settlement industry has been regulated in New York. It provides a comprehensive framework for the Department to regulate the life settlement business, including enhanced consumer protections. The law also amended the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud. The Bureau collaborates with industry and law enforcement in the investigation and prevention of life settlement fraud.

The Department licensed four life settlement providers and approved their Fraud Prevention Plans in 2011.

The Year in Review

1. Major Cases

The Bureau conducted its own investigations and was involved in a number of multi-agency investigations during 2011. These operations contributed to the total number of arrests and

convictions and the amount of court-ordered restitution for the year. Some of the noteworthy cases are summarized below.

- An Auburn man was convicted of insurance fraud and sentenced to serve one year in the Cayuga County Correctional Facility as the result of an investigation led by the Bureau. He was arrested in 2010 and charged with staging a slip-and-fall accident. Video surveillance images showed him deliberately pouring soda onto the floor of a convenience store and then lying down on the floor until customers and store employees came to his aid. He filed a claim with the store's insurer, Travelers Property & Casualty Insurance Company, for a purported back injury but later withdrew it.

- The defendant in this case began collecting workers' compensation benefits after injuring her foot, knee and back in 1998 while employed directing traffic at a construction site. During the benefit period, she submitted documents to the State Insurance Fund stating that she had not worked since the accident. However, she was arrested in January 2011 when an investigation by the Insurance Frauds Bureau found evidence that she had been working as part-time counter help and had accepted $20,300 in benefits to which she was not entitled.

- After an investigation led by the Insurance Frauds Bureau, an accountant was accused of falsifying the payroll records of a Syracuse cab driver who was killed in a robbery in 2009. The suspect performed payroll services for the owner of two taxi companies, only one of which had workers' compensation insurance coverage. At the time of the robbery, the driver was working for the company without coverage. A forensic examination of the accountant's computer showed that he added the driver as an employee of the company with proper coverage after his death. Workers' compensation benefits are used to pay death benefits to the beneficiaries of employees killed in work-related incidents. The Bureau was assisted in the investigation by the State Insurance Fund and the Workers' Compensation Board's Office of the Fraud Inspector General.

- An upstate man was reimbursed $300,000 by Nationwide Insurance Company after his home was destroyed by fire. The homeowner subsequently was contacted by a Nationwide claims representative who informed him that he believed he could get the homeowner an additional settlement with the help of an attorney, who would get half of any additional compensation the homeowner received. The homeowner agreed. The claims representative notified the homeowner that the attorney had been able to arrange an additional settlement of $89,822 and produced a check from Nationwide. As a claims representative, the defendant was authorized to settle claims and write settlement checks on behalf of the company. He told the homeowner that the attorney wanted to keep his name out of the transaction and asked the homeowner to write a personal check payable to the claims representative for $44.911 -- half the amount of the additional settlement. The claims representative advised the homeowner to deny any knowledge of the transaction if Nationwide inquired. A red flag went up and the homeowner reported his suspicions to Nationwide. The claims representative was fired after Nationwide learned that he had cashed the homeowner's check and deposited the money in his personal

account. He was arrested in April following an investigation by the Bureau with Nationwide's assistance.

- In May, the owner of a home heavily damaged in a 2009 fire, was sentenced to a year in jail and five years' probation for intentionally setting the fire. He was also ordered to pay New York Central Mutual Insurance Company $80,081 in restitution. He had pleaded guilty in March to attempted arson and insurance fraud. Approximately 75 firefighters from Oneonta and surrounding departments fought the blaze, in which two firefighters were injured. The Bureau conducted the investigation with the assistance of the Oneonta Police and Fire Departments, and New York Central Mutual.

- An investigation by the Bureau resulted in the arrest of a former New York State-licensed insurance agent who had formed three allegedly bogus business groups and submitted 35 applications for supplemental hospital insurance policies for 19 applicants through Aflac Insurance Company. Evidence from the investigation showed that the policies were written for persons who were either fictitious or unaware that the policies existed. The agent fraudulently collected $4,768 in advance commissions from Aflac.

- As the result of an investigation by the Bureau, a New York City man was arrested on allegations of filing nine fraudulent claims with Aetna Insurance Company for medical treatment he allegedly had received. One claim was for treatment by a particular doctor in 2010; however, the investigation disclosed that the doctor had died in 2009. Several other claims indicated treatment by another doctor at NYU Langone emergency room, but investigators found that there was no such doctor associated with NYU nor did the State Education Department Office of the Professions have any record of a health care provider with the name given on the suspect's claims. After filing the claims and before the investigation was initiated, the suspect had communicated with the Superintendent to complain about Aetna's handling of his claims. Aetna paid $11,256 on the nine claims, which totaled $22,570.

- An investigation by the Bureau, with assistance from the New Windsor Police Department and Allstate Insurance Company's SIU, led to the arrest of an Orange County resident who was accused of submitting a fraudulent invoice in support of a claim for losses incurred during a burglary at his home. The invoice listed items valued at $14,808; however, evidence uncovered during the investigation indicated that the business that purportedly authored the invoice had closed prior to the date that the items had supposedly been purchased.

- The president and CEO of the Otsego County Chamber of Commerce was arrested for his participation in a fraudulent health insurance scheme. He enrolled New York City residents in the Chamber's health plan by maintaining that they were Chamber members and offering them lower rates than they would have paid for coverage in the New York City area. He enrolled other individuals outside of Otsego County in the Chamber's legitimate health plan after creating a nonexistent "associate member" designation for them. The enrollees were unaware that they had been fraudulently listed as Chamber members. The Bureau began its investigation after being contacted by MVP Health Care,

which had noticed an unusual spike in new enrollments with many enrollees residing outside of Otsego County. After the scheme was discovered, the 400 New York City enrollees and 120 legitimate Otsego County enrollees lost their coverage. Coverage for the Otsego County enrollees subsequently was reinstated under a new plan. MVP lost more than $135,000 in premiums, and paid more than $654,000 in claims for medical treatments, plus $285,000 for prescription drugs for the fraudulently enrolled members.

- A New York City property/casualty broker was charged with grand larceny when investigators learned that, from December 2008 to April 2009, he had collected $261,000 in premiums from numerous clients for the purchase of directors and officers insurance but had failed to remit the money to an insurer. The Insurance Frauds Bureau took the lead in the investigation conducted with the Attorney General's Office.

- An arrest sweep covering 13 upstate counties in November netted 19 suspects. The Bureau was the lead investigative agency in the investigation which found that fifteen of the suspects were working while fraudulently collecting benefits, three suspects falsely reported that their injuries had occurred on the job, and the final suspect cashed seven benefit checks issued to her deceased husband. The 19 suspects fraudulently collected benefits in amounts ranging from $1,790 to $53,760.

- Two women, one from Maryland and the other from Virginia, were arrested in Erie County as the result of an investigation in which the Bureau was the lead investigative agency. The Maryland defendant, an investment adviser for several elderly clients, had named her co-defendant as beneficiary on the life insurance policies of nine clients without their knowledge. Three of the nine have died, allowing the women to collect $393,440. The remaining six victims have been made aware of the scheme and have made appropriate changes to their policies. The financial adviser pleaded guilty to scheme to defraud and three counts of attempted grand larceny and faces a maximum prison sentence of 21 years. Her co-defendant pleaded guilty to scheme to defraud and faces a maximum sentence of 4 years. The defendants each paid $98,000 in restitution at the time of their pleas.

- Five former employees of the now-defunct Rivertown Investments, a business that defrauded property owners, banks and lenders in a large-scale mortgage fraud scheme, were sentenced in December in Albany County Court to prison and together will owe $18,387,633 in restitution. The defendants solicited homeowners who were in financial distress to sell their homes to Rivertown, which agreed to lease the homes back to them and to apply their net equity as down payments on their eventual repurchases of the properties. In some cases, however, the homes were never sold back and some customers were evicted. In other cases, customers who repurchased homes were forced to spend thousands of dollars beyond their initial agreements. Rivertown sales agents duped customers into believing the company would buy the homes while it actually hired straw buyers to apply for mortgages. The straw buyers would sign a "series agreement" or other documents to become members of Rivertown holding companies that received titles to the properties but never paid any money required under the deals. The five suspects, namely, Rivertown's owner, manager, mortgage broker, office manager/realtor and

attorney, were arrested in 2010 on charges of grand larceny, scheme to defraud and related crimes. Then Attorney General Cuomo had requested the assistance of the Insurance Frauds Bureau, as well as the former Banking Department's Criminal Investigations Bureau, in the investigation that led to the arrests.

- The defendant began collecting lost-wage benefits after reporting three separate injuries to the State Insurance Fund stemming from her employment at Central New York Developmental Disabilities Services Office. During the benefit period from July 2008 to August 2011, the defendant had submitted numerous Work Activity Reports stating that her injuries left her unable to work. However, an investigation by the Bureau, with the assistance of the State Fund and the Workers' Compensation Board's Office of the Fraud Inspector General, found evidence that she was employed as a home health aide while collecting $48,982 in benefits to which she was not entitled. She was arrested in August and charged with insurance fraud and violation of the Workers' Compensation Law.

- A licensed Northwestern Mutual Insurance Company agent was arrested for allegedly forging the names of two clients on applications for life insurance policies in order to collect commissions generated by the sales. The matter came to light when the two clients contacted the insurer to report that they had not applied for life insurance. They had been told by the agent that they were purchasing a savings plan, a product that did not generate a commission. The Insurance Frauds Bureau investigated this matter with the Department's former Consumer Services Bureau (now the Consumer Assistance Unit).

- The vice president and an office manager/bookkeeper of a roofing company, Defendants #1 and #2, were arrested and charged with insurance fraud. An investigation by the Bureau and the State Police found evidence that, from March 2010 to the time of their arrests, the defendants had engaged in a scam that defrauded a number of insurance companies. They allegedly contacted homeowners in several upstate communities asking if they wanted their roofs inspected for wind and/or hail damage, and told the homeowners that their company would complete the work for the amount of any insurance settlement, if the home required a new roof. Defendant #2, acting as the homeowner, would then contact the insurer to set up an appointment for an insurance company inspection. Prior to the inspection, Defendant #1 would cause or enhance damage by removing roof shingles so the insurer would approve the cost of a new roof. Defendant #2 gave a written confession stating that she had misrepresented herself as homeowners when she contacted the insurers.

- A Saratoga County man reported to the Colonie Police Department in 2010 that his Jeep had been stolen from a local Chevy dealership and subsequently filed a $22,000 claim with Travelers Insurance Company. Investigators discovered that the defendant had removed the car from the lot himself in an effort to avoid paying a $3,709 repair bill. He then parked the car at the Albany International Airport and filed the claim. The Jeep was recovered and the defendant confessed to the staged theft. He was arrested in January 2011 and charged with insurance fraud, grand larceny and related charges. The

investigation that led to his arrest was conducted jointly by the Bureau and the Colonie Police Department.

- An investigation headed by the Insurance Frauds Bureau with assistance from the U.S. Postal Inspection Service and the Internal Revenue Service Criminal Investigation Division led to the arrest of eight individuals, most of whom were licensed insurance agents affiliated with the same agency. They were charged with recruiting elderly clients in a scam that involved stranger originated life insurance (STOLI). The agents submitted applications containing inflated net worth information for life insurance policies and then insured the elderly clients' lives for millions of dollars with various insurance companies. The agents subsequently sold or attempted to sell the policies after expiration of the two-year contestability period. The premiums were paid by the insurance agents, who used the commissions to continue to finance the scam, or by third-party investors. Some of the insureds were paid a specific amount of money, e.g., $500 a month, for their cooperation. Others were promised a piece of the profits when their policies were sold. The former wife of one of the agents, who was paid $10,000 in "hush money," was charged with extortion for threatening to go to the police unless she was paid.

- The owner of an insurance brokerage in Houston and five other defendants were indicted for conspiring to sell fake and fraudulent policies to nursing homes, apartment complexes, bars, restaurants and other businesses and, eventually, to Shoreline Cruises Inc. Shoreline operated a tour boat on Lake George. The boat sank in 2005, claiming the lives of 20 elderly tourists. The indictment alleged that the broker had backdated documents after the accident to make it appear that Shoreline had not purchased coverage when it had, in fact, purchased a policy. The six defendants also allegedly conspired to launder proceeds of the fraud through bank accounts in the Bahamas, Canada, Hong Kong and elsewhere. The Insurance Frauds Bureau and other federal and state law enforcement agencies conducted the four-year investigation.

- A 16-month undercover investigation led to the takedown of an auto theft ring accused of stealing 17 cars over the past year and reselling them on Craigslist, as well as to family members and friends. The crew stole the cars, changed the vehicle identification numbers (VINs) and registered them with "washed" titles. Ten suspects, six of whom were charged with enterprise corruption under New York State's Organized Crime Control Act, were arrested in February. The investigation used court-authorized wiretaps and surveillance, as well as undercover work. During the execution of a search warrant at the home of the alleged ringleader, investigators recovered 100 VIN plates and federal stickers, eight cell phones, numerous keys and a key-making kit, and titles. Evidence also indicated that the ringleader was bleaching $1 bills and using his printer to make counterfeit $100 bills. A second search warrant executed at the home of two co-defendants yielded a .22 caliber semi-automatic, numerous rounds of ammunition for a variety of firearms including an AK-47 and a .9mm, numerous stickers, VIN plates, titles and keys. The investigation was conducted by the Queens DA's Office and the NYPD's Auto Crime Division, with the assistance of the Insurance Frauds Bureau and the National Insurance Crime Bureau.

- Three drivers and five passengers were arrested in March for staging an accident in the Bronx in 2010 and subsequently filing no-fault claims for nonexistent injuries. Video surveillance caught them circling the block and then setting up the three-car collision. After assessing the damage, the drivers returned to their cars and repeated the "accident" to cause additional damage. They were treated for their alleged injuries at local Bronx medical clinics that billed insurers up to $39,000. The three drivers told investigators that one of them had stopped short, leaving no time for the other two to avoid hitting the stopped car. Evidence gathered during an investigation by the Bureau and the NYPD's Fraudulent Accident Investigations Squad indicated that the eight defendants were friends prior to the accident.

- A workers' compensation fraud sweep that began in early February and covered eight upstate counties nabbed its 13th and final suspect in March following investigations in which the Bureau was the lead investigative agency, assisted by the Workers' Compensation Board's Office of the Fraud Inspector General, the State Insurance Fund, insurance company SIUs, and local law enforcement agencies. The majority of the suspects were charged with cheating the workers' compensation system by working side jobs while collecting benefits for injuries they claimed left them physically unable to work. One suspect, who was accused of fraudulently collecting $10,000 while operating a ceramic supply store, made admissions after being shown surveillance videos which contradicted her previous statements that she was not working. In another case, a woman falsely claimed that she received home health care from two co-defendants, one of whom was her son, however, an investigation revealed that her son was in jail and the other defendant was working at a nursing home at the time of the purported care. Referrals leading to the investigations came from the State Fund and Ace, Travelers, First Cardinal and Hannaford Insurance Companies.

- An investigation by the Bureau, the Queens DA's Office and the NYPD's Computer Crimes Squad led to the March arrest of a New York-licensed broker. The investigation began when the Bureau received information that a subcontractor had submitted a fraudulent Certificate of Insurance to the State Insurance Fund as proof of workers' compensation coverage that did not exist. The subcontractor was interviewed in February and admitted filing the fraudulent Certificate. He agreed to cooperate in the investigation and told investigators that he had an agreement with a New York-licensed broker to pay a flat amount each year in return for a fraudulent Certificate of Insurance. Subsequently, three undercover meetings took place at which the subcontractor put up money and received a fraudulent Certificate from the broker.

- An Oneida County laborer was sentenced in April to five years' probation and ordered to pay $42,675 in restitution to the New York Liquidation Bureau. Following a work-related injury sustained in January 2001, the laborer began collecting workers' compensation benefits. (The Liquidation Bureau had paid the benefits on behalf of Legion Insurance Company which is in liquidation.) During the benefit period, he submitted Work Activity Reports stating that he was unable to perform the duties of his former job as a sanitation engineer at a local garbage collection company. He was arrested in 2010 after an investigation headed by the Insurance Frauds Bureau together with the Workers'

Compensation Board's Office of the Fraud Inspector General and the State Police revealed that from 2005 to 2009 he had fraudulently collected $43,410 in benefits while fully employed.

- An investigation by the Bureau and the State Insurance Fund resulted in the April arrest of the operator of a Putnam County construction company for fraudulently attempting to obtain workers' compensation coverage. He was accused of reversing his first and last names on an application for coverage to mask his identity and conceal the fact that his company's earlier policy had been cancelled for nonpayment of $41,000 in premiums in 2009. He also changed the name of his company and falsely reported that the company had never had prior coverage when he applied for a new policy with the Fund.

- An insurance broker from Long Island was sentenced in June one year in prison and ordered to pay $585,376 in restitution after his conviction on a charge of grand larceny. While acting as a financial adviser for an elderly Queens woman, he had diverted portions of the victim's funds to himself, received cash from her through confusion and deceit, and liquidated accounts so he could collect commissions on the transfer of those accounts. He was arrested in 2009 following an investigation by the Insurance Frauds Bureau and the Nassau County Police Department.

- The owner and president of Gotham Abstract, a title abstract company, was sentenced in June to serve 2-to-6 years in prison after he pled guilty to grand larceny in the 1st degree. The investigation, in which the Bureau was involved, found that his company had acted as a title agent for various title insurance companies, including Stewart Title Insurance Company. Between November 2006 and April 2008, Gotham Abstract's owner failed to record deeds, mortgages and other documents on more than 100 real estate closings, diverted $6.7 million to various accounts, and then depleted those accounts. Stewart Title, having been obligated to insure the transactions, ultimately sustained the loss from the thefts and paid nearly $5.4 million to cover unpaid fees and taxes.

- Sixteen individuals were arrested in June in connection with a scheme to steal hundreds of thousands of dollars from five insurance companies: Allstate, GEICO, GMAC, Liberty Mutual and Progressive. Evidence indicated that the defendants had submitted more than 100 fraudulent claims for vehicles involved in phantom accidents, costing the insurers almost $300,000 in payments for property damage claims. The ringleader of the scheme allegedly recruited most of the other defendants to file fraudulent claims, cash checks issued by the insurers and turn over most of the proceeds to the ringleader, who pocketed more than $100,000 and allegedly allowed the others to keep between $50 and $400 for each claim. In each case, an individual would pose as a customer of one of the insurers and ask to have an additional vehicle added to an existing policy. After coverage was extended to the additional vehicle, a defendant would call the insurer and report that the vehicle had been involved in an accident causing damage to another car. Another defendant, purporting to be the owner of the allegedly damaged car, would then place a call to the insurer and arrange to have the damage inspected, appraised and photographed by an insurance adjuster. Once the adjuster completed the inspection and appraisal, the insurer would issue a check payable to the individual who had filed the claim. All of the

defendants have been charged with grand larceny and some also face charges of money laundering and scheme to defraud. The arrests were the result of an investigation by the National Insurance Crime Bureau, the Bronx DA's Office, the Insurance Frauds Bureau and the victimized insurers.

- The owner of a liquor store was sentenced in July to five years' probation for setting fire to his store in 2008. He avoided jail time but will have to make full restitution to his mortgage insurer. He pleaded guilty to insurance fraud and arson in May. He originally reported that his business was set on fire by four strangers who assaulted and robbed him, tied him up, and left him in the burning building. He purportedly escaped through a basement door and was found standing outside the building with his hands bound behind him. A two-year investigation conducted by the Insurance Frauds Bureau, the Town of Kent Police Department and the Putnam County DA's Office led to his arrest in 2010. Investigators learned that he had deliberately set the fire because his business was in financial ruin, he was in the midst of foreclosure proceedings on a $365,000 mortgage for the business, and the State Tax Commission had three judgments against the business for more than $39,000 in unpaid taxes.

- An investigation by the Insurance Frauds Bureau, the State Police, the DMV and the Niagara County DA's Office resulted in the arrest of two Lockport men in July. While employed at a local auto sales shop, the suspects allegedly had collected $12,000 in premiums for extended auto repair warranties for vehicles purchased at the shop. The investigation began after the State Police received a complaint from one of the warranty buyers who found that the warranty was not valid. Investigators executed a search warrant at the shop and seized sales records and contracts. The documents showed that five victims had paid the two suspects for the warranties but the money had never been remitted to the insurer, Guardian Warranty Corporation.

- An Albany pub owner was charged with arson for allegedly intentionally setting a fire at his business in April 2011. An investigation by the Insurance Frauds Bureau, the Albany Police Department and the New York State Office of Fire Prevention and Control revealed that the pub owner and another person had been seen removing items from the property the night before the fire. The owner, who was the only person in the pub at the time of the fire, reported that a grease fire had started in the kitchen. The investigation, however, showed multiple points of origin in the kitchen area where accelerants were detected and the fire was deemed incendiary. The pub was insured for $900,000 by Alterra Insurance Company.

- An Orleans County pediatrician was sentenced in August to five years' probation, two hundred hours of community service, and ordered to pay $260,877 in restitution ($81,544 to insurers and $179,333 to Medicaid). He had pleaded guilty in March to grand larceny. He received free vaccines that were supposed to be dispensed to Medicaid patients; however, he used the vaccines for non-Medicaid patients and billed their private insurers. The investigation was conducted by the Western New York Health Care Fraud Task Force of which the Bureau is a member.

- An investigation by the Bureau and the State Police resulted in the arrest of a New York-licensed insurance broker. Evidence indicated she stole $16,620 in cash premium payments while employed at an insurance agency in Saugerties. The suspect also allegedly used the agency's accounting software to make false entries into its business records to conceal the theft.

- As a result of a warrant issued by the Rockland County DA's Office, the suspect was arrested for claiming that he had not received a $10,455 workers' compensation settlement check issued by CNA Insurance Company. The insurer issued a second check for the same amount. The suspect cashed the original check at a check-cashing facility knowing there was a stop payment on it and cashed the replacement check at his bank. Because of the stop payment, CNA did not cover the original check, leaving the check-cashing facility on the hook for the money. When interviewed during an investigation by the Insurance Frauds Bureau and CNA's SIU, the suspect admitted to cashing both checks.

- A Cortland man sustained a work-related back injury in 2003 and began collecting workers' compensation benefits. During 2011, he submitted several Work Activity Reports to the State Insurance Fund stating that he had not returned to work nor received payment for employment since his injury. However, an investigation by the Bureau with assistance from the State Fund and the Cortland City Police Department revealed that during that time he had been incarcerated in the Marcy Correctional Facility for the sale of drugs, from which he admitted obtaining financial gain. He collected $15,200 in benefits to which he was not entitled and was arrested and charged with violation of Section 114.1 of the Workers' Compensation Law and related crimes.

- Twelve suspects were indicted for their participation in a no-fault fraud scheme. The indictment charged that the suspects had staged auto accidents to generate fraudulent billing for unnecessary medical treatments and had coached legitimate accident victims to exaggerate injuries. They were accused of defrauding numerous insurers of more than $45,000. The Bureau, the NYPD's Fraudulent Accident Investigations Squad, the Queens DA's Office and the SIUs of Progressive, GEICO and Safeco Insurance Companies collaborated on the investigation that led to the arrests.

- Twenty-four defendants were charged with health care fraud for their participation in billing scams that defrauded insurers, Medicare and Medicaid out of millions of dollars. Twenty-two of the defendants were accused of causing no-fault insurers to pay millions of dollars in reimbursements for medical treatment that was never provided or that was medically unnecessary. Two indictments charged doctors who allegedly faked ownership of medical clinics and concealed that the true owners were not medical professionals. The "front" doctors and other health care providers and clinic employees caused fraudulent bills to be submitted to insurers. Charges were also brought against "runners" who were paid to recruit patients and patients who faked and exaggerated injuries from auto accidents. Clinic employees allegedly coached patients on how to describe their purported injuries if questioned by insurance companies. A third indictment named two operators of a medical supply company for allegedly forging doctors' signatures and

prescriptions to support fraudulent billing to Medicare and Medicaid for durable medical equipment. All of the defendants face a maximum sentence of 20 years in prison. Six search warrants were executed and ten accounts were frozen in connection with the investigation which was conducted jointly by the Bureau, the Office of the U.S. Attorney for the Southern District, the FBI, the NYPD, and U.S. Department of Health and Human Services.

- An investigation by the Insurance Frauds Bureau together with the FBI culminated in jail sentences and orders to pay restitution for two defendants for their parts in a scheme to defraud numerous medical insurance providers by submitting fraudulent claims. One woman was sentenced to six months and ordered to pay $247,391 after having been arrested in 2003 and subsequently pleading guilty to one count of health care fraud. Her co-defendant in the scheme, who billed massages as physical therapy and billed for services not provided, was sentenced to 30 months and ordered to pay $2.6 million. She had been arrested in 2003 and subsequently pled guilty to health care fraud and obstruction of justice.

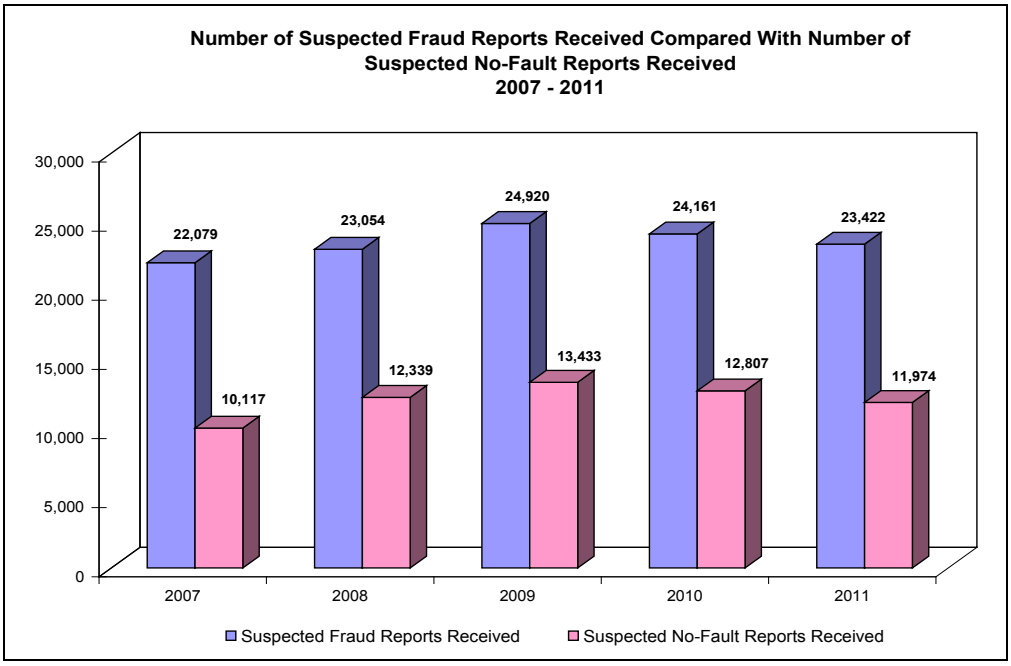
- An ongoing investigation into no-fault fraud led to the arrest of a Brooklyn man charged with larceny. He intentionally had crashed his vehicle into a bicycle to defraud Progressive Insurance Company. The defendant falsely reported the "accident" to Progressive, was treated for nonexistent injuries, and Progressive paid out more than $2,000 for unnecessary medical treatment. The man is the 60th defendant to be arrested in connection with this long-term investigation conducted by the Insurance Frauds Bureau and the NYPD's Fraudulent Accident Investigation Squad.

- The suspect submitted a $67,081 insurance claim to New York Central Mutual Insurance Company following a fire at her home. An investigation by the Ontario County Fire Coordinator's Office deemed the fire incendiary and the Ontario County Sheriff's Office subsequently located witnesses who stated that they saw the suspect leaving the residence before the fire was reported. The Sheriff's Office contacted the Insurance Frauds Bureau for assistance and investigators from both agencies interviewed the suspect, who admitted to being in the house prior to the fire but could not account for her whereabouts thereafter. Investigators subsequently interviewed witnesses who reported that, prior to the fire, the suspect had stated that she was having financial and marital problems and would be happy if the house burned down. She was indicted by an Ontario County grand jury on charges of insurance fraud, arson and animal cruelty. The last charge was based on allegations that the suspect had locked her two dogs in the kitchen where they both died in the fire.

2. No-Fault Fraud

The number of suspected no-fault fraud reports received by the Bureau began to rise in 2007 and posted small year-to-year increases through 2009. Reports declined in both 2010 and 2011. In 2011, the 11,974 suspected no-fault fraud reports accounted for 51 percent of all fraud reports received by the Bureau.

Graph 1



Combating no-fault fraud is an important component in mitigating increases in auto insurance rates. The Bureau's Medical/No-Fault Unit is dedicated to stamping out no-fault fraud and other forms of health insurance fraud. The Bureau currently is in the midst of a large-scale effort to root out no-fault fraud in connection with corrupt medical mills and medical providers who unlawfully "rent" their Taxpayer Identification Numbers to lay owners. Governor Cuomo's initiative in this area and the Bureau's role in it are discussed in more detail below under "Focuses for 2012."

3. Special Prosecutor Program

Created in 2006, the Special Prosecutor Program is a pilot program initiated by the Insurance Department in which Insurance Frauds Bureau attorneys assist local DA's Offices with insurance fraud prosecutions. The program has continued subsequent to the merger of the Insurance and Banking Departments into the Department of Financial Services. The program provides assistance to 14 participating county prosecutor's offices that have executed Memorandums of Understanding with the Department. As part of the program, Insurance Frauds Bureau attorneys are cross-designated as assistant district attorneys and assist in all aspects of the cases to which they are assigned. In one case prosecuted under the program in 2011, a Newburgh City Police Officer was convicted of insurance fraud in the 3rd degree, a class "D" felony, and falsifying business records in the 1st degree, a class "E" felony. The charges stemmed from the officer's filing of an auto insurance claim in which he fraudulently reported that damage to his vehicle was caused when he hit a deer while he was driving off-duty in October 2009. As part of the prosecution, the officer's friend, a tow-truck operator who aided him in filing the false claim, was convicted of perjury for falsely testifying before the Ulster County Grand Jury as to the

circumstances of the accident. The officer was sentenced on in February 2012 to 1-to-3 years in prison and ordered to pay $13,000 in restitution to State Farm Insurance Company.

In addition, under a program initiated in 2003, Insurance Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with the prosecutors' investigative staff. During 2011, investigators were assigned to the Suffolk, Westchester, Albany and Schenectady Counties DA's Offices.

4. Mobile Command Center ("MCC")

In response to back-to-back tropical storms Irene and Lee that hit New York in late August and early September 2011, respectively, the Department deployed its Mobile Command Center to more than a dozen counties to assist residents and businesses in dealing with a range of insurance-related issues. Insurance Frauds Bureau investigators were on board the MCC to set up shop. Superintendent Lawsky and Consumer Services staff were available to answer questions regarding insurance policies and coverage, as well as to assist with insurance-related complaints. The MCC is equipped with the latest in computer and communications technology, including broadband and broadcast satellite, as well as police and ham radio communications.

Most of New York City escaped the worst impact of Tropical Storm Irene but low-lying sections of Staten Island, lower Manhattan and Queens were underwater. Many parts of Long Island were without electricity. The storm also hit hard in upstate counties. Irene turned rivers and creeks into torrents, roadways were closed, and thousands of residents had to be evacuated. As people were trying to bounce back from Irene, Tropical Storm Lee hit. Highways, including sections of Interstate 88 and NY Route 17, were flooded. Upstate areas, already saturated from Tropical Storm Lee, suffered additional flooding. Thousands of citizens in the Binghamton area were ordered evacuated and road closures effectively shut the city off to outside traffic. Buses and boats were used to evacuate residents and National Guard helicopters were on standby. Governor Cuomo issued disaster declarations in 48 counties, both upstate and downstate, making them eligible for $93 million in federal disaster relief.

In the wake of the storms, the Department activated Disaster Assistance Centers at locations hard-hit by the flooding and staffed its Disaster Hotline to provide assistance to consumers who were unable to travel to the MCC or Disaster Assistance Centers. Superintendent Lawsky and other Department personnel visited a number of affected sites to assess the impact of the two storms. DFS staff members accompanied Superintendent Lawsky to several locations where they met with consumers, business owners and local officials to determine how the Department could best meet the needs of the affected communities.

5. Web-Based Case Management System

The Bureau's Web-Based Case Management System, known as FCMS, was fully implemented in the first quarter of 2007. In 2011, approximately 93 percent of the fraud reports ("IFBs") were electronically transmitted and received remotely from insurers. Insurers have access to FCMS through the Department portal using secure accounts. The benefits of FCMS to insurers include automatic acknowledgment of fraud reports, and automatic notification of case assignments and

eventual case disposition. Insurers also benefit from on-line help screens and an on-line manual of operations, as well as search and cross-reference features. Staff members from the Frauds and Systems Bureaus regularly monitor the system and make improvements and changes as necessary.

6. Recognition Awards

In November, the New York Anti-Car Theft and Fraud Association held its Annual State Education Conference at the Cradle of Aviation Museum in Garden, City, N.Y. At the conference, the Association honored Director Frank Orlando, Deputy Director Angelo Carbone, Deputy Chief Investigator August D'Aureli and Investigator Evelyn Cardenales with Certificates of Meritorious Achievement presented in acknowledgement of their "excellence in the investigation of vehicle theft and insurance fraud fighting in 2011."

Focuses for 2012

A primary focus of the Bureau for 2012 will be to look for opportunities to enhance its own investigations by leveraging the additional expertise brought by investigators in the former Banking Department's Criminal Investigations Bureau which, as of October 3, 2011, was merged with the Insurance Frauds Bureau into the Criminal Investigations Unit. Greater opportunities exist to investigate and ferret out criminal enterprises that are profiting by various insurance frauds schemes with the two formerly separate bureaus now working together as a single unit. In addition, the Bureau intends to focus its resources on the following areas in 2012:

1. No-Fault Fraud

The Bureau will continue to take an aggressive proactive approach with regard to its efforts to combat no-fault insurance fraud. No-fault fraud is often perpetrated by complex enterprises that consist of corrupt medical providers and attorneys. In early March 2012, Governor Cuomo announced a statewide initiative to stop deceptive doctors and shut down medical mills that plague New York's no-fault insurance payment system and cost New Yorkers hundreds of millions of dollars in insurance costs.

The initiative has two parts: 1) the Department has issued a new regulation that will enable it to ban doctors who engage in fraudulent and deceptive practices as part of the no-fault system. The regulation implements a 2005 law that gives DFS the power to regulate doctor participation in the no-fault system, and 2) as part of an ongoing investigation, the Bureau is sending letters to 135 medical providers, identified through audits as well as information from law enforcement and insurance companies, whose billing practices have raised concerns regarding possible no-fault fraud and demanding information regarding their corporate structures, payment requests, and their direct participation in the practice. Any provider who refuses to respond to the Bureau's letters may be banned from participating in the no-fault system.

The Bureau will also continue efforts designed to systematically address the problem of no-fault fraud, in addition to conducting targeted undercover investigations.

2. Stranger Originated Life Insurance (STOLI)

Stranger originated life insurance is a practice or arrangement in which a policy is issued for the intended benefit of a third party investor who, at the time of policy origination, has no insurable interest in the life of the insured. With STOLI, an investor without an insurable interest initiates and profits from a life insurance policy issued on the life of a stranger. Sales are usually driven by agents and other intermediaries, and policies are often resold to investors in a secondary market after the expiration of the two-year contestability period. Policyholders can be unwitting or willing participants in the scheme, ranging from elderly purchasers who are duped into buying life insurance using premium financing arranged by intermediaries to sophisticated purchasers who are paid to take out the policies. Life insurers are usually victims of the scams, issuing multi-million dollar policies frequently based on fraudulent applications that contain inflated valuations of assets and net worth of policyholders. The Bureau has seen a recent increase in such schemes and will direct resources to target the increase accordingly.

3. Ineligible Membership Fraud Schemes

Over the past few years, the Bureau has seen an increase in a type of medical fraud in which persons or entities create a fictitious membership category in order to recruit enrollees in a group health plan in which they are ineligible to participate. In other cases, they intentionally misrepresent material facts, such as employee or income information, to make it appear that certain individuals are eligible for government-subsidized programs such as Healthy New York when in fact they are not. The coverage is usually offered at premiums significantly lower than those offered by health plans in the geographical areas in which the individuals reside.

Bureau Appendices - 2011 Statistics

IFBs Received by Year	**2007**	**2008**	**2009**	**2010**	**2011**
Boat Theft	2	4	6	5	5
Auto Theft	1,679	1,610	1,429	1,084	922
Theft From Auto	62	38	34	33	28
Auto Vandalism	198	185	248	205	350
Auto Collision Damage	1,260	1,388	1,318	1,654	2,213
Auto Fraudulent Bills	145	79	114	98	114
Auto Miscellaneous	1,045	1,092	1,388	1,938	1,268
Auto I.D. Cards	180	10	5	11	9
No-Fault Insurance[1]	11,242	0	0	0	0
Total - Auto Unit	**15,813**	**4,406**	**4,542**	**5,028**	**4,909**
Workers' Compensation	1,472	1,428	1,486	1,352	1,584
Total - Workers' Comp Unit	**1,472**	**1,428**	**1,486**	**1,352**	**1,584**
Disability Insurance	245	382	242	193	144
Health Accident Insurance	1,212	1,421	1,488	1,625	1,915
No-Fault Insurance[2]	0	12,339	13,433	12,807	11,974
Total - Medical/No-Fault Unit	**1,457**	**14,142**	**15,163**	**14,625**	**14,033**
Boat Fire	2	1	2	1	4
Auto Fire	460	444	399	278	243
Fire – Residential	120	180	213	170	149
Fire – Commercial	23	29	40	40	34
Total - Arson Unit	**605**	**654**	**654**	**489**	**430**
Burglary - Residential	336	509	504	362	380
Burglary - Commercial	159	140	127	176	82
Homeowners	727	569	889	1,038	823
Larceny	43	44	45	33	36
Lost Property	158	254	154	108	219
Robbery	26	28	15	24	22

[1] Medical and No-Fault merged in January 2008. *See* combined numbers for Medical/No-Fault Units for data post-2007.

[2] *Id.*

Bonds	4	8	9	15	6
Life Insurance	180	199	392	378	407
Ocean Marine Insurance	12	7	13	9	10
Reinsurance	1	0	2	0	1
Appraisers/Adjusters	5	9	5	8	11
Agents	46	47	69	50	55
Brokers	85	72	106	100	50
Ins. Company Employees	7	12	5	3	3
Insurance Companies	36	34	27	23	42
Title/Mortgage	6	13	326	208	143
Commercial Damage	18	41	85	70	81
Unclassified	883	438	302	62	95
Total - General Unit	**2,732**	**2,424**	**3,075**	**2,667**	**2,466**

IFBs Received	**2007**	**2008**	**2009**	**2010**	**2011**
Auto Unit Totals[3]	15,813	4,406	4,542	5,028	4,909
Workers Comp Unit Totals	1,472	1,428	1,486	1,352	1,584
Medical/No-Fault Unit Totals[4]	1,457	14,142	15,163	14,625	14,033
Arson Unit Totals	605	654	654	489	430
General Unit Totals	2,732	2,424	3,075	2,667	2,466
Grand Total	**22,079**	**23,054**	**24,920**	**24,161**	**23,422**

Cases Opened by Year	**2007**	**2008**	**2009**	**2010**	**2011**
Boat Theft	0	0	2	3	0
Auto Theft	219	204	152	119	96
Theft From Auto	1	3	3	1	1
Auto Vandalism	6	16	19	14	9
Auto Collision Damage	51	62	66	63	65
Auto Fraudulent Bills	3	12	11	5	5
Auto Miscellaneous	31	25	85	61	39
Auto I.D. Cards	8	1	0	3	1
No-Fault Insurance*	160	0	0	0	0
Total - Auto Unit	**479**	**323**	**338**	**269**	**216**

Workers' Compensation	219	445	717	537	1,042
Total - Workers' Comp Unit	**219**	**445**	**717**	**537**	**1,042**

[3] Data prior to 2008 reflects Auto and No-Fault Unit totals.

[4] Data prior to 2008 reflects Medical Unit total only.

Disability Insurance	21	31	35	18	13
Health Accident Insurance	56	103	98	80	72
No-Fault Insurance[5]	0	128	101	72	88
Total - Medical/No-Fault Unit	**77**	**262**	**234**	**170**	**173**

Boat Fire	0	0	2	0	1
Auto Fire	59	64	69	59	48
Fire – Residential	23	47	53	28	19
Fire – Commercial	5	7	12	12	12
Total - Arson Unit	**87**	**118**	**136**	**99**	**80**

Burglary – Residential	19	26	15	15	12
Burglary – Commercial	20	3	6	5	2
Homeowners	45	51	52	25	22
Larceny	4	15	9	13	8
Lost Property	4	7	3	4	1
Robbery	1	0	1	0	1
Bonds	0	2	3	4	2
Life Insurance	8	16	26	9	13
Ocean Marine Insurance	4	4	4	1	1
Reinsurance	0	0	0	0	0
Appraisers/Adjusters	3	5	2	2	2
Agents	18	11	28	18	12
Brokers	18	11	42	15	17
Ins. Company Employees	3	5	3	1	1
Insurance Companies	9	9	9	9	10
Title/Mortgage	3	3	18	21	8
Commercial Damage	3	3	8	7	6
Miscellaneous	48	48	53	12	38
Total - General Unit	**210**	**219**	**282**	**161**	**156**
Grand Total	**1,072**	**1,367**	**1,707**	**1,236**	**1,667**

Investigations	**2007**	**2008**	**2009**	**2010**	**2011**
Auto Unit Totals[6]**	479	323	338	269	216
Workers Comp Unit Totals	219	445	717	537	1,042
Medical/No-Fault Unit Totals[7]	77	262	234	170	173

[5] Medical and No-Fault merged in January 2008.

[6] Data prior to 2008 reflects Auto and No-Fault Unit totals.

[7] Data prior to 2008 reflects Medical Unit total only.

Arson Unit Totals	87	118	136	99	80
General Unit Totals	210	219	282	161	156
Total	**1,072**	**1,367**	**1,707**	**1,236**	**1,667**

2007	**IFBs**	**Cases**	**Arrests**
No-Fault/Auto Unit Total	15,813	479	352
Workers' Comp Unit Total	1,472	219	149
Medical Unit Total	1,457	77	57
General Unit Total	2,732	210	85
Arson Unit Total	605	87	65
Grand Total	**22,079**	**1,072**	**708**

2008	**IFBs**	**Cases**	**Arrests**
Auto Unit Total	4,406	323	294
Workers' Comp Unit Total	1,428	445	159
Medical/No-Fault Unit Total	14,142	262	171
General Unit Total	2,424	219	69
Arson Unit Total	654	118	62
Grand Total	**23,054**	**1,367**	**755**

2009	**IFBs**	**Cases**	**Arrests**
Auto Unit Total	4,542	338	219
Workers' Comp Unit Total	1,486	717	184
Medical/No-Fault Unit Total	15,163	234	157
General Unit Total	3,075	282	110
Arson Unit Total	654	136	68
Grand Total	**24,920**	**1,707**	**738**

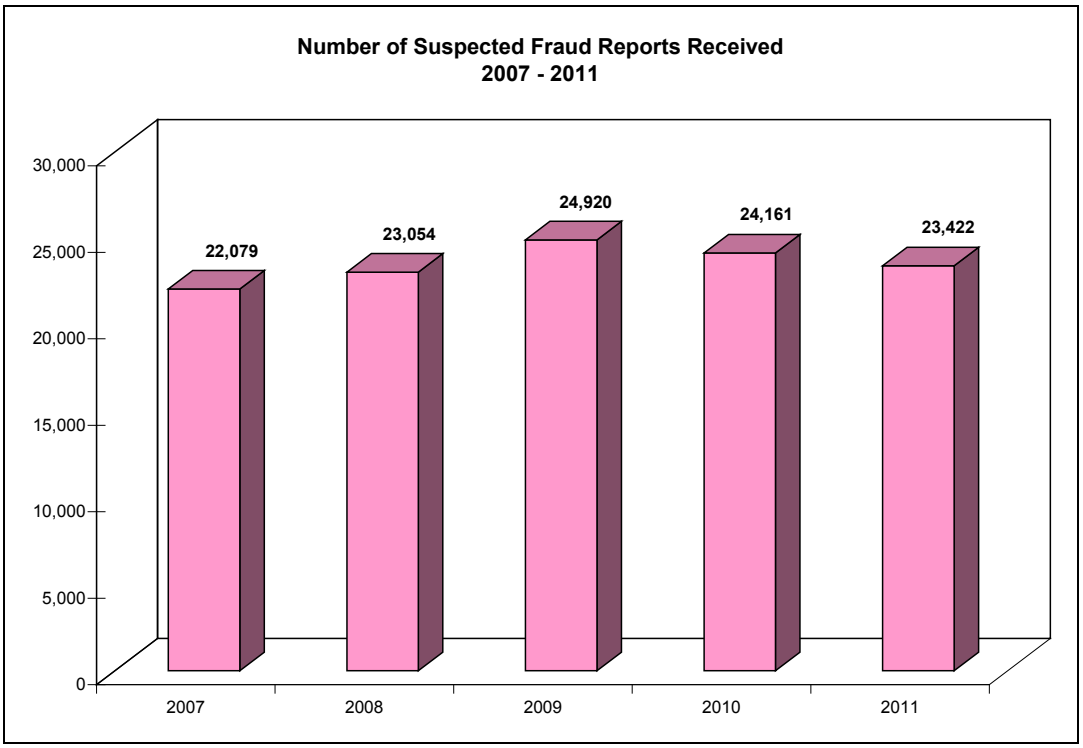
2010	**IFBs**	**Cases**	**Arrests**
Auto Unit Total	5,028	269	252
Workers' Comp Unit Total	1,352	537	119
Medical/No-Fault Unit Total	14,625	170	159
General Unit Total	2667	161	82
Arson Unit Total	489	99	56
Grand Total	**24,161**	**1,236**	**668**

2011	**IFBs**	**Cases**	**Arrests**
Auto Unit Total	4,909	216	225

Workers' Comp Unit Total	1,584	1,042	148
Medical/No-Fault Unit Total	14,033	173	210
General Unit Total	2,466	156	77
Arson Unit Total	430	80	43
Grand Total	**23,422**	**1,667**	**703**

After several years of increases, the number of suspected fraud reports received by the Insurance Frauds Bureau posted declines in the past two years. The Bureau received 23,422 reports in 2011.

Graph 2



Insurance Frauds Bureau
2011 Outreach Program
Insurers, Law Enforcement and Community Groups

Date	Group	Location	Number of Attendees
01/20/11	Office for the Aging (Caseworkers)	Hauppauge, NY	23
01/28/11	NYS Office of Fire Prevention and Control	Montour Falls, NY	12
02/24/11	Albany Police Department (Auto Unit)	Albany, NY	30
03/03/11	Preferred Mutual Insurance Company	New Berlin, NY	16
03/09/11	Nassau County Dept. of Senior Citizen Affairs	Merrick, NY	35
03/14/11	NYS Office of Fire Prevention and Control	Montour Falls, NY	25
03/22/11	Delaware County Dept. of Emergency Services (Fire Investigation Unit)	Delhi, NY	15
04/08/11	Co-op City Senior Center	Bronx, NY	50
04/26/11	NAIC International Fellows Program (Fellow)	New York, NY	1
04/28/11	New York State Special Investigations Unit	Saratoga, NY	100
05/06/11	Westchester County Police Academy (recruits)	Valhalla, NY	68
05/05/11	NYS Association of Self-Insured Counties	Saratoga, NY	50
05/05/11	New York Prosecutor's Training Institute	Brooklyn, NY	100
05/06/11	Westchester County Police Academy (recruits)	Valhalla, NY	15
05/11/11	Broome County Bank Security Officers	Binghamton, NY	9
06/04/11	Port Washington Senior Center	Port Washington, NY	26
06/06/11	New York State Insurance Department	New York, NY	28
06/13/11	NYS Office of Fire Prevention and Control	Montour Falls, NY	20
06/22/11	Liberty Mutual Insurance Company	Syracuse, NY	38
06/24/11	Delegation from Thailand	New York, NY	4
07/14/11	Port Washington Senior Center	Port Washington, NY	9
07/21/11	CCNS Bayside Senior Center	Bayside, NY	70
07/26/11	McNeil and Company	Cortland, NY	15
08/17/11	Hereford Insurance Company	Long Island City, NY	101
08/25/11	Young Israel of Midwood Senior Center	Brooklyn, NY	30
09/14/11	NYSID Examiner Trainees	New York, NY	27
12/08/11	Westchester County Police Academy (recruits)	Valhalla, NY	31
12/13/11	NYPD Police Academy (recruits)	New York, NY	640
12/15/11	NYPD Police Academy (recruits)	New York, NY	240
12/19/11	NYPD Police Academy (recruits)	New York, NY	200
12/21/11	NYPD Police Academy (recruits)	New York, NY	360
TOTALS	GROUPS 31	PARTICIPANTS	2,388

143 Fraud Prevention Plans on File as of 12/31/11

AM Trust Financial Services Inc.
ACE USA Group of Companies
Aetna Life Insurance Company
AIG Companies
Allstate Insurance Group
Allstate Life Insurance Company of New York
AM Trust Financial
Amalgamated Life Insurance Company
American Commerce Insurance Company
American Family Life Assurance of New York
American General Life Companies, LLC
American Medical and Life Insurance Company
American Modern Insurance Group
American Progressive Life and Health Insurance Company of New York
American Transit Insurance Company
Americhoice of New York, Inc.
Amex Assurance Company
Amica Mutual Insurance Company
Arch Insurance Company
Assurant Group
AutoOne Insurance Company
Capital District Physicians' Health Plan
Central Mutual Insurance Company
Central States Indemnity Company of Omaha
Centre Life Insurance Company
Chubb Group of Insurance Companies
CIGNA Health Group
Cincinnati Insurance Company
Clarendon National Insurance Group
CNA Insurance Companies
Combined Life Insurance Company of New York
Countryway Insurance Company
Country-Wide Insurance Company
CUNA Mutual Insurance Society
Dairyland Insurance Company
Delta Dental Insurance Company
Delta Dental of New York
Dentcare Delivery Systems
Eastern Vision Service Plan
Electric Insurance Company
EmblemHealth
Erie Insurance Group
Esurance Insurance Company
Eveready Insurance Company

Excellus BlueCross BlueShield
Farm Family Casualty Insurance Company
Farmers' New Century Insurance Company
Fiduciary Insurance Company of America
Fireman's Fund Insurance Company
First Ameritas Life Insurance Company of New York
First Central National Life Insurance Company of New York
First Rehabilitation Life Insurance Company of America
First Reliance Standard Life Insurance Company
Fort Dearborn Life Insurance Company of New York
GEICO
General Casualty Insurance of Wisconsin
Genworth Life Insurance Company of New York
Gerber Life Insurance Company
Global Liberty Insurance Company of New York
GMAC Insurance
Great American Insurance Group
Guard Insurance Group
Guardian Life Insurance Company of America
Hanover Group
Harleysville Insurance Company
Hartford Fire and Casualty Group
Hartford Life Insurance Company
Health Net
HealthNow of New York Inc.
Hereford Insurance Company
HM Life Insurance Company of New York
IDS Property Casualty Insurance Company
Independent Health Association, Inc.
Infinity Property Casualty Company
ING Insurance Company of North America
Interboro Insurance Company
John Hancock Life Insurance Company of New York
Kemper
Lancer Insurance Company
Liberty Mutual Insurance (Agency Markets)
Liberty Mutual Insurance (Commercial Lines)
Liberty Mutual Insurance (Personal Lines)
Life Insurance Company of Boston and New York
Lincoln General Insurance Company
Lincoln Life & Annuity Company of New York
Magna Carta Companies
Main Street America Group
MassMutual Financial Group
Merchants Insurance Company
Mercury Insurance Group

Metropolitan Life Insurance Company
Metropolitan Property and Casualty Insurance Group
Mutual of Omaha Insurance Company
MVP Health Plan
National Benefit Life Insurance
Nationwide Insurance Group
New York Automobile Insurance Plan
New York Central Mutual Fire Insurance Company
New York Life Insurance Company
New York State Insurance Fund
Nippon Life of America
Northwestern Mutual Life Insurance Company
Nova Casualty Company
Ocean Harbor Insurance Company
OneBeacon Insurance Company
Oxford Health Plans
Permanent General Assurance Corporation
Preferred Mutual Insurance Company
Presidential Life Insurance Company
Principal Life Insurance Company
Progressive
Prudential
QBE Insurance Group Limited
Response Insurance
Safeco Insurance Company
SBLI Mutual Life Insurance Company
Securian Financial Group
Security Mutual Life Insurance Company of New York
Selective Insurance Group, Inc.
Standard Life Insurance Company of New York
Standard Security Life Insurance Company of New York
State Farm Mutual
State-Wide Insurance Company
Sun Life Insurance and Annuity Company of New York
Torchmark
Tower Group of Companies
Transamerica Financial Life Insurance Company
Travelers
Tri-State Consumer Insurance Company
Triton Insurance Company
Trustmark Insurance Company
Unicare Life and Health Insurance Company
Unimerica Insurance Company of New York, Inc.
Union Labor Life Insurance Company
Union Security Life Insurance Company of New York
United Concordia Insurance of New York

United Healthcare Insurance Company of New York
United Healthcare of New York, Inc.
Unum Provident Company
USAA Group
Utica National Insurance Group
Wellpoint, Inc.
Zurich North American

III. THE CONSUMER ASSISITANCE UNITS ("CAU")

As of October 3, 2011, the former Banking Department's Consumer Assistance Bureau merged with the Insurance Department's Consumer Services Bureau to form the Consumer Assistance Unit of the Financial Frauds & Consumer Protection Division.

Prior to the merger, the Insurance Department had developed a new system to increase efficiency and streamline the complaint process. That system, the New York Complaint Information System ("NYCIS"), was developed on a platform that allows improved electronic processing to minimize paper handling for complaint in-take and closure and allow companies to access the system and provide responses and documentation in real time. NYCIS is designed to save resources and ensure that documentation does not get lost or misfiled. It has been implemented on the insurance side and is in the process of being expanded to increase efficiency and contain information for all complaints under the authority of the DFS, including insurance, banking, regulatory bureau review (Health, Property, and Life), as well as civil investigation files. Files will be easily moved and shared among the various units as necessary, which is particularly important because the Division has staff in several cities and physical locations. A system-wide full-text search tool is projected for release by year-end 2012. This function will enhance consumer protection efforts by allowing staff to more easily identify potential problems and trends, as well as assist in large scale investigations when collecting documents and reviewing past complaints.

Among the improvements already implemented or currently in the process of being implemented are the following:

- Complaint Resolution

  The new Consumer Assistance Unit is focused on providing a more hands-on approach to consumer issues through informal mediation and negotiation. When possible, CAU will attempt to resolve issues that extend beyond strict violations of law to the satisfaction of all parties. The merger has also created opportunities to coordinate investigations between the insurance and banking units, which are working together to resolve complaints involving property insurance which has been forced placed by the lender. While some of these complaints are handled on the insurance side, those which involve mortgage servicers are handled on the banking side with information shared cooperatively between the two units.

- Complaint Triaging

  Improvement of processes for triaging complaints and reevaluation of staff assignments have enabled CAU to route complaints more quickly and use resources and staff more efficiently depending on the level of complexity of the issues.

- Prompt Pay

  The Division is currently analyzing the high volume of complaints received under the prompt pay law (Insurance Law §3224-a) to ascertain and correct deficiencies in the processing of the complaints. The Division is also engaging in outreach to the providers who submit the complaints, particularly those that submit the largest volumes, to improve the quality of their complaint submissions. The Division's goal is to correct systemic issues and address problems before they enter the Division's system. Moreover, since it appears that some providers attempt to use the Department's services to do their back office collections, they are now required to document that an attempt was made to submit the claim to the insurer before filing a complaint with the Division.

  As a result of the Division's efforts to reduce the number of these complaints, the backlog of prompt pay complaints decreased dramatically from more than 5500 cases in December 2010 to approximately 297 as of February 29, 2012, a little more than one year later.

  As in the Division's overall strategy, the Division will identify workflow areas that can be addressed via technology or support staff training. The Division is considering implementing the following rules or requirements to help control the volume of prompt pay claims received and provide for the best use of resources going forward:

  - a claim submission cut-off date of two to three years using NYIL Section 3224-b, which contains a two year timeframe for recovery of overpayments, as a guideline;

  - that a complaint be submitted with evidence that it was submitted to the insurer on a timely basis;

  - that providers electronically submit complaints, which will be rejected if submitted without required information; and

  - the right to submit complaints will be suspended if it is established that the provider has abused the right by submitting a high volume of unsubstantiated complaints.

A. The Insurance CAU

Operations and Activities

The Insurance CAU staffs a call center Monday through Friday during business hours. Hours are extended as necessary during disasters such as the tropical storms in the fall of 2011. Customer service representatives handle phone calls and respond to e-mails and correspondence from consumers and licensees. As of February 2012, the call center has been manned by call takers out of the New York State Department of Taxation and Finance pursuant to a shared agency service level agreement.

2. Call Center

During 2011, the Unit assisted clients who contacted the Call Center via telephone or email. There were 35,177 emails (4,162 consumer-related and 31,015 relating to licensing) and 102,887 telephone calls (34,870 consumer-related and 68,017 relating to licensing).

3. External Appeals

Under Article 49 of the Insurance Law, Utilization and External Appeal, consumers have the right to request a review of certain coverage denials by medical professionals who are independent of the health care plan issuing the denial. An external appeal can be requested when a health plan denies insurance coverage because they deem specific health care services to be experimental or investigational, not medically necessary, for treatment of a rare disease or for participation in a clinical trial. Additionally, consumers covered by an HMO may file for an external appeal when their requests for out-of-network exceptions are denied and the HMO offers an alternate in-network treatment.

This table summarizes the appeals received and the appeals closed for 2011 and the preceding six years.

Summary of External Appeal Applications Received by Year

Year	Received	Ineligible	Voluntary Reversals	Upheld Insurer's Denial	Overturned*
2005	2,475	649	214	829	707
2006	2,858	787	287	867	823
2007	2,987	887	289	918	787
2008	3,920	1,566	325	1,145	890
2009	4,260	1,783	350	1,218	815
2010	4,955	1,869	361	1,430	940
2011	5469	1754	362	2117	1183

Voluntary Reversals - Plan overturned its denial before the appeal was submitted to a reviewer
Ineligible - The appeal was not eligible for an external review
** includes decisions that overturned the denial in whole and in part.*

delays in claims payments, and disputes over settlement amounts. Department staff worked closely with FEMA to help consumers navigate between state and federal authorities. Insurance Examiners conducted targeted outreach to educate providers on how to submit complaints.

B. Banking CAU

Background

The mission of Banking CAU is to ensure that banks and other financial institutions chartered or licensed by DFS are in compliance with applicable laws and regulations in providing banking and other financial services to ensure that consumers of those services are protected and that financial institutions are practicing due diligence. To fulfill that mission, members of the examiner staff with the assistance of CAU representatives act as intermediaries between consumers and banks to resolve complaints and answer inquiries. Banking CAU's goals are to monitor bank activities that impact the general public; to receive and resolve complaints against supervised institutions; and to offer banking and financial information and education to the public.

Banking CAU is the Department's door to New York consumers with mortgage and other banking-related issues. Its primary responsibilities include handling consumer complaints against financial institutions under the supervision of DFS, disseminating information and responding to consumer inquiries, and mediating and resolving disputes that consumers would otherwise be unable to resolve on their own. Banking CAU also acts as industry watchdog, promoting industry accountability by working closely with financial institutions to investigate and help correct patterns of consumer abuse and fraud.

Operations and Activities

Banking CAU maintains a toll-free foreclosure prevention hotline to allow consumers to register complaints about institutions supervised by the Department. As of February 2012, the hotline has been manned by call takers out of the New York State Department of Taxation and Finance pursuant to the shared agency service level agreement. Banking CAU also has a general toll-free telephone line for other banking-related inquiries and complaints which, like the foreclosure prevention hotline, is manned by the Department of Taxation and Finance.

Banking CAU also responds to e-mails and electronically submitted complaints from consumers needing immediate assistance, as well as more traditional correspondence via fax and U.S. mail. Banking CAU provides consumer information (via "News Releases") on the Department's website, and is also actively involved in the recently launched statewide mobile command foreclosure relief unit that seeks to help homeowners facing foreclosure in New York's hardest-hit communities.

Banking CAU representatives are assigned caseloads of formal complaints that often originate from the telephone inquiries and written complaints as well as from consumers who visit the

New York City office in person. Banking CAU also receives complaints for handling from other government agencies and public officials.

2011 Complaints, Referrals and Inquiries

1. Mortgage-Related Complaints, Referrals and Inquiries

Banking CAU processed an aggregate 2,190 mortgage complaints, referrals and inquiries in 2011, an increase of 5.9% compared to 2010. A breakdown is set out below:

	12/31/2011	12/31/2010	Change%
Complaints	1,596	1,522	4.86%
Referrals	588	531	10.73%
Written Inquiries	6	16	-62.50%
Aggregate Volume	2,190	2,069	5.85%
Phone Inquiries	13,446	14,807	-9.19%

Mortgage modification requests accounted for 49% of the aggregate volume (779 out of 1,596) of complaints processed during 2011.

2. Non-Mortgage Related Complaints, Referrals and Inquiries

Banking CAU processed an aggregate volume of 1,180 non-mortgage related complaints, referrals and inquiries in 2011, representing a 23% decline from 1,537 in 2010. A breakdown is set out below:

	12/31/2011	12/31/2010	Change%
Complaints	395	577	-31.54%
Referrals	732	889	-17.66%
Written Inquiries	53	71	-25.35%
Aggregate Volume	1,180	1,537	-23.23%
Phone Inquiries	45,744	40,970	11.65%

Complaint Resolution on Mortgage Modification Cases

The following are examples of mortgage modification cases mediated by Banking CAU.

- Banking CAU assisted an individual by mediating a successful mortgage modification that previously had been denied three times by the lender, which claimed it had not received updated financial data from the consumer to determine HAMP qualifications. Banking CAU mortgage examiners made the time commitment necessary to mediate this case and numerous others by personally contacting the financial institution, communicating with the central point of contact , and forwarding and tracking the consumer documentation needed to qualify the consumer for a successful mortgage modification.

- In another case, Banking CAU achieved exceptional results in mediating a case and obtaining restitution for a homeowner who was owed funds for overpayment to her closing agent during the rescission period. Through the efforts of Banking CAU examiners, the homeowner received a restitution check in the amount of $1,578 within five (5) days after Banking CAU received the complaint.

Complaint Resolution on Consumer Restitution Cases

Banking CAU also provided important assistance in mediating non-mortgage related complaints, including the following cases:

- Banking CAU examiners successfully intervened in a case where a consumer had used the services of Pay-O-Matic Check Cashing Corporation to access her income tax refund via a prepaid debit card. After visiting the check casher, the consumer was unable to access her funds because Pay-O-Matic inadvertently had credited a prepaid debit card that had been issued to another customer. Pay-O-Matic failed to resolve the error when initially contacted by the consumer, however, after the consumer contacted Banking CAU, which interviened in the matter, Pay-O-Matic made restitution of $8,390 to the consumer's prepaid debit card.

- In another case, Banking CAU examiners successfully intervened for a 75 year old consumer who recently had moved and was charged a monthly $15 Return Mail Charge by New York Community Bank for a period of seven months. The consumer's daughter had power of attorney over her account. The daughter contacted Banking CAU and filed a complaint in late July. Banking CAU immediately contacted the bank. The bank confirmed that the account had incurred Return Mail Fees because of the consumer's recent move and reimbursed the consumer $105 in less than three weeks after the daughter had filed the complaint.

Banking CAU's Current and Future Focuses and Challenges

- With the the mortgage foreclosure crisis and the Governor's statewide foreclosure relief effort initiated on February 9, 2012, Banking CAU is receiving a vastly increased number

of complaints and developing new procedures to ensure that complaints are handled and mediated expeditiously and effectively. The additional workload requires additional staff with expertise in loss mitigation and foreclosure issues, and Banking CAU is working with other staff throughout the Department to build appropriately trained staff to to do this important job.

- The AS400 system used by Banking CAU since 1990 is antiquated, limited and cumbersome, and it is unable to customize processing and reporting of consumer complaint data. The Department is in the process of importing to Banking CAU the more functional and advanced NYCIS system, already used by the Insurance CAU. The system will allow for the tracking of CAU complaints to enable FFCPD to identify trends and enhance the Division's enforcement efforts.

IV. The Consumer Examination Unit

Background

The mission of the Consumer Examination Unit is to maintain and enhance consumer confidence in New York's banking system by ensuring that regulated institutions abide by the State's consumer protection, Fair Lending and Community Reinvestment Act ("CRA") regulations; increase consumer access to traditional banking services in under-served communities by effectively administering the Department's Banking Development District program and other community development initiatives; and harmonize the FFCPD's examination and enforcement activities with those of the Department's federal counterparts.

Operations and Activities

A. Consumer Compliance Examinations

The Consumer Compliance Unit promotes consumer confidence in DFS-regulated depository institutions by monitoring institutions' compliance with consumer protection statutes and regulations through biennial onsite compliance examinations. Although consumer compliance examinations are not required by statute, the Department believes that not performing periodical reviews of the entities it regulates for compliance with New York laws and regulations could negatively impact the financial well-being of consumers and diminish the importance of the regulations through non-enforcement.

Approaches

- Conduct intensive onsite consumer compliance examinations of regulated institutions;
- Improve compliance by identifying deviations from bank policy and/or industry "best practices" during the examination process;
- Create written, value-added examination findings that will help bank management implement strong compliance procedures;
- Ensure that examiners are trained not only to identify routine compliance issues but also to anticipate and detect new risks that surface as emerging technologies and products are adopted;

- Familiarize examiners with "home state" (out-of-state) consumer compliance regulations that supersede NYS regulations. This issue can arise when a bank chartered by another state expands its branch network and related operations into NYS.

In 2011, the Consumer Examination Unit conducted 28 consumer compliance exams. As a result of consumer compliance examinations in 2011, the unit uncovered depository institutions overcharging consumers for service charges on dormant accounts and check return items, and restitution was made to aggrieved consumers. The Unit also uncovered objectionable practices in the overdraft programs and is pursuing restitution for affected consumers.

B. Fair Lending Examinations

The Department seeks to ensure that consumers who borrow money from DFS-regulated institutions are treated fairly and equitably in all aspects of the credit application, underwriting and servicing processes. The Fair Lending Unit directs all aspects of the Department's Fair Lending examination process, including onsite examinations, targeted examinations and in-depth investigations; obtains, processes and analyzes pertinent data from regulated entities; and guides institutions on the content and implementation of their formal Fair Lending plans. The Fair Lending Unit's subject area extends to predatory lending, reviewing sub-prime loans for appropriateness, and supporting mortgage fraud investigations. Although Fair Lending examinations, like consumer compliance examinations, are not statutorily required, failure to perform them could lead consumers to question the Department's commitment to protect them against discriminatory lending practices, as outlined in Executive Law 296A. The Department accordingly undertakes a diligent and strenuous examination process.

Approaches

- Initiate fair lending examinations of mortgage brokers to address the risks inherent in a segment of the industry that presents unique and potentially problematic fair lending risks. The need for these examinations is underscored by mortgage brokers' increasing role in the market as more and more banks exit the one-to-four family mortgage lending business;
- Coordinate with and perform examinations on behalf of the Community and Regional Banks, Mortgage Banking and Licensed Financial Services Divisions to ensure that all DFS-regulated lenders are held to the same fair lending standards and expectations;
- Conduct advanced analyses to determine the relationship between exotic mortgage products and economic factors that lead to foreclosures.

In 2011, the Consumer Examination Unit conducted 41 fair lending exams and conducted reviews of 106 fair lending plans. As a result of these examinations involving mortgage bankers and brokers, the Unit uncovered errors in key fields in the Home Mortgage Disclosure Act loan application registry; commingled fees, and fees charged to consumers at closing that were not itemized on the final Good Faith Estimate. The Unit will continue to seek restitution for aggrieved consumers.

(i) To ensure the continued safety and soundness of New York's banking, insurance and financial services industries, as well as the prudent conduct of the providers of financial products and services, through responsible regulation and supervision;

(j) To protect the public interest and the interests of depositors, creditors, policyholders, underwriters, shareholders and stockholders;

(k) To promote the reduction and elimination of fraud, criminal abuse and unethical conduct by, and with respect to, banking, insurance and other financial services institutions and their customers; and

(l) To educate and protect users of banking, insurance, and financial services products and services through the provision of timely and understandable information.

§ 103. Explanation of order of provisions.

In this financial services law, the provisions have been divided in descending order of application, with illustrations, as follows:

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Article 1
 Section 101
  Subsection (a)
   Paragraph (1)
    Subparagraph(A)
     Item(i)
      Clause(I)
       Subitem(aa)
        Subclause(aaa)
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§ 104. Definitions.

(a) In this chapter, unless the context otherwise requires:

(1) "Department" shall mean the department of financial services.

(2) "Financial product or service" shall mean:

(A) any financial product or financial service offered or provided by any person regulated or required to be regulated by the superintendent pursuant to the banking law or the insurance law or any financial product or service offered or sold to consumers except financial products or services: (i) regulated under the exclusive jurisdiction of a federal agency or authority, (ii) regulated for the purpose of consumer or investor protection by any other state agency, state department or state public authority, or (iii) where rules or regulations promulgated by the superintendent on such financial product or service would be preempted by federal law; and

(B) "Financial product or service" shall also not include the following, when offered or provided by a provider of consumer goods or services: (i) the extension of credit directly to a consumer exclusively for the purpose of enabling that consumer to purchase such consumer good or service directly from the seller, (ii) the collection of debt arising from such credit, or (iii) the sale or conveyance of such debt that is delinquent or otherwise in default.

(2-a) A "financial product or service regulated for the purpose of consumer or investor protection": (A) shall include (i) any product or service for which registration or licensing is required or for which the offeror or provider is required to be registered or licensed by state law, (ii) any product or service as to which provisions for consumer or investor protection are specifically set forth for such product or service by state statute or regulation and (iii) securities, commodities and real property subject to the provisions of article twenty-three-a of the general business law, and (B)

shall not include products or services solely subject to other general laws or regulations for the protection of consumers or investors.

(3) "Person" shall mean any individual, partnership, corporation association or any other entity.

(4) "Regulated person" or "person regulated" shall mean any person (A) operating under or required to operate under a license, registration, certificate or authorization under the insurance law or the banking law, (B) authorized, accredited, chartered or incorporated or possessing or required to possess other similar status under the insurance law or the banking law, or (C) regulated by the superintendent pursuant to this chapter.

(5) "Superintendent" shall mean the superintendent of financial services of this state.

(b) Whenever the terms "include", "including" or terms of similar import appear in this chapter, unless the context requires otherwise, such terms shall not be construed to imply the exclusion of any person, class or thing not specifically included.

(c) A reference in this chapter to any other law or statute of this state, or of any other jurisdiction, means such law or statute as amended to the effective date of this chapter, and unless the context otherwise requires, as amended thereafter.

ARTICLE 2: ORGANIZATION OF THE DEPARTMENT OF FINANCIAL SERVICES

§ 201. Declaration of policy.

(a) It is the intent of the legislature that the superintendent shall supervise the business of, and the persons providing, financial products and services, including any persons subject to the provisions of the insurance law and the banking law.

(b) The superintendent shall take such actions as the superintendent believes necessary to:

(1) foster the growth of the financial industry in New York and spur state economic development through judicious regulation and vigilant supervision;

(2) ensure the continued solvency, safety, soundness and prudent conduct of the providers of financial products and services;

(3) ensure fair, timely and equitable fulfillment of the financial obligations of such providers;

(4) protect users of financial products and services from financially impaired or insolvent providers of such services;

(5) encourage high standards of honesty, transparency, fair business practices and public responsibility;

(6) eliminate financial fraud, other criminal abuse and unethical conduct in the industry; and

(7) educate and protect users of financial products and services and ensure that users are provided with timely and understandable information to make responsible decisions about financial products and services.

§ 202. Superintendent.

(a) The head of the department shall be the superintendent of financial services, who shall be appointed by the governor, by and with the advice and consent of the senate, and who shall hold office at the pleasure of the governor. The superintendent shall possess the rights, powers, and duties in connection with financial services and protection in this state, expressed or reasonably implied by this chapter or any other applicable law of this state.

(b) The superintendent may, in the superintendent's discretion, designate one of the superintendent's deputies to act as superintendent during the superintendent's absence or inability to act. If the office of superintendent is vacant, or if the superintendent's absence or inability to act continues for a period of more than thirty successive days, the governor may designate a deputy to act as superintendent until the filling of the vacancy or the return or recovery of the superintendent.

(c) Whenever in this chapter, the banking law, the insurance law or any other law the superintendent is authorized but not required to take any action or the superintendent's approval is required as a condition precedent to the doing of any act, the taking of such action and the giving of such approval shall be within the superintendent's sound discretion. In taking any action with respect to any banking organization, and in approving or disapproving any application made by a banking organization, the superintendent shall give due consideration to the policy of the state of New York as set forth in section ten of the banking law.

§ 203. Deputies; employees.

(a) The superintendent shall appoint a deputy for insurance who shall be the head of the insurance division and a deputy for banking who shall be the head of the banking division. The superintendent may appoint such other deputies as the superintendent deems necessary to fulfill the responsibilities of the department. The superintendent may remove at will any deputy appointed by the superintendent, except as may be otherwise provided by the civil service law.

(b) The superintendent may appoint and remove from time to time, in accordance with law and any applicable rules of the state civil service commission, such employees, under such titles as the superintendent may assign, as the superintendent may deem necessary for the efficient administration of the department. They shall perform such duties as the superintendent shall assign to them. The compensation of such employees shall be determined by the superintendent in accordance with law.

(c) Any action that the superintendent is required or authorized hereinafter by this chapter, the banking law, the insurance law or other laws to take may be taken by a deputy or authorized employee to whom the duty of taking such action has been delegated or assigned by the superintendent.

§ 204. Offices of the department.

Suitable offices for conducting the business of the department shall be located in the cities of Albany and New York, and such other cities as the superintendent deems necessary. Necessary additional office, filing and storage space that cannot be supplied by the state commissioner of general services may be leased by the superintendent, and rent or expenses incurred pursuant to any such lease shall, unless otherwise provided

for, be paid on the certificate of the superintendent and the audit and warrant of the comptroller.

§ 205. Bureaus.

The superintendent shall establish an insurance division and a banking division. The superintendent may establish such other bureaus, divisions, and other units within the department as may be necessary for the administration and operation of the department and the proper exercise of its powers and the performance of its duties, under this chapter, and may, from time to time, consolidate or abolish such divisions, bureaus or other units within the department. Notwithstanding any inconsistent provision of law, the superintendent may determine the official functions of each division, bureau, or other unit within the department. There shall be a head of each bureau, division or other unit to be appointed by the superintendent, who shall serve at the pleasure of the superintendent, except as may be otherwise provided by the civil service law. The heads of bureaus, divisions or units in the banking and insurance departments who are in office when this chapter takes effect shall continue in office at the pleasure of the superintendent, except as may be otherwise provided by the civil service law.

§ 205-a. Report.

The governor shall by June thirtieth, two thousand eleven, create a working group to examine ways to improve the efficiency and effectiveness of banking regulation and insurance regulation, including opportunities to integrate certain regulatory activities prescribed by the banking law and the insurance law. Such working group shall consult, in making its examination, with representatives of the banking, insurance and financial services industries. On or before January first, two thousand twelve, the superintendent shall issue a report on the results of this review to the governor, the speaker of the assembly and the temporary president of the senate.

§ 205-b. State charter advisory board.

There shall be within the department a state charter advisory board to work with the superintendent in retaining state chartered banking institutions, encouraging federally chartered institutions to convert to a state charter and promoting the state banking system. There shall be nine members of the advisory board who shall be appointed by the superintendent. The membership shall consist of: (a) one representative of credit unions, (b) one representative of consumers, (c) one representative of foreign banks; and (d) representatives of banks which, to the extent practicable, reflect a range of size and geographical location, provided, however, that at least one shall represent institutions of more than three billion dollars in assets; at least two shall represent institutions of less than five hundred million dollars in assets. The superintendent shall make rules to govern the method by which state chartered institutions may nominate persons to the board and the process for selecting such members, provided that the representative of consumers shall be selected by the superintendent. The term of each member of such advisory board shall be three years, or until a successor is appointed and vacancies shall be filled for the unexpired term only. The board shall meet at least three times annually pursuant to the call of the superintendent. Such meetings may be held by means of a conference telephone or similar communications equipment allowing all persons participating in the meeting to hear each other at the same time. The members of the advisory board shall receive no compensation nor reimbursement for expenses.

The advisory board may:

(1) consider and recommend ways to maintain the state charter as a viable and attractive option, including bringing to the superintendent's attention issues of concern to state chartered banking institutions;

(2) consider and recommend ways to encourage banking institutions to offer a diversity of financial products and services throughout the state;

(3) recommend to the superintendent the establishment of such laws as may be deemed necessary, and the amendment or repeal thereof;

(4) recommend to the superintendent the promulgation of rules and regulations not inconsistent with the law, as may be deemed necessary, and the amendment or repeal thereof; and

(5) report within thirty days after receipt, on any proposed regulations, amendments thereto, or repeal thereof, prior to final action thereon by the superintendent.

The advisory board shall have no executive, administrative or appointive powers or duties.

§ 206. Assessments to defray operating expenses of the department.

(a) For each fiscal year commencing on or after April first, two thousand twelve, assessments to defray operating expenses, including all direct and indirect costs, of the department, except expenses incurred in the liquidation of banking organizations, shall be assessed by the superintendent in accordance with this subsection. Persons regulated under the insurance law shall be assessed by the superintendent for the operating expenses of the department that are solely attributable to regulating persons under the insurance law, which shall include any expenses that were permissible to be assessed in fiscal year two thousand nine-two thousand ten, with the assessments allocated pro rata upon all domestic insurers and all licensed United States branches of alien insurers domiciled in this state within the meaning of paragraph four of subsection (b) of section seven thousand four hundred eight of the insurance law, in proportion to the gross direct premiums and other considerations, written or received by them in this state during the calendar year ending December thirty-first immediately preceding the end of the fiscal year for which the assessment is made (less return premiums and considerations thereon) for policies or contracts of insurance covering property or risks resident or located in this state the issuance of which policies or contracts requires a license from the superintendent. Persons regulated under the banking law shall be assessed by the superintendent for the operating expenses of the department that are solely attributable to regulating persons under the banking law in such proportions as the superintendent shall deem just and reasonable. Operating expenses of the department not covered by the assessments set forth above shall be assessed by the superintendent in such proportions as the superintendent shall deem just and reasonable upon all domestic insurers and all licensed United States branches of alien insurers domiciled in this state within the meaning of paragraph four of subsection (b) of section seven thousand four hundred eight of the insurance law, and upon any regulated person under the banking law, other than mortgage loan originators, except as otherwise provided by sections one hundred fifty-one and two hundred twenty-eight of the workers' compensation law and by section sixty of the volunteer firefighters' benefit law. The provisions of this subsection shall not be applicable to a bank holding company, as that term is defined in article three-A of the banking law. Persons regulated under the banking law will not be assessed for expenses that the superintendent deems to benefit solely persons regulated under the insurance law, and persons regulated under the insurance law will not be assessed for expenses that the superintendent deems to benefit solely persons regulated under the banking law.

(b) For each fiscal year commencing on or after April first, two thousand twelve, a partial payment shall be made by each entity subject to this section in a sum equal to twenty-five per centum, or such other per centum or per centums as the superintendent may prescribe, of the annual expenses assessed upon it for the fiscal year as estimated by the superintendent. Such payment shall be made on March tenth of the preceding fiscal year and on June tenth, September tenth and December tenth of each year, or at such other dates as the superintendent may prescribe. The balance of assessments for the fiscal year shall be paid upon determination of the actual amount due in accordance with the provisions of this section. Any overpayment of annual assessment resulting from complying with the requirements of this subsection shall be applied against the next

estimated quarterly assessment, if less than or equal to such amount, with any excess refunded to the assessed. As an alternative, if the estimated annual assessment for the fiscal year is equal to or less than the annual minimum assessment set by the superintendent, the superintendent may require full payment to be made on or before September thirtieth or such other date of the fiscal year as the superintendent may determine.

(c) The expenses incurred in making examinations of, or for special services performed on account of, any bank holding company, as that term is defined in the banking law, or any regulated person under the banking law, shall be assessed provided, however, that the superintendent, in the superintendent's sole discretion, may determine, with respect to expenses incurred in the making of any specific examination or investigation, or the performing of any special services, that any such expense shall be assessed against and paid by the bank holding company or any other regulated person under the banking law for which they were incurred or performed.

(d) The expenses incurred in making an examination of any affiliate of a banking organization pursuant to the banking law, and the expenses incurred in making an examination, pursuant to the banking law, of a non-banking subsidiary of a corporation or any other entity that is an affiliate of a banking organization, shall be assessed against and paid by such banking organization if the affiliate cannot be assessed pursuant to the provisions of the banking law.

(e) The superintendent may, in the superintendent's sole discretion, upon notice, suspend the license, registration, certificate or authority (for purposes of this section, a license) granted to any person pursuant to this chapter, the banking law or insurance law, upon the failure of such person to make any payment required by this section within thirty days after the due date. If the superintendent has suspended any such license, such license may be reinstated if the superintendent determines that such person has made any such payments within ninety days after the date of such notice of suspension. Otherwise, unless the superintendent, in the superintendent's sole discretion, has extended such suspension, the license of such person shall be deemed to be automatically terminated by operation of law at the close of business on such ninetieth day.

(f) (1) The expenses of every examination of the affairs of any regulated person subject to the insurance law, including an appraisal of such regulated person's real property or of any real property on which such regulated person holds a mortgage, made pursuant to the authority conferred by any provision of this chapter, the insurance law or the banking law, shall be borne and paid by the regulated person so examined, but the superintendent, with the approval of the comptroller, may in the superintendent's discretion for good cause shown remit such charges.

(2) (A) For any such examination by the superintendent or a deputy superintendent personally, the charge made shall be only for necessary traveling expenses and other actual expenses. In all other cases, the expenses of examination shall also include reimbursement for the compensation paid for the services of persons employed by the superintendent or by the superintendent's authority to make such examination or appraisal.

(B) Notwithstanding any provisions of this section to the contrary, in case of an examination or appraisal of a domestic insurer made within this state, the traveling and living expense of the person or persons making the examination shall be considered a cost of operation, as referred to in section three hundred thirty-two of the insurance law and not an expense of examination.

(3) All charges, including necessary traveling and other actual expenses, except as hereinabove provided, as audited by the comptroller and paid on the comptroller's warrant in the usual manner by the comptroller to the person or persons making the examination or appraisal, shall be presented to the insurer, or other person whose duty

it is to pay the same, in the form of a copy of the itemized bill therefor as certified and approved by the superintendent or by any deputy superintendent or authorized employee of the department. Upon receiving such certified copy the insurer or other person whose duty it is to pay such charges shall pay the amount thereof to the superintendent, to be paid by the superintendent into the state treasury.

ARTICLE 3: ADMINISTRATIVE AND PROCEDURAL PROVISIONS

§ 301. Powers of the superintendent.

(a) The superintendent shall have such powers as are conferred upon the superintendent by this chapter, the banking law, the insurance law or any other law of this state.

(b) The superintendent shall have the power to conduct investigations, research, studies and analyses of matters affecting the interests of consumers of financial products and services, including tracking and monitoring complaints.

(c) The superintendent shall have the power to protect users of financial products and services, including:

(1) taking such actions as the superintendent deems necessary to educate and protect users of financial products and services;

(2) receiving complaints of consumers of financial products and services, and where appropriate (A) providing assistance to consumers;

(B) mediating the resolution of such complaints with providers of financial products and services; or (C) referring such complaints to the appropriate federal, state or local agency authorized by law for appropriate action on such complaints;

(3) studying the operation of laws and advising and making recommendations to the governor on matters affecting consumers of and investors in financial products and services and promoting and encouraging the protection of the legitimate interests of users of such financial products and services;

(4) cooperating with, assisting and, when appropriate, referring matters to the attorney general in the carrying out of the attorney general's legal enforcement responsibilities for the protection of consumers of and investors in financial products and services;

(5) initiating and encouraging consumer financial education programs, and disseminating materials to educate users of financial products and services;

(6) providing technical assistance to local governments and not-for-profits in the development of consumer protection measures with respect to financial products and services; and

(7) continuing and expanding the detection, investigation and prevention of insurance

fraud.

§ 302. Regulations by superintendent.

(a) The superintendent shall have the power to prescribe and from time to time withdraw or amend, in writing, rules and regulations and issue orders and guidance involving financial products and services, not inconsistent with the provisions of this chapter, the banking law, the insurance law and any other law in which the superintendent is given authority:

(1) effectuating any power given to the superintendent under the provisions of this chapter, the insurance law, the banking law, or any other law to prescribe forms or make regulations;

(2) interpreting the provisions of this chapter, the insurance law, the banking law, or any other applicable law; and

(3) governing the procedures to be followed in the practice of the department.

(b) The superintendent may promulgate a list of financial products and services excluded from regulation by the superintendent, provided that such exclusion shall not limit in any way the ability of the superintendent to take any actions with respect to fraud provided for in this chapter, the insurance law, the banking law or any other applicable law.

§ 303. Orders of superintendent; when writing required.

Whenever by any provision of this chapter, the insurance law, the banking law or and other applicable law the superintendent is authorized to grant any approval, authorization or permission or to make any other order or determination affecting any person subject to the provisions of this chapter, the insurance law, the banking law or any other law, such order or determination shall not be effective unless made in writing and signed by the superintendent or by the superintendent's authority.

§ 304. Notice; how given.

(a) (1) Except when other notice is required by law, whenever the provisions of this chapter, the insurance law, the banking law or any other applicable law require the superintendent to give notice to any person of any authorized action or proposed action, it shall be sufficient to give such notice in writing either by delivering it to such person or by depositing the same in the United States mail, postage prepaid, registered or certified, and addressed to the last known place of business of such person or if no such address is known to the superintendent, then to the residence address of such person.

(2) Such notice shall refer to the provisions of this chapter, the insurance law, the banking law or any other applicable law pursuant to which the authorized action was taken or is proposed to be taken and the grounds therefor, but failure to make such reference shall not render the notice ineffective if the person to whom it is addressed is thereby or otherwise reasonably apprised of such grounds.

(3) If the person being notified is entitled to a hearing by the provisions of this chapter, the banking law, the insurance law or any other law, the notice of proposed action may specify that such proposed action may be considered, or when authorized, taken on a date specified in the notice unless such person shall notify the superintendent in writing that a hearing is demanded; in such case the superintendent shall give such person a further notice of the time and place of such hearing in the manner stated in this paragraph, and to the address specified by such person if provided.

ARTICLE 5: RESTRICTIONS ON OFFICERS AND EMPLOYEES OF THE DEPARTMENT

§ 501. Restrictions on officers and employees of the department; penalty.

(a) No officer or employee of the department shall obtain a loan or extension of credit from any regulated person or be interested in any such regulated person as a director, partner, owner, officer, attorney, agent, trustee or employee, or own or deal in, either directly or indirectly, the stocks or obligations of any such regulated person. A violation of the provisions of this section by any officer or employee shall constitute sufficient grounds for his or her removal by the superintendent.

(b) Nothing in this section shall be construed to prohibit any officer or employee from obtaining financing from a regulated person upon his or her primary or secondary residence, provided that the premises securing such loan are occupied by such employee, and further provided that such loan is reported to the department, which shall keep a record thereof. The term "residence," for the purposes of this section, shall mean a single family or two family residence, condominium apartment or cooperative apartment, occupied in whole or in part, by the officer or employee. The term "cooperative apartment" means a residence where ownership is evidenced by certificates of stock or other evidence of an ownership interest in, and a proprietary lease from, a corporation or partnership formed for the purpose of the cooperative ownership of real estate.

(c) Nothing in this section shall be construed to prohibit any officer or employee from: (1) obtaining a loan secured by an assignment of his or her deposit in a banking organization, or an assignment or pledge of his or her shares in a savings and loan association or credit union; (2) accepting financing of an automobile, truck or other personal property from a banking organization or a sales finance company; (3) entering into a premium finance agreement with a premium finance agency; or (4) owning shares of an investment company (mutual fund) that may incidentally invest in the securities of any regulated person, provided that the purpose of the investment portfolio of such investment company may not be to invest primarily or exclusively in the securities of banking or insurance entities. For purposes of this section, investment companies include open-end and closed-end investment companies and unit investment trusts as those terms are defined in an Act of Congress entitled "The Investment Company Act of 1940," as amended.

(d) Nothing in this section shall be construed to prevent any officer or employee from becoming a policyholder of any insurer or from taking out a loan under the officer's or employee's insurance policy, or prevent or impair the ability of the superintendent to act as a liquidator, rehabilitator, or conservator pursuant to article seventy-four of the insurance law or article thirteen of the banking law.

(e) The superintendent may promulgate policies and procedures for exempting particular employees, or classes of employees, from investment restrictions in subsection (a) of this section as to regulated persons with which such employee or class of employees has no authority or involvement.

(f) This section shall not apply to investments held in a blind trust approved by the superintendent or the superintendent's designee.