RGA CLAIMS MANAGEMENT
Antifraud Plan

The National Association of Insurance Commissioners (NAIC) has determined that Insurers should have a plan to fight fraudulent insurance claims. Inherent to this plan is an understanding of fraud, investigative practices, client procedures and cooperation with governmental agencies. Prior to the involvement by the NAIC, only a few states had promulgated requirements for reporting suspicious or fraudulent claims in the late 1970's. These consisted of reporting basic details and answering any questions posed by the state commissioner's offices. Although the commissioners offered no assistance in handling a fraudulent claim, their influence gave rise to data collection with the implementation of the Property Insurance Loss Register (PILR) promoted by a division of Property Claims Services (PCS) named Property Loss Research Bureau (PLRB). It also gave rise to a few states requiring insurers to have a Special Investigative Unit (SIU) that would be responsible for the handling of suspected fraudulent claims.

As Independent Adjusters, RGACM partners with its clients to fulfill the requirements pertaining to fraudulent claims. Therefore, we need to identify which of our clients have actual SIU's and formal antifraud plans. This will allow us as adjusters to compliment the client's practices and procedures by coordinating tasks according to the roles of involved parties. Where the client has no SIU, we will fulfill that role for our client but we will not report directly to the governmental authorities unless asked by our client and only after the client has approved the information to be provided to these authorities. We must always manage the risks associated with our actions, especially when taking on additional responsibilities. Normally, the facts of the loss are self-evident, but handling suspected fraud by the Insured opens more dimensions to investigate. Due to the nature of fraud, the burden of proof increases and so does our activity to secure evidence to prove the fraud.

The NAIC has promulgated recommendations to be addressed in any fraud plan. In addition to working in tandem with the Client's SIU, RGACM will also assure compliance by providing the details listed below.

1. A statement that RGACM has established criteria for the investigation of acts of suspected insurance fraud.
2. An acknowledgement that the investigating adjuster will record the date that suspected fraudulent activity is detected and the date that reports concerning the suspected insurance fraud are sent to the Department of Insurance or Fraud Bureau which must be prompt.
3. In cases where the Client has no internal SIU but has asked us to fulfill that role, then RGACM will provide a statement to the Client that we will assist the client in fulfilling that role. In doing so, RGACM must provide an organizational chart identifying the investigating adjuster(s) and supervisor, along with some brief background information of training and experience and contact information for each person identified. Furthermore, we must identify our Client contact that will be responsible for the decision-making on the suspected fraudulent claim.

4. If we are hired to provide surveillance, then we must provide to our client a description of the policies and procedures implemented. These are described in Addendum A.
5. We will remind our client to include the NAIC individual and group code numbers with the initial reporting of a suspected fraudulent claim.
6. Our Client may have other requirements to fulfill that address their internal operations. When requested, we will assist the Client in developing appropriate responses for an effective Fraud Plan. See Addendum B for an overview of fraud plan requirements. If any aspect of the requirements is unclear, then the client should seek clarification from counsel.

A fraudulent claim is:

Any claim that contains misrepresentations or mischaracterizations of material facts so as to induce the insurer to pay a claim that would otherwise not be paid in whole or in part. The misrepresentations must be intentional and could be described as trickery, inflated amounts, bending the truth, falsified facts or outright lies. The fraudulent claim perpetrator intends to recover money from a claim that is not payable for whatever reason. Insurance contracts prohibit acceptance of any claim that contains fraudulent aspects.
Some examples help to demonstrate the fraud:

1. An account adjuster requests a vendor to provide receipts showing materials and labor for repairs to covered property. However, the vendor did not do the work but the adjuster knew that the Insured had the work completed by its employees for the amounts being claimed. Except for the issue of the false receipts, the claim would have been payable. So this nice adjuster was just trying to help the Insured recover what they were entitled to under the policy. Why argue over little details when the amounts are accurate and the coverage insures the loss?

2. An Insured has a covered cause of loss to property insured by the policy. He asks the contractor to include an extra $1,000.00 in labor so that his $1,000.00 deductible would be recovered. Please note that if the amount has been inflated to induce the Insurer to pay a little more than the Insured is entitled to receive, then fraud has been committed and voids the policy with regard to the claim. Some courts have overlooked the fraud aspect and required the Insurer to pay the legitimate amount. In other words, the judge didn't want the Insurer to weasel out of its obligations.

3. An Insured hires a Public Adjuster to make claim to the Insurer. The PA provides his estimate of repairs to the adjuster who finds that estimate to be three times greater than his own estimate. Is this fraud and why? What should the adjuster do in this case?

4. The Insured is a retail mortgage bank. An employee was found to have authorized mortgage loans secured by the collateral houses. Several of the loans went into default which prompted their internal auditors to investigate. They learned that the suspect employee failed to properly document everything needed to grant the loans. The employee clearly did not follow all of the rules and requirements. His past performance reviews had not addressed the errors in making loans. The bank had insurance for loss due to fraud by an employee and submitted a claim for over one million dollars. As the adjuster, what would you include in your investigation? Is this fraud by the employee or by the employee's boss for not discovering the missing items in the loan documentation files? Substantiate your coverage position based on the facts.

5. The Insured's corporate office computer system was subjected to sprinkler leakage after a bitter cold spell hit the area. The corporate computer system controlled all sales and supplies to its subsidiaries, thus, it was critical to have the system back up and running without failure as soon as possible. The Insured met with their vendor who sold him all new equipment because they would not recertify the computers for warranty work. The Insured made claim to the Insurer for $10,000,000.00 for the new equipment stating that the damaged equipment could not be repaired. The adjuster could only find documentation of damage for one server at a cost to repair/replace of $800,000.00. The claim has been reassigned to you as the new adjuster. You have a computer vendor test some of the suspect equipment and could find no damage. Is the Insured guilty of fraud in this claim?

6. The husband and wife Insureds are experiencing marital difficulties. During a fit of rage, the husband sets fire to the detached garage. Fire spreads to the house resulting in a total loss. The wife's attorney submits claim to you for the limits of the Home Owner's policy. During your examination of the husband, you learn that the husband did not intend to destroy the house. He merely wanted to vent his anger for his wife. What part of the claim would you pay and why?

7. ABC Company is one of the largest employers in Illinois and is well connected to the Illinois Department of Insurance. This is a closed corporation and owned by ten people. One of the owners was going through some tough times and asked the other owners for a loan from the company. The request was denied due to allegations of gambling by the loan requester. The troubled employee sought revenge for the loan denial by setting fire to the company's warehouse in Downers Grove, IL. The treasurer of the corporation makes claim for $20,000,000.00 for the total loss of the warehouse and contents. This amount is verified by you to be fair and accurate for the cost of repairs and replacement. What part of the claim would you pay and why? Assume no deductible applies.

8. An electrical utility inadvertently causes a power spike that damages a large transformer servicing an island which is a large tourist attraction. The businesses on the island individually made claim to the utility for the lost income during the power outage. The utility hires you to adjust all claims. One restaurant with full bar makes claim for three days lost income over the three-day holiday weekend. The amount claimed was $75,000.00 but the documentation you reviewed supports a loss of only $25,000.00. When you inquire as to why there is no documentation for the additional $50,000.00 the owner merely states that he has a cash business and the $75,000.00 is his actual loss. He asks you to own up to the fact of his real loss and to pay it as requested. How would you handle this situation?

The Fraud Triangle:

Motive, means and intentional misrepresentation of a material fact is the key elements that prove a fraud. Just like an arson fire, the burden of proof must support each element to defend the policy. While the Proof of Loss in an arson claim states that the Insured had no involvement with the cause, similarly, the Proofs of Loss in other types of fraudulent claims contain this same misrepresentation prohibition as part of the standard wording. Requiring the submission of a properly executed Proof of Loss is a policy provision that should never be waived.

Having the means to cause an intentional loss is a matter of documenting who had access and control of the property lost. Ideally, the adjuster would want to support that only the Insured had the access and ability to cause the loss. However, the ideal situation is to have direct evidence, which could include security camera recordings, witness statements or even confessions by co-conspirators cooperating with the authorities. An examination of the business and process controls helps to narrow the scope to those parties who could have defeated the controls on the property lost. Investigating and documenting who had keys, combination lock knowledge, an understanding of the value of property to other parties as an outlet to convert the property to cash, the time and place of the wrongful extraction of property or the lack of controls, are some of the areas that could support access and ability to cause the loss. Also, scrutiny of the evidence supporting the claimed loss can reveal anomalies such as inaccurate dates on receipts and other records, inaccurate inventories, inaccurate valuations, or even discrepancies in the Insured's scenario of the loss. Scrutiny of the physical evidence is always mandatory and could reveal facts such as: whether the doors were locked at time of loss; physical impossibilities such as water stains oriented sideways on product cartons, or access by rope from the roof skylight with no crushing of cardboard boxes directly under the rope; whether the volume of product stolen was even possible within the time available, or even whether the receipt documents are valid.

Investigating the motive for causing the loss can span the spectrum of human experience but will always involve an actual or perceived need of the perpetrator. Revealing this need requires an open mind and a close analysis of the evidence and statements made by the Insured. Some of the areas to investigate include the financial condition of the Insured, challenges of the Insured's business, health of the Insured or of people close to the Insured, personal activities of the Insured and family members, travel or business expenses of the Insured, the Insured's attitude towards entitlement or the lifestyle of the Insured. Sometimes interviewing the Insured's employees or family members helps to focus on some of the influences in the Insured's life. The adjuster should review the underwriting history with our client or even prior Insurers.

Finding evidence of fraud implies criminal activity. Government authorities require crimes to be reported. This is not the role of the adjuster but is reserved to the client through its defined process. The client should have legal representation once fraud is suspected. The adjuster will share all evidence and concerns with the client and its counsel and take specific directions from counsel in completing the investigation. Where the client has provided direction under their fraud investigation plan, the adjuster will proceed as directed and if unclear, will discuss with RGACM Management for clarification. Due to the criminal overtone of a fraudulent claim, courts are reluctant to sustain a policy defense unless the evidence is compelling. Accordingly, evidence handling must be secure and safeguarded and only shared on a need to know basis.

Materiality:

Policies require a misrepresentation of material facts concerning the claim before a defense of the policy is required. Courts have vacillated on what constitutes materiality. Note that if the misrepresentation results in only a small increase in the claimed amount, chances are the courts will merely allow deletion of that small amount. Materiality would certainly apply to the trigger of coverage, large but false amounts claimed, and all fraudulent documents. To evaluate whether an item is material to the claim, the adjuster might use the "but for" approach to test the impact on the overall claim. However, keep in mind that if the Insured has changed its scenario of what occurred, this could be a material fact, so the adjuster with counsel should question the Insured at length to understand the reasonableness of the change. If it defies common sense, it is probably fraudulent but understand that a jury will hear both sides and determine whose version of the truth they will follow. Evidence must be compelling!

Schemes and Broken Dreams:

Connecting evidence to the fraud can be difficult but not impossible. The following scenarios come from actual fraudulent claims and are cited to provide the adjuster with knowledge of how the evidence revealed the fraud. Schemes often fall apart when the perpetrator fails to handle all the evidence consistently.

1. Accounting records can be the adjuster's best friend:
    a. While sample testing the amounts on receipts, the adjuster found that the receipt amounts did not correspond with the amounts entered in the accounting system months earlier;

b. While checking the list of stolen products against the inventory records, the adjuster found that the Insured was claiming more than the total of inventory present at time of loss;
c. While checking the list of stolen items, the adjuster noted that some of the items were not of the type that the Insured held in inventory and could not find any records for these dissimilar products. The Insured had confirmed at the onset of the investigation that no changes in business had occurred.
d. While examining the sales records for product claimed in the theft loss, the records demonstrated that sales had fallen so low that the business could not be considered a going concern. Hard times had caused the need to file a false claim to keep the business alive.
e. While comparing the list of stolen retail products against inventory records, the adjuster could not find consistent correlations. Further investigation revealed that employees had been recording items sold as different less expensive items and pocketing the difference. The inventory records were useless and did not compare to actual physical inventory on hand. Upon questioning employees, one admitted to the thefts but stated he only did it to pay for his wife's cancer treatments. After her death, this employee named all the employees tied to the thefts.
f. While auditing the claimed business income loss for a manufacturer, the adjuster noted an abrupt change in the cost of raw materials corresponding to the more recently manufactured items. When the adjuster compared the claimed costs of raw materials to historic costs, there was a large difference. Upon examining purchase invoices, he discovered that material costs had not changed. The Insured had changed these costs only for the calculation of lost profits to recover a greater amount than the actual loss sustained.

2. Physical evidence and the Insured's scenario of loss do not fit together:
   a. During the site visit to investigate a claimed theft of rare metals from the location, the adjuster noted the physical evidence could not support the Insured's description of how the theft occurred. The Insured stated that thieves had entered the premises by sliding down a rope from a skylight and took 1,800 pounds of a rare metal during the night. The adjuster took a statement from the Insured who stated that he left his two trucks locked and backed up to the two loading bays. Also, the only forklift on the premises had been out of service for a week while awaiting parts to repair the motor. The adjuster documented that there was broken glass on top of the cardboard cartons stacked six feet high directly under the skylight with the rope still hanging from it. He photographed the top of the cartons

showing the broken glass but no crushing of the cartons existed. The rare metal was split between two 55 gallon steel drums with about 900 pounds in each. The metal belonged to three customers and the Insured wanted payment immediately. The adjuster made copies of the customer inventories and noted that the payments had not been made to these customers for over three months. Before leaving, the adjuster asked the Insured how the thieves could have removed 1,800 pounds with no forklift, no truck access and no keys to the front door which was found locked when the Insured arrived that morning? He didn't know. One week later he called the adjuster demanding an advance payment. The next day police found his body tied and gaged with two bullet holes in his head. One of the customers was a known mafia business front.

b. The Insured reported a total loss of contents consisting of computers when their foreign warehouse burned to the ground. Shortly before the fire, which was of suspicious origin, the Insured relocated its warehoused products from other European locations to the one that burned down. The Insured claimed $100,000,000.00 for the contents. Investigation revealed that the warehouse security guard had a hero complex which arose after he would start a small fire and extinguish it. This continued for a few years before the Insured consolidated its products into this one warehouse. The European operation was losing about one billion dollars per year. Further investigation also revealed that the stock claimed was outdated and had a value of $60,000,000.00. The fire occurred about one week before the bank was going to recall its loan to the Insured. The fire allowed the Insured to book $100,000,000.00 in sales the day after the fire. The bank withdrew its default notice after hearing of the large sale to the insurance company. What elements would you use to prove fraud? Would it make a difference if the Insured was 96% owned by the government of the country warehousing the obsolete product?

c. The Insured sells commercial aircraft parts certified by the FAA. A fire occurred at the single location that housed their inventory and office. The day before the fire, the Insured requested a reduction in policy limits which was granted by the insurer. Upon arriving at the location the adjuster was met by the authorities who cautioned the adjuster to be careful and thorough. Site inspection revealed evidence of an incendiary fire that died out due to lack of oxygen as the arsonist failed to open any windows. As the adjuster perused the claim documents, he noted two skids of aircraft break pads in the inventory were claimed as destroyed, but his inspection found one skid still in the building with other product claimed as destroyed but was merely soot covered. Shortly after the fire, the employees disappeared. When a few employees were finally found in other cities far away, they refused to talk for fear of their lives. Further research revealed that the owner of the company was the number two mafia head in the nearby major city. How would you defend the policy?

d. An insured reports heavy vandalism damage to one of his summer rentals in a tourist town on Cape Cod. The adjuster documents the damage consisting of heavy scratches on several doors caused by a large dog, cracked and broken kitchen cabinet doors and drawers, torn screens on the first level windows, flooring that was obviously worn through in several areas and the front storm door was broken. The adjuster asked whether all the damage was a result of an event or an accumulation of wear and tear? Rather than answering the question, the Insured offered the adjuster a case of fine whiskey to get this claim settled quickly. If you were the adjuster, what kind of whiskey would you want?

e. The Insured supplies room and board to its on-site attendant who feeds and cares for special animals housed by the Insured's business. A forest fire destroys the house and other buildings on the property. The policy includes coverage for property of the Insured's employees while on the premises. This attendant makes claim for dozens of sets of cloths, shoes, sporting equipment, bedroom furniture and an antique. He states that it was all new except for the antique rocker. The site visit reveals the house to be a typical mountain cabin that could not hold the amount of property claimed. The attendant could not recall where he purchased the items but he said he paid cash for everything and the receipts were destroyed in the fire. How would you address the claim, especially, after you learn that the attendant is a claim-wise CPA and does the Insured's books?

f. A covered cause of loss damages production machinery at the Insured's production plant causing a covered interruption of business operations for three months. The adjuster verifies the scope and cost with the manufacturer of the equipment and agrees to expedite the repairs due to the significant business income loss potential as purported by the EVP of Finance for this large public company. After the production machinery is repaired and back into production, the adjuster reaches agreement on the indemnity period and assists the Insured's personnel in structuring the lost income calculation. When the adjuster receives the BI claim he projects the annual BI exposure and compares it with the values reported to the underwriter for the current and past two years. He notes that the prior two years actual income compares exactly with the values reported but the current year is nowhere close to the report value. When this variance is discussed with the Insured, the adjuster was told that sales had been increasing during the current year. The adjuster compared production and sales records for the current year and discovered that sales exceeded production, which is impossible. The adjuster performed further analysis on cost ratios and found them to be substantially different from prior years.

Finally, the adjuster discovered that the Insured had changed their accounting approach by booking sales when received. They also put controls in place to assure that the orders were produced and shipped to the customers. With this new information, the Insured's calculation of loss made sense. If you were the adjuster how would you complete the adjustment of the BI claim which includes the expediting cost?

Addendum A

RGACM adheres at all times to ethical and lawful practices on all assignments. Our adjusters treat Claimants, Insureds and Clients with dignity and respect in performing all assignments. Investigations are prompt and professional while verifying the facts of loss and valuations. As Independent Adjusters, RGACM respects the rights and obligations of parties related to our assignments and stands ready to assist the Insureds and Claimants in properly documenting claims for recovery of loss in accordance with policy provisions. If any issues arise during the investigation, adjusters are required to consult with the appropriate party, e.g., RGACM Management, Client or Counsel.

If any assignment involves surveillance, RGACM will never violate any person's Constitutional rights. The following practices are prohibited by any RGACM employee:

Recording conversations without explicit agreement by the parties being recorded;

Surveillance that infringes anyone's rights of privacy, or

Any conduct that involves coercion, trickery, pretense, impersonation or unlawful practices.

Addendum B

ANTIFRAUD PLAN GUIDELINE

Table of Contents

Section 1. Application

The purpose of this guideline is to establish standards for state fraud bureaus, insurance company SIU's and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements for submitting a plan with a State Department of Insurance. Currently, twenty states require that fraud plans be prepared for inspection by the State Department of Insurance. The concept of mandating the submission of an insurer fraud plan was developed to encourage those insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to fight fraud. This plan, along with audits, inspections, or in conjunction with a market conduct examinations, ensure the insurer is following its submitted antifraud plan.

These guidelines are primarily intended for state fraud bureaus as a guide in the preparation of new antifraud plan legislation, revision of existing mandated antifraud plans and for insurer SIUs in the preparation of its antifraud plans. The intention of this guideline is to collate the current twenty states' antifraud plan requirements into a guide for those states researching what should go into a plan. Most national fraud fighting agencies believe it is a good practice for all insurers, whether it is state mandated or not, to develop an internal insurance antifraud plan. Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meets state compliance standards.

This guideline does not preempt other state laws. This guideline is not intended to preempt or amend any guidance previously published by the NAIC Antifraud Task Force or in the NAIC Fraud Prevention Law Model Act. This document is intended to provide a road map for state fraud bureaus, insurers' SIUs or contracted SIU vendors for preparation of an antifraud plan.

Section 2. Definitions Reserved For State Specific Information

Section 3. Antifraud Plan Submission Requirement

An insurer, if required by a Department of Insurance, subject to (insert appropriate state code), shall submit to the Commissioner (or Fraud Bureau) a detailed description of the company's antifraud plan. All antifraud plans submitted shall be subject to review by the Commissioner.

Section 4. Antifraud Plan Requirements

The following information should be included in the submitted antifraud plan to satisfy this Section. The plan is an acknowledgment that the insurer and its SIU has established criteria that will be used to detect suspicious or fraudulent insurance activity relating to the different types of insurance offered by that insurer. All antifraud plans submitted shall be subject to review by the Commissioner.

One SIU antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities.

The plan should include:

A. General Requirements

1. An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer.

2. An acknowledgment that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the Fraud Bureau/Department within a specific time frame.

3. A provision stating whether the SIU is an internal unit or an external or third party unit.

4. If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments.

5. A written description or chart outlining the organizational arrangement of the insurer's antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts.

    a. If SIU is an internal unit, the insurer shall provide general contact information for the company's SIU.

b. If SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU Company.

c. If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented.

6. A provision where the insurer provides the NAIC individual and group code numbers:

7. A statement as to whether the insurer has implemented a fraud awareness or outreach program. If insurer has an awareness or outreach program, a brief description of the program shall be included:

8. If the SIU is a third party unit, a description of the insurer's policies and procedures for ensuring that the third party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third party vendor.

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

B. Prevention, Detection and Investigation of Fraud

1. A description of the insurer's corporate policies for preventing fraudulent insurance acts by its policy holders.

2. A description of the insurer's established fraud detection procedures (I.E. technology and other detection procedures).

3. A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by SIU.

4. A description of SIU investigation program (IE by business line, external form claims adjustment, vendor management SOPs).

5. A description of the insurer's policies and procedures for referring suspicious or fraudulent activity from the claims or underwriting departments to the SIU.

C. Reporting of Fraud

1. A description of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the Commissioner/Bureau/Division pursuant to Section (Insert applicable State code).

2. A description of the insurer's criteria or threshold for reporting fraud to the Commissioner.

3. A description of insurer's means of submission of suspected fraud reports to the Commissioner (e.g. NAIC OFRS, NICB, NHCAA, electronic state system, or other).

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

Drafting Note: If a state has a mandatory reporting method, this section should be adjusted to reflect an acknowledgment of the reporting method.

D. Education and Training

1. If applicable, a description of the insurer's plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:

   a. The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointment agents, attorneys, etc.

   b. If the training will be internal and/or external.

   c. Number of hours expected per year.

   d. If training includes ethics, false claims or other legal-related issues.

E. Internal Fraud Detection and Prevention

1. A description of insurer's internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.

2. A description of insurer's internal fraud reporting system.

Section 5. 18 USC 1033 & 1034 Compliance

The insurer shall include a description of its policies and procedures for candidates for employment and existing employees for compliance with 18 USC 1033 & 1034 (insert applicable state code if appropriate).

Section 6. Regulatory Compliance

A Department of Insurance has the right to review insurer antifraud plans in order to determine compliance with appropriate state laws. A Department further has the right, in accordance with Section (insert specific state code) to take appropriate administrative action against an insurer if it fails to comply with the mandated requirements and/or state laws.

Section 7. Confidentiality of Antifraud Plan

The submission of required information is not intended to constitute a waiver of an insurer's privilege trade secret, confidentiality or any proprietary interest in its antifraud plan or its antifraud related policies and procedures. The Commissioner shall maintain the antifraud plan as confidential. Submitted plans shall not be subject to the Freedom of Information Act if submitted properly under the state statutes or regulations which would afford protection of these materials (insert appropriate State code).

Drafting note: State will need to cite state specific privacy and protection authority.

Section 8. Required Antifraud Plan Submission

An insurer, if required by a Department of Insurance, shall submit its antifraud plan within ninety days of receiving a certificate of authority. Plans shall be submitted every 5 years thereafter. An insurer shall submit revisions to its plans within thirty days of a material change being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

2011 Spring National Meeting (adapted)

ANTIFRAUD PLAN GUIDELINE

These charts are intended to provide the readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings which are related to the NAIC model. Such guidance provides the reader with a starting point from which they may review how each state has addressed the model and the topic being covered.
The NAIC Legal Division has reviewed each state's activity in this area and has made an interpretation of adoption or related state activity based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This state page does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Every effort has been made to provide correct and accurate summaries to assist the reader in targeting useful information. For further details, the laws cited should be consulted. The NAIC attempts to provide current information; however, due to the timing of our publication production, the information provided may not reflect the most up to date status. Therefore, readers should consult state law for additional adoptions and subsequent bill status.

Model Regulation Service – January 2012

ANTIFRAUD PLAN GUIDELINE

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