INSURANCE FRAUD

8519 Eagle Point Boulevard, Suite 100 • Lake Elmo, Minnesota 55042 • 651-290-6500 • www.jlolaw.com

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OVERVIEW

Insurance Fraud can take many forms. In 1994, the United States General Accounting Office, the National Association of Insurance Commissioners and industry groups estimated that insurance fraud annually costs approximately 110 billion dollars. Unfortunately, no one knows how much fraud actually occurs. That is, in part, caused by the inability to detect fraud and abuse; and caused, in part, by the failure to report insurance fraud and abuse. This brief outline will provide you with some basics concerning fraud detection, the need to report fraud and what to do when you detect fraud.

UNFAIR CLAIMS PRACTICES ACT

Minnesota has adopted an Unfair Claims Practices Act. It controls claims handling procedures for insurance claims asserted in Minnesota.

I. Claims Handling Standards.

Pursuant to Minn. Stat. §72A.20, subd, 12(3), an insurer is required to adopt and implement standards for the prompt investigation of claims. The Act goes on to state that all claims professionals must understand and appreciate the claims handling standards adopted by the insurer.

This particular statutory provision is a rather simple one. It requires an insurer to adopt standard claims handling procedures for the investigation of claims, and it requires insurers to abide by its adopted claims handling standards.

II. Notification of Claim.

Minn. Stat. §72A.20, subd. 12(3) states an insurance company must do certain things when it receives notification of a potential claim or loss. Basically, the statute requires that when an insurer receives notice of a claim or loss, it must take action. This particular statutory provision is very important. For compliance purposes, the date the insurer receives notification of a claim or loss, is the date by which other activities are to be completed.

III. Responses to Notification of a Claim or Loss.

As soon as an insurer receives notification of a loss or claim, the insurer must acknowledge to the insured or the claimant, a receipt of notification of a claim or loss. Preferably, the acknowledgment of the notice of that claim or loss will be in writing so as to properly document the claim file. At the same time, pursuant to Minn. Stat. §72A.201, subd. 4(1), an insurer should send to the claimant or insured all proofs of loss or other written information and documentation necessary to assert a claim with that insurer.

The Unfair Claims Practices Act also requires that in that initial acknowledgment, the insurer must give the insured or claimant a telephone number of an insurance company representative who will assist the insured or claimant in preparing their claim and an address or other means to communicate with the insurer.

If the initial acknowledgment of the loss by the insurer is an oral communication, the claim file, under the Unfair Claims Practices Act, must document the telephone number called by the insurance claim professional, the person spoken to and the date and time of that call and the information conveyed by the insurance claim professional to the insured or claimant.

These basic requirements, regarding the adoption of claims handling standards, what to do when there is a notification of a loss or claim and what sort of acknowledgment should be provided upon notification of a claim or loss, are very basic claim procedures. They are a simple statutory scheme under which an insurer should document their file.

IV. Proofs of Loss.

Minn. Stat. §72A.201, subd. 4(6) states that the insurer may be violating the Unfair Claims Practices Act when it sends a proof of loss to an insured or a claimant advising them to complete the proof of loss by a specified time and then denies the claim based on the failure to comply with the time constraints. In essence, this portion of the Act requires that the insurer tell the insured or claimant that if they do not get a proof of loss prepared and submitted by a given date, the insurer must tell the insured or claimant that the insurer will be prejudiced and because of that prejudice, the insurer may deny the claim.

As a matter of policy, when a blank proof of loss is sent to an insured or claimant, it is a good business practice to tell the insured or claimant the date by which the fully completed proof of loss is to be sent back to the insurer. Further, it is a good business practice to tell the insured or claimant that if they did not submit the fully completed proof of loss by the specified date, the

insurer will be prejudiced. A common claim of prejudice may include limitation statutes running, notice requirements running for products liability claims, waste of salvageable property and other items which may work a prejudice to the insurer.

V. Communications with the Insured and Claimant.

The Unfair Claims Practices Act requires that insurance claims professionals reply within ten business days to all communications about a claim from an insured or a claimant. Minn. Stat. §72A,201, subd. 4(2). It is good policy to respond to all inquiries by the claimant or insured. If the response is over the telephone or another form of oral response, the claims professional should document in their file, the telephone number called, the person spoken with and the items discussed. If the response is a written reply, the insurance claims professional should simply indicate they are replying to some sort of communication from the insured or claimant.

VI. Time Constraints for Completing Claims Investigation.

The investigation of a claim must be completed within 30 business days after receipt of notification of a claim or loss. Minn. Stat. §72A.201, subd. 4(3). In the event the investigation cannot reasonably be completed within that time, the insurer must notify the insured or the claimant within the 30 business days why the investigation cannot be completed and when it is expected to be completed.

Where there is evidence of fraud, the requirement to disclose an insurer's reasons for failure to complete an investigation within 30 days is relaxed. Minn. Stat. §72A.201,1 subd. 4(4). In essence, because fraud and abuse cases are unique, their investigation may not always be completed within 30 business days. In that event, the Unfair Claims Practices Act provides a specific exception. It allows an insurer to take more than 30 business days to complete an investigation. Typically, where there is suspected fraud, and the investigation of the claim cannot be completed within 30 business days, an insurer will send a letter to the insured that the investigation cannot be

completed within the 30 business days and that the claim is being referred to an attorney for completion of the investigation and legal advice. The basis for not completing the investigation need not be specific.

Typically, when the investigation takes more than 30 business days, the claimant may call the insurer or the Insurance Commissioner. Upon notification of a delay in the investigation, and upon receipt of a complaint from an insured or claimant, the Insurance Commissioner will typically call the insurance carrier and ask them why there is a delay.

In the past, the Insurance Commissioner has traditionally asked for basic information, some evidence of the fraud, and then it will merely close its file and tell the insured or claimant that the insurer's act is in compliance with the Unfair Claims Practices Act. Further, the Insurance Commissioner's office typically returns all information submitted by the insurer or the insurer's attorney after they close their file. That way, the insured or claimant does not have access to that evidence of fraud and the insurer's theories of fraud and abuse before the insurer makes it decision to pay, compromise or deny a claim.

VII. Compromising, Paying or Denying Claims.

Within 30 business days after receipt of a properly prepared and executed proof of loss, the insurer must advise the claimant or insured of the acceptance or denial of a claim. Minn. Stat. §72A.201, subd. 4(3). By the time a proof of loss is tendered by the insured or claimant to the insurer, as a business practice, the insurer should have determined all of its coverages. Minn. Stat. §72A.20, subd. 12(5).

Even if the investigation of a claim cannot be completed within 30 business days of receipt of notification of a claim, the insurer still must accept or deny the claim within 60 business days after receipt of a properly prepared and executed proof of loss.

Again, all the time constraints under the Unfair Claims Practices Act, start to run after the initial notice or notification of a claim or loss. It is of critical importance that an insurer acknowledges receipt of notice of a claim or loss, that it provides all the necessary paper work for preparing a proof of loss upon notification of a claim, that it completes its investigation within 30 business days and, if that is not possible, that it provides the insured or claimant with written explanation why more than 30 business days are needed to complete the investigation. Finally, the insurer must accept or deny the claim within 60 business days after receiving a properly prepared and executed proof of loss.

VII. Claim Denial.

When an insurer denies a claim, or any part of a claim, and the denial is based upon a policy provision, the insurer must quote that policy provision in its denial letter. The denial, preferably sent out in writing, must include: (1) the basis for the denial, (2) the name, address and telephone number of the claims professional who will take any questions or complaints regarding the denial, and (3) the claim number and policy number and other pertinent information. Minn. Stat. §72A.201, subd. 8(5)

When the claim is denied, again, preferably in writing, not only should the specific policy provisions, exclusions and definitions incorporated into the denial letter, but the denial letter should also state the limitation statute that would apply to any lawsuit brought because of the denial.

HOMEOWNER CLAIMS

Minnesota has adopted the standard fire policy. Minn. Stat. §65A.01, subd. 3. Basically, that means that all insurance policies affording coverage to dwellings must conform, at the least, to the terms specified in the Minnesota Statutes. The Minnesota Standard Fire Policy mirrors the old New York Standard Fire Policy with a couple of exceptions. In Minnesota, the standard fire policy states that an insurer must tell an insured, before an examination under oath is taken, that the insured has the right to have an attorney present at the examination under oath and that everything stated during the course of the examination under oath may and will be used in all subsequent civil or criminal proceedings. Otherwise, the Minnesota Standard Fire Policy is essentially the same as the old New York Standard Fire Policy.

Homeowner fraud and abuse claims are first party coverage claims. That means that the insured has alleged to have sustained property damage or some other loss that is covered under the policy. The fraud and abuse claims may be as dramatic as arson of an entire home, a bogus burglary claim where a certain property is alleged to have been stolen or willful padding of a proof of loss.

I. Arson Claims.

Minnesota has some case law on arson claims. *Weber v. Travelers Home & Marine Ins. Co.*, 801 F.Supp.2d 819 (D. Minn. 2011); *DeMarais v. Northstar Mutual Ins. Co.*, 405 N.W.2d 507 (Minn. Ct. App. 1987); *Quast v. Prudential Property & Cas. Co.*, 267 N.W.2d 493 (Minn. 1978). In order to prove a homeowner arson claim in Minnesota, the homeowner insurer must establish the following:

A. That the fire was of an incendiary nature;

B. That the insured had motive to set or procure the setting of the fire.

It used to be said that the burden that was on the insurer was to prove a fire of an incendiary cause, motive and opportunity. In Minnesota, under *Weber*, *DeMarais*, and *Quast*, the insurer need only show incendiarism and motive.

II. Arson - Motives.

A. Financial:

1. Stress, fraud to avoid loss.
2. Greed, arson for profit.
3. Combination of 1 and 2.

B. Revenge-Spite-Jealousy:

1. Arsonist wants victim to be afraid, uses fire as a weapon.
2. Domestic disputes.
3. Romance problems.

C. Homicide-Suicide:

1. Crime itself, used as the instrument to murder someone.
2. Life insurance, (also financial).

D. Crime Concealments and Diversionary Tactics:

1. Homicide, killed by other means.
2. Burglary, cover m.o. (staged burglaries to blame criminal).

E. Vanity:

1. Hero, fire discoverer, rescuer.
2. Job importance, janitor, caretaker, security guard, fire fighters.

F. Psychological Disorders:

1. Pyromania, sensual satisfaction, maybe erotic, serial act.
2. Psychotics, delusional.

3. Psychopaths, cold, cunning, like to see people suffer.

4. Mental defectives.

G. Intimidation, Extortion, Sabotage:

1. Witnesses.

2. Crime territory, drugs, protection.

3. Civil disorder, riots, revolts.

H. Actions of Juveniles, Adolescents, and Children:

1. Vandalism, malicious mischief.

2. Psychological stress, victim of child abuse, unhappy regarding environment.

3. Experimentation, lack of intent.

All of the motives listed herein above, were put together by the Minnesota Bureau of Criminal Apprehension. When investigating arson, it is of critical importance for the claims professional to rule out all motives but the financial motive. If there is some other motive, some other person out there who is not ruled out as an arsonist that will later raise proof problems for the insurer. There may be more than one motive to set a home on fire. For example, a person may have a financial reason and a personal reason for setting a home on fire.

III. Burglary and Theft Losses.

When insureds find themselves short on cash, in need of money, they sometimes stage a burglary or allege a theft loss in order to present a claim to an insurance company to get insurance proceeds. Whenever a property claim is submitted, whether it is a burglary, theft or arson loss, the claims professional should determine the following:

A. Determine the applicable coverages.

B. Inspect the remains of the fire damage property, or place where the burglary or theft loss occurred.

C. Determine all insureds and all claimants.

D. Obtain written authorizations from the insured or claimant to obtain police, fire and sheriff department reports.

E. Obtain written authorization to examine the insured's financial records.

F. Thoroughly pre-interview the insured or claimant about employment, financial status, income and expenses, access to the buildings, the fires, burglary or theft, marital status, enemies, problems with electrical and/or gas appliances, security to the premises, whereabouts of the insured or claimant at the time of the burglary/fire/theft, insured's first knowledge of the burglary/fire/theft, first person or persons the insured or claimant told about the fire/burglary/theft and any other information the insurer or claims professional needs to know.

G. Obtain a recorded or hand written statement of the insured or claimant covering all information covered in the pre-interview and any other information which would affect the settlement of the claim.

H. Determine when the fire/burglary/theft was first discovered.

I. Determine the security of the premises when the fire/burglary/theft was first approached by law enforcement personnel or others discovered in the fire/burglary/theft.

J. As quickly as is possible, retain a qualified fire investigator or origin and cause expert and instruct that expert to investigate, photograph and otherwise inspect fire losses.

K. Instruct your expert to discuss the fire/burglary/theft with the law enforcement personnel, including firemen, where applicable, who responded to the loss.

L. Obtain all police and fire insurance reports concerning the loss.

M. Obtain all financial information on the insured and claimants and determine if the insured and/or claimant had a financial motive to collect insurance proceeds.

N. Rule out all motives for the staging of a fire/burglary/theft.

O. Identify and interview neighbors and/or adjacent businesses about the fire/burglary/theft.

KNOWN RISK DOCTRINE

The previous cases and statutes apply to misrepresentations made before the loss occurs. However, once a loss has occurred, there is no longer any "risk." Therefore, whether the material misrepresentation increases the risk of loss is irrelevant, because the loss has already occurred. The question then is whether the insured knew of the loss at the time of application. Where the insured fails to disclose to the insurer a known risk or known loss that has occurred prior to the application and issuance of insurance, there is no meeting of the minds and the insurance policy does not cover the previously existing loss.

Minnesota courts, in applying the preclusion of coverage for failure to disclose a known risk, do not require any showing whatsoever of fraud. There must only be a showing that the insured knew of a loss and failed to disclose it prior to issuance of insurance coverage.

The doctrine of known risk was first dealt with by the Minnesota courts in the 1885 case of *Wales v. New York Bowery Fire Ins. Co*., 37 Minn. 106, 33 N.W. 322 (1887). In *Wales*, plaintiff insured some wood under a policy which expired on May 13, 1885. On May 15, 1885, the wood was destroyed by fire. Knowing that the wood had burned, plaintiff procured new policies covering the wood. The insurance agent, having no notice that the wood had burned, back-dated the policies to May 13, 1885, knowing that plaintiffs previous policy had expired on that date, to "make the insurance continuous."

The court held that "if on May 18 both parties had been ignorant of the loss, it would have been competent for them, by antedating the policy, to have made it retroactive, but in fact, the plaintiff then knew the property had been destroyed but did not communicate the fact to defendant's agent, who in ignorance of the loss, accepted the risk, and issued the policy.

Under these circumstances, the policy is void and does not cover the loss." *Id*. at 323. The court further reasoned that as in the case of any other contract, to constitute a contract of

insurance, the parties minds must meet and concur as to terms. Clearly, there is no meeting of the minds when one party is ignorant of the loss.

Other states have also addressed the issue of known loss, and have similarly held that "antedated contracts of insurance are valid provided neither party knows of the loss, at the time the contract is made." The policy is void where ignorance of the loss is not mutual when the contract is entered. *Oster v. Riley*, 150 N.W.2d 43 (Minn. 1967) *citing Matlock v. Hollis*, 109 P.2d 119, 123 (Kan. 1941). The court in *Matlock* stated, "If the employer conceals the fact of an injury to an employee which would be covered by an antedated policy which he accepts, he is taking no chance, the contingency, the risk is not mutual." *Matlock*, 109 P.2d at 124.

Where an insured reasonably believes that coverage existed from the time of his initial call obtaining an oral binder, and before the agent ordered the policy from the underwriter, the insured does not have a duty to notify the agent of the accident. *Oster*, 150 N.W.2d at 49. *But see Farm Bureau Mut. Cas. Co. v. Stein*, 170 N.W.2d 334 (Minn. 1969) (giving deference to the language in a policy for when it becomes effective). The court in *Oster* did, however, reaffirm the holding of *Wales* that "an insurer is protected from liability upon a predated insurance policy if it appears that the insured concealed his knowledge of a loss at a time he knew the insurance had not yet been effected."

The known risk doctrine applies to preclude coverage even where no fraud can be attributed to the insured. *Waseca Mut. Ins. Co. v. Noska*, 331 N.W.2d 917 (Minn. 1983). In *Noska*, the insured set the countryside ablaze as he hauled barrels containing hot coals in the bed of his pickup truck over several miles. The fire covered several thousands of acres and damaged or destroyed numerous farm properties and homes. The insured had a $100,000 personal liability coverage on his homeowners policy that expired three days before the fire. As Waseca Mutual

did not provide notice of intent not to renew to the insured, they conceded that pursuant to Minn. Stat. §65A.29 (1982) the $100,000 of coverage afforded by that policy continued in effect.

Several days after the fire, the insured in *Noska* met with his insurance agent who brought up the idea of increasing the policy limits for personal liability from $100,000 to $300,000. The insured then increased his insurance to $300,000. The agent, on his own initiative, backdated the new policy with a $300,000 limit to the date of expiration of the previous policy. Therefore, the $300,000 policy was effective three days before the fire. The insured did not request that the agent backdate the policy. At the time that the coverage was renewed and increased, the insured was well aware of his involvement in the fires but said nothing to the agent. The agent knew nothing of the insured's involvement with the fire.

The trial court found no fraud on the part of the insured, and that as the renewal and increase of policy limits were sought in good faith, Waseca Mutual was bound by the action of its agent who backdated the policy, and therefore $300,000 of coverage was available. The Minnesota Supreme Court reversed and limited Waseca Mutual's liability to the original $100,000. The Supreme Court found that if the insured intended the policy be backdated, his conduct would have been fraudulent. However, as the insured had no such knowledge or intent, no fraud could be attributed to him. Without the insured's intent to backdate the policy, there could be no meeting of the minds to do so and as a result, the increased coverage took effect on the date the new policy was procured, several days after the fire. Therefore, had the insured fraudulently concealed his involvement with the fires for the intent of backdating the policy, the known risk doctrine would have applied to preclude coverage because the insured knew of the loss and failed to disclose it to the insurer who was ignorant of the known loss involving the insured. On the other hand, if the insurer did not intend to backdate the policy, there would be no meeting of the minds and therefore no insurance contract.

NO-FAULT INSURANCE FRAUD

No-fault insurance, or personal injury protection benefits, are prescribed by statute. There are a number of different types of fraud that can be developed under a motor vehicle accident scheme. First, the accident itself may not have occurred or could have been staged. Second, some claimants claim wage loss benefits at a weekly compensation rate that is actually higher than what they are earning prior to the accident. Others claim weekly wage loss benefits while they are still working or take another job with another employer. Worse still, some healthcare providers bill for medical and other healthcare services rendered which were not, in fact, rendered. Some healthcare providers also "up code" the services they do render. Up coding basically means that a healthcare provider designates a higher C.P.T. code for a service provided to an injured claimant so as to get more money for that visit.

The last area of no-fault fraud concerns replacement services. Some claimants assert claims for replacement services when, in fact, they are not incurring that expense or, alternatively, claim replacement services benefit through a "straw person" who does not render the replacement services but acts as a conduit by which the claimant asserts the expense for replacement services, gets compensation for the services and keeps the cost of those services for him or herself.

I. Minnesota Law.

In relevant part, Minn. Stat. §65B.54, subd. 4 states as follows:

Subd. 4. A reparation obligor may bring an action to recover benefits which are not payable, but are in fact paid, because of an intentional misrepresentation of a material fact upon which the reparation obligor relies, by the claimant or by a person providing products or services for which basic economic loss benefits are payable. The action may be brought only against the person providing the products or services, unless the claimant has intentionally misrepresented

the facts or knew of the misrepresentation. A reparation obligor may offset amounts the reparation obligor is entitled to recover from the claimant under this subdivision against any basic economic loss benefits otherwise due the claimant.

A. This statute allows a no-fault insurer to bring a civil action in district court to recover no-fault benefits which were paid but were not owed.

1. The right of action must be based on an intentional misrepresentation;

2. Upon which the no-fault insurer relies;

3. Made by the claimant;

4. Or made by a person providing products or services for which no-fault benefits are payable.

B. The suit, brought based on the statute, may only be brought against the person guilty of the intentional misrepresentation or the claimant, if the claimant knew that the person providing the products or services intentionally misrepresented facts.

C. It appears that the suit to recoup no-fault benefits wrongfully received must be brought in district court. It appears that original jurisdiction for this claim lies in the state district courts and that an affirmative claim for relief may not be brought in a no-fault arbitration.

D. However, it does appear that the no-fault insurer may offset amounts wrongfully received, or paid out based on a material misrepresentation, against no-fault benefits that are genuinely due and owing.

E. Further, it appears that a no-fault insurer could claim an offset for no-fault benefits wrongfully received in response to a claimant's petition for no-fault arbitration. It also appears that a no-fault insurer could assert a counterclaim to the claimant's petition for no-fault arbitration.

F. When these claims are brought in state district court, the following claims may arguably be alleged against a claimant who has wrongfully received no-fault benefits:

1. Intentional misrepresentation or fraud;

2. Money had and received;

3. Declaratory relief;

4. Statutory right to recover benefits under Minn. Stat. §658.54, subd. 4.

G. There are two reported cases interpreting this statutory provision in Minnesota. *Johnson v. United Services Auto. Ass'n*, 493 N.W.2d 570 (Minn. 1992); *Minnesota Mut. Fire & Cas. Co. v. Rudzinski*, 347 N.W.2d 848 (Minn. Ct. App. 1984). In *Rudzinski* the Minnesota Court of Appeals stated that Minn. Stat. 65B.54, subd. 4 "Makes no provision for restitution in the event of a mutual mistake" by the claimant and no-fault insurer where no-fault benefits were mistakenly claimed and mistakenly paid." In *Rudzinski* the claimant and the no-fault insurer were not aware of an exclusion that precluded no-fault coverage. Restitution was allowed to the no-fault insurer but not under Minn. Stat. §65B.54, subd. 4. In *Johnson*, the Minnesota Supreme Court interpreted Minn. Stat. §65B.54, subd. 4 to provide a limited right to recover overpaid basic economic loss benefits where there was a material misrepresentation (i.e., fraud).

H. There is an argument to be made that a no-fault insurer could assert an extra contractual claim for "reverse bad faith" against the claimant because of the claimant's fraud.

EXAMINATIONS UNDER OATH

The Minnesota Standard Fire Policy and, in some other policies, contain provisions requiring the insured to submit to an "examination under oath". Very briefly, an examination under oath is a pre-suit sworn statement, normally conducted by an attorney, and reported by a court reporter that thoroughly examines the insured regarding the facts and circumstances of the loss and of all other matters reasonably related to the loss. Examinations under oath are routinely conducted in homeowner claims. They are a quick, efficient and invaluable tool in investigating a loss, pinning down the facts and circumstances to a loss and for confronting the insured with the evidence of the fraud. In Minnesota, there are two unique provisions that concern examinations under oath. Minn. Stat. §65A.01, subd. 3. (1) The insured must be told that the answers given in an examination under oath may be used against him in a later civil or criminal proceeding. (2) At the time of the examination under oath, the insured may be required to produce, for examination, all records and documents reasonably related to the loss.

A named insured under a policy must appear at the examination under oath. An insured by definition, such as a child or other member of the household, may also be required to appear at an examination under oath. The Minnesota Supreme Court has held that participation in an examination under oath is a condition to recovery under the insurance policy. *McCullough v. Travelers Companies*, 424 N.W.2d 542 (Minn. 1988). In *McCullough*, the Minnesota Supreme Court stated that the insured's refusal to submit to an examination under oath was not fatal to his subsequent lawsuit as long as the insured expressed a willingness to participate in a deposition, shortly after commencing suit against the insurer. Formerly, insurers denied claims based upon an insured's refusal to participate in an examination under oath. Today, according to *McCullough*, a claim cannot be solely denied based on the insured's refusal to submit to an examination under oath. If there are other circumstances, such as a failure to cooperate in the

investigation and adjustment of a loss, coupled with the refusal to submit to an examination under oath, there are probably sufficient grounds to deny a claim.

BODILY INJURY CASUALTY FRAUD

When claimants are involved in an accident and willfully exaggerates injuries to their physical and mental condition, there is fraud. However, proving malingering, exaggeration of symptoms, the non-existence of injuries or ailments are all very difficult to prove.

Index bureaus have helped insurers and other claims professionals track the number of accidents or ailments concerning a given claimant.

Whenever a person goes through the insurance claims process, they acquire knowledge. They learn how to prepare a proof of loss, what injuries or damages to complain of and how to be compensated for those losses.

When investigating a bodily injury claim, make certain you obtain the following information:

A. The claimant's full and complete name.

B. All prior names, including maiden names.

C. The names, addresses and telephone numbers of all physicians, chiropractors and other healthcare professionals treating the claimant for the injuries sustained, or allegedly sustained in the accident.

D. The names, addresses and telephone numbers of all persons who have ever rendered any care and treatment or have ever examined the plaintiff at any time in their life prior to or subsequent to the accident.

E. The name, address and telephone number of the place of employment for the claimant at the time of the loss. The name, address and telephone number of all prior places of employment.

F. All wage loss information.

G. Prior and subsequent state and federal income tax returns.

1. Workers' compensation records.

J. Unemployment compensation records.

K. All city, county and state reports, including accident reports.

L. The names, addresses, telephone numbers and relationship to the claimant of all witnesses to the accident.

M. All appropriate health, medical and chiropractic records.

Above all, when dealing with a bodily injury claim, the burden is on the casualty insurer to prove the physical and mental condition of the claimant before the accident and that such condition remains unchanged or has not been dramatically changed by the accident. If that cannot be proved, the claimant will prevail.

SURVEILLANCE

Surveillance is typically used in bodily injury suits to show that the claimant is not as disabled as they claim to be and to show that the claimant is lying about the nature and extent of their disability.

If, in a civil case, a claimant's attorney demands production of all surveillance tapes, photographs and other "impeaching evidence", the defense may be under an obligation to produce that evidence. *Boldt v. Sanders*, 111 N.W.2d 225 (Minn. 1961). If there has been a discovery demand for the surveillance tapes, videotapes or film, and it is not produced, the defense runs the risk of the trial court not allowing the introduction of that impeaching evidence upon trial.

Because good surveillance can literally destroy a plaintiff's case, the defense frequently chooses to retain a private investigator to conduct surveillance of a claimant. The Minnesota Rules of Professional Conduct prevent a lawyer from contacting a claimant who is represented. They also prevent a lawyer from directing others to contact a claimant who is represented. Hence, if surveillance is to be done, the defense should be careful to instruct the private investigator conducting the surveillance to not directly communicate with the claimant.

When surveillance is conducted, make certain the private investigator is surveilling the correct person.

FRAUD REPORTING STATUTES

Minnesota has three reporting statutes as follows:

A. Minnesota Disclosure of Motor Vehicle Theft Information Act.

B. Minnesota Arson Reporting Immunity Law.

C. Minnesota Fraud Reporting Act.

The act requiring the disclosure of motor vehicle theft and arson mirror each other. Minn. Stat. §65B.80 et seq. and §299F.052. In essence, both the Motor Vehicle Theft Act and the Arson Reporting Act require insurers to provide to an "authorized person" all information in the insurer's possession relating to a fire loss or motor vehicle loss where the insurer has "reason to believe" the loss is "of other than accidental cause." The statute is mandatory.

If the state fire marshal's office, city fire marshal's office, local prosecutor or other governmental person or "authorized person", under the acts, sends a request to an insurance company, requesting their file, the insurer must send their file to that authorized person. The purpose is to help law enforcement people investigate bogus fires and bogus motor vehicle losses. In exchange for complying with the statute, the insurer is entitled to receive from the state fire marshal, prosecuting authority, police or other "authorized person", the contents of their complete file.

When the insurer provides this information to an "authorized person" they receive immunity under the Arson Reporting Immunity Law and the Motor Vehicle Theft Information Act for all information they release in good faith.

Hence, an insurer providing this information to, for example, a prosecutor, can seek immunity from these two acts to exculpate itself from an allegation that it sought a prosecution of an insured or claimant. Minn. Stat. §299F.054, subd. 4 and Minn. Stat. §6513.81, subd. 5.

CONCLUSION

Insurance fraud claims require special handling and investigation. In addition, fraud and abuse claims frequently place obligations on the insurer to report suspected fraud. When presented with a suspected insurance fraud claim, special care should be taken to comply with all of the statutory requirements and to concomitantly prove that the claim is fraudulent.