The Road to Victory

Effective Resources for Detecting, Investigating, and Reporting Premium Fraud

Table of contents

Foreword 2

The cost of insurance fraud 3

How do companies commit premium fraud? 4
- Underreporting payroll, sales, or other rating figures 4
- Case study: Detecting underreported payroll 5
- Misclassifying employee duties and/or business operations 5
- Misrepresenting claims histories to lower the experience modification rating 8

Types of premium fraud 9
- Application fraud 9
- Operations fraud 11

Types of risks 14
- Leasing companies 14
- Construction 15
- Trucking 15
- Temporary labor agencies 17

Premium fraud indicators 18
- A list of common fraud indicators 18

Third-party premium fraud data 20
- Coalition Against Insurance Fraud 20
- National Insurance Crime Bureau (NICB) 21
- National Association of Insurance Commissioners (NAIC) 21
- Federal Bureau of Investigation (FBI) 22
- National Council on Compensation Insurance (NCCI) 22
- ISO 22
- Premium Audit Advisory Service (PAAS®) 23

State fraud bureaus 24
- State fraud bureau contact information 25

State fraud statutes 34

Success stories 54

Footnotes 59

Foreword

Premium fraud spans all business sectors — from small artisan contractors to large multioperational ventures. To avoid paying the proper premiums for their insurance policies, some businessowners commit a variety of premium fraud acts.

In this white paper, we provide an in-depth analysis of a number of premium fraud schemes. We also explain how companies perpetrate premium fraud, and we examine different types of fraudulent activities.

This paper also analyzes a number of cases under current investigation and prosecution by carrier special investigation units, federal and state law enforcement agencies, and public-interest fraud organizations at the national, regional, and local levels.

Our goal is to provide you with:

- resources to help you detect, prevent, and reduce premium fraud
- a list of common fraud indicators
- contact information for state fraud bureaus
- a state-by-state list of the current laws and penalties associated with insurance fraud
- related articles that describe the successful prosecution of insurance fraud

The cost of insurance fraud

The Coalition Against Insurance Fraud places the cost of insurance fraud in the United States at **$80 billion annually.** That figure is more than twice the amount insurance carriers pay for all legitimate insurance claims each year.

Consider the following:

- States that prosecute fraud and generate detailed records claim that for every $1 insurers lose from claims fraud, they lose $4 to $5 — and in some states as much as $10 — from premium fraud.[2]
- In 1996, insurance carriers in Texas spent an average of $1,257 on each claims fraud investigation but only $991 on every premium fraud case.[3]
- The National Insurance Crime Bureau estimates that workers compensation fraud costs the insurance industry $5 billion each year.
- Every $1 invested in workers compensation antifraud efforts returned $6.17, or $260.3 million total, in 2006–2007.[4]

Recent legislative initiatives and new laws have increased the sentencing and financial penalties that judges and juries can assess against these white-collar criminals. Yet each year, the insurance industry continues to lose millions of dollars from premium fraud.

> “Only in America can you steal more money with a ballpoint pen than with a gun.”[1]
>
> Dennis Jay
> Executive Director
> Coalition Against Insurance Fraud

How do companies commit premium fraud?

Insurance fraud occurs when a person knowingly or intentionally conceals, misrepresents, or makes a false statement to deny or obtain benefits or insurance coverage or otherwise profit from the deceit.

Premium fraud occurs when a company intentionally makes misrepresentations on insurance documents or misrepresents business operations to obtain insurance at a lower rate.

Companies commit premium fraud in three ways:
- by underreporting payroll, sales, or other rating figures
- by misclassifying employee duties and/or business operations
- by misrepresenting claims histories to lower the experience modification rating

Underreporting payroll, sales, or other rating figures

One way employers perpetrate fraud is by underreporting the payrolls insurers use to calculate premium. For example, to calculate workers compensation premium, an underwriter multiplies the classification rate associated with the type of work each employee performs by every $100 of payroll. So by underreporting the payroll for an employee, the insured can reduce its workers compensation premium.

Businesses underreport their payrolls by:
- providing an insurance auditor with a phony set of payroll records and tax reports
- paying employees in cash
- paying bonuses off the books
- hiring employees as independent contractors
- paying employees on a nonwage basis, such as a reduction in rent
- logging payments to subcontractors as supply purchases

Employers may also underreport sales, payroll, or other rating data to reduce the premium for general liability coverage. In addition, they may underreport the number of fleet vehicles or the radius of operation to reduce the premium for a commercial automobile policy.

Case study: Detecting underreported payroll

Payroll comparison is a very effective way to detect premium fraud, as shown in a case study from the October 2006 issue of *Insurance Journal:*

Cover-All, Inc., a flooring and carpet installation company headquartered in Chatsworth, California, obtained a workers compensation policy from the State Compensation Insurance Fund on September 1, 2001.

The company's annual insurance audit revealed that the payroll it reported to the carrier was significantly lower than the payroll it reported to the Employment Development Department. As a result, the State Compensation Insurance Fund referred the case to the California Insurance Department Fraud Division.

The investigation revealed that the officers of Cover-All prepared and approved the alleged fraudulent monthly payroll reports the company provided to the carrier. The investigation determined that from September 1, 2001, to April 16, 2005, Cover-All, Inc., underreported its actual payroll of $26,937,575. The underreported payroll resulted in a premium loss of $7,565,009.[5]

In its study *The Grey Economy,* the University of California Berkeley estimated unreported payroll by comparing U.S. Census Bureau and industry payroll statistics against payroll data from the Workers' Compensation Insurance Rating Bureau of California. The comparison estimated that employers neglected to report between 6% and 10% of payroll in 1997. That percentage jumped to between 19% and 23% in 2002. Those estimates projected that the value of unreported payroll for that time period would be in the range of $31 billion to $106 billion. Based on a premium estimate of just 6% of payroll, the lost premium dollars amount to approximately $6 billion. Since that estimate is for a single state, the figure for lost premium at the national level would be astronomical.[6]

Misclassifying employee duties and/or business operations

Another way employers perpetrate fraud is by misclassifying business operations. When calculating an insured's workers compensation premium, the objective is to choose one basic classification that best describes the overall business of an entity within a state.

It's important to remember that a classification does not pertain to the different types of work each employee performs for that business but to the overall operations of a business. All employees who perform work that is normal and prevailing to business operations fall under one classification.

The loss costs associated with each classification correspond to the likelihood that an employee will be injured while working at that business. The higher the risk, the higher the loss cost for that classification. For example, a business that

performs fireworks manufacturing is going to fall under a much-higher-rated classification than a risk that operates a retail store business.

But there are exceptions to every rule — and those exceptions open the door to misclassification.

For example, clerical offices can classify outside sales personnel and drivers separately as long as the employees performing those duties meet very restricted criteria from state rules manuals. And certain businesses can classify their employees separately based on the type of work they perform. Employees in the construction industry, temporary agencies, and employee leasing firms are some examples.

A recent study conducted by the School of Industrial Labor Relations at Cornell University estimates that approximately 10% of workers reviewed from audits conducted by the Department of Labor were misclassified as independent contractors. In the construction industry, this number increased to 15%.[7]

How misclassification occurs

Misclassification can occur in a number of ways. Leased employees, temporary workers, and construction employees may perform duties related to several different classifications. In addition, it's rare for an insurance auditor to observe the work employees perform in those businesses.

So, in many cases, the auditor must rely on the word of the insured. And that leaves the door wide open for the businessowner to misclassify employees into lower-rated classifications. Those misclassifications often remain uncovered until a claim investigation reveals that the employee was working in an operation more hazardous than disclosed to the auditor.

Consider this example:

Assume that the rate for roofing employees is $20 for each $100 of payroll and that the rate for carpentry employees is only $10 for each $100 of payroll. An insured could reduce its premium by 50% on each roofer it misclassifies as a carpenter.

The insurer can lose in two ways. First, the company would collect only half the premium appropriate for the exposure. And second, in the event the insured submitted a claim for the misclassified employee, the insurer would likely pay out more than anticipated. Roofing employees sustain injuries that are much more severe and costly, on average, than carpentry employees.

The employee vs. independent contractor dilemma

Misclassification also occurs when businesses classify employees as independent contractors.

Companies do so to avoid paying payroll taxes, the minimum wage, or overtime; to avoid complying with other wage-and-hour legal requirements, such as meal periods and rest breaks; or to avoid reimbursing workers for business expenses incurred while performing their jobs. In addition, companies are not required to cover independent contractors under workers compensation insurance and are not liable for payments under unemployment insurance, disability insurance, or Social Security.

The misclassification of workers as independent contractors has been a hot topic among premium fraud investigators and in legal departments for many years.

The Internal Revenue Service has established general rules to help clarify the issue:

- An individual who performs services for a business is an employee **if the business can control what work the individual does and how the individual performs the work.**
- An individual who performs services for a business is an independent contractor if a businessowner has only **the right to control or direct the result of the work an individual does and not the means and methods of accomplishing the result.**

The following chart illustrates IRS guidelines for determining employee status based on direction and control:

Behavioral Control	Financial Control	Relationship of the Parties
Facts illustrating whether there is a right to direct or control how the worker performs a task: • instructions • training	Facts illustrating whether there is a right to direct or control how the business aspects of a worker's activities occur: • significant investment • unreimbursed expenses • services available to the relevant market • method of payment • opportunity for profit or loss	Facts illustrating how the parties perceive their relationship: • intent of parties and/or written contracts • employee benefits • discharge/termination • regular business activity

Note: IRS guidelines are federal guidelines. Each state may choose to adopt the guidelines or use its own.

Misrepresenting claims histories to lower the experience modification rating

The experience modification — or "experience mod" — is a numerical expression of a company's accident and injury record compared against the average for the firm's industry.

An experience mod of 1.0 means a company has an average safety record, while an experience mod of 0.80 means a company has a good safety record that could merit a 20% discount. An experience mod of 1.20 means the firm's accident rate is above the industry norm and could raise a company's insurance costs by 20%.

A single accident — or even a notice of a workers compensation claim — can raise the experience modifier, in turn increasing the premium. Insurers commonly create a reserve fund to cover anticipated claims, raising the premium for the insured company. The insurer can lower the premium later if the final claims are significantly less than the reserve fund.

Businessowners misrepresent company claims histories by not reporting injuries or by creating shell companies to give the impression of a nonexistent or lower claims history. Such fraud schemes hurt insurance carriers by not allowing them to collect adequate premiums. But those schemes also increase overall insurance program costs for honest businessowners. And insurers pass the increased costs on to consumers in the form of higher prices for goods and services.

Statistical data published by the Coalition Against Insurance Fraud estimates that insurance fraud increases the premiums paid by the average American consumer by an estimated $1,200 per year — a considerably steep figure, especially for working families.

Types of premium fraud

Employers, employees, agents, brokers, insurers, and others involved in the insurance transaction may perpetrate fraud. Fraud can occur at any stage in the policy life cycle — from initial completion of the insurance application to the payment of claims.

Whenever there is an intentional act to misrepresent or omit the information an insurer needs to accept or price a risk, an act of fraud occurs.

Premium fraud generally falls under one of two categories:
- application fraud
- operations fraud

Application fraud

The insurance application is the initial step in creating a contractual agreement between the insured and the insurer. Insurance underwriters rely on the information in an application to assess the hazards of a risk properly, analyze appropriate coverages, and calculate the initial premium using current rating factors.

By intentionally falsifying, omitting, or misrepresenting information on an insurance application, an individual commits fraud.

An insurer can prove application fraud if:
- **the information the insured submitted was untruthful**
  If the insured knew the information it supplied was false when it completed the application, then fraud occurred.
- **the misrepresented information is material to the risk**
  A misrepresentation is material as a matter of law when knowledge of the truth would naturally influence the judgment of the insurer and the way the insurer writes the contract, inspects the risk, and calculates the premiums.
- **the insurer actually or reasonably relies on the information to issue the policy**
  An insurer is entitled to rely on complete and honest information from the insured on an application for insurance.

ACORD forms may reveal application fraud

ACORD Form 130, Workers Compensation Application, is the most widely used application for workers compensation coverage in the insurance industry. Several fields in ACORD Form 130 may reveal misrepresentation of information.

Here's a summary of those fields and questions to consider when reviewing applications for misrepresentation of information:

- **Mailing address**
  Is the insured's mailing address in a different state from the one where the business operates? Is it in a different state from the insurance agent?
- **Years in business**
  How old is the business? Since an experience modification rate exists only for companies that are three years of age or more, a company may claim that it is less than three years old. Doing so would suggest that the underwriter assign an experience mod of 1.0, lowering the company's premium.
- **Federal Employer ID Number (FEIN)**
  Does the insured's FEIN match the business's state of operations? Was the business incorporated in a state different from the one where it conducts business?
- **Locations**
  Has the insured provided the insurer with all locations where it conducts business?
- **Individuals included/excluded**
  Has the insured provided the names, titles, and duties of all owners and officers?
- **Rating information**
  - Has the insured indicated two locations on the first page of the application but included classifications, duties, and estimated payroll for only one location?
  - Does there seem to be an extremely high payroll estimate in lower-rated classifications (such as clerical office code 8810) compared with other business classifications?
  - Do the classifications differ from the information in the "Nature of Business/ Description of Operations" section of the application?
- **Prior carrier information/loss history**
  Has the insured left this section blank? If the business has existed for several years but the insured doesn't supply information about previous carriers or loss histories, it may be attempting to lower its experience modification rating.
- **Nature of business/description of operations**
  Has the insured misrepresented or omitted information about business operations? If an insured omits operations that fall under higher-rated classifications, the underwriter might assign a lower-rated classification, lowering the premium.
- **General information**
  This section consists of 24 yes/no questions related to the operational attributes of a risk. The information may trigger premium adjustments or alert the underwriter to operations that the carrier may not wish to cover, such as operation of aircraft or watercraft, operations subject to the U.S. Longshore and Harbor Workers Compensation Act, or seasonal operations.

Fraud warning in the ACORD Form 130 Workers Compensation Application
Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and (NY: substantial) civil penalties. (Not applicable in CO, FL, HI, MA, NE, OH, OK, OR, TN, or VT; in DC, LA, ME, VA, and WA, insurance benefits may also be denied.)

Operations fraud

Here's a brief overview of activities that fall under the category of operations fraud:

Certificates of insurance
An insurance company or authorized agent issues a certificate of insurance to a third party to provide information about the insured, including the insurance policy coverages, effective dates and limits, and other contractual provisions. A certificate of insurance verifies that the insurance carrier issued an insurance policy for the named insured.

Certificates of insurance are informational documents that show compliance with insurance requirements. They also provide verification of coverage as of the issue date. Certificates of insurance are used often in the construction industry. A general contractor, for example, would require a certificate of insurance from all its subcontractors.

While useful in establishing the existence of coverage, a certificate of insurance is not an insurance policy. Coverage specifications listed on a certificate may not be binding on the insurer. The insurance policy, not the certificate, controls the scope of coverage. In the event of a conflict between the certificate of insurance and insurance policy, the policy will generally prevail.

One area of concern is that practically anyone can forge a certificate of insurance. An unscrupulous individual with a computer, access to the Internet, and a printer can download, create, and print a fraudulent certificate of insurance from literally hundreds of websites.

Consider this example:
A subcontractor forges a certificate of insurance. One of the subcontractor's employees is hurt on the job. Because the subcontractor doesn't have insurance, the general contractor's insurance policy will cover the workers compensation claim. Yet, because the auditor saw a certificate of insurance for the subcontractor during the general contractor's audit, the general contractor didn't pay a premium that appropriately covered the risk.

Another area of concern is the notice-of-cancellation provision. Here's the wording from the ACORD 25-S cancellation provision:

> **CANCELLATION:** Should any of the above-described policies be canceled before the expiration date thereof, the issuing insurer will endeavor to mail ___ days' written notice to the certificate holder named to the left, but failure to do so shall impose no obligation or liability of any kind upon the insurer, its agents, or representatives.

The cancellation notice states that the insurer should "endeavor" to provide a certificate holder with notice of cancellation but does not legally bind the insurer to notify. As many risks rely on the certificate of insurance to verify that the insured has fulfilled its contractual insurance requirements, the fact that a carrier may cancel an insurance policy before expiration opens the door to fraud.

In that case, if a carrier canceled a subcontractor's insurance policy before the policy expired and an employee was hurt on the job, the general contractor's insurance policy would have to cover the workers compensation claim.

Cash payments

Companies pay "under-the-table" cash payments to employees to avoid incurring employment taxes and insurance premiums for their employees. Prosecuting and detecting that type of fraud is very difficult. In today's economy, large numbers of immigrants are willing to accept cash payments in lieu of paychecks.

Paying employees in cash deprives the employee of many mandated state and federal benefit programs, including Social Security tax payments. It may also prevent employees from earning the minimum wage and overtime wages. Finally, paying employees in cash provides a way for the business to decrease its insurance premium by underreporting payroll.

To hide cash payments, businessowners often bundle them inside other expense accounts, such as supplies or materials, utility payments, equipment purchases, and other subsidiary expenses. To uncover that activity, a fraud investigator would have to conduct a very detailed analysis by comparing expense payments against actual invoices.

Case Study

A court found a North Dartmouth, Massachusetts, husband and wife guilty for their roles in running the largest cash wage scheme in state history. The court convicted the pair of paying out more than $40 million in cash wages through their temporary employment agency to evade millions of dollars in tax payments and workers compensation insurance premiums. The court sentenced the man to nine years in federal prison and ordered him to pay $12.1 million in restitution. The court sentenced the woman to six and a half years in federal prison and ordered her to pay $9.1 million in restitution.[8]

Entity structure: shell companies

A shell company is one that serves as a vehicle for business transactions but has no significant operations or assets. Many shell companies are legitimate businesses. For example, some shell companies manage the assets of a parent company. But sometimes businesses use shell companies to hide businessowner names, assets, payroll, or income.

To perpetrate premium fraud, a parent company will write large checks to the shell company, which will in turn use that money for payment of payroll. The parent company will record those payments to the shell company in non-payroll accounts and then advise the insurance company it has no or very few employees, when in fact it may have many employees. So the company won't pay a premium for the policy that covers the risk.

Agent/broker fraud

Agent/broker fraud is perhaps one of the most serious types of insurance fraud because it undermines the trust that customers have in insurance agents and brokers. The most common forms of fraud perpetrated by agents and brokers include:

- failure to forward premiums to the insurance carrier, leaving the client uninsured
- issuing fraudulent certificates of insurance
- filing fraudulent claims information
- diverting premiums for personal use
- deliberate manipulation of information on an insurance application to provide the client with a lower insurance premium
- lowballing estimated payroll and sales data to give the client an unreasonably low estimated premium at the beginning of a policy period

Types of risks

Here's a summary of the types of risks most often associated with premium fraud:

Leasing companies

The concept of leasing employees first emerged in the late 1970s. Employee leasing allows a company to staff its workforce, in whole or in part, from another company. The company providing the workers is known as the leasing company, or labor contractor. The company using the workers is known as the client company.

Often, the client company will terminate some or all of its employees and then hire the same individuals back through a leasing company.

Both parties benefit from the arrangement. The client company won't incur the overhead cost of the leased positions or have to deal with the problems associated with employee benefits and payroll. And the leasing company, which often leases out large numbers of employees, can provide better or more comprehensive benefits to its employees.

In the 1980s, some leasing companies abused the workers compensation insurance system. Employers with experience modifications greater than 1.0 lowered their premiums by manipulating experience rating plan rules. Since all client payroll fell under a master policy, "mod renting" became a common practice. An employer with a large experience modifier would transfer its employees to a leasing company policy with a modifier of 1.0 and avoid the increased modification factor premium surcharge.

Even more disturbing was the outright premium fraud perpetrated through leasing arrangements. Because leasing companies pooled the payrolls of a large number of clients, employee misclassification and intentional misrepresentation of payrolls occurred with little risk of detection during premium audits.

Most states have since closed those loopholes by restricting the use of master policies. Each client in an employee leasing arrangement must issue a workers compensation policy in the name of the client under a multiple coordinated

policy. Each client's classifications, payroll estimates, and current experience modification apply to the policy. That makes it harder for a leasing company to manipulate payrolls and classifications of individual clients.

Construction

Many potential areas of premium fraud are associated with construction risks:
- underreporting of payrolls
- misclassification of employee duties or business operations
- issuance of fraudulent certificates of insurance for subcontractors
- treatment of workers as independent contractors
- shell companies to hide payroll or avoid experience modification increases
- payment of wages in cash

Employee misclassification is of particular concern in the construction industry. The misclassification of a small percentage of a construction company's payroll from a high-rated to a lower-rated classification can decrease that company's premium significantly.

For both workers compensation and general liability rating, manual rules allow an employer to divide a single employee's payroll among construction classifications unless an operation falls under the scope of another classification. Those rules allow construction companies to misclassify employee payrolls to lower-rated classifications.

Another way to misclassify construction risks is to allocate payrolls associated with idle time, vacation time, holiday pay, and sick pay to a lower-rated classification (such as clerical) or a yard classification. Such misclassification will again result in a significant decrease in premium. However, according to the manual rules, those forms of payroll should fall under the construction classifications normally performed by the employees.

Trucking

The trucking industry encompasses everything from 18-wheelers to small trucks that transport merchandise from a small business to an individual or company. Because of the industry's complexity, auditors find it difficult to verify and report accurate premium basis and subsequent corrections to premiums. Premium leakage and premium fraud can result.

Here's a description of the types of premium fraud common to the trucking industry:

Underreported and unreported payroll
Payroll in the trucking industry is complicated. Drivers generally receive a salary by the hour, mile, or as a percentage of the cost or revenue of the haul. Companies can manipulate the last two methods of salary payment fairly easily. Employers

can understate the cost or revenue of the haul or manipulate the percentage paid to the employee. Employers can also understate the miles that employees or contractors drive.

Contract haulers that are owner-operators calculate payroll based on both use of the tractor and/or trailer and for the service of driving. Owner-operators who receive a combined check for all services are generally included at 33.34% of the cost of hire. Employers have attempted to understate the driving wage and overstate the value of the tractor/trailer reimbursement. Employers will pay a very low hourly rate for the driving service and then pay the driver several checks for the cost of travel, per diem, truck rental, and trailer rental, among others. Trucking companies may also submit multiple checks to drivers using the same tactic. The result is that auditors seldom see all the payments drivers receive.

To uncover that type of fraud, investigators must examine all disbursements and contracts signed by owner-operators. They must verify figures using annual financial reports and state-submitted annual filings. Investigators can also examine trip lease agreements and reconcile trip miles to verify that wages earned are reasonable to revenue received by the trucking entity.

Misclassification of payroll

Various workers compensation classifications exist to serve the needs of the trucking industry. Codes 7228 and 7229 are the most generic classifications and are generally used without consideration to special hauling and cumbersome loads.

Auditors should physically examine terminal sites and loading docks of the insured to make sure the employer has classified its employees appropriately. Yard locations and a customer listing can yield information to help determine the nature of the goods hauled and the appropriate workers compensation classification. Auditors should also examine Certificates of Authority, as such documents may detail the types of goods hauled. They should also observe and verify the type of equipment in use, such as flatbed trailers, lowboy trailers for heavy equipment, and cranes and lifts at terminals and yards. A review of oversize/overweight permits can also reflect the nature of the goods hauled.

Territorial misassignment

Interstate haulers operate across the United States. Trucking companies generally set terminal sites at strategic locations to serve the needs of their customers. Drivers, however, can live in any state and work as employees or owner-operators of the trucking entity.

Classification of drivers in the state of operation can be tricky. Classification rates vary greatly by state. Tennessee and Indiana, for example, have lower-than-average rates compared with other states. Employers that wish to decrease their premium for workers compensation may claim to operate out of a lower-rated

state even when they have exposures in higher-rated states. By reporting nonexistent terminal locations or misrepresenting states of employment, employers can get lower premiums.

Auditors have few options to verify locations of operations for trucking companies. Examining claims and employee W-4 and 1099 forms is not the best way to verify locations. Instead, the auditor will need to visit the locations in the states where the trucking entity receives a lower rate. Verification with the Surface Transportation Board Financial Statements and state regulatory agencies of the trucking industry can confirm that the terminals and their locations of operations are legitimate.

Experience modification avoidance

Trucking companies may misrepresent company claims histories by not reporting injuries or by creating shell companies to give the impression of a nonexistent or lower claims history. Businesses that appear separate but in reality don't operate separately will interchange employees, business transactions, assets, and customers in such cases.

Auditors can use observations and details from accounting records, filings with secretaries of state, and claims records to yield a more realistic picture of operations in such cases.

Temporary labor agencies

Temporary labor agencies provide a valuable service to many types of business by supplying employees temporarily during employee vacations, temporary production increases, and seasonal periods.

Unlike employee leasing arrangements, the responsibility for workers compensation coverage remains with the temporary labor agency and not the client company. Thus, a single workers compensation policy for a temporary labor agency may encompass a multitude of classifications spanning many diversified businesses.

The misclassification of employees assigned to a wide range of businesses is a common fraudulent act — and one virtually impossible for an auditor to detect. A temporary labor agency can easily misclassify several employees to lower-rated classifications without detection at the time of audit.

Normally, misclassifications remain uncovered until the company reports a claim, because the claim will not match the exposure to the employee's duties. For example, an employee misclassified as clerical staff might be injured while unloading a truck at a manufacturing plant.

Premium fraud indicators

A variety of indicators can alert agents, auditors, and investigators to potential premium fraud, including the information a business submits on an application for insurance, the records it supplies to an auditor, and the details it provides in claim reports.

A list of common fraud indicators

Premium fraud may exist if an insured:

- requests that the auditor perform the audit at an agent's office
- fails to report claimants on unemployment returns
- fails to display its company name on premises
- lists a P.O. box as its primary address
- reports a change in ownership (for example, from husband to wife, or father to son)
- chooses a lower-rated classification for exposure (for example, choosing Oil or Gas Lease Work rather than Oil or Gas Well Drilling)
- reports a reduction in payroll from previous years' exposures
- uses a captive employee leasing company
- leases workers from an employee leasing firm and assigns them to clerical classification
- operates multiple businesses from the same address
- provides a volume of records that's inconsistent with the level of estimated payroll on the policy
- provides pictures and promotional materials that are inconsistent with business operations
- provides separate locations for operations and records
- includes travel or downtime for construction crews operating in a permanent yard
- uses company letterhead in which the company name consists of ambiguous initials (possibly representing more than one entity)

Premium fraud may also exist if:

- the name of the business varies from report to report
- the officers on company letterhead differ from the officers listed on the application for insurance
- the insured's payroll for first quarter exceeds annual estimated payroll
- there's a high/frequent use of independent contractors coupled with an experience rating form that indicates large payroll exposures
- there's a large number of voided/missing checks in the insured's checkbook or cash disbursements journal
- the insured's bookkeeper/audit contact isn't knowledgeable about operations and owners
- a construction company provides only clerical exposure estimates
- the same individual or group of people owns multiple entities with very similar operations
- there's no delivery exposure estimated for entities that normally have such exposure
- a large number of certificates of insurance exist without corresponding payroll or subcontractor expense

Finally, premium fraud may exist if an auditor:

- is unable to verify tax/unemployment reports
- sees fresh ink on aged documents
- spots improper allocation of payroll to job costs by contractors
- sees high experience modifications with low premium exposure
- sees equipment and vehicles in yard without operator/mechanic exposure

When investigating these indicators, remember that persistence is the key. Auditors must remain alert to the possibility of fraud and know how to spot missing information or information that seems out of place or inconsistent. Don't leave any question unanswered. Often by pursuing information on one indicator, you'll find additional questions that need further investigation.

Third-party premium fraud data

The war on insurance fraud takes place on many fronts, including not-for-profit public interest organizations, such as the Coalition Against Insurance Fraud and the National Insurance Crime Bureau; federal, state, and local law enforcement agencies, including the Federal Bureau of Investigation; and state fraud bureaus and insurance carrier special investigation units.

Coalition Against Insurance Fraud

www.insurancefraud.org/index.lasso

The Coalition Against Insurance Fraud, founded in 1993, is the nation's only antifraud alliance. Speaking for consumers, insurance companies, government agencies, and others, the coalition helps unify the fight against fraud in the United States. It is the voice of the antifraud community and a trusted source of information on all aspects of insurance fraud.

The coalition has worked with many government agencies and has been steadfast in its battle against insurance fraud on a national level. Examples of major achievements include:

- **Enact stronger insurance fraud laws**
  Nineteen states have passed antifraud laws based on the coalition's model insurance fraud bill — the most comprehensive model ever drafted for insurance fraud. Visit www.insurancefraud.org/model_fraud_act.htm for more information.

- **Create model fraud bills**
  - ***Model Insurance Fraud Act*** (www.insurancefraud.org/model_fraud_act.htm)
    Adopted in March 1995 and amended in September 1995, the Model Insurance Fraud Act serves as the cornerstone for the expansion of individual state fraud laws and establishment of fraud bureaus.
  - ***Model Fraud Bureau Act*** (www.insurancefraud.org/fraud_bureau_act.htm)
    The act is model legislation for establishing insurance fraud bureaus and defines fraud bureau duties. It also suggests ways to fund the operations of the bureau and provides guidelines for the prosecution of fraudulent acts.

- **Strengthen antifraud legislation**
  The coalition works closely with state legislators and regulators on antifraud laws and strategies and acts as the official advisor to key organizations that represent state lawmakers, regulators, investigators, and consumers.

- **Sponsor conferences**
  The coalition sponsors national, state, and local conferences that bring together members of the insurance industry, governmental agencies, and other antifraud organizations to focus on current fraud issues.

National Insurance Crime Bureau (NICB)

www.nicb.org/cps/rde/xchg/nicb/hs.xsl/index.htm

The National Insurance Crime Bureau (NICB) is a not-for-profit organization that facilitates a partnership between insurance carriers and state law enforcement agencies to identify, detect, and prosecute insurance fraud. The NICB was formed in 1992 from a merger between the National Automobile Theft Bureau (NATB) and the Insurance Crime Prevention Institute (ICPI). Today, its membership includes more than 1,000 commercial and personal line property/casualty insurers, self-insured organizations, and rental car companies.

The NICB is one of the foremost insurance fraud training organizations in America. The organization's training department offers a number of programs to address the educational needs of members and law enforcement agents. Those programs provide fraud and theft fighters with the fraud detection skills and expertise necessary to fight fraud. Educational programs consist of special investigation academies, the National Insurance Crime Training Academy, the FraudSmart℠ Training Program, online training for law enforcement, and customized training.

National Association of Insurance Commissioners (NAIC)

www.naic.org

State insurance regulators created the NAIC in 1871 to address the need to coordinate regulation of multistate insurers and to help state insurance regulators:

- protect the public interest
- promote competitive markets
- facilitate the fair and equitable treatment of insurance consumers
- promote the reliability, solvency, and financial solidity of insurance institutions
- support and improve state regulation of insurance

Within the NAIC framework is the Antifraud (D) Task Force, which serves the public interest by helping state insurance supervisory officials detect, monitor, and appropriate referrals for the investigation of insurance crimes. The task force maintains and improves electronic databases regarding fraudulent insurance activities and disseminates research about insurance fraud trends to the

insurance regulatory community. The Antifraud (D) Task Force also functions as a liaison between insurance regulators; federal, state, local, and international law enforcement; and other specific antifraud organizations.

Federal Bureau of Investigation (FBI)

www.fbi.gov/whitecollarcrime.htm

Insurance fraud continues to be an investigative priority for the FBI's Financial Crimes Section. The FBI works closely with the National Association of Insurance Commissioners, the NICB, the Coalition Against Insurance Fraud, state fraud bureaus, state insurance regulators, and other federal agencies to combat insurance fraud. In addition, the FBI is a member of the International Association of Insurance Fraud Agencies, an international nonprofit organization whose mission is to maintain an international presence to address insurance and insurance-related financial crimes worldwide.

With the cooperation of the insurance industry and through referrals from industry liaisons and other law enforcement agencies, the FBI targets individuals and organizations committing insurance fraud. The FBI initiates and conducts traditional investigations and uses sophisticated techniques, including undercover investigations, to apprehend criminals.

National Council on Compensation Insurance (NCCI)

www.ncci.com/ncci/index.aspx

The National Council on Compensation Insurance, Inc. (NCCI), based in Boca Raton, Florida, manages the nation's largest database of workers compensation insurance information. The NCCI analyzes industry trends, prepares workers compensation insurance rate recommendations, determines the cost of proposed legislation, and provides a variety of services and tools to maintain a healthy workers compensation system.

ISO

www.iso.com

Since 1971, ISO has been a leading source of information about risk. ISO supplies data, analytics, and decision-support services for professionals in many fields, including:

- property/casualty insurance
- mortgage lending
- healthcare
- government
- human resources

ISO also offers information for risk managers in all industries.

ISO has developed ISO ClaimSearch® — the property/casualty insurance industry's first and only comprehensive system for improving claims processing and fighting fraud. Each year, participating insurers and other organizations submit tens of millions of reports on individual insurance claims. ISO stores those reports in a single database that helps insurers, self-insureds, law enforcement agencies, and governmental fraud bureaus detect and prevent fraud and process meritorious claims.

To serve its clients, ISO draws upon its vast experience in data management and security and expertise in predictive modeling. The company analyzes data and presents information in formats customers can use. And it develops practical tools that integrate into its customers' workflow.

In the United States and around the world, ISO products help customers protect people, property, and financial assets.

Premium Audit Advisory Service (PAAS®)

www.iso.com

ISO's Premium Audit Advisory Service (PAAS®) is a leading industry source of technical information and training for premium auditors. PAAS information helps to classify exposures for commercial casualty insurance, including general liability, commercial auto, and workers compensation. PAAS also provides a liaison between premium audit managers and regulators in the areas of manual rules, legislation, and other industry-related concerns, including the fight against premium fraud.

State fraud bureaus

Currently, 47 states have fraud bureaus to investigate all types of fraudulent insurance activities. Many fraud bureaus fall under the jurisdiction of state departments of insurance. They are responsible for the investigation, detection, and prosecution of illegal activities associated with claims fraud, agent fraud, insurance company fraud, medical care provider fraud, insurance document fraud, premium fraud, and workers compensation fraud.

The Coalition Against Insurance Fraud's Progress Report, 2001–2006, found that the major measurements of success — referrals received, cases opened and presented for prosecution, convictions, and restitution ordered — increased from 2004 to 2005. However, results appear to have leveled off in recent years.

Here are additional findings from the report:

- Referrals grew 20% from 2004 to 2005. Half of all referrals came from three states — New York, California, and Florida.
- Cases opened grew 6.5%, but the average number of cases opened per bureau has been flat since 2001.
- Prosecutions and criminal convictions have increased. But the average number of prosecutions has been flat, and convictions were down at 18 state bureaus.
- Court-ordered restitution increased at most fraud bureaus and totaled $298 million in 2005. The Coalition Against Insurance Fraud notes that if all of this money were repaid, the total collected would be twice the operating costs of the 31 bureaus that provided restitution data.

State fraud bureau contact information

Alabama
Office of Attorney General
Alabama State House
11 South Union Street, Third Floor
Montgomery, AL 36130
To report workers compensation fraud: 1-800-923-2533

Alaska
Division of Insurance
Anchorage Office
Robert B. Atwood Building
550 W. 7th Avenue, Suite 1560
Anchorage, AK 99501-3567
Phone: 907-269-7900
Fax: 907-269-7910
TDD: 907-465-5437
www.dced.state.ak.us/insurance/insurancefraud.htm

Arizona
Arizona Department of Insurance
2910 W. 44th Street, Suite 210
Phoenix, AZ 85018-7256
To report fraud: 602-912-8418
www.id.state.az.us/fraud.html

Arkansas
Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904
To report fraud: 501-371-2790
insurance.arkansas.gov

California
California Department of Insurance
9342 Tech Center Dr., Suite 500
Sacramento, CA 95826
To report fraud: 1-800-927-HELP
www.insurance.ca.gov/0300-fraud/index.cfm

Colorado
Office of Attorney General
Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202

Connecticut
State's Attorneys Office
300 Corporate Place
Rocky Hill, CT 06067
To report fraud: 860-258-5800
www.ct.gov/csao/site/default.asp

Delaware
Delaware Department of Insurance
841 Silver Lake Blvd.
Dover, DE 19904
To report fraud: 1-800-632-5154
www.delawareinsurance.gov/departments/fraud/FRAUD.shtml

District of Columbia
Department of Insurance and Securities Regulation
810 First Street, N.E., Suite 701
Washington, DC 20002
To report fraud: 202-727-8000
disr.washingtondc.gov/disr/site/default.asp

Florida
Florida Department of Insurance
200 E. Gaines Street, Larson Bldg.
Tallahassee, FL 32399-0324
To report fraud: 1-800-378-0445
www.myfloridacfo.com/fraudpage.asp

Georgia
Department of Insurance
2 MLK Jr. Dr., 708 W. Tower/Enforcement
Atlanta, GA 30334
To report fraud: 404-656-2070

Workers' Comp Fraud Unit
270 Peachtree St. N.W.
Atlanta, GA 30303-1299
To report fraud: 404-656-3875
www.inscomm.state.ga.us/INSURANCE/Enforcement.aspx

Hawaii
Insurance Fraud Investigations
250 S. King St., 5th floor
Honolulu, HI 96813
www.hawaii.gov/dcca/areas/ins/other_ins/fraud_referral_form/

Idaho
Fraud Unit, Department of Insurance
700 W. State Street
Boise, ID 83720-0043
To report fraud: 208-334-4250

Illinois
Illinois Department of Financial & Professional Regulation, Division of Insurance
100 W. Randolph Street, #9-301
Chicago, IL 60601
To report fraud: 312-814-5394

Indiana
Department of Insurance
311 West Washington St., Suite 300
Indianapolis, IN 46204-2787
Phone: 317-232-2385
Fax: 317-232-5251
www.in.gov/idoi

Iowa
Iowa Department of Insurance
Lucas State Office Building, 330 S. Maple St.
Des Moines, IA 50319
To report fraud: 515-242-5304
www.iid.state.ia.us/about_us/Fraud/default.asp

Kansas
Division of Workers' Compensation
800 SW Jackson Street, Suite 600
Topeka, KS 66612-1227
To report fraud: 1-800-332-0353
www.ksinsurance.org/fraud/fraud.htm

Kentucky
Department of Insurance
909 Leawood Drive
P.O. Box 4050
Frankfort, KY 40604-4050
Phone: 502-564-1461
To report fraud: 1-800-595-6053
www.doi.state.ky.us/kentucky/documents/fraud/report.asp

Louisiana
Department of Labor
P.O. Box 94060
Baton Rouge, LA 70804-9040
To report fraud: 1-800-332-0353

Louisiana State Police
P.O. Box 66614
Baton Rouge, LA 70896
To report fraud: 225-925-3818

Louisiana Department of Insurance
1702 N. 3rd Street
Baton Rouge, LA 70802
1-800-259-5300, 1-800-259-5301
225-342-5900, or 225-342-0895
ldi.state.la.us/Legal_Services/Fraud/index.htm

Maine
Department of Insurance
34 State House Station
Augusta, ME 04333-0034
Phone: 207-624-8475
Toll-free: 1-800-300-5000 (in state)
Fax: 207-624-8599
www.maineinsurancereg.org

Maryland
Maryland Insurance Administration
201 E. Baltimore St., Suite 700
Baltimore, MD 21202
To report fraud: 1-800-846-4069
www.mdinsurance.state.md.us/sa/jsp/consumer/Fraud.jsp

Massachusetts
Insurance Fraud Bureau of Massachusetts
101 Arch Street
Boston, MA 02110
To report fraud: 1-800-32FRAUD
www.ifb.org/default_java.htm

Michigan
Department of Insurance
P.O. Box 30220
Lansing, MI 48909-7220
Phone: 517-335-3167
Fax: 517-335-4978
www.michigan.gov/ofis

Minnesota
Department of Commerce
To report fraud: 1-888-372-8366
www.doli.state.mn.us/isu.html

Mississippi
Mississippi Attorney General
P.O. Box 2
Jackson, MS 39205
To report fraud: 1-888-528-5780
www.doi.state.ms.us/

Missouri
Department of Insurance
P.O. Box 690
Jefferson City, MO 65102-0690
To report fraud: 573-751-2640

Department of Labor & Industrial Relations
P.O. Box 1009
Jefferson City, MO 65102-1009
To report fraud: 573-526-6630
www.insurance.mo.gov/industry/fraud.htm

Montana
State Compensation Insurance Fraud
P.O. Box 4795
Helena, MT 59604
To report fraud: 1-800-332-6148

Attorney General's Office
303 N. Roberts, Room 367
Helena, MT 59620
To report fraud: 406-444-3874
sao.mt.gov

Nebraska
Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, NE 68508-3639
To report fraud: 402-471-4999
www.doi.ne.gov/fraud/ifpdindex.htm

Nevada
Office of the Attorney General
1325 Airmotive Way, #340
Reno, NV 89502
To report fraud: 1-800-266-8688
ag.state.nv.us/

New Hampshire
Department of Insurance
P.O. Box 112
Manchester, NH 03105-0112
To report fraud: 603-271-2261
doj.nh.gov/insurance.html

New Jersey
Office of the Attorney General
25 Market Street, CN 080
Trenton, NJ 08625
To report fraud: 1-877-55-FRAUD

Department of Banking & Insurance
P.O. Box 324
Trenton, NJ 08625
www.njinsurancefraud.org/

New Mexico
Insurance Fraud Bureau
P.O. Box 1269
Santa Fe, NM 87504-1269
To report fraud: 1-877-807-4010
www.stopfraud.org

New York
Insurance Frauds Bureau
25 Beaver Street
New York, NY 10004
To report fraud: 1-888-FRAUDNY
www.ins.state.ny.us/fdidxa_i.htm

North Carolina
Department of Insurance
Dobbs Building
430 N. Salisbury St.
Raleigh, NC 27611
To report fraud: 919-733-7434

Industrial Commission
Fraud Investigations Section
4319 Mail Service Center
Raleigh, NC 27699-4319
To report fraud: 1-888-891-4895
www.comp.state.nc.us/ncic/pages/fraud.htm

North Dakota
Workers' Compensation Fraud Unit
500 E. Front Ave.
Bismarck, ND 58504
To report fraud: 1-800-243-3331
www.workforcesafety.com/fraud-awareness/SIU.asp

Ohio
Department of Insurance
2100 Stella Court
Columbus, OH 43215-1067
To report fraud: 614-644-2671
www.ohioinsurance.gov

Oklahoma
Office of Attorney General
4545 North Lincoln, Suite 24B
Oklahoma City, OK 73105
To report fraud: 405-522-3403

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
Phone: 405-521-6614
Fax: 405-522-6779
To report fraud: 1-800-522-0071
www.oid.state.ok.us

Pennsylvania
Office of Attorney General
Insurance Fraud Section
1600 Strawberry Square
Harrisburg, PA 17120

Insurance Fraud Prevention Authority
4720 Carlisle Pike, Suite 205
Mechanicsburg, PA 17055-3023
To report fraud: 1-888-565-4372
www.helpstopfraud.org/content/?/

Rhode Island
Workers' Comp. Fraud Prevention Unit
1 Capital Hill, 2nd floor
Providence, RI 02903
To report fraud: 401-222-3232

South Carolina
Office of Attorney General
P.O. Box 11549
Columbia, SC 29211
To report fraud: 1-888-95-FRAUD
www.scattorneygeneral.com/public/insurance.php

South Dakota
Insurance Fraud Prevention Unit
118 West Capitol
Pierre, SD 57501
To report fraud: 605-773-6325
www.state.sd.us/drr2/reg/insurance/fraud/

Tennessee
Tennessee Department of Commerce and Insurance
Fraud and Special Investigations Unit
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-5341
www.state.tn.us/commerce/

Texas
Workers' Compensation Commission
4000 S. IH-35 MS-11
Austin, TX 78704-7491
To report fraud: 512-440-3836

State of Texas – Fraud Unit
P.O. Box 149104
Austin, TX 78714-9104
To report fraud: 1-888-327-8818
www.tdi.state.tx.us/fraud/index.html

Utah
State of Utah Insurance Fraud Division
230 South 500 East #170
Salt Lake City, UT 84102
To report fraud: 1-800-440-7021
www.ifd.state.ut.us/Index.html

Vermont
89 Main Street, Drawer 20
Montpelier, VT 05620-3101
Phone: 802-828-3301
Fax: 802-828-3306
www.bishca.state.vt.us

Virginia
Insurance Fraud Program
Virginia State Police
P.O. Box 27472
Richmond, VA 23261-7472
To report fraud: 1-877-62-FRAUD
www.stampoutfraud.com/

Washington
Department of Labor and Industries
P.O. Box 44277
Olympia, WA 98504-4277
To report fraud: 360-902-5156

West Virginia
WV Insurance Commission Fraud Unit
Greenlee Building, Ste. 300
Smith Street
Charleston, WV 25301
To report fraud: 1-800-642-9004
www.wvinsurance.gov/

Wisconsin
Department of Insurance
P.O. Box 7873
Madison, WI 53707
Phone: 608-266-3585; 1-800-236-8517
Fax: 608-266-9935
www.oci.wi.gov/complaints@oci.state.wi.us.

Wyoming
Department of Insurance
Herschler Building, 3rd Fl. East
122 W. 25th Street
Cheyenne, WY 82002
Phone: 307-777-7402; 1-800-438-5768
Fax: 307-777-5895
insurance.state.wy.us

State fraud statutes

This chart includes excerpts from state fraud statutes. The complete statutes are available at each state government's website.

STATE	FRAUD STATUTE	PENALTIES
ALABAMA	**Workers' Compensation: AL ST §13A-11-124** Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining compensation for himself or herself or any other person is guilty of a Class C felony.	**Workers' Compensation: AL ST §13A-11-124** Guilty of a Class C felony.
http://www.legislature.state.al.us/CodeofAlabama/1975/coatoc.htm		
ALASKA	**AK ST § 21.36.360** A fraudulent insurance act is committed by a person who with intent to deceive, knowingly exhibits a false account, document, or advertisement, relative to the affairs of an insurer, a corporation, or syndicate of the kind described in AS 21.69.060, formed or proposed to be formed.	**AK ST § 21.36.360** Level of penalty will depend on monetary value ranging between class B or C felony to class A or B misdemeanor.
http://touchngo.com/lglcntr/akstats/Statutes/Title21/Chapter36/Section360.htm		
ARIZONA	**Workers' Compensation: AZ ST § 23-1028; AZ ST § 20-466.02** Knowingly making a false statement or representation in order to obtain any compensation, benefit or payment.	**AZ ST § 20-466.01; AZ ST § 20-466.02** Class 6 felony. Fine not to exceed $50,000 and civil penalty not to exceed $5,000 for each violation and possible restitution.
http://www.azleg.state.az.us/FormatDocument.asp?inDoc=/ars/23/01028.htm&Title=23&DocType=ARS		
ARKANSAS	**AR ST § 11-9-106** Where the Workers' Compensation Commission or the Insurance Commissioner finds that false statements or representations were made willfully and knowingly, that material information was willfully and knowingly omitted or concealed, or that any device, scheme, or artifice was willfully and knowingly employed for the purpose of: (3) Obtaining or avoiding workers' compensation coverage or avoiding payment of the proper insurance premium under this chapter or that any other criminal violations related thereto were committed, the chairman of the Workers' Compensation Commission or the Insurance Commission shall refer the matter for appropriate action to the prosecuting attorney having jurisdiction in the matter.	**AR ST § 23-505** Guilty of a Class A misdemeanor **AR ST § 66-512** Suspension or revocation of license, civil penalties of up to ten thousand dollars ($10,000) per violation, or both.
http://www.arkleg.state.ar.us/NXT/gateway.dll?f=templates&fn=default.htm&vid=blr:code		

STATE	FRAUD STATUTE	PENALTIES
CALIFORNIA	**Title 10, Chapter 5, Section 2698.30 (p)** "Suspected insurance fraud" includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud."	Any person convicted of violating this subdivision shall be punished by imprisonment in the county jail for one year, or in the state prison for two, three, or five years, or by a fine not exceeding fifty thousand dollars ($50,000), or double the value of the fraud, whichever is greater, or by both imprisonment and fine.
http://www.insurance.ca.gov/0300-fraud/0100-fraud-division-overview/0350-spec-invest-units/state-reg-mandating-siu/upload/siuregseffective.pdf http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=9483151558+1+0+0&WAISaction=retrieve		
COLORADO	**CO ST § 8-43-402** If, for the purpose of obtaining any order, benefit, award, compensation, or payment under the provisions of articles 40 to 47 of this title, either for self-gain or for the benefit of any other person, anyone willfully makes a false statement or representation material to the claim, such person commits a class 5 felony and shall be punished as provided in section 18-1.3-401, C.R.S., and shall forfeit all right to compensation under said articles upon conviction of such offense.	**CO ST § 18-1.3-401** Class 5 felony punishable by 1 to 3 years imprisonment and/or fine of $1,000 to $100,000.
http://www.michie.com/colorado/lpext.dll?f=templates&fn=main-h.htm&cp		
CONNECTICUT	**CT ST § 31-290c** (a) Any person or his representative who makes or attempts to make any claim for benefits, receives or attempts to receive benefits, prevents or attempts to prevent the receipt of benefits or reduces or attempts to reduce the amount of benefits under this chapter based in whole or in part upon (1) the intentional misrepresentation of any material fact including, but not limited to, the existence, time, date, place, location, circumstances or symptoms of the claimed injury or illness or (2) the intentional nondisclosure of any material fact affecting such claim or the collection of such benefits.	**CT ST § 31-290c** Class C felony if the amount of benefits claimed or received, including but not limited to, the value of medical services, is less than two thousand dollars, or shall be guilty of a class B felony if the amount of such benefits exceeds two thousand dollars. Such person shall also be liable for treble damages in a civil proceeding under section 52-564.
http://search.cga.state.ct.us/dtsearch_pub_statutes.html		

STATE	FRAUD STATUTE	PENALTIES
DELAWARE	**DE ST TI 18 § 2407** It shall be a fraudulent insurance act for a person to knowingly, by act or omission, with intent to injure, defraud or deceive to present, cause to be presented, prepare, assist, abet, solicit or conspire with another to prepare or make any oral or written statement with knowledge or belief that it will be presented to an insurer in connection with, or in support of, any application for the issuance of an insurance policy, containing false, incomplete or misleading information concerning any fact material to the application for issuance of an insurance policy.	**DE ST TI 18 § 2411** Up to a $10,000 administrative penalty for each act of insurance fraud plus costs incurred by the Bureau.
http://delcode.delaware.gov/title18/c024/index.shtml		
DISTRICT OF COLUMBIA	**Workers' Compensation: DC ST § 32-1533** Any person who knowingly makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment under this chapter shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not to exceed $1,000 or by imprisonment of not to exceed 1 year, or by both such fine and imprisonment.	**DC ST § 22-3225.02;** **DC ST § 22-3225.03;** **DC ST § 22-3225.04** 1st degree up to $50,000 fine and/or up to 15 years' imprisonment. 2nd degree up to $5,000 fine and/or up to 5 years' imprisonment. Subsequent offense up to $10,000 fine and/or up to 10 years' imprisonment
http://weblinks.westlaw.com/Find/Default.wl?DB=DC%2DST%2DTOC%3BSTADCTOC&DocName=DCCODES32%2D1533&FindType=W&AP=&fn=_top&rs=WEBL8.07&vr=2.0&spa=DCC-1000&trailtype=26&Cnt=Document		
FLORDIA	**Workers' Compensation: FL ST § 440.105** To knowingly make any false, fraudulent, or misleading oral or written statement, or to knowingly omit or conceal material information, required by s. 440.185 or s. 440.381, for the purpose of obtaining workers' compensation coverage or for the purpose of avoiding, delaying, or diminishing the amount of payment of any workers' compensation premiums. To knowingly misrepresent or conceal payroll, classification of workers, or information regarding an employer's loss history which would be material to the computation and application of an experience rating modification factor for the purpose of avoiding or diminishing the amount of payment of any workers' compensation premiums.	**FL ST § 817.234;** **FL ST § 775.082;** **FL ST § 775.083** Third degree felony $20,000 or less, Second degree felony $20,000–$100,000, and First degree felony $100,000 or more.
http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0440/SEC105.HTM&Title=->2008->Ch0440->Section%20105#0440.105 http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0817/SEC234.HTM&Title=->2008->Ch0817->Section%20234#0817.234		

STATE	FRAUD STATUTE	PENALTIES
GEORGIA	**GA ST 33-1-16; GA ST 33-1-9** Any act of knowingly and with intent to defraud, causing to be presented to or by an insurer or any agent thereof, any written statement in support of an application issuance, rating, claim for payment or other benefit pursuant to an insurance policy which contains materially false information.	**GA ST 33-1-9** A felony punishable by 2 to 10 years in prison and/or up to $10,000 fine.
http://www.lexis-nexis.com/hottopics/gacode/		
HAWAII	**Workers' Compensation: HI ST § 386-98** (a) A fraudulent insurance act, under this chapter, shall include acts or omissions committed by any person who intentionally or knowingly acts or omits to act so as to obtain benefits, deny benefits, obtain benefits compensation for services provided, or provides legal assistance or counsel to obtain benefits or recovery through fraud or deceit by doing the following: Presenting, or causing to be presented, any false information on an application; Misrepresenting or concealing a material fact;	**Workers' Compensation: HI ST § 386-98; HI ST § 431:14A-116** Class C felony if the value obtained or denied is more than $2,000; a misdemeanor if the value obtained or denied is less than $2,000; petty misdemeanor if the providing of false information did not cause any monetary loss. Restitution required. Administrative penalties: restitution of benefits or payments received, and one or more of the following: fine of not more than $10,000 for each violation; and suspension or termination of benefits in whole or in part.
http://www.pibureau.com/WorkerCompensation.htm		
IDAHO	**ID ST 41-293. INSURANCE FRAUD.** Insurance fraud includes: (j) Any employer or other person who, with intent to defraud or deceive, presents or causes to be presented to an insurer, producer or any other person or governmental agency any statement containing the number of employees, amount of payroll, job description or job title or any other statement material to worker's compensation insurance which contains false, misleading or incomplete information.	**ID ST 41-293** Any violator of this section is guilty of a felony and shall be subject to a term of imprisonment not to exceed fifteen (15) years, or a fine not to exceed fifteen thousand dollars ($15,000), or both and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section. Each instance of violation may be considered a separate offense.
http://www3.state.id.us/cgi-bin/newidst?sctid=410020093.K		

STATE	FRAUD STATUTE	PENALTIES
ILLINOIS	**Workers' Compensation Act – §25.5** (a) It is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to intentionally present or cause to be presented: Any false or fraudulent claim, material statement or representation to obtain or deny workers' compensation benefits, for the payment of any workers' compensation benefit, prepare or provide an invalid, false, or counterfeit certificate of insurance as proof of workers' compensation insurance, false or fraudulent material statement or material representation for the purpose of obtaining workers' compensation insurance at less than the proper rate for that insurance	**Workers' Compensation Act – §25.5** Any person violating subsection (a) is guilty of a Class 4 felony. Any person or entity convicted of any violation of this Section shall be ordered to pay complete restitution to any person or entity so defrauded in addition to any fine or sentence imposed as a result of the conviction.
http://www.state.il.us/agency/IIC/FraudAct.pdf		
INDIANA	**IN35-43-5-4.5** **Insurance fraud; insurance application fraud Sec. 4.5.** (a) A person who, knowingly and with intent to defraud: Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, an oral, a written, or an electronic statement that the person knows to contain materially false information as part of, in support of, or concerning a fact that is material to: The rating of an insurance policy; a claim for payment or benefit under an insurance policy; premiums paid on an insurance policy; payments made in accordance with the terms of an insurance policy; an application for a certificate of authority; the financial condition of an insurer, or the acquisition of an insurer.	**IN ST § 35-43-5-4;** **IN ST §35-50-2-7** Class D felony punishable by imprisonment for a fixed term of between six (6) months and three (3) years, with the advisory sentence being one and one-half (1½) years. In addition, the person may be fined not more than $10,000.
http://www.in.gov/legislative/ic/code/title27/ar1/ch3.html		
IOWA	**IA ST § 507E.3** Presents or causes to be presented to an insurer, any written document or oral statement, including a computer-generated document, as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that such document or statement contains any false information concerning a material fact.	**IA ST § 507E.3** Class D felony
http://www.legis.state.ia.us/IACODE/2001/507E/3.html		

STATE	FRAUD STATUTE	PENALTIES
KANSAS	**K.S.A. § 40-2,118.** A fraudulent insurance act is "an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, or in support of an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance which such person knows to contain materially false information concerning any fact material thereto."	**KS ST § 40-2,118** (e) Except as otherwise specifically provided in K.S.A. 21-3718 and amendments thereto and K.S.A. 44-5,125 and amendments thereto, a fraudulent insurance act shall constitute a severity level 6, nonperson felony if the amount involved is $25,000 or more; a severity level 7, nonperson felony if the amount is at least $5,000 but less than $25,000; a severity level 8, nonperson felony if the amount is at least $1,000 but less than $5,000; and a class C nonperson misdemeanor if the amount is less than $1,000. Any combination of fraudulent acts as defined in subsection (a) which occur in a period of six consecutive months which involves $25,000 or more shall have a presumptive sentence of imprisonment regardless of its location on the sentencing grid block. (f) In addition to any other penalty, a person who violates this statute shall be ordered to make restitution to the insurer or any other person or entity for any financial loss sustained as a result of such violation. An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act.
http://www.kslegislature.org/legsrv-statutes/getStatuteFile.do?number=40-2,118.html		

STATE	FRAUD STATUTE	PENALTIES
KENTUCKY	**KY ST § 304.47-020 Fraudulent insurance acts** (1) For the purposes of this subtitle, a person or entity commits a "fraudulent insurance act" if he or she engages in any of the following, including but not limited to matters relating to workers' compensation: (a) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Board of Claims, Special Fund, or any agent thereof, any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy or from a "self-insurer" as defined by KRS Chapter 342, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim; (b) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, Board of Claims, or any agent thereof, any statement as part of, or in support of, an application for an insurance policy, for renewal, reinstatement, or replacement of insurance, or in support of an application to a lender for money to pay a premium, knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the application;	**KY ST § 304.47-020** (2) (a) Except as provided in paragraphs (b) and (c) of this subsection, a person convicted of a violation of subsection (1) of this section shall be guilty of a misdemeanor where the aggregate of the claim, benefit, or money referred to in subsection (1) of this section is less than or equal to three hundred dollars ($300), and shall be punished by: 1. Imprisonment for not more than one (1) year; 2. A fine, per occurrence, of not more than one thousand dollars ($1,000) per individual nor five thousand dollars ($5,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or 3. Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph. (b) Except as provided in paragraph (c) of this subsection, where the claim, benefit, or money referred to in subsection (1) of this section exceeds an aggregate of three hundred dollars ($300), a person convicted of a violation of subsection (1) of this section shall be guilty of a felony and shall be punished by: 1. Imprisonment for not less than one (1) nor more than five (5) years; 2. A fine, per occurrence, of not more than ten thousand dollars ($10,000) per individual nor one hundred thousand dollars ($100,000) per corporation or twice the amount of gain received as a result of the violation, whichever is greater; or 3. Both imprisonment and a fine as set forth in subparagraphs 1. and 2. of this paragraph. (c) Any person, with the purpose to establish or maintain a criminal syndicate, or to facilitate any of its activities, as set forth in KRS 506.120(1), shall be guilty of engaging in organized crime, a Class B felony, and shall be punished by: 1. Imprisonment for not less than ten (10) years or more than twenty (20) years.
http://www.lrc.ky.gov/KRS/304-47/020.PDF		

STATE	FRAUD STATUTE	PENALTIES
LOUISIANA	**LA R.S. 23:1208** Misrepresentations concerning benefit payments; penalty A. It shall be unlawful for any person, for the purpose of obtaining or defeating any benefit or payment under the provisions of this Chapter, either for himself or for any other person, to willfully make a false statement or representation. B. It shall be unlawful for any person, whether present or absent, directly or indirectly, to aid and abet an employer or claimant, or directly or indirectly, counsel an employer or claimant to willfully make a false statement or representation.	**LA R.S. 23:1208** Workers' compensation benefit or payment obtained valued at $10,000 or more, imprisonment up to 10 yrs and/or fine up to $10,000; Benefits/payments obtained valued at $2500 or more, but less than $10,000, imprisonment up to 5 yrs and/or fine up to $5,000; benefits/payments obtained valued at less than $2500, imprisonment up to 6 months and/or fine to $500. Restitution may be ordered.
http://www.legis.state.la.us/lss/lss.asp?doc=83440		
MAINE	**ME ST T. 24-A § 2186** A. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud: (1) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following: (a) An application for the issuance or renewal of an insurance policy; (b) The rating of an insurance policy; (c) A claim for payment or benefit pursuant to an insurance policy; (d) Payments made in accordance with an insurance policy; or (e) Premiums paid on an insurance policy; *See note below.	**ME ST T. 39-A § 360** **2. General authority.** The board may assess, after hearing, a civil penalty in an amount not to exceed $1,000 for an individual and $10,000 for a corporation, partnership or other legal entity for any willful violation of this Act, fraud or intentional misrepresentation. The board may also require that person to repay any compensation received through a violation of this Act, fraud or intentional misrepresentation or to pay any compensation withheld through a violation of this Act, fraud or misrepresentation, with interest at the rate of 10% per year.
http://janus.state.me.us/legis/statutes/24-A/title24-Asec2186.pdf http://janus.state.me.us/legis/statutes/39-a/title39-Asec360.pdf		

STATE	FRAUD STATUTE	PENALTIES
MASSACHUSETTS	**MA ST 152 § 14** (3) Notwithstanding any provision of section one hundred and eleven A of chapter two hundred and sixty-six to the contrary, any person who knowingly makes any false or misleading statement, representation or submission or knowingly assists, abets, solicits or conspires in the making of any false or misleading statement, representation or submission, or knowingly conceals or fails to disclose knowledge of the occurrence of any event affecting the payment, coverage or other benefit for the purpose of obtaining or denying any payment, coverage, or other benefit under this chapter; and any person or employer who knowingly misclassifies employees or engages in deceptive employee leasing practices for the purpose of avoiding full payment of insurance premiums; and any law firm, healthcare establishment or agent thereof that employs or contracts persons or firms to personally coerce or encourage individuals to file compensation claims	**MA ST 152 § 14** Punishment punished by imprisonment in the state prison for not more than five years or by imprisonment in jail for not less than six months nor more than two and one-half years or by a fine of not less than one thousand nor more than ten thousand dollars, or by both such fine and imprisonment. The court shall, after conviction, conduct an evidentiary hearing to ascertain the extent of the damages or financial loss suffered as a result of the defendant's crime. A person found guilty of violating this section shall, in all cases, upon conviction, in addition to any other punishment, be ordered to make restitution for any financial loss sustained to an aggrieved person as a result of the commission of the crime. Such restitution shall be ordered in accordance with the provisions contained in section one hundred and eleven B of chapter two hundred and sixty-six and shall be reduced by any amount previously recovered under subsection (2).
http://www.mass.gov/legis/laws/mgl/152-14.htm		
MICHIGAN	**MI ST § 500.4503** A fraudulent insurance act includes, but is not limited to, acts or omissions committed by any person who knowingly (a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer or any agent of an insurer, or any agent of an insurer, reinsurer, or broker any oral or written statement knowing that the statement contains any false information concerning any fact material to an application for the issuance of an insurance policy.	**MI ST § 500.4511** A person who commits a fraudulent insurance act under section 4503 is guilty of a felony punishable by imprisonment for not more than 4 years or a fine of not more than $50,000.00, or both, and shall be ordered to pay restitution as provided in section 1a of chapter IX of the code of criminal procedure, Act No. 175 of the Public Acts of 1927, being section 769.1a of the Michigan Compiled Laws, and in the crime victim's rights act, Act No. 87 of the Public Acts of 1985, being sections 780.751 to 780.834 of the Michigan Compiled Laws.
http://www.legislature.mi.gov/(S(hrlwyi4531j4th45ggj0qu45))/mileg.aspx?page=getObject&objectName=mcl-500-4503 http://www.legislature.mi.gov/(S(hrlwyi4531j4th45ggj0qu45))/mileg.aspx?page=getObject&objectName=mcl-500-4511		

STATE	FRAUD STATUTE	PENALTIES
MISSISSIPPI	**MS ST § 7-5-303** (5) A person or entity shall not, in any matter related to any insurance plan, knowingly and willfully falsify, conceal or omit by any trick, scheme, artifice or device a material fact, make any false, fictitious or fraudulent statement or representation or make or use any false writing or document, knowing or having reason to know that the writing or document contains any false or fraudulent statement or entry in connection with the provision of insurance programs.	**MS ST § 7-5-309** (1) A person who violates any provision of Section 7-5-303 shall be guilty of a felony and, upon conviction thereof, shall be punished by imprisonment for not more than three (3) years, or by a fine of not more than Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or both. Sentences imposed for convictions of separate offenses under Sections 7-5-301 through 7-5-311 may run consecutively. (2) If the defendant found to have violated any provisions of Section 7-5-303 is an organization, then it shall be subject to a fine of not more than One Hundred Fifty Thousand Dollars ($150,000.00) for each violation. "Organization" for purposes of this subsection means a person other than an individual. The term includes corporations, partnerships, associations, joint-stock companies, unions, trusts, pension funds, unincorporated organizations, governments and political subdivisions thereof and nonprofit organizations.
http://www.mscode.com/free/statutes/07/005/0303.htm http://www.mscode.com/free/statutes/07/005/0309.htm		
MISSOURI	**MO ST § 375.991** 2. For the purposes of sections 375.991 to 375.994, a person commits a "fraudulent insurance act" if such person knowingly presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker, or any agent thereof, any oral or written statement including computer generated documents as part of, or in support of, an application for the issuance of, or the rating of, an insurance policy for commercial or personal insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance, which such person knows to contain materially false information concerning any fact material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto.	**MO ST § 375.991** First offense is a class D felony, subsequent offense is a class C felony
http://www.moga.mo.gov/statutes/C300-399/3750000991.HTM		

STATE	FRAUD STATUTE	PENALTIES
MONTANA	**MT ST § 33-1-1202** (2) assists, abets, solicits, or conspires with another to prepare or make any written or oral statement containing false, incomplete, or misleading information concerning any fact that is intended to be presented to any insurer or purported insurer or in connection with, material to, or in support of any claim for payment or other benefit pursuant to an insurance policy or contract.	**MO ST § 33-1-1302** (4) The commissioner may require a person who commits insurance fraud to make full restitution to any insurer, purported insurer, or insurance producer who may have sustained any losses as a result of the fraud with interest of 10% a year from the date of the loss plus any costs and reasonable attorney fees. (5) An insurer, insurance producer, or other person who sustained any losses and who was awarded restitution may bring suit to recover those sums, including any attorney fees, interest at 10% a year, and costs incurred in obtaining a judgment.
http://data.opi.mt.gov/bills/mca/33/1/33-1-1202.htm http://data.opi.mt.gov/bills/mca/33/1/33-1-1302.htm		
NEBRASKA	**NE ST § 44-6604** Knowingly and with intent to defraud presents, assists or conspires to present statements in support or denial of claims or other insurance benefit knowing statement contains false, incomplete and/or misleading information concerning facts material to claim; makes false or fraudulent statements as to death or disability of own entitled to money or benefit under policy; embezzles money or premium from insurance or otherwise converts money to own benefit, makes false entries or destroys or alters insurance company records or makes false insurance department filings.	**NE ST § 44-6607** A person or entity who is found to have committed a fraudulent insurance act set forth in NE ST § 44-6604 is subject to a civil penalty not to exceed $5,000 for the 1st violation, $10,000 for the 2nd violation, and $15,000 for each subsequent violation. An action under this section shall be in lieu of a prosecution under section 28-631.
http://uniweb.legislature.ne.gov/LegalDocs/view.php?page=s4466004000 http://uniweb.legislature.ne.gov/LegalDocs/view.php?page=s2805005000		
NEVADA	**NRS 686A.2815** "Insurance fraud" means knowingly and willfully: 1. Presenting or causing to be presented any statement to an insurer, a reinsurer, a producer, a broker or any agent thereof, if the person who presents or causes the presentation of the statement knows that the statement conceals or omits facts, or contains false or misleading information concerning any fact material to an application for the issuance of a policy of insurance pursuant to this title.	**NRS 686A.291** **Criminal penalty for insurance fraud.** A person who commits insurance fraud is guilty of a category D felony.
http://www.leg.state.nv.us/NRS/NRS-686A.html#NRS686ASec2815		

STATE	FRAUD STATUTE	PENALTIES
NEW HAMPSHIRE	**NH ST § 638:20** II. A person is guilty of insurance fraud, if, such person knowingly and with intent to injure, defraud or deceive any insurer, conceals or causes to be concealed from any insurer a material statement, or presents or causes to be presented to any insurer, or prepares with knowledge or belief that it will be so presented, any written or oral statement including computer-generated documents, knowing that such statement contains any false, incomplete or misleading information which is material to: (a) An application for the issuance of any insurance policy. (b) The rating of any insurance policy. (c) A claim for payment or benefit pursuant to any insurance policy. (d) Premiums on any insurance policy.	**NH ST § 638:20** IV. (a) Insurance fraud is: (1) A class A felony if the value of the fraudulent portion of the claim for payment or other benefit pursuant to an insurance policy is more than $1,000. (2) A class B felony if the value of the fraudulent portion of the claim for payment or other benefit pursuant to an insurance policy is more than $500, but not more than $1,000. (3) A misdemeanor in all other cases.
http://www.gencourt.state.nh.us/rsa/html/LXII/638/638-20.htm		
NEW JERSEY	**NJ ST § 34:15-57.4** 1.a. A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly: (1) Makes, when making a claim for benefits pursuant to R.S. 34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining the benefits; (2) Makes a false or misleading statement, representation or submission, including a misclassification of employees, or engages in a deceptive leasing practice, for the purpose of evading the full payment of benefits or premiums pursuant to R.S. 34:15-1 et seq.; or (3) Coerces, solicits or encourages, or employs or contracts with a person to coerce, solicit or encourage, any individual to make a false or misleading statement, representation or submission concerning any fact that is material to a claim for benefits or the payment of benefits or premiums, pursuant to R.S. 34:15-1 et seq. for the purpose of wrongfully obtaining the benefits or of evading the full payment of the benefits or premiums.	**NJ ST § 34:15-1** A person who evades the full payment of premiums pursuant to R.S.34:15-1 et seq. or improperly denies or delays benefits pursuant to R.S.34:15-1 et seq. is liable to pay the sum due and owing plus simple interest and shall be civilly liable to any person injured by the violation for damages and all reasonable costs and attorney fees of the injured person.
http://lwd.dol.state.nj.us/labor/forms_pdfs/wc/pdf/wc_law.pdf http://lwd.dol.state.nj.us/labor/wc/employer/fraud.html		

STATE	FRAUD STATUTE	PENALTIES
NEW MEXICO	**NM ST § 59A-16-23** A. An agent, broker, solicitor, examining physician, applicant or other person shall not knowingly or willfully: (1) make a false or fraudulent statement or representation as to a material fact in or with reference to an application for insurance or other coverage; (2) for the purpose of obtaining money or benefit, present or cause to be presented a false or fraudulent claim or proof in support of such a claim for payment of loss under a policy; (3) prepare, make or subscribe a false or fraudulent account, certificate, affidavit or proof of loss or other document with intent that the same may be presented or used in support of such a claim; or (4) make a false or fraudulent statement or representation on or relative to an application for a policy for the purpose of obtaining a fee, commission or benefit from an insurer, agent, broker or individual.	**NM ST § 59A-16-23** B. A false statement or representation made under oath shall constitute and be punishable as perjury. A violation of the provisions of this section when the purported loss or potential loss to the victim insurer is: (1) two hundred fifty dollars ($250) or less is a petty misdemeanor; (2) over two hundred fifty dollars ($250) but not more than five hundred dollars ($500) is a misdemeanor; (3) over five hundred dollars ($500) but not more than two thousand five hundred dollars ($2,500) is a fourth degree felony; (4) over two thousand five hundred dollars ($2,500) but not more than twenty thousand dollars ($20,000) is a third degree felony; or (5) over twenty thousand dollars ($20,000) is a second degree felony.
http://www.conwaygreene.com/nmsu/lpext.dll?f=templates&fn=main-h.htm&2.0		
NEW YORK	**INS § 402 § 403** "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act."	**INS § 402 § 403** "Civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."
http://www.ins.state.ny.us/ogco2004/rg040801.htm		

STATE	FRAUD STATUTE	PENALTIES
NORTH CAROLINA	NC ST § 58 2 161 (b) Any person who, with the intent to injure, defraud, or deceive an insurer or insurance claimant: (1) Presents or causes to be presented a written or oral statement, including computer generated documents as part of, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning any fact or matter material to the claim, or (2) Assists, abets, solicits, or conspires with another person to prepare or make any written or oral statement that is intended to be presented to an insurer or insurance claimant in connection with, in support of, or in opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information concerning a fact or matter material to the claim	NC ST § 58 2 161 Class H felony. Each claim shall be considered a separate count. Upon conviction, if the court imposes probation, the court may order the defendant to pay restitution as a condition of probation. In determination of the amount of restitution pursuant to G.S. 15A 1343(d), the reasonable costs and attorneys' fees incurred by the victim in the investigation of, and efforts to recover damages arising from, the claim, may be considered part of the damage caused by the defendant arising out of the offense.
http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_58.html		
NORTH DAKOTA	ND ST § 26.1-02.1 3. "Fraudulent insurance act" includes the following acts or omissions committed by a person knowingly and with intent to defraud: a. Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to or by an insurer, reinsurer, insurance producer, or any agent thereof, false or misleading information as part of, in support of, or concerning a fact material to one or more of the following: (1) An application for the issuance or renewal of an insurance policy or reinsurance contract; (2) The rating of an insurance policy or reinsurance contract; (3) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract; (4) Premiums paid on an insurance policy or reinsurance contract; (5) Payments made in accordance with the terms of an insurance policy or reinsurance contract; (6) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction; (7) The financial condition of an insurer or reinsurer; (8) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer.	ND ST § 26.1-02.1-05 Class C felony if the value of any property or services retained exceeds $5,000. Class A misdemeanor in all other cases.
http://www.legis.nd.gov/cencode/t261c021.pdf		

STATE	FRAUD STATUTE	PENALTIES
OHIO	**OH ST § 3999.31** "Fraudulent insurance act" means an act committed by a person who, knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of a policy or contract for property insurance, casualty insurance, life insurance, sickness and accident insurance, or an annuity, or a claim for payment or other benefit pursuant to such a policy or contract, that the person knows to contain materially false information concerning any fact material thereto, or conceals, for the purpose of misleading, information concerning any fact material thereto. "Fraudulent insurance act" also includes any such written statement, claim, or concealment in relation to such an insurance policy or contract that constitutes a criminal offense under Title XXIX [29] or XXXIX [39] of the Revised Code.	**OH ST § 2913.47** (C) Whoever violates this section is guilty of insurance fraud. Except as otherwise provided in this division, insurance fraud is a misdemeanor of the first degree. If the amount of the claim that is false or deceptive is five hundred dollars or more and is less than five thousand dollars, insurance fraud is a felony of the fifth degree. If the amount of the claim that is false or deceptive is five thousand dollars or more and is less than one hundred thousand dollars, insurance fraud is a felony of the fourth degree. If the amount of the claim that is false or deceptive is one hundred thousand dollars or more, insurance fraud is a felony of the third degree.
http://codes.ohio.gov/orc/3999.31 Ohio Revised Code » TITLE [39] XXXIX INSURANCE » CHAPTER 3999: CRIMES RELATING TO INSURANCE http://codes.ohio.gov/orc/2913.47		
OKLAHOMA	**Title 21 §21-1663. Workers' compensation fraud** C. A person is guilty of workers' compensation fraud who: 1. Presents, causes to be presented or intends to present to another, any statement as part of or in support of any of the purposes described in subsection B of this section knowing that such statement contains any false, fraudulent, incomplete or misleading information concerning any fact or thing material to the purpose for the statement;	**§21-1663. Workers' compensation fraud – Punishment.** A. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony punishable by imprisonment in the State Penitentiary for not exceeding five (5) years or by a fine not exceeding Five Thousand Dollars $5,000.00) or by both such fine and imprisonment.
http://oklegal.onenet.net/oklegal-cgi/ifetch?Oklahoma_Statutes.99+900315308872+F		

STATE	FRAUD STATUTE	PENALTIES
OREGON	**Workers' compensation: OR ST § 656.990** Any person who knowingly makes any false statement or representation to the Workers' Compensation Board or its employees, the Workers' Compensation Board chairperson, the Director of the Department of Consumer and Business Services or employees of the director, the insurer or self-insured employer for the purpose of obtaining any benefit or payment under this chapter, either for self or any other person, or who knowingly misrepresents to the board, the board chairperson, the director or the corporation or any of their representatives the amount of a payroll, or who knowingly submits a false payroll report to the board, the board chairperson, the director or the corporation	**Workers' compensation: OR ST § 656.990** (2) Violation of ORS 656.052 is a Class D violation. Each day during which an employer engages in any subject occupation in violation of ORS 656.052 constitutes a separate offense. (3) Violation of ORS 656.056 is a Class D violation. (4) The individual refusing to keep the payroll in accordance with ORS 656.726 or 656.758 when demanded by the director or corporation, is punishable, upon conviction, by a fine of not more than $100 or by imprisonment in the county jail for not more than 90 days, or by both. Circuit courts and justice courts shall have concurrent jurisdiction of this offense. (5) Failure on the part of an employer to send the signed payroll statement required by ORS 656.504 within 30 days after receipt of notice by the director or corporation is a misdemeanor. (6) Violation of ORS 656.560 (4) is a Class D violation. [Amended by 1959 c.450 §9; 1965 c.285 §93; 1977 c.804 §33; 1981 c.535 §48; 1981 c.854 §56; 1985 c.770 §9; 1990 c.2 §44; 1999 c.876 §10; 1999 c.1051 §216].
http://www.leg.state.or.us/ors/656.htm		
PENNSYLVANIA	**18 PA. C.S. § 4117** "Fraudulent insurance act" means an act committed by a person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or broker, or an agent of an insurer, purported insurer or broker, a written statement as part or in support of an application for the issuance or rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to contain materially false information concerning a fact material to the statement or claim or to conceal, for the purpose of misleading, information concerning a fact material to the statement or claim.	**18 PA. C.S. § 4117** If a person is found by court of competent jurisdiction, pursuant to a claim initiated by a prosecuting authority, to have violated any provision of this section, the person shall be subject to civil penalties of not more than $5,000 for the first violation, $10,000 for the second violation and $15,000 for each subsequent violation. The penalty shall be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting insurance fraud. The court may also award court costs and reasonable attorney fees to the prosecuting authority.
http://members.aol.com/StatutesP4/18PA4117.html		

STATE	FRAUD STATUTE	PENALTIES
RHODE ISLAND	**RI ST § 11-41-29** (b) Every person who, with the intent to deceive, prepares or assists, abets, or solicits another to prepare or make any written statement that is intended to be presented to any insurer in connection with, or in support of, any application for the issuance of an insurance policy, knowing that the statement contains any false information material to the application,	**RI ST § 11-41-29** Guilty of a misdemeanor, and, upon conviction, shall be punished by a fine of not more than one thousand dollars ($1,000), or by imprisonment for a period of not more than one year, or both.
http://www.rilin.state.ri.us/Statutes/TITLE11/11-41/11-41-29.HTM		
SOUTH CAROLINA	**SC ST § 38-55-540** Any person or insurer who makes a false statement or misrepresentation, and any other person knowingly, with an intent to injure, defraud, or deceive, who assists, abets, solicits, or conspires with such person or insurer to make a false statement or misrepresentation,	**SC ST § 38-55-540** (1) Misdemeanor – first offense if economic value is less than $1,000, fine not less than $100 nor more than $500 and not more than thirty days. (2) Misdemeanor – first offense if economic value is $1,000 or more but less than $50,000, fine is not less than $2,000 nor more than $10,000 or imprisonment not more than three years, or both. (3) Felony if economic advantage is $10,000 or more but less than $50,000. Fine is not less than $10,000 nor more than $50,000 or five year imprisonment, or both. (4) Felony for a first offense if economic value is $50,000 or more. Upon conviction, person must be fined not less than $20,000 nor more than $100,000 or imprisoned not more than ten years, or both. (5) Felony for second or subsequent violation, regardless of the economic advantage received. Upon conviction, the person must be fined not less than $20,000 nor more than $100,000 or imprisoned not more than ten years, or both.
http://www.scstatehouse.gov/code/t38c055.htm		

STATE	FRAUD STATUTE	PENALTIES
SOUTH DAKOTA	**SD ST § 58-4A-2** Fraudulent insurance acts — Certain violations as misdemeanor — Certain violations as felony. For purposes of this chapter, a person commits a fraudulent insurance act if the person: (1) Knowingly and with intent to defraud or deceive issues or possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;	**SD ST § 58-4A-2** Any violation of this section for an amount of four hundred dollars or less is a Class 2 misdemeanor. Any violation of this section for an amount in excess of four hundred dollars and less than one thousand dollars is a Class 1 misdemeanor. Any violation of this section for an amount of one thousand dollars and greater is a Class 4 felony. Any other violation of this section is a Class 1 misdemeanor.
http://legis.state.sd.us/statutes/DisplayStatute.aspx?Type=Statute&Statute=58-4A-2		
TENNESSEE	**TN ST § 56-53-103** A fraudulent act is committed if a person knowingly presents to an insurer, insurance professional, or insurance finance company false information to material fact or conceals factual information for application of any insurance policy; fraudulent claims from which the person benefits, payments with terms of the insurance policy; or application to a financial company for insurance premium.	**TN ST § 56-53-104** Punished as in the case of theft.
http://www.michie.com/tennessee/lpext.dll?f=templates&fn=main-h.htm&cp=		
TEXAS	**§ 701.001** (2) "Fraudulent insurance act" means an act that is a violation of a penal law and is: (A) committed or attempted while engaging in the business of insurance; (B) committed or attempted as part of or in support of an insurance transaction; or (C) part of an attempt to defraud an insurer.	**TX Labor § 415.022** Class B administrative violation, punishable by an administrative penalty not to exceed $5,000.
http://www.statutes.legis.state.tx.us/SOTWDocs/IN/htm/IN.701.htm http://www.statutes.legis.state.tx.us/DocViewer.aspx?K2DocKey=odbc%3a%2f%2fSOTW%2fASUPUBLIC.dbo.vwSOTW%2fLA%2fS%2fLA.415%40SOTW&QueryText=415.022&HighlightType=1		
UTAH	**31A-31-103. Fraudulent insurance act.** (1) A person commits a fraudulent insurance act if that person with intent to deceive or defraud: (a) knowingly presents or causes to be presented to an insurer any oral or written statement or representation knowing that the statement or representation contains false, incomplete, or misleading information concerning any fact material to an application for the issuance or renewal of an insurance policy, certificate, or contract.	**UT ST § 76-6-521** Class B misdemeanor
http://le.utah.gov/~code/TITLE31A/htm/31A31_010300.htm http://le.utah.gov/~code/TITLE76/htm/76_06_052100.htm		

STATE	FRAUD STATUTE	PENALTIES
VERMONT	**VT ST Ti. 13 § 2031** (b) Fraudulent insurance act. No person shall, with intent to defraud: (1) present or cause to be presented a claim for payment or benefit, pursuant to any insurance policy, that contains false representations as to any material fact or which conceals a material fact; or (2) present or cause to be presented any information which contains false representations as to any material fact or which conceals a material fact concerning the solicitation for sale of any insurance policy or purported insurance policy, an application for certificate of authority, or the financial condition of any insurer.	**VT ST Ti. 13 § 2031** (c) Penalties. A person who violates subsection (b) of this section shall: (1) if the benefit wrongfully obtained or the loss suffered by any person as a result of the violation has a value of less than $900.00, be imprisoned for not more than six months or fined not more than $5,000.00, or both; or (2) if the benefit wrongfully obtained or the loss suffered by any person as a result of the violation has a value of more than $900.00, be imprisoned for not more than five years or fined not more than $10,000.00, or both; or (3) for a second or subsequent offense, regardless of the value of the benefit wrongfully obtained, be imprisoned not more than five years or fined not more than $20,000.00, or both.
http://www.leg.state.vt.us/statutes/fullsection.cfm?Title=13&Chapter=047&Section=02031		
VIRGINIA	**VA ST § 52-36** Insurance fraud means any commission or attempted commission of the criminal acts and practices defined in section 18.2-178 which involve any type of insurance as defined in section 38.2-110 through section 38.2-122.2 and section 38.2-124 through section 38.2-132.	**VA ST § 18.2-178** Guilty of a Class 4 felony
http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+52-36		
WASHINGTON	**Workers' Compensation: WA ST § 51.48.020** Any person claiming benefits under this title, who knowingly gives false information required in any claim or application under this title	**Workers' compensation: WA ST § 51.48.020** Guilty of a felony, or gross misdemeanor in accordance with the theft and anticipatory provisions of Title 9A RCW.
http://apps.leg.wa.gov/RCW/default.aspx?cite=51.48.020		

STATE	FRAUD STATUTE	PENALTIES
WISCONSIN	**WI ST § 895.486** The presentation or preparation of any statement, document or claim, with the knowledge that it will be presented, the person knew or should have known contained materially false, incomplete or misleading information concerning an insurance policy application, claim for payment, reimbursement or benefits payable under an insurance policy, premium on an insurance policy, or rating of an insurance policy.	
http://nxt.legis.state.wi.us/nxt/gateway.dll?f=templates&fn=default.htm&d=index&jd=top		
WYOMING	**WY ST § 26-13-201. False applications, claims and proofs of loss prohibited.** (a) No person shall knowingly or willfully: (i) Make any false or fraudulent statement or representation in or with reference to any application for insurance or for the purpose of obtaining any money or benefit;	**WY ST § 26-1-107** Any person who commits a fraudulent insurance act is subject to the penalty provided in section 26-1-107, or as provided by any other applicable law which provides a greater penalty.
http://legisweb.state.wy.us/statutes/statutes.aspx?file=titles/Title26/Title26.htm		

Success stories

Measuring the success rate of any insurance fraud program isn't easy. For every case prosecuted, there are hundreds of scams that go undetected. But our industry has made progress.

Below are excerpts from cases that members of the PAAS® Premium Fraud Panel have submitted. You'll see examples of different types of insurance fraud that have occurred across the country. The cases represent different types of risks and fraud schemes perpetrated by insureds, agents, brokers, and insurance company employees.

1 "The owners of an Orange County (Florida) roofing company were arrested for workers compensation fraud and organized fraud. Clifton Meyer and Mark Lee failed to report payroll for workers compensation on 85 employees and more than $900,000 to either their leasing company or the insurance carrier as a result of discovery at time of audit." (*Fraud Digest,* February 2003)

2 "Eugene Crucean (Indiana) was sentenced to five years for mail fraud. Premium fraud amounting to $15,073,746 was committed by underreporting payroll and misrepresenting the type and location of the work. This fraud case was discovered during the analysis of a claims run at the time of audit. Several claimants did not appear on the payroll." (*Fraud Digest,* February 2001)

3 "Laura Krpan (Illinois) pled guilty to one count of mail fraud, two counts of tax fraud and premium fraud in the amount of $413,154 for underreporting of payroll and misclassification of the nature of the work. Sentenced to two years in prison and three years of supervised released." (*Fraud Digest,* February 2008)

4

"Kenneth DeSalvo, an insurance agent with operations in Brooklyn and Staten Island, NY and Newark, NJ, pled guilty on April 12, 2002, to one count of mail fraud in U.S. District Court, District of New Jersey, Newark Division. He was sentenced in July, 2002. DeSalvo was prosecuted for his role in a hidden payroll scheme involving B.S. Pollack Nursing Center in Jersey City, NJ; Meadowview Nursing Center in Secaucus, NJ and Supreme Management, Inc. in Brooklyn, NY. At the time of the mail fraud, the New Jersey nursing homes were owned by Hudson County, NJ and operated under an interim management agreement by Progressive Health Care, Inc., a corporation owned by Michael Konig of Teaneck, NJ.

"DeSalvo submitted two applications to the New Jersey Compensation Rating & Inspection Bureau for workers' compensation coverage for the nursing homes. In one application, he fraudulently claimed that the annual payroll for the Pollack facility was approximately $1 million when the payroll actually exceeded $6 million. In the second application, he fraudulently claimed that the annual payroll for the Meadowview facility was approximately $825,000 when the payroll actually exceeded $4 million. Liberty Mutual Insurance Company, the assigned risk servicing carrier, was defrauded of over $120,000 in deposit premium as a result of the false applications." (Submitted by Neil Johnson, Manager Special Investigations Unit, Liberty Mutual Insurance Company)

5

"On October 2, 2007, Charles J. Spinelli was sentenced in federal court in Fort Lauderdale, Florida, to 21 months in prison and ordered to pay restitution of $43.4 million to CNA Insurance for his role in an insurance fraud scheme involving phony letters of credit given to CNA to secure large deductible workers' compensation policies issued to an employee leasing company, Cura Group, Inc. (Submitted by Michele Ersnt, CNA Insurance Company)

6

"Five individuals have been charged in federal court with participating in a massive tax and insurance fraud scheme in connection with their operation of temporary employment agencies in Southeastern Massachusetts.

"They are accused of paying employees more than $30 million in cash 'under-the-table' in order to evade millions of dollars in payroll taxes and workers' compensation premiums for their businesses.

"United States Attorney Michael Sullivan; Joseph Galasso, Special Agent in Charge of the U.S. Internal Revenue Service, Criminal Investigation; Kenneth Kaiser, Special Agent in Charge of the Federal Bureau of Investigation in New England; and Daniel Skelly, Chief of Investigations for Insurance Fraud Bureau of Massachusetts, announced that Daniel W. McElroy, 53, of Sharon, Aimee J. King Mc Elroy, 47, of Sharon, and Xieu Van Son, 47, of Lowell, have been indicted by a federal grand jury. In addition,

Charles J. Wallace, 53, of East Bridgewater, and Dich TrieuI, 56, formerly of Lowell, now living in Utica, New York, have been charged in an Information.

"The Indictment charges McElroy, his wife, King McElroy, and Van Son with conspiracy to defraud the United States and to commit mail fraud by deceiving workers' comp insurers regarding the size and payroll of their business." ("Southeastern Mass. Payroll Scam Busted," *Insurance Journal,* January 27, 2005)

7

"San Diego County Superior Court sentenced Big Bear Lake resident Donald Souza, owner of Donald Souza Construction, Inc., to 181 days of home arrest and five years' probation following his conviction on felony workers' compensation and unemployment insurance fraud.

"State Fund, which assisted the San Diego County District Attorney's Office in its investigation, will collect approximately $60,000 in workers compensation insurance premiums owed to State Fund, which insured Donald Souza Construction, Inc. from August 3, 2000 to October 10, 2002.

Souza was convicted of felony workers' compensation insurance premium fraud (Insurance Code 11880), unemployment insurance fraud (Insurance Code 2117.5) and insurance violation 1871.4(a)(4), conspiracy to deny claim for injured worker, according to San Diego County Deputy District Attorney Ernie Marugg.

"Souza was involved in a scheme to avoid paying workers comp premiums and employment taxes by using a third party (subcontractor) through which it would run its payroll. The subcontractor would later pay Souza employees in cash.

"Donald Souza also conspired to deny a workers' compensation claim to one of his employees. He offered his injured worker the sum of $2,000 in order for him not to report his injury to State Fund. The injured worker who suffered a severe foot fracture turned down the offer and filed a valid workers' compensation claim with State Fund.

"'We hope this conviction underscores State Fund's commitment and resolve to investigate and combat all types of fraud which robs California's workers' compensation system of millions of dollars each year,' said Donna Gallagher, who manages State Fund's Fraud Investigation Program (FIP). 'Through our Fraud Investigation Program and positive relationships with law enforcement officials, State Fund will maintain its effort to protect California's employers, injured workers and the integrity of the workers' compensation system.' The sentencing capped a multi-year investigation aided by State Fund." (*Business Press,* San Bernardino, CA, May 3, 2004)

8

"An Abington, MA man has pleaded guilty to charges he schemed, along with his insurance agent, to avoid paying more than $131,000 in workers compensation insurance premiums, Attorney General Tom Reilly announced today.

"Patrick J. O'Shaughnessy, 61, of Abington pleaded guilty yesterday to two counts each of workers' compensation fraud and larceny over $250, and four counts of conspiracy. Suffolk Superior Judge Christine McEvoy sentenced O'Shaughnessy to serve two years in the House of Correction, with 30 days to be served under house arrest on an electronic monitoring bracelet and the remainder suspended for two years. O'Shaughnessy also was fined a total of $10,000 and ordered to paid full restitution in the amount of $65,757.

"O'Shaughnessy on behalf of the corporation, O'Shaughnessy Plumbing, Inc. additionally pleaded guilty to two counts each of workers' compensation fraud and larceny over $250. For those charges, Judge McEvoy fined O'Shaughnessy Plumbing, Inc. $15,000.

"The case arose from a workers' compensation premium avoidance scheme run by O'Shaughnessy, president of O'Shaughnessy Plumbing, Inc., and his insurance agent, William McGowan, owner of McGowan Insurance Company. Together, the two evaded workers' compensation premiums by under reporting the company's payroll to their insurance company.

"Workers' compensation insurance premiums are calculated based on a rate associated with the work that is being performed, history of prior claims and the total payroll for the company.

"The investigation found that between 1995 and 2000, McGowan and O'Shaughnessy conspired to avoid premiums of more than $131,000. The pair underreported the payroll for O'Shaughnessy Plumbing, Inc. by presenting fake payroll records and tax returns at annual audits conducted by the insurance carriers.

"The case was prosecuted by Assistant Attorney General Tracey A. Brown of AG Reilly's Insurance and Unemployment Fraud Division and was jointly investigated by the Insurance Fraud Bureau of Massachusetts." ("Mass. Plumber to Spend Time at Home for WC Fraud," *Insurance Journal,* April 27, 2004)

9

"New York's Superintendent of Insurance Gregory V. Serio announced that the owner of Village Pizza & Burger, located at 156 North Main Street in Spring Valley, N.Y., has been arrested and charged with insurance fraud, falsifying business records, and submitting fraudulent workers' compensation documents.

"Yuri Milshtein, a resident of New City, was arrested Friday by the Clarkstown Police Department and his business has been closed. He allegedly submitted false workers' compensation documents stating that he was a sole proprietor and had no employees.

"A joint investigation, led by the Department's Insurance Fraud Bureau, the Clarkstown Police Department, and the New York State Workers' Compensation Board – Office of the Fraud Inspector General, revealed, however, that Milshtein did indeed employ two workers and that 'the fraudulent documents were an attempt to avoid paying into the workers' compensation system.'

"The bulletin also indicated that he 'submitted fraudulent insurance documents and falsified business records to substantiate this scheme, and faces charges on these accounts as well.'" (Press Release, New York State Insurance Department, Issued March 3, 2004)

Footnotes

[1] Dennis Jay, "Preventing Insurance Fraud: Identifying Trends and Encouraging Collaboration" (2004), Coalition Against Insurance Fraud

[2] Congressional Record — Extension of Remarks, October 11, 1998

[3] Greg Tarpinian, "Workers' comp fraud: the real story," *TRIAL,* March 1999

[4] 2007 Annual Report, California Insurance Department

[5] *Insurance Journal,* "Fraud Roundup: CEO and wife arrested for alleged workers' comp fraud," October 2006

[6] Frank Neuhauser and Colleen Donovan, Survey Research Center/UC Data Archive and Technical Assistance, University of California, Berkeley, "Fraud in Workers' Compensation Payroll Reporting: How Much Employer Fraud Exists? What Is the Impact on Honest Employers? (August 2007), The California Commission on Health and Safety and Workers' Compensation

[7] Melody Finnemore, "Misclassifying Workers," *Portland Business Journal,* October 26, 2007

[8] Insurance Fraud Bureau of Massachusetts Annual Report

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