STATE OF NEW YORK
INSURANCE DEPARTMENT
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David A. Paterson
Governor

James J. Wrynn
Superintendent

March 12, 2010

To the Governor and the Legislature:

I am pleased to submit the Annual Report of the Superintendent of Insurance on the operations of the Insurance Frauds Bureau and an assessment of the insurance industry's anti-fraud efforts for 2009. Over the past year, the Frauds Bureau continued its longstanding tradition of collaborating with law enforcement agencies and the insurance industry to aggressively target insurance fraud throughout New York State.

I am also pleased to report that Frauds Bureau investigations led to a total of 738 arrests for insurance fraud and related crimes in 2009. In addition, 499 criminal convictions were obtained by prosecutors handling referrals of Frauds Bureau cases, up from 402 in 2008.

Over the past year, the Bureau established a Mortgage and Title Unit to combat a proliferation of schemes that target consumers in the real estate market. The Unit received more than 300 reports of suspected fraud and executed 19 arrests.

In the coming year, the Frauds Bureau will continue to aggressively combat mortgage fraud and will also direct substantial resources to combating the recent increase in no-fault fraud, which directly results in increased costs to consumers. We look forward to meeting the challenges that lie ahead and welcome the opportunity to continue to serve the people of New York State.

Sincerely,

James J. Wrynn
Superintendent of Insurance

The Annual Report

to the Governor

and the Legislature

of the State of New York

on the Operations

of the Insurance Frauds Prevention Act

(Article 4 of the Insurance Law)

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I. Insurance Frauds Bureau
2009 Highlights

- **Investigations conducted by Frauds Bureau staff resulted in 738 arrests during 2009.**

- **The number of criminal convictions obtained by prosecutors in Frauds Bureau cases totaled 499 in 2009, up from 402 in the prior year.**

- **The Bureau's newly established Mortgage and Title Unit concentrated Frauds Bureau resources to address an increase in theft of premiums and monies held in escrow by title agents and the proliferation of schemes targeting indebted homeowners and other consumers in the real estate market.**

- **During 2009, the Mortgage and Title Unit received 326 reports of suspected fraud. The reports included allegations of agent defalcations, straw-buyer transactions and fraudulent mortgage applications. Investigators opened 18 cases for investigation and executed 19 arrests.**

- **A total of 1,707 new cases were opened for investigation in 2009, a marked increase of nearly 25 percent over 2008.**

- **The Workers' Compensation Unit posted 184 arrests for 2009, outpacing the prior year's total by 16 percent.**

- **The General Unit recorded 110 arrests in 2009, versus 69 in the prior year. Arrests resulting from investigations involving agents, brokers and adjusters accounted for almost a quarter of the year-to-year increase.**

- **New York State received almost $12 million in refunds and $124,000 in fines from a number of health care providers who improperly billed United Healthcare, administrator for the Empire Plan.**

II. The Insurance Frauds Bureau

A. Team Building

Team building has long been a hallmark of the Frauds Bureau and the tradition continued in 2009. The Bureau's vision of collaborative alliances with the insurance industry, prosecutors and law enforcement agencies on the federal, state and local levels was reinforced over the past year. Teamwork, dedication and hard work resulted in 738 arrests and 499 convictions throughout the State.

B. Multi-Agency Investigations

Several successful multi-agency investigations are summarized below.

The operator of three title insurance agencies in New York and Suffolk Counties was charged with misappropriating millions of dollars in escrow and other client funds and embezzling a part of those funds for his personal use. The investigation that led to his arrest was conducted by the Frauds Bureau, the FBI and the Office of the U.S. Attorney for the Southern District.

The owner of a home heavily damaged in a fire was arrested and charged with deliberately setting the blaze in an unsuccessful attempt to collect more than $500,000 from New York Central Mutual Insurance Company. About 75 firefighters from Oneonta and surrounding departments, two of whom were injured at the scene, fought the blaze. The Frauds Bureau and the Oneonta Police and Fire Departments conducted the investigation that determined the fire was incendiary.

These cases and many others in which the Frauds Bureau pooled resources with fraud-fighting partners are summarized in Section *IV.* A.

The Bureau also teamed up with the NYPD's Fraudulent Accident Investigation Squad and Auto Crime Division in the investigation of many no-fault and other auto-related fraud cases, and with the Workers' Compensation Board's Office of the Fraud Inspector General and the State Insurance Fund on cases involving workers' compensation fraud.

Additionally, Arson Unit investigators worked closely with the FDNY's Bureau of Fire Investigations, the NYPD's Arson Explosion Squad and the Bureau of Alcohol, Tobacco, Firearms and Explosives. The Frauds Bureau also acts as a liaison with the New York State Office of Fire Prevention and Control, as well as local arson units and fire departments throughout the State.

Moreover, DA's Offices, the New York State Attorney General's Office, the New York State DMV, the U.S. Postal Inspection Service and the FBI, as well as local police departments and sheriff's offices across the State, are partners in many Frauds Bureau investigations of all types of insurance fraud.

C. Task Force/Working Group Participation

The Frauds Bureau is an active participant in numerous task forces and working groups designed to foster cooperation, commitment and communication among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing investigative skills. Among the groups of which the Bureau is a member 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 New York Health Care Fraud Task Force
- NICB Medical Working Group
- FBI/U.S. Attorney Health Care Fraud Working Group
- Motor Vehicle Theft and Insurance Fraud Prevention Board (DCJS)
- 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

The Medicare Fraud Strike Force supplements the health care fraud enforcement activities of the U.S. Attorneys' Offices by targeting chronic fraud, as well as emerging or migrating schemes perpetrated by criminals operating as health care providers or suppliers. In addition to the Frauds Bureau, Strike Force members include the Department of Justice Criminal Division's Fraud Section, law enforcement partners in the Department of Health and Human Services (HHS), and state and local law enforcement agencies.

In May 2009, the Strike Force expanded its operations into Brooklyn, NY, Tampa, FL, and Baton Rouge, LA, in a targeted criminal, civil and administrative effort against individuals and health care companies that fraudulently bill the Medicare program. The Frauds Bureau began its participation in the Strike Force with the expansion into Brooklyn.

From the inception of operations in March 2007 to the May 2009 expansion, the Strike Force obtained indictments of more than 460 individuals and organizations that falsely billed the Medicare program for more than $1 billion. Moreover, the HHS Centers for Medicare & Medicaid Services is working together with its Office of the Inspector General to take steps to increase accountability and decrease the presence of fraudulent providers.

III. Operational Overview

A. Administration

The Frauds Bureau was established by an act of the Legislature in 1981 as a law enforcement agency within the New York State Insurance Department. The Bureau's primary mission is the detection and investigation of insurance fraud and the referral for prosecution of persons or groups that commit acts of insurance fraud. The Bureau is headquartered in New York

City, with six additional offices across the State: Mineola, Albany, Syracuse, Oneonta, Rochester and Buffalo. A full list of office locations, including addresses and telephone/fax numbers, appears in the Appendices to this Report.

B. The Staff

The Director of the Bureau is responsible for all of the Bureau's operations, with the assistance of the Deputy Director. In addition, the Bureau's Assistant Director of Research reports to the Director and the Deputy Director.

Bureau staff consists of 18 Senior Investigators and 18 Investigators who staff the Bureau's eight specialized units: Major Case, Arson, General, Auto, Workers' Compensation, Medical/No-Fault (merged in January 2008), Upstate and a newly established Mortgage and Title Unit. (See Section *V.* A for more information about the activities of the Mortgage and Title Unit.) Each Unit is supervised by a Deputy Chief Investigator. General oversight of the investigative staff is the responsibility of the Chief Investigator with the assistance of two Assistant Chief Investigators.

A Counsel and an Assistant Counsel are responsible for all legal matters as they relate to fraud investigations. In addition, the Bureau has a Manager of Information Technology Services who coordinates the activities of the Department's Mobile Command Center.

The Bureau's Training Officer provides in-service training for Bureau staff and conducts training for law enforcement, industry and community groups. The Training Officer reports to the Chief Investigator. (Section *III.* F provides more information about Bureau training.)

In addition, the Bureau has a unit that includes a Senior Insurance Examiner and an Insurance Examiner who report to a Principal Examiner. The examiner staff are responsible for insurer compliance with Article 4 of the New York Insurance Law and Department Regulation 95. The examiner staff may perform market conduct examinations of insurer Special Investigation Units.

The Bureau also has two support staff members who report to the Secretary to the Director.

C. Investigations

The Frauds Bureau received 24,920 reports of suspected fraud in 2009, an increase of more than 8 percent over the 23,054 reports received the year before. Of the 2009 total, 24,119 were received from licensees required to submit such reports to the Department and 801 were received from other sources, such as consumers and anonymous tips. A total of 1,707 new cases were opened for investigation during the past year versus 1,367 opened in 2008, an increase of nearly 25 percent. Investigations also continued in numerous cases opened in prior years. Tables showing the number of fraud reports received, investigations opened and arrests by type of fraud appear in the Appendices to this Report.

During 2009, the Bureau referred 533 cases to prosecutorial agencies for criminal prosecution and another 65 to the Department's Office of General Counsel for civil proceedings.

D. Arrests

Frauds Bureau investigations led to 738 arrests for insurance fraud and related crimes during the past year, compared with 755 in 2008. In one investigation, the owner of an insurance brokerage on Staten Island was arrested in March and charged with misappropriating $407,000 in premiums collected from 16 insureds. Another investigation led to the arrest in June of a Bay Shore, Long Island, doctor who filed $800,000 in allegedly fraudulent claims with numerous health care programs, including Medicare, for services that were never provided. Court papers also alleged that he evaded almost $1.3 million in income taxes from 2001 to 2003.

E. Civil Enforcement, Restitution and Forfeitures

Section 403 of the New York Insurance Law authorizes the Insurance Department to levy civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. Under the provisions of Section 2133 of the New York 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.

The Frauds Bureau began prosecution proceedings in 72 civil fine cases in 2009, versus 59 cases in 2008, an increase of 22 percent over the prior year. In addition, 36 civil fine cases were concluded during 2009, improving on the 2008 total of 24 cases by 50 percent. Among the types of civil fine cases in which the Bureau saw increases were fraudulent homeowners, workers' compensation and disability claims. The number of civil fine cases involving fraudulent auto theft and vehicle arson remained steady over the prior year. As a result of the Bureau's increased civil enforcement activities, $2.86 million in penalties were imposed during 2009, up from $1.68 million in the prior year, a year-to-year gain of 70 percent.

Court-ordered restitution totaled $5.1 million during the past year as a result of Frauds Bureau criminal investigations. Moreover, insurers saw savings of $4.0 million in connection with fraudulent claims investigated by the Bureau, an amount more than three times greater than the prior year's total of $1.2 million and the highest savings total in the past five years.

In addition, defendants in five separate cases were ordered to make asset forfeitures totaling $26.1 million in connection with their plea agreements during 2009. In one case alone, a former chief underwriter for an insurance company forfeited $22.5 million along with real estate. He was sentenced to ten years in federal prison for selling $535 million in fraudulent surety bonds and stealing $22.5 million in premiums.

F. Training

Investigators participate in the Bureau's In-Service Training Program designed for all investigative staff. In addition, newly hired investigators participate in an Entry-Level Training Program. Both programs were developed by the 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). Frauds Bureau investigators are seasoned professionals with broad law enforcement experience and often exceed the high standards set by DCJS.

Frauds Bureau Training Officer John Marcone and Senior Investigator Mark Sirkin are Certified Firearms Instructors and provide both upstate and downstate investigators with appropriate instruction in firearms safety and proficiency. While certification in firearms aptitude is required by DCJS on an annual basis, all Frauds Bureau investigators must recertify semi-annually, demonstrating the importance the Bureau attaches to the responsibilities involved in the proper use of firearms.

The Bureau's Training Officer conducted two training sessions at the New York City Police Academy during 2009, attended by 480 recruits. In addition, two sessions were given to 63 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. Therefore, the Bureau has placed great emphasis on the training of police recruits.

Frauds Bureau staff also provided training to members of the insurance industry and local police and fire departments throughout the State. In addition, investigators joined the Department's Deputy Superintendent for Community Affairs, Ivan Lafayette, to give presentations to a number of community groups during 2009. Deputy Superintendent Lafayette is responsible for planning and directing the Department's outreach and community affairs initiatives, services and programs on issues affecting a broad spectrum of consumers, including the senior population. In the photo at left are Frauds Bureau Deputy Chief Investigator John McDonald (at the microphone) and Deputy Superintendent Lafayette conducting a presentation on December 16 at the Jewish Association for Services for the Aged.

In 2009, the Bureau provided training for 35 groups comprising 1,597 participants. A complete list of the groups for which Frauds Bureau investigators provided training during 2009 appears in the Appendices to this Report.

G. 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 in order to stay current with emerging developments in the area of insurance fraud.

During 2009, Bureau staff took advantage of many of the educational opportunities offered by the New York Anti Car Theft and Fraud Association, the National White Collar Crime Center, the Division of Criminal Justice Services and the New York Prosecutors Training Institute, among others. Moreover, the Insurance Department mandated courses in Diversity Awareness; Ethics; and Workplace Violence Prevention/Domestic Violence and the Workplace/Hazardous Materials: Your Right to Know for all staff members. An annual course in defensive driving is also available to all Department staff and is required every three years for the investigative staff.

H. Fraud Prevention Plans/Public Awareness Programs

Section 409(a) of the New York Insurance Law (NYIL) and Department Regulation 95 require all insurers writing automobile, workers' compensation and accident and health insurance that write at least 3,000 policies annually to submit to the Department a Fraud Prevention Plan (Plan). The Plan must provide for a Special Investigations Unit (SIU), separate from claims and underwriting, responsible for investigating cases of suspected fraud and for implementation of the insurer's fraud prevention and reduction activities. In lieu of an SIU, an insurer may contract with a separate provider of such services and then must provide to the Superintendent a detailed copy of the signed contract. The Plan must address training for claims and underwriting personnel, a public awareness program, interface with law enforcement and prosecutorial agencies, among several other requirements.

Affiliated insurers may submit one Fraud Prevention Plan covering multiple insurers. Additionally, some insurance carriers submit more than one Plan to address different lines of business or different SIUs within the insurer. At year-end 2009, there were 133 Plans on file. A complete list of insurer or group Plans on file as of 12/31/09 appears in the Appendices to this Report.

Regulation 95 and Section 409(c)(5) of the NYIL require that Fraud Prevention Plans provide for a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in its prevention. The programs must be geared to reach a wider audience than an insurer's policyholders and applicants. In an effort to achieve that goal, the New York Alliance Against Insurance Fraud (NYAAIF) performs advertising campaigns using newspapers, radio and television to target insurance consumers. There were 108 insurers with Fraud Prevention Plans on file with the Department that participated in the NYAAIF public awareness campaign. Additionally, 21 health plans or groups of affiliated health plans are members of the National Health Care Anti-Fraud Association (NHCAA), which carries out a public awareness campaign using newspapers and radio advertising. Moreover, several individual insurers have ongoing programs to heighten awareness and reduce public tolerance for insurance fraud. As a result, these anti-fraud messages reach millions of New Yorkers during the course of the year. The Bureau also has a hotline for reporting suspected insurance fraud (1-888-FRAUDNY) and consumers are encouraged to do so. The Bureau recorded on average 28 calls a week in 2009.

I. Electronic Filing of Annual SIU Reports

According to Section 409(g) of the New York Insurance Law, those insurers with Fraud Prevention Plans on file must also file an Annual Report by March 15 of each year. The Annual Report must describe the SIU's experience, performance and cost effectiveness in implementing the Plan. Since 2008, insurers are required to submit the Annual SIU Report electronically. Hard copy submissions of the report are no longer accepted.

IV. The Year in Review

A. Major Cases

The Frauds Bureau was involved in a number of multi-agency investigations during 2009. These operations, in addition to the day-to-day investigations conducted by Frauds Bureau investigators, contributed to the total number of arrests for the year. Some of these major cases are summarized below.

January

PAYMENT AVOIDED

- An investigation by the Frauds Bureau and the Workers' Compensation Board's Office of the Fraud Inspector General led to the arrest of the owner of a Yonkers, NY, bus service. Investigators found evidence indicating that the suspect in this case employed 25 workers from 2006-2008 but did not have workers' compensation coverage. Section 52(1)(a) of the Workers' Compensation Law makes it a felony to employ more than five workers without coverage. As a result of his allegedly fraudulent act, the defendant avoided paying an estimated $130,000 in workers' compensation premiums.

CO-DEFENDANTS CAUGHT

- An investigation by the Frauds Bureau and Progressive Insurance Company's SIU resulted in the arrest of an upstate woman when she surrendered to the Depew Police Department on 1/28/09. The investigation revealed that on 7/17/08, the defendant's car accidentally struck a parked car owned by a co-worker who is a co-defendant in this case. (The co-defendant surrendered on 1/21/09.) After learning that her auto insurance policy with Allstate Insurance Company had been cancelled, she purchased coverage from Progressive. She and the co-defendant then allegedly changed the date on the Police Accident Report to 7/24/08 when the newly purchased coverage was already in effect and filed a claim for $1,640. Progressive denied the claim after contacting a witness who provided proof that the actual date of the accident was 7/17/08.

February

CONVICTED

- After a six-week trial in Brooklyn Supreme Court, Dr. Alexander Rozenberg and his clinic, AR Medical Art, were convicted on 2/20/09 of numerous charges. The doctor was found guilty of insurance fraud in the 5th degree and falsifying business records in the 1st

degree. The clinic was found guilty of scheme to defraud in the 1st degree, insurance fraud in the 5th degree and falsifying business records in the 1st degree. Evidence showed that Rozenberg and his clinic purported to treat people injured in real and staged accidents in a complex scheme to defraud no-fault insurers. "Steerers" referred accident victims to the clinic where Rozenberg falsely diagnosed injuries, provided unnecessary medical treatments and prescribed costly medical equipment. The convictions were the result of a 20-month joint investigation by the Attorney General's Office, the Frauds Bureau and the NYPD's Fraudulent Accident Investigation Squad in which 25 defendants were charged. Twenty-three have pleaded guilty to criminal charges in connection with their involvement in the scheme. The case against the 25th defendant was dismissed.

DERELICT AUTO

- An investigation by the Frauds Bureau and the FDNY's Bureau of Fire Investigations resulted in the arrest of a Queens woman who falsely reported to the NYPD and her insurance carrier that she had parked, secured and last seen her 2005 Dodge Magnum at 6:00 p.m. on 8/22/08. She further reported that when she returned to the location on 8/23/08 between 5:00 p.m. and 5:30 p.m., the car was missing. However, investigators found that at 8:50 p.m. on 8/21/08, FDNY units responded to a fire involving a vehicle identified as the Dodge Magnum. Investigators contacted the New York City Department of Sanitation's Derelict Auto Program and learned that on 8/22/08 at 12:56 p.m., the vehicle was tagged for removal from public view and the car was removed on 8/25/08.

KEEPING THE HOME FIRES BURNING

- A fire at the home of a Rochester woman on 6/15/07 caused severe damage. However, she did not have insurance coverage for the property at the time of the fire. She applied for and was issued coverage by American Bankers Insurance Company on 6/16/07. She then faxed allegedly fraudulent documents to the insurer indicating that the fire had occurred on 6/16, the day the insurance coverage became effective. The total value of the claim was $100,000. The insurer paid out $4,933 for living expenses before the fraud was discovered and the defendant was ordered to repay that amount. Investigators from the Frauds Bureau and the Bureau of Alcohol, Tobacco, Firearms and Explosives conducted the investigation that led to her arrest.

March

MISAPPROPRIATION

- An investigation by the Frauds Bureau and the U.S. Postal Inspection Service resulted in the arrest of the owner of an insurance brokerage on Staten Island. The investigation was initiated based on a complaint from a broker and former employee alleging that the defendant had misappropriated premiums. The defendant was an agent for Navigators Insurance Company which provided cargo insurance for companies that shipped merchandise overseas. She was responsible for collecting the premiums for each shipment, issuing a certificate of insurance to the insureds, and remitting the premiums to Navigators. However, investigators discovered that when one insured filed a claim with Navigators, there was no coverage in place. Further investigation revealed that the defendant misappropriated a total of $407,000 in premiums collected from 16 insureds.

INCARCERATION & RESTITUTION

- Jeffrey C. Seifts, a former insurance agent from Poughkeepsie, NY, was sentenced on 3/19/09 to a year in federal prison and ordered to make $133,000 in restitution to retirees, small business owners and others in the upstate area. He was convicted of running a phony insurance scheme that victimized 240 people in Dutchess, Ulster and Columbia Counties. His arrest stemmed from an investigation initiated in 2003 when the Insurance Department was contacted by a Dutchess County woman who incurred $50,000 in medical expenses resulting from complications during a pregnancy. She told the Department's Consumer Services Bureau she was unable to have the expenses paid through the insurance she purchased from Seifts and was subsequently forced to file for bankruptcy. At the same time, MVP Health Care, a health maintenance organization in Schenectady, reported suspected irregularities in numerous applications it had received from Seifts. Investigators from the Frauds Bureau and the U. S. Postal Inspection Service found that applications from four different people contained the same handwriting and that suspicious alterations appeared to have been made on several applications. In addition, a large number of applicants were identified as "management" employees for the same organization, Professional Employees Management Corporation (PEMC), a company later determined to be fictitious. The suspect solicited business from customers on the basis that they could obtain less costly insurance through the small group plan he purportedly operated. However, a review of the suspect's records revealed that his customers were actually paying more than they would have paid through other insurance plans and that they were overcharged by a total of $76,747. In addition, Seifts was charging customers a $12 monthly union fee. These customers were not members of a union nor was the money turned over to any union. While some people who purchased insurance did receive coverage for their medical expenses, Seifts failed to forward $60,645 in premiums to MVP Health Care. Moreover, he collected $13,232 in unauthorized fees. Seifts was arrested in July 2007 and in October 2008 pleaded guilty to theft from a health benefit plan. His corporation, JC Seifts & Company, Inc., pleaded guilty to mail fraud. The Insurance Department revoked his license to sell insurance in 2005.

April

THAT'S A LOT OF CLAIMS

- Between February 2005 and February 2008, the defendant in this case submitted 113 claims to United Healthcare Insurance Company for medical services he and his estranged wife allegedly received at a local family health care practice. He stated on the claims that they received medical treatments for which they paid $370 per visit. However, an investigation by the Frauds Bureau and the State Police revealed that neither the defendant nor his wife received any medical services at the health care facility in question. Over the three-year period, the defendant fraudulently collected $233,138 in reimbursements from United Healthcare.

PREMIUMS PAST DUE

- An investigation by the Frauds Bureau with the assistance of the Broome County DA's Office resulted in the arrest of a self-employed Binghamton woman charged with

attempting to defraud the State Insurance Fund. On 2/19/07, she knowingly filed an application for workers' compensation and general liability insurance coverage that contained materially false information. The defendant owed the Fund more than $144,000 in past premiums and knew she would not get the required coverage using her own name. Therefore, with consent she used the name of a third party on the application in an attempt to avoid paying the past due premiums.

SHOPLIFTING & INSURANCE FRAUD

- The defendant in this case reported her 1998 Chevrolet Blazer stolen just hours after she abandoned the vehicle while it was being observed by the State Police in connection with a shoplifting investigation. She was arrested for filing a fraudulent insurance claim with Progressive Insurance Company for the purported theft of the vehicle. The arrest was part of an investigation begun on 8/28/08 after the defendant and an unnamed companion were identified as shoplifters by merchants at a Waterloo, NY, shopping mall. She abandoned her vehicle in the mall's parking lot after police were called by the merchants. Several hours later, she reported to the police that her vehicle had been stolen and filed an insurance claim for the loss. The State Police subsequently informed her that they had recovered her vehicle and requested that she come to the State Police station in Waterloo, where she was arrested for criminal possession of stolen property in connection with the shoplifting. The Frauds Bureau, with the assistance of the State Police and the Rochester Police Department, conducted the investigation that led to her arrest on a charge of insurance fraud. The claim was never paid.

May

ESCROW/OTHER FUNDS STOLEN

- The operator of three title insurance agencies in New York and Suffolk Counties was charged with misappropriating millions of dollars in escrow and other client funds and embezzling a part of those funds for his personal use. An investigation by the Frauds Bureau, the FBI and the Office of the U.S. Attorney for the Southern District found evidence that between January 2008 and April 2009, the defendant allegedly withdrew about $2.2 million in cash from one of the companies. These withdrawals at times totaled $300,000 or more in a single month. To sustain the company's operations, the defendant essentially used new funds from clients to pay off debts to older clients. In addition, the defendant failed to record dozens of real estate transactions in a timely fashion in spite of the fact that he had already been paid to record them.

UNDERREPORTED

- An investigation by the Frauds Bureau resulted in the arrest of the president of a roofing company who was charged with defrauding the State Insurance Fund. The defendant allegedly underreported his payroll and gross sales in order to reduce the amount of premiums he paid for workers' compensation and general liability insurance coverage. Based on his underreporting, the State Insurance Fund lost $89,287 in premiums for the two-year period from 1/1/07 to 1/1/09.

FRAUDULENT MORTGAGE LOAN

- A former physician, whose license was revoked in 2005, acquired a property in Saratoga, N.Y., from its former owners who were facing foreclosure. No money changed hands. Then, based on a fraudulent mortgage loan, the new owner insured the vacant building for $475,000. However, a month later, on April 30, 2009, the building – vacant, abandoned and without power – burned to the ground under suspicious circumstances. An investigation conducted by the Frauds Bureau, the Town of Colonie Police and Fire Departments, the State Police, the Albany County DA's Office, the State Office of Fire Prevention and Control and the Albany County fire coordinator revealed that accelerants had been used inside and outside the building, a fact later confirmed by laboratory tests. Investigators alleged that the owner acquired the building for the purpose of setting the fire to collect the insurance payout. He was arrested on 5/27/09.

June

WORTHLESS BONDS

- William Raymond Miller, former chief underwriting officer of Upper Hudson National Insurance Company in Monticello, NY, was sentenced to ten years and one month in federal prison for selling $535 million in fraudulent surety bonds and stealing $22.5 million in premiums. The court also ordered a personal money judgment of $22 million against Miller, who has already forfeited $22.5 million to the government, along with real estate in Maryland and Florida. The Frauds Bureau began investigating Miller in early 2008 after he was fired by Upper Hudson. The insurance company contacted authorities after learning that Miller had sold a worthless $38 million performance bond purportedly authorized by Upper Hudson. He was accused of keeping $1.9 million in premiums paid for the bond by a construction company engaged in a project in Nebraska. Under a plea agreement with federal authorities, Miller admitted that from 2005 to April 2008 he used the names of several corporations to sell the worthless bonds on construction projects throughout the U.S. Besides the New York investigation which was conducted by the Frauds Bureau and the U.S. Postal Inspection Service, Miller was also investigated by the FBI and state authorities in Maryland and Florida.

HEALTH CARE FRAUD & TAX EVASION

- An investigation by the Frauds Bureau and the Internal Revenue Service resulted in the 6/19/09 arrest of a Bay Shore, Long Island, doctor who filed $800,000 in allegedly fraudulent claims with numerous health care programs, including Medicare, for services that were never provided. Court papers also alleged that he evaded almost $1.3 million in income taxes from 2001 to 2003.

July

MORTGAGES & DEEDS UNRECORDED

- The owner/operator of several title insurance companies was arrested on charges that between 2006 and 2008 he stole more than $1.7 million from clients of those companies, including $384,000 from a church in Queens. The suspect's companies acted as settlement or escrow agents in real estate deals. They received large sums of money to pay mortgage

recording fees, real estate taxes and other fees attendant to the purchase of commercial and residential properties. However, the suspect instead allegedly used the money collected to pay the operating expenses of his companies. As a result, several mortgages and deeds went unrecorded. The Frauds Bureau and the FBI conducted the investigation that led to his arrest.

FORGED DIAGNOSIS

- An investigation by the Frauds Bureau and the State Police brought about the arrest of a woman for her unsuccessful attempt to defraud Hartford Insurance Company of $2,246 in disability payments. The defendant admitted that she produced a letter on her home computer using the University of Rochester Medical Center logo, stating that she had been diagnosed with cancer and could not return to work. She forged a doctor's signature and submitted the letter to Hartford in support of her claim. She told investigators that she lied about the diagnosis so that she could stay at home with her newborn child.

REPOSSESSED

- An Endicott man reported his 2008 Chevy Impala stolen on 5/14/09 and filed an $18,000 claim with Farmers Insurance Company for the loss. However, an investigation by the Frauds Bureau revealed that on the day he filed the claim, he was notified by the Endicott Police Department that the car had been repossessed for nonpayment of his loan. On 5/20/09, he submitted a "proof of loss" statement to the insurer and then went to the towing company to remove personal belongings from the repossessed vehicle. He was arrested on 7/1/09 and charged with insurance fraud in the 3rd degree.

August

OWNER GIVE-UP

- The defendant in this case reported to the NYPD that her 2005 Nissan Altima was stolen and she filed a $13,380 claim with GEICO Insurance Company for the loss. The defendant claimed that all keys to the vehicle were in her possession and were never duplicated. The vehicle was factory-equipped with a transponder system that prevented the vehicle from being operated unless one of the programmed keys was used. However, FDNY Fire Marshals responding to a report of a vehicle fire found the same 2005 Nissan Altima on fire with no broken windows or glass in the surrounding area. A forensic examination concluded that the vehicle was not forcibly entered, the keys were not duplicated and there was no visible evidence that the vehicle's door locks or ignition systems were defeated. An investigation conducted jointly by the Frauds Bureau and the FDNY Fire Marshals resulted in the arrest of the defendant on 8/24/09.

HOUSE AFIRE

- The owner of a home heavily damaged in a 7/23/09 fire was arrested on 8/14/09 and charged with deliberately setting the blaze. The home was insured through New York Central Mutual Insurance Company for more than $500,000 and, though a claim was filed, it was never paid. The arrest followed a two-week investigation into the fire at the two-story frame structure where the defendant lived with his wife and three children. No one was at home when the fire was discovered by a neighbor who called the fire department. About 75 firefighters from Oneonta and surrounding departments, two of whom were injured at the scene, fought the

blaze. The Oneonta Police and Fire Departments and the Frauds Bureau, with the assistance of a private investigator from New York Central Mutual, conducted the investigation that determined the fire was incendiary.

INSUFFICIENT FUNDS

- The defendant in this case arranged with an agent of Allstate Insurance Company to purchase an annuity policy in December 2008. He paid the initial premium of $29,000 drawn on an account that he had opened earlier the same day with an initial deposit of $50. The policy was issued but the check was returned for insufficient funds. However, an investigation by the Frauds Bureau revealed that before the insurer received the returned check, the defendant cancelled the policy and insisted on an immediate refund. Allstate issued a check for $29,000, which the defendant brought to a local check-cashing service and collected the money in cash.

September

SOMEONE ELSE'S COVERAGE

- A Bronx man with no medical insurance allegedly used the identity he stole from an acquaintance to obtain $70,000 in medical treatment and sue a landlord for injuries he suffered when he fell from a fire escape trying to get into his mother's locked apartment in January 2007. An investigation by the Frauds Bureau revealed that the suspect received emergency care and follow-up medical treatment for leg injuries under the identity he assumed without that person's knowledge. He was also charged with using the stolen identity to file a negligence lawsuit against the landlord. He claimed he suffered his injuries when he fell on an interior stairway. The landlord's insurer, Technology Insurance Company, contacted the Frauds Bureau after discovering discrepancies in the lawsuit. That led investigators to look into the health insurance claims the suspect filed with Fidelis Healthcare, his former acquaintance's health insurer. He was arrested on 9/2/09 and charged with identity theft, insurance fraud and falsifying business records.

COUNTERFEIT

- A Suffolk County financial consultant was charged with defrauding TD Bank of $6,900. An investigation by the Frauds Bureau and the Suffolk County Police Department's Identity Theft Unit revealed that the defendant produced three computer-generated "Group Health Inc." (GHI) checks in July 2009. She made the checks payable to herself and deposited them into her bank account. GHI verified that they were not official company checks and banks are liable when they cash counterfeit checks.

STIFF PENALTY

- The owner of a pizza parlor in Westchester County reported to the Workers' Compensation Board that he had no employees. However, an investigation by the Frauds Bureau and the Board's Office of the Fraud Inspector General found evidence that he had at least one employee for 11 years, for whom he avoided paying $2,500 in premiums. As a result, the Board assessed a $97,000 penalty for failure to maintain proper workers' compensation coverage.

NO STOLEN VEHICLE ALERT

- The defendant in this case reported to the NYPD that she had parked her 2004 BMX SUV on a Manhattan street at 7:00 p.m. on 8/18/09 and when she returned at 10:40 the next morning the car was gone. She subsequently filed a claim with Tri-State Insurance Company for the loss. However, FDNY records revealed that units had responded to a vehicle fire in the Bronx at 10:21 p.m. on 8/15/09. The car was identified as the SUV belonging to the defendant. Further investigation showed that the Police Department had not issued a stolen vehicle alert on the car prior to its recovery, proving that it had not been reported stolen at the time of the fire. The Frauds Bureau, the NYPD and the FDNY collaborated in this investigation.

October

OVER-BILLING

- In a case investigated by the Frauds Bureau, the FBI and the U.S. Attorney's Office, a Monroe County podiatrist was arrested on 10/28/09 and charged with health care fraud and mail fraud. He treated elderly patients at nursing homes and retirement homes, usually clipping their toenails and performing other routine procedures that are not covered services. Then he billed Medicare for complicated surgical procedures. The investigation uncovered many discrepancies in the doctor's billing records and medical charts that indicated a pattern of fraudulent billing. The amount of the alleged fraud is estimated at more than $750,000. If convicted, he faces ten years in prison, a $250,000 fine and restitution of the $750,000 in fraudulent claims he filed with Medicare.

EMPTY TANK

- On 2/3/09, the defendant in this case reported to New York Central Mutual Fire Insurance Company that a broken pipe in his home caused $20,000 in water damage. The insurer subsequently determined that there was no oil in the heating unit causing the heat to shut off and requested the defendant to submit proof of a recent oil delivery. An investigation by the Frauds Bureau revealed that the defendant changed the address on a receipt for oil that had been delivered to another home he owned. Investigators for the insurer found that the oil tank was empty in the home that was damaged. This contradicted the defendant's claim that the home was heated and that the damage resulted because the furnace malfunctioned.

WORKING WHILE COLLECTING

- While working as a Spanish teacher in Kingston, NY, an Ulster County woman allegedly suffered injuries after falling out of a chair and began collecting workers' compensation benefits. She claimed to be totally disabled and stated on three occasions that her injuries prevented her from working. However, in investigation by the Frauds Bureau and the State Police found evidence that she was working at a youth sports camp while fraudulently collecting $73,000 in benefits. She was arrested on 10/2/09 and charged with insurance fraud and violation of the Workers' Compensation Law.

November

STAGED ACCIDENT SCAM

- The defendant in this case was arrested on 11/19/09 for his part in a staged accident ring, bringing to 11 the number of suspects arrested thus far in this case. An investigation by the Frauds Bureau, the NYPD's Fraudulent Accident Investigation Squad and the U.S. Postal Inspection Service revealed that this defendant was a passenger in a car that caused a staged accident. He subsequently sought and received medical treatment for nonexistent injuries under the no-fault portion of his auto insurance coverage. He was charged with insurance fraud. This is an ongoing investigation and additional arrests are anticipated.

EMBEZZLEMENT

- A licensed life insurance agent was charged with embezzling $109,000 from 29 clients and using the money for personal gain. An investigation by the Frauds Bureau revealed that between 2007 and 2009, he changed the addresses on clients' insurance policies to his own address and then requested loans against those policies. The checks were made out to his clients but mailed to the agent. He allegedly forged the clients' signatures and deposited the checks into accounts he controlled. Records obtained by investigators indicated that the defendant used the money for gambling. He was arrested on 11/19/09 and charged with grand larceny and forgery.

VIDEOTAPED

- An investigation by the Frauds Bureau led to the 11/9/09 arrest of a customer service representative for a major insurance company for filing an allegedly fraudulent insurance claim. The defendant reported to New York Central Mutual Fire Insurance Company that her iPod, GPS and laptop computer were stolen from her car while it was parked on a local street in Albany and she filed a $1,620 claim for the loss. However, investigators reviewed a bank's surveillance video which contradicted her contention that someone had taken the items from her car. The surveillance camera was located near her parking space. When shown the video, she admitted that she had lied.

December

THREE CONVICTED

- After a 16-day trial, Jeffrey Alnutt, his daughter Aubrey Alnutt-Pagan and her husband, Victor Pagan, were convicted on 12/15/09 of insurance fraud, grand larceny, reckless endangerment and conspiracy for their part in a 2004 fire at an apartment building in Gloversville, NY, owned by Jeffrey Alnutt and in which his daughter and son-in-law lived. Jeffrey Alnutt was also convicted of arson. The three subsequently filed an insurance claim and were paid $210,000 for the loss. The fire was originally blamed on cooking oil that had been accidentally left heating on the stove. However, the case was reopened following a fatal fire in December 2007 at another property owned by Jeffrey Alnutt. He has been charged in a separate indictment in that fire. The case is tentatively scheduled for trial in April 2010. Alnutt is currently incarcerated in Schoharie County Correctional Facility following a conviction on a weapons possession charge.

CORRUPT CHIROPRACTOR

- An investigation by the Frauds Bureau, the Queens DA's Office and Empire Blue Cross and Blue Shield led to the 12/15/09 arrest of a Queens chiropractor charged with insurance fraud after investigators found evidence that he convinced a "patient" to fabricate injuries and then billed Empire Blue Cross and Blue Shield over a three-month period for more than $26,000 in medical treatments. He allegedly paid a $1,000 kickback to the "patient" who was actually an undercover investigator. According to the charges, the defendant met the undercover at his office on 9/16/08, where he instructed the undercover to fabricate back and knee injuries in order to obtain insurance payments. The defendant was charged with grand larceny in the 3rd degree, insurance fraud in the 3rd degree and falsifying business records in the 1st degree.

GRAND OPENING

- Following a work-related injury in January 2006, a New Paltz, NY, woman allegedly collected $6,749 in workers' compensation benefits to which she was not entitled. An investigation by the Frauds Bureau revealed that she was the proprietor/operator of a nail salon, although she falsely claimed she had no other employment. Subsequent surveillance disclosed that she was actively involved in the operation of the business. In fact, she was photographed with family members and city officials for a press release issued by the City of Newburgh announcing the grand opening of the salon on 2/25/09. She was arrested on 12/23/09 and charged with insurance fraud and violation of the Workers' Compensation Law.

BAD BACK NO OBSTACLE

- Jacob Bancroft of Hudson Falls, NY, pleaded guilty to a felony charge of falsifying business records in December and was sentenced to five years' probation and restitution of at least $54,000 over the next four years. The money will go to First Cardinal LLC, the insurer who paid Bancroft $83,000 in lost-wage and medical benefits after he purportedly sustained a job-related back injury. However, investigators from the Frauds Bureau retrieved a surveillance video that showed him hiking while wearing a backpack and skydiving. In addition, evidence indicated that he owned and operated a construction company, served as a volunteer firefighter and was a member of a hot-air balloon team. He could face up to 1 1/3-to-4 years in state prison if he does not comply with the terms of probation and pay the court-ordered restitution.

UNAUTHORIZED PRACTICE

- An investigation by the Frauds Bureau resulted in the 11/16/09 arrest of a man accused of falsely representing himself as a doctor and treating several patients at a Staten Island medical facility. He purportedly used the tax ID numbers of licensed physicians associated with the clinic for billing purposes. This was allegedly done with the knowledge of those physicians, who were sometimes present during treatment. One of the physicians involved in the scheme was also arrested on 11/16/09 and a second physician was arrested on 12/3/09. The unlicensed man was charged with insurance fraud and scheme to defraud. In addition, all three defendants were charged with unauthorized practice of a profession. The investigation was conducted jointly by the Frauds Bureau and the NYPD.

B. Recognition Awards

Frauds Bureau Investigator William Fedrau was presented with a Certificate of Achievement in Fraud Fighting by the New York Anti Car Theft & Fraud Association on December 22, 2009. The Certificate recognized Investigator Fedrau's "outstanding achievement in the areas of claims investigation and insurance fraud prevention." Pictured in the photo are Investigator Fedrau (Certificate in hand), flanked by Deputy Chief Investigator Ed Silvestrini (l.) and Assistant Chief Investigator Sean Ralph.

The Frauds Bureau's Manager of Information Technology Services, Nikki Brate (pictured at right), co-chairs the New York State Digital Forensics Work Group that won the 2009 Best of New York Award. The Award was presented on September 24, 2009 for "the Most Innovative Use of Technology." The State Office of Cyber Security and Critical Infrastructure Coordination sponsors the work group which brings together digital forensics professionals from state agencies. The aim is to improve consistency in the application of international standards of practice. In addition, Ms. Brate and two of her work-group colleagues placed fourth overall in a global forensic cyber challenge sponsored by the U.S. Defense Department. The teams were given a mock-up of the kind of evidence an examiner might face in a digital forensics lab. The challenge was to draw and analyze as much information as possible from the material and interpret its significance. They learned in December that they had scored the most points (1,682) among the 1,153 civilian, government, military and commercials teams who competed in the challenge.

Fulton County District Attorney Louise Sira was named 2009 Arson Prosecutor of the Year by the New York State Fire Investigators Association on November 5, 2009. She was nominated for the award by Frauds Bureau Investigator Philip D'Angelo, who called DA Sira "an exemplary prosecutor." Pictured in the photo with DA Sira are Investigator D'Angelo (l.), Deputy Chief Investigator Chris Lehenbauer (r.) and Assistant Chief Investigator Sean Ralph (far r.).

C. Moving Up

Senior Investigator Chris Lehenbauer moved up to Deputy Chief Investigator on March 23, 2009. In his new position, he will oversee the day-to-day operations of the Frauds Bureau's Albany and Oneonta Offices. Congratulations, Chris.

D. Special Prosecutor Program

The Special Prosecutor Program is a pilot program initiated by the Insurance Department in which Frauds Bureau attorneys assist local DA's Offices with prosecutions. In 2009, the program was expanded and now has a Memorandum of Understanding with 12 participating county prosecutor's offices. As part of the program, Frauds Bureau attorneys are cross-designated as assistant district attorneys and assist in all aspects of the cases to which they are assigned. During 2009, there were 17 cases assigned to Ulster County, resulting in 12 felony convictions. In ten of those cases, the defendants pleaded guilty to multiple felonies. A case prosecuted under the program in 2009 is summarized below:

- In the first of these cases to go to trial, a couple who were charged with 3rd degree insurance fraud agreed to a plea bargain on 10/31/09 after a jury heard three days of testimony. Michelle Pike pleaded guilty to a reduced charge of insurance fraud in the 4th degree, a felony. She agreed to pay a $2,500 fine and provide a DNA sample for the State database. Her husband, Kenneth Pike, pleaded guilty to insurance fraud in the 5th degree, a misdemeanor, and agreed to pay a $1,000 fine. The case stemmed from a claim filed by the couple stating that a June 2008 lightning strike caused extensive damage to electrical appliances in their home.

In addition, under a program initiated in 2003, Frauds Bureau investigators are assigned to prosecutors' offices to work side-by-side with their investigative staff. During 2009, investigators were assigned to the Suffolk, Queens and Westchester County DA's Offices.

E. Waiver of Co-Insurance

The Frauds Bureau, in conjunction with the New York State Comptroller's Office, continued to recoup refunds for New York State from health care providers who submitted inflated bills to United Healthcare, which administers the Empire Plan, the primary health insurance plan for State employees. To date, New York State has received almost $12 million in refunds and $124,000 in fines from a number of health care providers. The bills submitted by the providers did not reflect the fact that the out-of-network providers were systematically waiving co-insurance payments that were required to be paid by Empire Plan members. Because payments should reflect the actual charge, the bills were improperly inflated by the amount waived. Following reports by the New York State Comptroller that the providers were waiving the required co-insurance payments, the New York State Insurance Department conducted its own investigation and as a result received signed stipulations from a number of the providers. In those stipulations, the providers agreed to pay civil fines and to reimburse United Healthcare for the overpayment of claims. The stipulations also state that the providers will discontinue the practice of waiving co-insurance payments for Empire Plan patients. The Department is

negotiating fines and reimbursements with a number of other providers involved in this investigation.

F. NAIC Internship Program

The National Association of Insurance Commissioners sponsors an International Internship Program to advance working relations with foreign markets with an emphasis on the exchange of regulatory techniques and technology. Interns participate in a weeklong orientation at NAIC headquarters, focusing on the broad principles of insurance regulation. Then each intern travels to a different state for five weeks, working in technical areas of their specialization. In November and December 2009, the Frauds Bureau gave presentations to Ma Bing, an intern from the China Insurance Regulatory Commission. The presentations included an overview of the Bureau's operations, followed by a question-and-answer session. Such discussions provide an opportunity for the exchange of ideas on topics that are of particular interest to the interns. Pictured during one of the presentations are Frauds Bureau Training Officer John Marcone, NAIC intern Ma Bing (center) and Nancy Lu (r.) of the Insurance Department's Life Bureau, who acted as interpreter.

G. Mobile Command Center

The Department's Mobile Command Center (MCC) was dispatched to Gowanda and Silver Creek in the State's Southern Tier to assist residents in Chautauqua, Cattaraugus and Erie Counties affected by serious flooding that occurred August 9-10. Personnel staffing the MCC were available to answer questions regarding insurance policies and coverage, as well as to assist with insurance-related complaints. The Frauds Bureau's Manager of Information Technology Services Nikki Brate, Senior Investigator John Toucher and members of the Department's Consumer Services Bureau staffed the MCC on site during the disaster recovery efforts. At right is a scene of the destruction left in the wake of the flooding in Gowanda.

In addition to disaster response, the MCC has proven to be a valuable state resource. It has been used by a number of Executive branch agencies to provide the equipment and facilities necessary to conduct field audits and for executing law enforcement operations.

H. Web-Based Case Management System

The Frauds Bureau's Web-Based Case Management System, known as FCMS, was fully implemented in the first quarter of 2007. In 2009, approximately 90 percent of the Bureau's 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 to insurers include automatic acknowledgment of fraud reports, 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. Frauds and Systems Bureaus staff continually monitor the system and make improvements and changes as necessary.

V. Directions for 2010

A. Mortgage and Title Unit

The Mortgage and Title Unit was created in the summer of 2009 to concentrate Frauds Bureau resources to address two significant trends resulting from the downturn in the economy: an increase in theft of premiums and monies held in escrow by title agents; and the proliferation of schemes targeting indebted homeowners and other consumers in the real estate market. The Unit works closely with law enforcement agencies across the State, including the FBI, U.S. Attorneys, local district attorneys and the New York State Banking Department, to investigate and prosecute these crimes. Title insurance policies are designed to protect buyers and lenders in real estate transactions by ensuring that sellers have legal title to properties being sold. While title insurance business is regulated by the Insurance Department, there are currently no licensing requirements for individuals selling the insurance. The Department has recommended legislation that would require licensing of title insurance agents.

The Unit's investigators also focus on corrupt mortgage rescue companies that engage in a variety of fraudulent schemes promising to help consumers who fall behind in mortgage payments. These groups have targeted financially-troubled homeowners, low-income people and legitimate title insurance companies.

During 2009, the Unit received 326 reports of suspected fraud. The reports included allegations of agent defalcations, straw-buyer transactions and fraudulent mortgage applications. Investigators opened 18 cases for investigation and executed 19 arrests.

B. Life Settlements

In November 2009, legislation pertaining to life settlements was passed by the Assembly and the Senate and signed into law by Governor Paterson. The Life Settlement Act provides a

new comprehensive framework for the Department to regulate the life settlement business, including enhanced consumer protections. The new law also amended the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud.

A life settlement is the sale of a life insurance policy to a third party called a 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, or may resell the policy to a third party.

The Act created a new Penal Law section that defines a fraudulent life settlement act as well as the new crime of life settlement fraud. The new law provides that a fraudulent life settlement act is committed when a person knowingly and with the intent to defraud presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by a life settlement provider, broker, intermediary, agent or owner, any written statement or other physical evidence as part of, or in support of, an application for a life settlement contract or a claim for payment under a life settlement contract that contains materially false information concerning any material fact, or conceals for the purpose of misleading any information concerning any material fact.

The provisions of the new life settlement fraud statute range in severity from the fifth degree, a class “A” misdemeanor, to the first degree, a class “B” felony, based on the value of the property that was wrongfully taken, withheld or obtained as a result of the fraudulent life settlement act. If an individual commits a fraudulent life settlement act and does not obtain any property as a result, that individual has committed the crime of life settlement fraud in the fifth degree. Individuals are guilty of life settlement fraud in the first degree when they commit a fraudulent life settlement act and as a result obtain property having a value greater than $1 million.

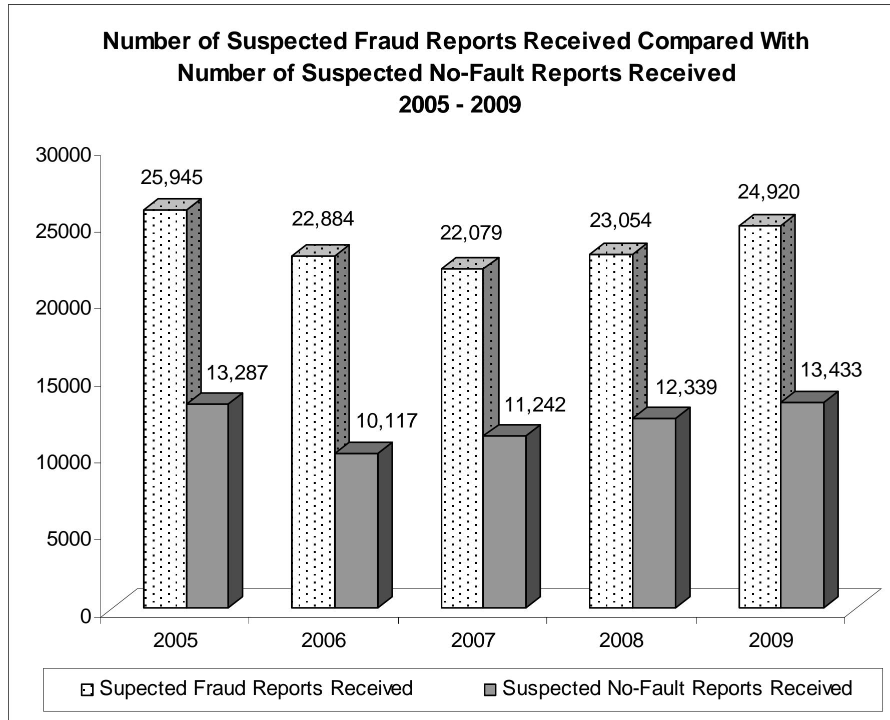
Among other provisions, the legislation:

- Makes the commission of a fraudulent life settlement act a violation of the Insurance Law;
- Defines a fraudulent life settlement act by reference to Penal Law Section 176.40;
- Adds “fraudulent life settlement act” as one of the actions for which the Superintendent is empowered to impose a civil penalty;
- Amends the Insurance Law to include the business of life settlements within the activities that the Superintendent may investigate;
- Amends Section 405 of the Insurance Law to require life settlement providers to report to the Insurance Frauds Bureau suspected instances of insurance fraud; and
- Creates Section 411 of the Insurance Law, which provides detailed requirements for life settlements fraud prevention plans that must be implemented and reported annually to the Superintendent.

C. Proposed Revisions to Regulation 68

After several years of decline, the number of suspected no-fault fraud reports began to rise in 2007 and that trend continued through 2009. Suspected no-fault claims totaled 13,433 in 2009, an increase of almost 9 percent from 2008, and accounted for 54 percent of all fraud reports received during 2009.

Graph 1



Data in a recent analysis by the Insurance Information Institute (I.I.I.) showed that the average no-fault claim cost in New York was $8,690 in 2009, surpassing the average of $5,615 in late 2004 by a significant 55 percent. I.I.I. reports that New York's no-fault claim costs are the second highest in the country and are 109 percent higher than the U.S. average of $4,152. As an inevitable consequence, auto insurance rates for New York drivers are increasing as well.

No-fault fraud is often perpetrated by highly organized criminal entities that can include corrupt medical clinics and corrupt attorneys, acting with staged accident/solicitation rings to submit fraudulent no-fault and bodily injury claims.

In an effort to combat no-fault fraud and abuse and to help keep New Yorkers' automobile insurance premiums from skyrocketing, Superintendent James J. Wrynn has proposed revisions to Department Regulation 68, which implements the no-fault statute. The proposed revisions include:

- Modifying prescribed forms to require more information to ensure that claims paid are medically necessary and reduce the need for additional verification by the insurer, thereby expediting claims processing and legitimate payment to consumers. Insurers would have greater latitude to deny health services that are not provided or are not billed in compliance with the applicable fee schedule, thus reducing payment of fraudulent claims and instances of over-billing.
- Simplifying procedures required for insurers to suspend all payments for claims submitted by the owners of medical clinics suspected of fraud while an investigation of the clinics' licensing status is underway.
- Insurers would have to schedule medical examinations they request so as not to overly burden the insured. For example, examinations may not be scheduled in geographically inconvenient locations and multiple exams may not be scheduled on the same day.
- Raising the maximum attorney fee from $850 to $2,500 to reflect inflation and to reduce the incentive for claimants and providers to file small claims separately, and eliminate the minimum attorney fee to encourage the consolidation of claims in arbitration and litigation.

Combating no-fault fraud remains an important part of mitigating the increase in auto insurance costs. The Frauds Bureau's No-Fault/Medical Unit is dedicated to rooting out no-fault fraud, as well as other forms of health insurance fraud.

VI. Legislation

The Frauds Bureau requests and/or supports the following legislative changes:

- Upgrading the status of Insurance Frauds Bureau investigators from peace officers to police officers, enabling them to act independently in the execution of such tasks as search and arrest warrants, court orders relating to electronic surveillance and summary arrests;
- Making it a crime to present materially false statements on an insurance application for personal lines insurance;
- Making it a felony for third parties, known as runners, to recruit patients and clients for health care providers and attorneys in insurance fraud schemes;
- Adding language to Section 176.05 of the New York State Penal Law to specifically include electronic and oral communications in the definition of insurance fraud;
- Requiring a periodic certification of continued eligibility by recipients of workers' compensation or disability benefits;
- Creating a class E felony for unlicensed insurance activity by any individual;
- Subjecting unlicensed insurance activity to civil penalties after notice and hearing before the Insurance Department;
- Increasing civil penalties for knowingly possessing, transferring or using fraudulent insurance documents;
- Creating a class E felony for possessing or uttering a false insurance document/instrument;
- Increasing penalties in the Vehicle and Traffic Law to reduce the number of uninsured or unlicensed motorists in New York State; and
- Amending Section 109 of the Insurance Law to increase the penalty from $500 to $2,500 for licensees who willfully violate the Insurance Law.

VII. Appendices

IFBs Received by Year	2005	2006	2007	2008	2009
Boat Theft *	0	0	2	4	6
Auto Theft	1,082	1,360	1,679	1,610	1,429
Theft From Auto	67	90	62	38	34
Auto Vandalism	263	326	198	185	248
Auto Collision Damage	1,071	1,287	1,260	1,388	1,318
Auto Fraudulent Bills	19	39	145	79	114
Auto Miscellaneous	1,335	1,125	1,045	1,092	1,388
Auto I.D. Cards**	0	0	180	10	5
No-Fault Insurance***	13,287	10,117	11,242	0	0
Total - Auto Unit	**17,124**	**14,344**	**15,813**	**4,406**	**4,542**
Workers' Compensation	1,118	1,034	1,472	1,428	1,486
Total - Workers' Comp Unit	**1,118**	**1,034**	**1,472**	**1,428**	**1,486**
Disability Insurance	96	129	245	382	242
Health Accident Insurance	2,183	1,495	1,212	1,421	1,488
No-Fault Insurance***	0	0	0	12,339	13,433
Total - Medical/No-Fault Unit	**2,279**	**1,624**	**1,457**	**14,142**	**15,163**
Boat Fire *	0	0	2	1	2
Auto Fire	309	310	460	444	399
Fire – Residential	154	157	120	180	213
Fire – Commercial	36	24	23	29	40
Total - Arson Unit	**499**	**491**	**605**	**654**	**654**
Burglary - Residential	333	228	336	509	504
Burglary - Commercial	108	72	159	140	127
Homeowners	651	705	727	569	889
Larceny	48	56	43	44	45
Lost Property	339	256	158	254	154
Robbery	16	20	26	28	15
Bonds	5	1	4	8	9
Life Insurance	251	130	180	199	392

Ocean Marine Insurance	30	18	12	7	13
Reinsurance	0	0	1	0	2
Appraisers/Adjusters	4	3	5	9	5
Agents	42	41	46	47	69
Brokers	71	29	85	72	106
Ins. Company Employees	3	3	7	12	5
Insurance Companies	9	29	36	34	27
Title/Mortgage *	0	0	6	13	326
Commercial Damage*	0	0	18	41	85
Auto I.D. Cards**	214	73	0	0	0
Unclassified	429	881	883	438	302
Total - General Unit	**2,553**	**2,545**	**2,732**	**2,424**	**3,075**

IFBs Received	**2005**	**2006**	**2007**	**2008**	**2,009**
Auto Unit Totals^	17,124	14,344	15,813	4,406	4,542
Workers Comp Unit Totals	1,118	1,034	1,472	1,428	1,486
Medical/No-Fault Unit Totals^^	2,279	1,624	1,457	14,142	15,163
Arson Unit Totals	499	491	605	654	654
General Unit Totals	2,553	2,545	2,732	2,424	3,075
Unassigned	2,372	2,846	0	0	0
Grand Total	**25,945**	**22,884**	**22,079**	**23,054**	**24,920**

*** New categories added in 2007.**
**** Auto ID Card Unit merged into Auto Unit in January 2007.**
***** Medical and No-Fault merged in January 2008.**
^ Data prior to 2008 reflects Auto and No-Fault Unit totals.
^^ Data prior to 2008 reflects Medical Unit total only.

<u>**Cases Opened by Year**</u>	<u>**2005**</u>	<u>**2006**</u>	<u>**2007**</u>	<u>**2008**</u>	<u>**2009**</u>
Boat Theft *	0	0	0	0	2
Auto Theft	86	124	219	204	152
Theft From Auto	3	4	1	3	3
Auto Vandalism	13	8	6	16	19
Auto Collision Damage	30	41	51	62	66
Auto Fraudulent Bills	3	1	3	12	11
Auto Miscellaneous	11	29	31	25	85
Auto I.D. Cards**	0	0	8	1	0
No-Fault Insurance***	122	142	160	0	0
Total - Auto Unit	**268**	**349**	**479**	**323**	**338**
Workers' Compensation	624	440	219	445	717
Total - Workers' Comp Unit	**624**	**440**	**219**	**445**	**717**
Disability Insurance	12	21	21	31	35
Health Accident Insurance	59	57	56	103	98
No-Fault Insurance***	0	0	0	128	101
Total - Medical/No-Fault Unit	**71**	**78**	**77**	**262**	**234**
Boat Fire *	0	0	0	0	2
Auto Fire	60	52	59	64	69
Fire – Residential	24	24	23	47	53
Fire – Commercial	9	8	5	7	12
Total - Arson Unit	**93**	**84**	**87**	**118**	**136**
Burglary – Residential	7	8	19	26	15
Burglary – Commercial	6	6	20	3	6
Homeowners	20	24	45	51	52
Larceny	4	8	4	15	9
Lost Property	3	3	4	7	3
Robbery	0	1	1	0	1
Bonds	2	1	0	2	3
Life Insurance	4	7	8	16	26
Ocean Marine Insurance	3	4	4	4	4

Reinsurance	0	0	0	0	0
Appraisers/Adjusters	2	2	3	5	2
Agents	21	7	18	11	28
Brokers	9	12	18	11	42
Ins. Company Employees	2	1	3	5	3
Insurance Companies	1	1	9	9	9
Title/Mortgage *	0	0	3	3	18
Commercial Damage*	0	0	3	3	8
Auto I.D. Cards**	5	10	0	0	0
Miscellaneous	34	55	48	48	53
Total - General Unit	**123**	**150**	**210**	**219**	**282**

Grand Total	**1,179**	**1,101**	**1,072**	**1,367**	**1707**

Investigations	**2005**	**2006**	**2007**	**2008**	**2009**
Auto Unit Totals^	268	349	479	323	338
Workers Comp Unit Totals	624	440	219	445	717
Medical/No-Fault Unit Totals^^	71	78	77	262	234
Arson Unit Totals	93	84	87	118	136
General Unit Totals	123	150	210	219	282
Total	**1,179**	**1,101**	**1,072**	**1,367**	**1707**

*	**New categories added in 2007.**
**	**Auto ID Card Unit merged into Auto Unit in January 2007.**
***	**Medical and No-Fault merged in January 2008.**
^	**Data prior to 2008 reflects Auto and No-Fault Unit totals.**
^^	**Data prior to 2008 reflects Medical Unit total only.**

2005	IFBs	Cases	Arrests
No-Fault/Auto Unit Total	17,124	268	391
Workers' Comp Unit Total	1,118	624	147
Medical Unit Total	2,279	71	68
General Unit Total	499	123	88
Arson Unit Total	2,553	93	59
Grand Total		**1,179**	**753**

2006	IFBs	Cases	Arrests
No-Fault/Auto Unit Total	14,344	349	334
Workers' Comp Unit Total	1,034	440	142
Medical Unit Total	1,624	78	26
General Unit Total	491	150	81
Arson Unit Total	2,545	84	21
Grand Total		**1,101**	**604**

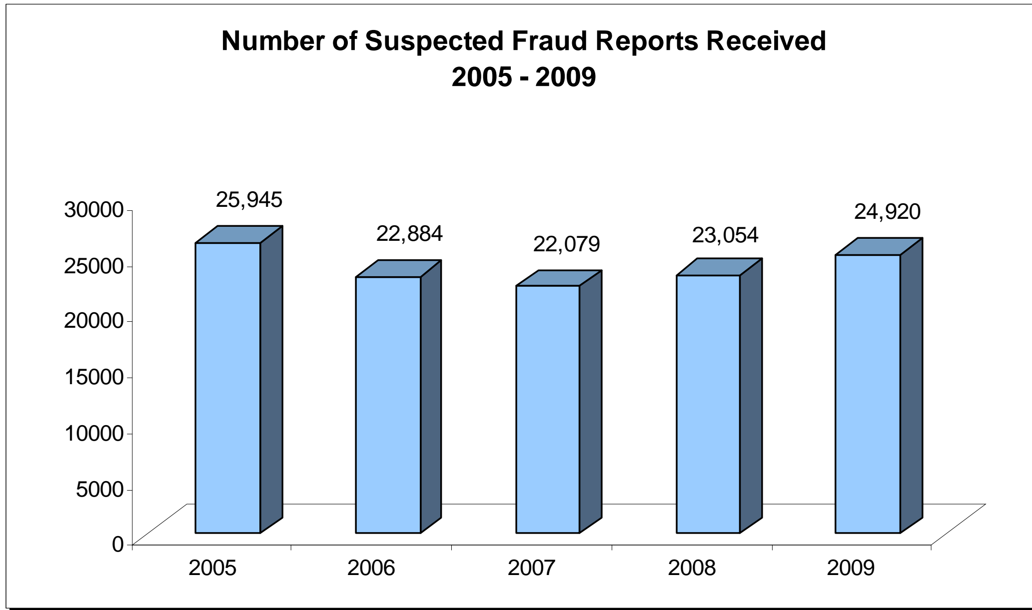
2007	IFBs	Cases	Arrests
No-Fault/Auto Unit Total	15,813	479	352
Workers' Comp Unit Total	1,472	219	149
Medical Unit Total	1,457	77	57
General Unit Total	2,732	210	85
Arson Unit Total	605	87	65
Grand Total	**22,079**	**1,072**	**708**

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**

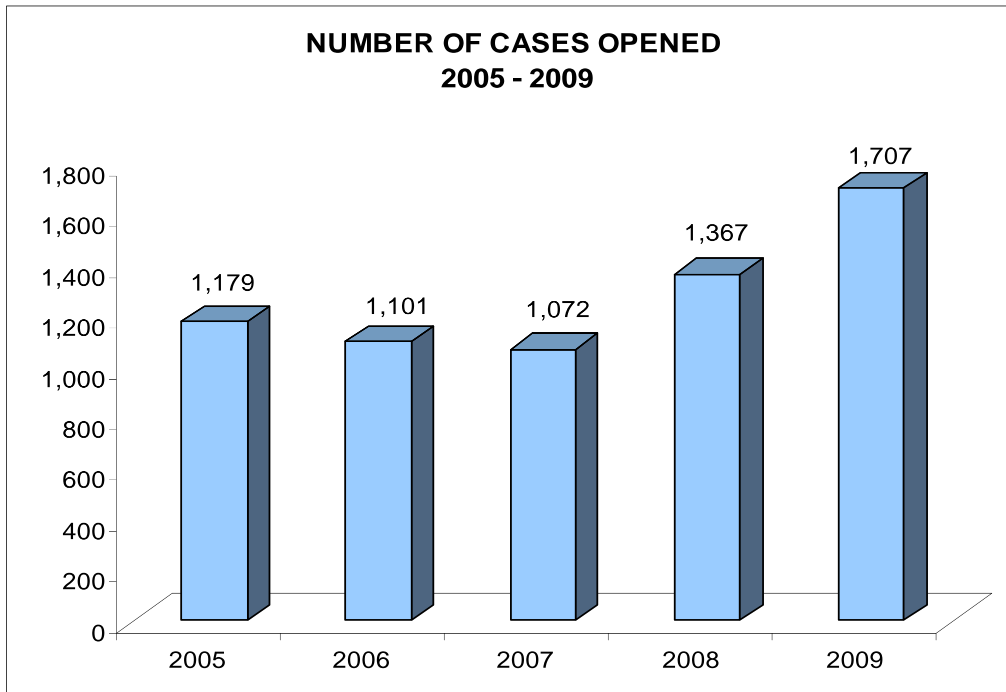
Trends – After several years of decline, reports of suspected fraud have shown over-the-year increases in 2008 and 2009.

Graph 2



Investigations – During 2009, the Bureau opened 1,707 new cases for investigations, the largest total since 1997.

Graph 3



Insurance Frauds Bureau
Training Program
Insurers, Law Enforcement and Community Groups
2009

Date	Group	Location	Number of Attendees
01/29/09	New York State Insurance Fund	Albany, NY	25
02/05/09	Worcester Central School	Worcester, NY	15
02/11/09	Great American Insurance Company	New York, NY	14
02/24/09	National Insurance Crime Bureau	Melville, NY	68
03/06/09	Capital District Auto Crimes Task Force	Albany, NY	30
03/12/09	ING Insurance Company	Windsor, CT	19
03/16/09	New York State Fire Academy	Montour Falls, NY	30
03/30/09	NYPD Police Academy (Recruits)	New York, NY	250
03/31/09	Westchester County Police Academy (Recruits)	Valhalla, NY	14
04/01/09	Finger Lakes Insurance Claim Council	Chittenango, NY	30
04/14/09	American Association of Retired Persons	New York, NY	62
04/21/09	Office of Medicaid Fraud Inspector General	Albany, NY	25
05/13/09	AIG Insurance Company	Latham, NY	50
05/13/09	Public Employer Risk Management Assn.	Latham, NY	50
05/14/09	American Association of Retired Persons	Staten Island, NY	65
05/15/09	American Association of Retired Persons	Bronx, NY	53
05/20/09	National Association of Insurance Commissioners (Interns)	New York, NY	2
06/08/09	NYS Office of Fire Prevention and Control	Montour Falls, NY	19
06/16/09	MVP Healthcare Insurance Company	Schenectady, NY	25
06/30/09	Greenwich Village Community Center	New York, NY	10
07/10/09	Lenox Hill Senior Center	New York, NY	25
07/13/09	Goddard Riverside Senior Center	New York, NY	75
07/29/09	Carter Burden Senior Center	New York, NY	65
08/03/09	Stein Senior Center	New York, NY	19
08/06/09	Caring Community Center	New York, NY	32
08/19/09	NYPD Auto Crime Division	Queens, NY	23
08/19/09	Hudson Senior Center	New York, NY	41
08/20/09	Swiss Re Insurance Company	Armonk, NY	45
08/26/09	Glen Cove Senior Center	Glen Cove, NY	65
09/28/09	NYS Office of Fire Prevention and Control	Montour Falls, NY	30
10/05/09	Westchester County Police Academy (Recruits)	Valhalla, NY	49

11/04/09	**National Association of Insurance Commissioners (Intern)**	**New York, NY**	**1**
120/1/09	**National Association of Insurance Commissioners (Intern)**	**New York, NY**	**1**
12/16/09	**Jewish Association for Services for the Aged**	**New York, NY**	**40**
12/17/09	**NYPD Police Academy (Recruits)**	**New York, NY**	**230**
TOTALS	**GROUPS 35**	**PARTICIPANTS**	**1,597**

Fraud Plans on File as of 12/31/09

ACE USA Group of Companies
Aetna Life Insurance Company
AIG Companies
Allstate Insurance Company
Allstate Life Insurance Company of New York
AM Trust Financial
Amalgamated Life 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
AMEX Assurance Company
Amica Mutual Insurance Company
Arch Insurance Company
Assurant Group
AutoOne Insurance Company
Balboa Life Insurance of New York
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
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
Firemans' 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 Dearborne Life Insurance Company of New York
GEICO
General Casualty Insurance of Wisconsin – Blue Ridge
Genworth Financial
Gerber Life Insurance Company
Global Liberty Insurance Company of New York
GMAC Insurance
Great American Insurance Company Group
Guard Insurance Group
Guardian Life Insurance Company of America
Hanover Group
Harleysville
Hartford Fire and Casualty Group
Hartford Life Insurance Company
Health Net of New York, Inc.
HealthNow New York Inc.
Hereford Insurance Company
HM (Highmark) Life Insurance Company of New York
IDS Property and Casualty Insurance Company
Independent Health Association, Inc.
Infinity Insurance
ING Insurance Company of North America
Interboro Insurance Company
John Hancock Life Insurance Company of New York
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 Group
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
OneBeacon Insurance Company
Oxford Health Plans
Preferred Mutual Insurance Company
Principal Life Insurance Company
Progressive
Prudential
QBE Insurance Group Limited
Response Insurance
Safeco Insurance Company
SBLI USA Mutual Life Insurance Company
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 Insurance Companies
State - Wide Insurance Company
Sun Life Insurance and Annuity Company of New York
The Prudential of America Group
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
Union Labor Life Insurance Company (ULLICO)
Union Security Life Insurance Company of New York
United Concordia Insurance of New York
UnitedHealthcare Insurance Company of New
UnitedHealthcare of New York, Inc
Unitrin Direct Insurance Company
Unum Provident Company
USAA Group
Utica National Insurance Group
Wellpoint, Inc.
Zurich North America

Insurance Frauds Bureau Staff – December 31, 2009

NEW YORK CITY OFFICE
Director
Deputy Director

1 Counsel
1 Assistant Chief Investigator
7 Deputy Chief Investigators
12 Senior Investigators
7 Investigators

1 Principal Insurance Examiner
1 Senior Insurance Examiner
1 Insurance Examiner

1 Senior Training Officer

1 Assistant Director of Research

1 Secretary I
1 Calculations Clerk 2
1 Keyboard Specialist

MINEOLA OFFICE
1 Deputy Chief Investigator
2 Senior Investigators
2 Investigators

ALBANY OFFICE
1 Assistant Counsel
1 Deputy Chief Investigator
2 Senior Investigators
4 Investigators
1 Manager of Technical Services

BUFFALO OFFICE
1 Deputy Chief Investigator
1 Senior Investigator
1 Investigator

ROCHESTER OFFICE
1 Investigator

SYRACUSE OFFICE
1 Senior Investigator

ONEONTA OFFICE
1 Assistant Chief Investigator
3 Investigators

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