

Texas Department of Insurance
FRAUD UNIT



FY 2011 Annual Report

Prepared for Eleanor Kitzman, Commissioner of Insurance

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Executive Summary

Annual Report Requirement

Texas Insurance Code, Section 701.101 (c) (1) and (2) requires the Insurance Fraud Unit to report annually in writing to the Commissioner the number of cases completed and any recommendations for new regulatory and statutory responses to the types of fraudulent activities encountered by the Insurance Fraud Unit.

FY 2011 Statistics

Fraud reports received	11,124
Calls received via toll-free Insurance Fraud Hotline	4,410
Cases opened for investigation	577
Cases referred for prosecution	187
Amount of fraud identified in referred cases	\$23,814,341
Indictments resulting from investigations	116
Convictions from cases referred	112
Restitution assessed by courts on Fraud Unit cases	\$6,527,227
Subpoenas issued	553
Open records requests processed	99

Noteworthy Accomplishments

In Fiscal Year 2011, the Insurance Fraud Unit:

- Renewed a memorandum of understanding (MOU) for an insurance fraud prosecutor and established a second MOU for an insurance fraud investigator with the Dallas County District Attorney's Office. The fraud prosecutor achieved 51 convictions for insurance fraud with \$569,598 in restitution and \$66,900 in fines.
 - Hosted the 13th Annual Fraud Conference with 254 fraud investigators from state government, law enforcement, and insurance industry attending.
 - Conducted 12 public presentations on insurance fraud.
 - Made 713 liaison contacts with state law enforcement agencies.
 - Participated in statewide task forces in several metropolitan areas, including Austin, Dallas, Houston, San Antonio, and McAllen.
 - Served on the Texas Committee on Insurance Fraud, the Texas Residential Mortgage Fraud Task Force, and the Medicaid and Public Assistance Fraud Oversight Task Force.
 - Completed attorneys and peace officers mandated training.
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Executive Summary, continued

Top Adjudicated Cases This report summaries ten investigations that resulted in criminal prosecutions and convictions. The fraud schemes are associated with agent fraud, mortgage fraud, health care fraud, provider fraud and disaster fraud.

Legislative Recommendations There are three recommendations for legislative changes included in this report. The recommendations relate to enhancement provisions in the Texas Insurance Code, Criminal Code of Procedure, and Penal Code.

Fraud Unit Overview

Fraud Unit Purpose and Organization

Texas Insurance Code, Section 701.101(a) establishes that the purpose of the Texas Department of Insurance (TDI) Insurance Fraud Unit is to enforce laws relating to fraudulent insurance acts. The unit reviews reports of suspected fraud, initiates inquiries, and conducts investigations when TDI has reason to suspect insurance fraud has occurred or is about to occur. In addition, the unit actively seeks criminal indictments, makes arrests, and assists in prosecutions to deter insurance fraud in Texas. See Attachment A: Fraud Report and Case Flow Process.

The Fraud Unit receives reports of suspected insurance fraud from insurers and the public. The unit maintains a toll-free Insurance Fraud Hotline (888-327-8818) and an online fraud reporting system on the TDI Fraud website at <http://www.tdi.state.tx.us/fraud/index.html>. Investigations may occur inside or outside of Texas and typically involve one of the following types of fraud:

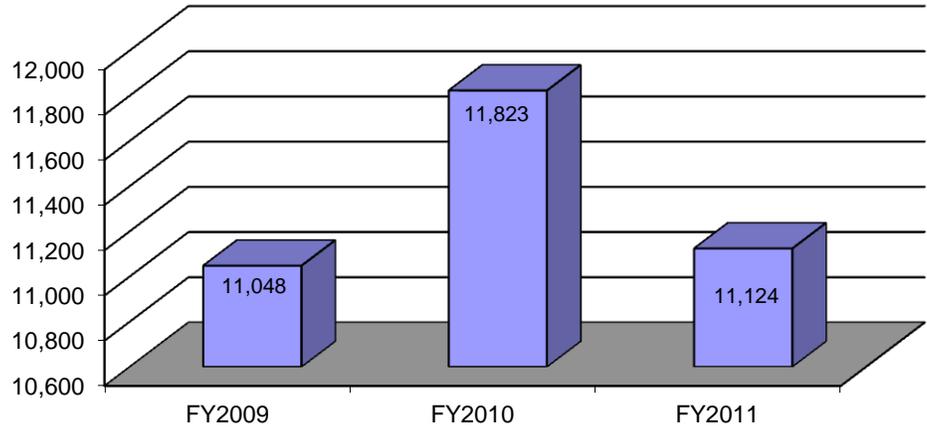
- claim fraud committed against an insurer
- fraud by TDI licensees against their company or the public
- insurance application fraud
- unauthorized business of insurance, including operating without proper authority or the sale of fraudulent insurance products
- workers' compensation, premium, claim and provider fraud, and
- mortgage fraud committed by a person licensed by TDI.

The Fraud Unit is comprised of management, fraud counsel, special prosecutor, investigators, and administrative support. Investigative positions are staffed with commissioned peace officers and civilian investigators. Under Texas Insurance Code, Section 701.104(b), the Chief Investigator supervises and directs all peace officers and coordinates and oversees all investigations conducted by the Fraud Unit. See Attachment B: Fraud Unit Organizational Chart.

Fraud Reports

Reports Received

FY 2009 - FY 2011 Fraud Reports Received

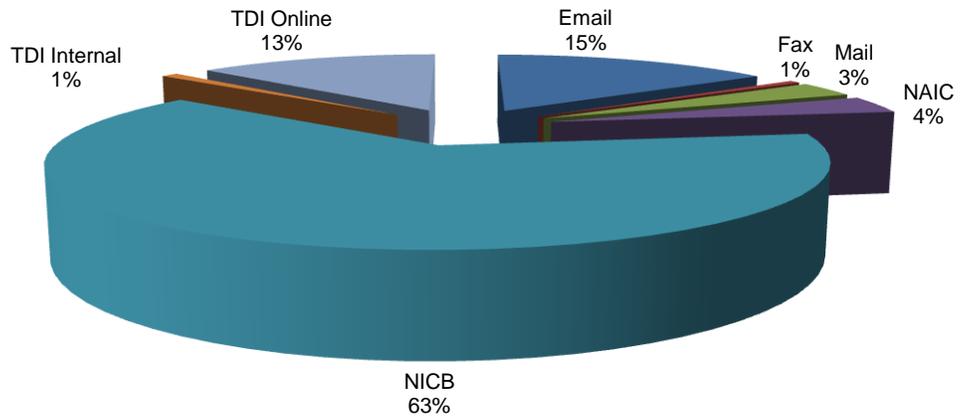


Analysis of Trends

The increase in the number of reports in FY 2010 is attributable to fraudulent insurance acts driven by the economic downturn. The Fraud Unit continues to promote investigator and consumer outreach liaison activities to encourage insurers and the public to report insurance fraud.

Method Reported

FY 2011 Fraud Reports Received by Method Reported
 11,124 Total Reports



NICB – National Insurance Crime Bureau
 NAIC – National Association of Insurance Commissioners

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Fraud Reports, continued

**Fraud Report
Schemes**

Fraud Scheme	FY 2009 % 11,021 reports	FY 2010 % 11,823 reports	FY 2011 % 11,124 reports
Adjuster Fraud	0.47	0.26	0.16
Agent Fraud	3.71	2.52	2.83
Arson for Profit	1.94	1.67	1.54
Auto Body Shop Fraud	0.78	0.79	0.58
Auto Burglary	N/A	1.33	1.55
Auto Theft	8.83	7.81	7.40
Company Employee Fraud	1.02	1.22	0.22
Company Officer Fraud	0.57	0.58	0.05
Disaster Adjuster Fraud	0.21	0.04	0
Disaster Agent Fraud	0.69	0.03	0
Disaster Claim Fraud	3.91	0.63	0.15
Escrow/Fee Attorney	0.17	0.10	0.01
Faked Death	0.03	0.01	0.02
False Billing	0.04	0.10	0.55
False Claim Documents	44.02	44.12	46.08
Fictitious Insurance Card	0.56	0.16	0.14
Fictitious Insurance Certificate	2.81	0.21	0.21
Identity Theft ^①	NA	NA	0.28
Inflated Claim	0.02	4.90	4.42
Mortgage Fraud	3.12	2.87	1.86
Owner Give Up	3.52	4.68	3.70
Paper Accident	1.06	2.76	1.62
Policy Application Fraud	4.57	5.99	6.05
Premium Fraud	1.08	1.09	1.10
Provider Billing Fraud	7.96	6.59	6.65
Runner/Capper	1.45	1.80	0.89
Slip & Fall	1.47	1.52	1.46
Soft Tissue Injury	0.94	0.97	0.47
Staged Accident	2.72	3.53	2.90
Theft	0.69	0.85	4.77
Theft from Elderly	0.03	0.03	0.11
TPA Fraud	0.01	0.01	0.02
Undetermined	0.75	0.14	0.90
Unlicensed Agent	0.27	0.30	0.24
Unlicensed Company	0.28	0.09	0.14
Viatical	0.04	0.04	0.03
Water Damage - HO	0.29	0.28	0.31
Working & Drawing ^{① ②}	NA	NA	0.56

^①Data was not captured before FY 2011

^②Working and drawing represents workers' compensation and disability claim fraud

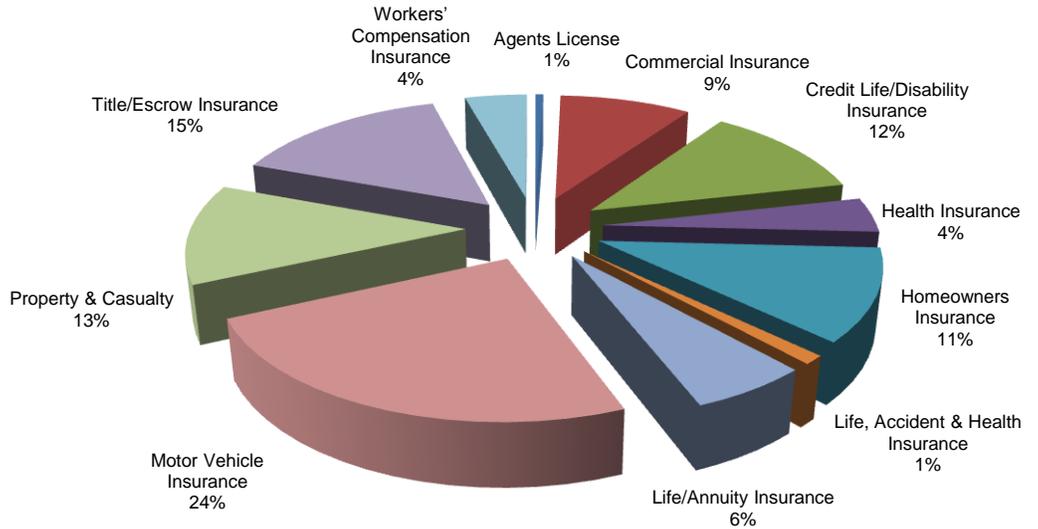
**Analysis of
Trends**

The increase in the number of theft reports in FY 2011 is attributable to an increase in reports associated with suspicious losses in homeowners' claims.

Referrals by Fraud Type

FY 2011 Referrals by Fraud Type

FY 2011 Referrals for Prosecution by Fraud Type
 187 Total Referrals



FY 2009-2011 Referrals by Fraud Type

Fraud Type	FY 2009% 206 Referrals	FY 2010% 208 Referrals	FY 2011% 186 Referrals
Agents License	2	0	1
Casualty Insurance	0	1	0
Commercial Insurance	12	5	9
Credit Life/Disability Insurance	7	11	12
Health Insurance	9	6	4
Homeowners Insurance	18	11	11
Life, Accident & Health Insurance	1	1	1
Life/Annuity Insurance	1	2	6
Motor Vehicle Insurance	22	30	24
Property & Casualty	7	6	13
Title Insurance	7	16	15
Unauthorized Property & Casualty Insurance	0	1	0
Workers' Compensation Insurance	14	10	4

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Referrals by Fraud Type, continued

Analysis of Trends

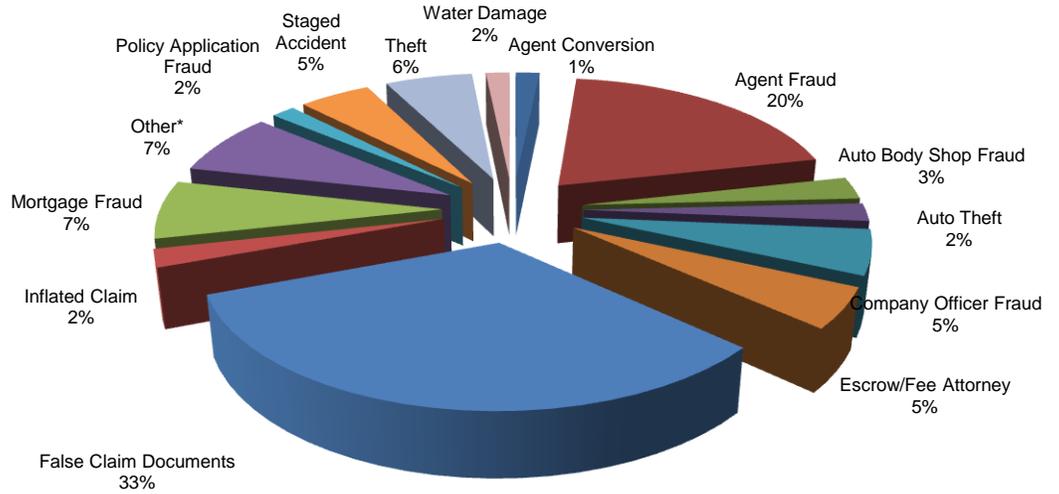
Three fraud types had significant variances between FY 2010 – FY 2011.

- **Motor Vehicle Insurance** – The number of investigations associated with motor vehicles declined this year as the Fraud Unit forwarded reports to the North Texas Auto and Burglary Theft Task Force to investigate. This allowed TDI investigators to focus on other claim fraud types.
 - **Property and Casualty Insurance** – Many of these referrals are associated with agent fraud, in which an agent diverted premiums for the agent's personal gain.
 - **Workers' Compensation Insurance** – There were fewer workers' compensation investigations that resulted in referrals because the evidence did not support the allegation of fraud.
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Referrals by Fraud Scheme

FY 2011 Referrals by Fraud Scheme

FY 2011 Referrals for Prosecution by Fraud Scheme
187 Referrals



*Other category includes schemes 1 percent or less

- Adjuster Fraud
- Arson for Profit
- Auto Burglary
- Disaster Agent Fraud
- Disaster Claim Fraud
- False Statement(s)
- Owner Give Up
- Premium Fraud
- Provider Billing Fraud
- Slip and Fall

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Referrals by Fraud Scheme, continued

**FY 2009-2011
 Referrals by
 Fraud Scheme**

Fraud Scheme	FY 2009% 206 Referrals	FY 2010% 208 Referrals	FY 2011% 186 Referrals
Adjuster Fraud	1	0	0.5
Agent Fraud	19	14	21.5
Arson for Profit	1	0.5	0.5
Auto Body Shop Theft*	NA	NA	3
Auto Burglary*	NA	NA	1
Auto Theft	1	2	2
Company Employee Fraud	4	1	5
Disaster Agent Fraud	5	2	1
Disaster Claim Fraud	6	4	1
Escrow/Fee Attorney	0	0.5	5
False Claim Documents	44	43	34
Inflated Claim*	NA	NA	2
License Application Misrepresentation	1	0	0
Mortgage Fraud	2	15	7
Owner Give Up	3	2	0.5
Policy Application Fraud	1	6	2
Premium Fraud*	NA	NA	1
Provider Billing Fraud	5	1	0.5
Runner/Capper	0	0.5	0
Slip & Fall	2	1	0.5
Staged Accident	0	3	5
Theft	3	3	6
Unlicensed Agent	1	1	0
Water Damage - HO	0	0.5	1.5

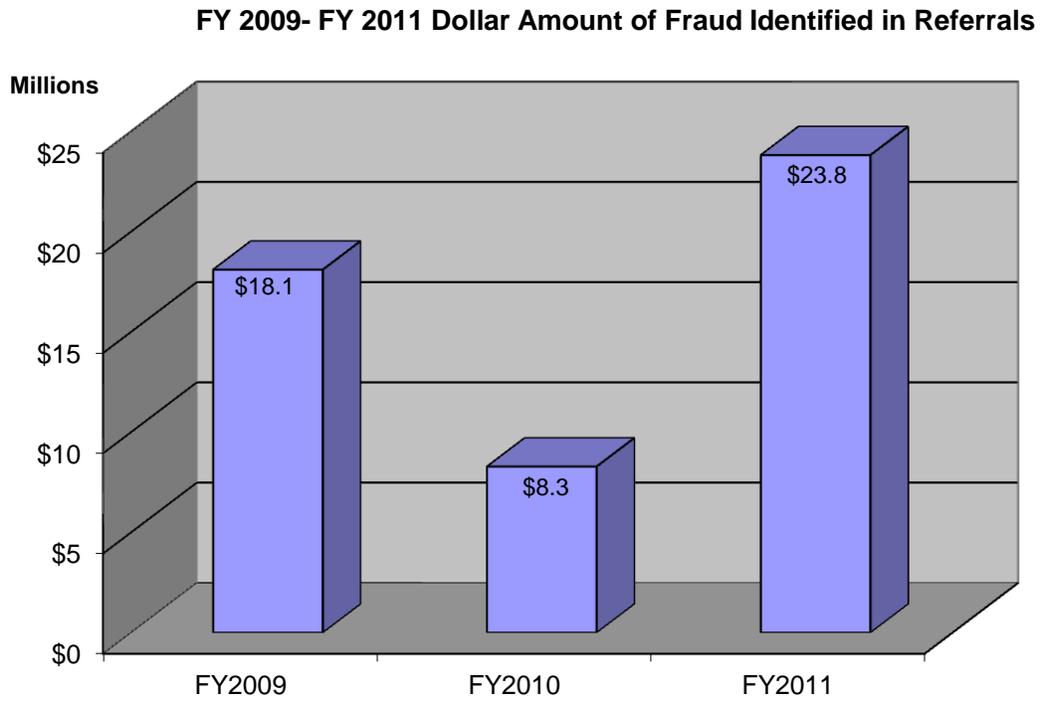
* Data not captured before FY 2011.

**Analysis of
 Trends**

Two fraud schemes had significant variances between FY 2010 – FY 2011.

- **Agent Fraud** – There has been an increase in the number of cases associated with agents diverting premiums for their personal gain.
- **False Claim Documents** – Investigation resources have focused on other more egregious claim fraud types, such as those involving auto body shop theft, auto burglary, and auto theft.

Amount of Fraud Referred for Prosecution



Analysis of Trends

The size of an insurance fraud investigation and the dollar amount of fraud referred for prosecution may vary from one fiscal year to another. The dollar amount of fraud referred is limited to the total amount of fraud committed in conjunction with a scheme or continuing course of conduct for all persons involved in an insurance fraud case.

Referrals and Court Actions

FY 2011 Referrals and Court Actions by County and Federal Agency	County^①	Referrals	Indictments	Judgments
	Atascosa	1	0	0
	Bee	1	0	0
	Bell	1	0	0
	Bexar	23	4	6
	Bowie	1	0	1
	Brazoria	1	2	2
	Brazos	0	1	0
	Cameron	1	0	0
	Chambers	0	1	1
	Collin	1	1	1
	Comal	0	1	1
	Cooke	0	1	0
	Dallas	39	28	29
	Dawson	1	0	0
	Denton	0	1	1
	El Paso	2	0	1
	Ellis	0	0	3
	Fort Bend	3	2	5
	Galveston	2	3	3
	Grayson	2	3	3
	Guadalupe	1	0	0
	Harris	29	34	25
	Hays	1	0	0
	Hidalgo	0	1	3
	Jefferson	1	0	0
	Johnson	1	0	0
	Kaufman	1	2	1
	Limestone	1	0	0
	Lubbock	0	0	1
	McLennan	6	1	0
	Midland	1	0	0
	Montague	0	1	0
	Montgomery	2	2	1
	Nacogdoches	1	0	0
	Nueces	0	2	1
	Parker	0	1	1
	Polk	3	0	0
	Potter	1	0	0

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Referrals and Court Actions, continued

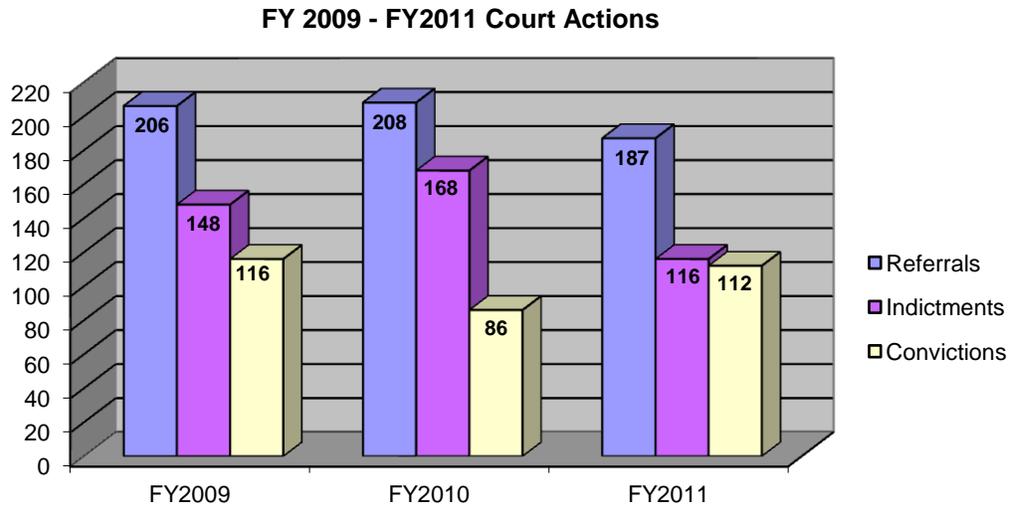
FY 2011 Referrals and Court Actions by County and Federal Agency, continued	County ^①	Referrals	Indictments	Judgments
	Randall	0	0	1
	Tarrant	21	5	3
	Travis	11	5	11
	Tyler	0	2	1
	Val Verde	0	1	0
	Webb	0	1	1
	Wichita	0	0	1
	Williamson	4	1	0
	Wilson	0	1	1
	Federal Prosecutors	23	8	3
	Fiscal Year Totals^②	187	116	112

①The Fraud Unit may refer cases to any one of the 254 county district attorneys' offices where venue is appropriate. The Fraud Unit may also refer to one of the four U.S. Attorney offices in Texas or other federal enforcement authority.

②Totals include current and prior-year referrals.

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Referrals and Court Actions, continued



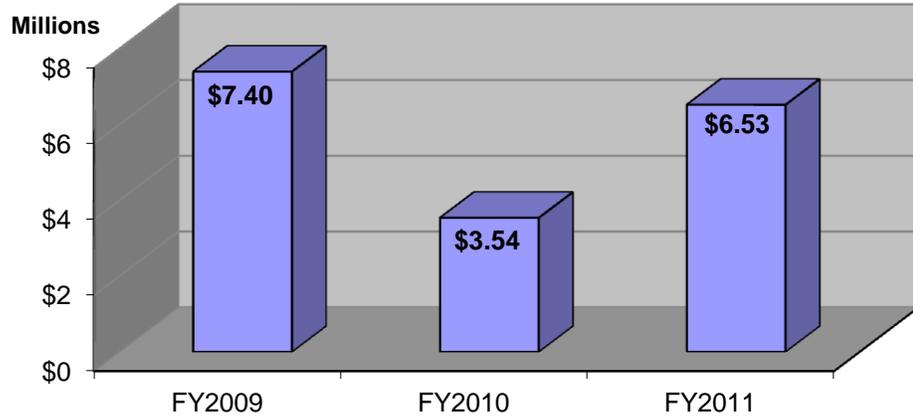
Analysis of Trends

The decline in referrals during fiscal year 2011 is due to fewer workers' compensation cases being referred. Although there were numerous cases rigorously investigated by the Unit, many were closed because the evidence did not support the allegation of fraud or because fraud could not be proven. The Fraud Unit will more actively pursue its liaison and outreach efforts. The Fraud Unit has already scheduled three workers' compensation presentations in the first quarter of fiscal year 2012 at workers' compensation forums. The purpose of these presentations is to communicate the importance of timely, effective, and comprehensive detection and reporting of workers' compensation fraud.

Indictment and conviction data varies from year to year since those actions are directly the result of actions by prosecuting agencies.

Restitution

FY 2009 - FY 2011 Restitution Assessed by Courts



Analysis of Trends

Courts determine the amount of restitution in criminal insurance fraud cases, usually at the request of the prosecutor. The dollar amount of restitution will vary by year. The Fraud Unit provides prosecuting entities with data to assist the courts with appropriately assessing restitution to insurance fraud victims.

FY 2011 Top Adjudicated Cases

Debbie Alas

Debbie Alas, a formerly licensed agent, was convicted in Houston for misapplication of fiduciary property, a third-degree felony. Alas accepted insurance premiums from clients for homeowners, workers' compensation, and general liability policies, but failed to remit the money to the insurance company. She instead used the money for her own personal use. Alas was sentenced to 10 years of deferred adjudication, 120 hours community service, and ordered to pay \$64,744 in restitution.

Dwaine Baldwin

Dwaine Baldwin received 10 years of deferred adjudication in Dallas County for the first-degree felony offense of organized criminal activity. Baldwin participated in a mortgage fraud scheme in which properties were purchased from a builder at a discount then sold at an inflated price to "straw buyers" recruited by Baldwin. Baldwin was ordered to pay \$2,227,900 restitution and fined \$1,000.

Sherelle Ballard

Sherelle Ballard obtained multiple hospital intensive care unit indemnity policies for members of her family and submitted forged and altered itemized medical treatment statements totaling \$583,239 to her insurer over a seven-month period. Ballard received \$93,900 in benefits from her insurer before the scheme was discovered. Ballard was convicted in Harris County of insurance fraud, a third-degree felony, and was sentenced to 24 months probation and restitution of \$88,000.

**Chiropractor
Nicholas Joseph
Cianelli**

Chiropractor Nicholas Joseph Cianelli offered to create fraudulent medical records for an automobile accident victim and her husband so they could be paid under her personal injury protection coverage. He accepted \$2,000 to create their fraudulent claims. The accident victim reported the information to authorities who initiated an investigation. Dr. Cianelli was caught offering his fraudulent services during an undercover investigation. After confronted with the evidence by prosecutors in Fort Worth, Cianelli pleaded to the offense of insurance fraud, a state jail felony. He received five years of deferred adjudication.

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FY 2011 Top Adjudicated Cases, continued

Dawn Fisher

Dawn Fisher, a formerly licensed agent from Garland, Texas, was convicted in Dallas County for the offense of theft, a second-degree felony. Fisher and husband, also a former agent, operated Fisher Insurance Agency. They collected premium payments from customers totaling \$155,415, but instead of remitting the premium to the insurance company, they used the money for their own personal enrichment. Dawn Fisher was sentenced to 10 years of probation, 240 hours of community service, and was ordered to pay \$155,415 in restitution. Her husband Peter was sentenced to 10 years of deferred adjudication for misapplication of fiduciary property and ordered to serve 240 hours of community service.

Chasiti Miller

Chasiti Miller, a formerly licensed agent, was convicted in Dallas County for theft, a state jail felony. Miller defrauded her employing insurance agency by submitting 109 fraudulent insurance applications to receive advanced commissions. Miller was paid \$18,797 in advance commissions for the fraudulent policies. Miller was sentenced to five years of deferred adjudication, 120 hours of community service, and was ordered to pay \$18,797 in restitution.

Robert Reagan

Robert Reagan was convicted in Tyler, Texas, for submitting forged receipts for damaged personal property and additional living expenses after his house was damaged during Hurricane Ike. Reagan received \$34,357 in additional benefits from his insurer as a result of the forged receipts. Reagan pleaded guilty to insurance fraud, a third-degree felony, and was sentenced to 96 months of deferred adjudication, 120 hours of community service, ordered to pay restitution of \$38,387.16, and fined \$1,500.

Michael Swetnam

Michael Swetnam, a formerly licensed insurance agent from McGregor, Texas, was convicted in U.S. federal district court in Houston, for mail fraud. Swetnam grossly over-inflated the premiums on two liability policies he sold to the Valley Baptist Health System. He also sold Valley Baptist Health System additional coverage, allegedly issued by an off-shore British Virgin Island company that did not exist. Swetnam was sentenced to 37 months in jail, three years probation on release, and was ordered to pay \$2,950,301 in restitution.

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FY 2011 Top Adjudicated Cases, continued

Cynthia Taylor

Cynthia Taylor was employed by a medical health group. She copied legitimate medical records from patient files and then inserted her name as the patient receiving medical care. Taylor used the medical records to file 35 false claims through her own health insurance program, including three separate claims for an appendectomy. Taylor reported to the insurer that she paid for the medical treatments and was requesting reimbursement. She received \$39,994 in benefits from her insurer before the scheme was discovered. Taylor was convicted in Dallas for insurance fraud, state jail felony. She was sentenced to 84 months of probation, 120 hours of community service, ordered by the court to pay \$39,994 in restitution, and fined \$2,500.

Ali Yazdchi

Ali Yazdchi, also known as Al Giovanni, masqueraded as an attorney and befriended exotic dancers in the Houston area to handle their auto accident claims. Yazdchi forged employment records and Internal Revenue Service records to get additional insurance benefits for the women. When the insurers paid the settlements, Yazdchi kept the money for himself. Yazdchi was convicted in Houston for theft and falsely holding oneself out as a lawyer, both third-degree felonies. Yazdchi was sentenced to 10 years imprisonment.

Legislative Recommendations

**Investigation of
Certain
Fraudulent
Insurance Acts**

Enhance Provisions of Insurance Fraud Investigations, Texas Insurance Code § 701.102

BACKGROUND: Recent legislation has expanded Chapter 35, Texas Penal Code, to include application fraud and claim fraud for all lines of insurance. In the past claim fraud was limited to Section 35.02(a) of the Penal Code. Now subsections (a) (a-1) and (b) are the relevant portions of the statute for purposes of Texas Insurance Code, Section 701.102. The Fraud Unit investigates fraudulent criminal acts found in the Texas Insurance Code and other sections of the Penal Code, including mortgage fraud found in Section 32.32.

PROBLEM: Section 701.102 should be amended to delete any reference to the specific subsection of 35.02(a) of the Penal Code. Doing so does not diminish the intent of the Legislature, but rather more succinctly describes the powers of the commissioner. A “fraudulent insurance act” is defined in Section 701.001 as “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.” Thus, Section 701.102 no longer requires reference to a particular criminal statute.

RECOMMENDATION:

Proposed Draft Changes Relating to Insurance Fraud Investigations:

If the commissioner has reason to believe a person has engaged in, is engaging in, has committed, or is about to commit a fraudulent insurance act ~~or the offense of insurance fraud under Section 35.02(a), Penal Code~~, the commissioner may conduct any investigation necessary inside or outside the state to:

- (1) determine whether the act or offense occurred; or
- (2) aid in enforcing laws relating to fraudulent insurance acts or insurance fraud

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Legislative Recommendations, continued

**Penal Code
Definitions**

Expand Insurance Fraud Definition in Texas Penal Code § 35.01

Expand Penal Code Insurance Fraud definition to include entities that do not fall under the traditional definition of insurer in the Texas Insurance Code but are regulated by the Texas Department of Insurance and the Labor Code.

Background: The Texas Department of Insurance continues to learn of fraudulent insurance acts committed by or against self-insurers and other entities that might not fall under the Texas Insurance Code definitions of insurer or business of insurance. The Penal Code also uses an outdated Texas Insurance Code reference since Art. 102 has been recodified.

Proposed Draft Changes Relating to Insurance Fraud Investigations

Penal Code 35.01 Definitions:

- (1) “Insurance policy” means a written instrument ~~in which is provided~~ provides the terms of any certificate of insurance, binder of coverage, contract of insurance, benefit plan, nonprofit hospital service plan, motor club service plan, surety bond, cash bond, or any other alternative to insurance authorized by Chapter 601, Transportation Code, the State’s Financial Responsibility Act, worker’s compensation self insurance as defined by the Labor Code, or other written instrument that provides the terms of self-insurance as authorized by the Texas Insurance Code. The term includes any instrument authorized to be regulated by the Texas Department of Insurance.
- (2) “Insurer” ~~has the meaning assigned by Article 1.02, Insurance Code~~ means any person purporting to engage in the business of insurance or authorized to do business in the state or subject to regulation by the state who undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event. “Insurer” includes, but is not limited to, an insurance company; self-insurer; reinsurer; reciprocal exchange; interinsurer; risk retention group; Lloyd’s insurer; fraternal benefit society; surety; medical service, dental, optometric, or any other similar health service plan; and any other legal entity engaged or purportedly engaged in the business of insurance, including any person or entity that falls within the definition of “insurer” in the Texas Insurance Code.

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Legislative Recommendations, continued

**Criminal Penalty
and Statute of
Limitations for
Unauthorized
Insurance**

Enhance Criminal Penalty for Unauthorized Insurance, Texas Insurance Code § 101.106

Expand the statute of limitations for Unauthorized Insurance, Texas Criminal Code of Procedure, Chapter 12 Limitation and Venue

BACKGROUND: The Texas Department of Insurance continues to learn of unauthorized insurance schemes in Texas and of claims going unpaid by those who operate these schemes. These entities market their products outside the scope of insurance regulations to people and businesses. They claim their products indemnify both property and lives in exchange for participation in their plan. The most prevalent of these schemes involves the marketing of fraudulent health plans. In these schemes, people have paid thousands of dollars in premiums only to learn that they have no coverage and mounting health care bills.

PROBLEM: The current maximum penalty under Texas Insurance Code, Section 101.106 for a person who commits the offense of unauthorized insurance is a third-degree felony, regardless of the amount of money fraudulently appropriated or the economic harm caused to victims of their scheme. Two of the largest unauthorized health care scams nationally enrolled more than 7,200 Texas residents, leaving hundreds of them without insurance and \$712,000 in unpaid claims. The penalty for this offense should be enhanced similar to the penal code offense of theft to discourage this type of insurance fraud in Texas. Additionally, many of these activities go undetected for one to two years before an investigation is even begun. An investigation into this type of business activity requires the acquisition and analysis of business and financial records and because of its complex nature, requires an extensive amount of investigative research in order to fully understand and document the financial impact associated with this activity. The statute of limitation should be extended from three to five years. This will allow the state adequate time to thoroughly investigate unauthorized insurance fraud.

RECOMMENDATION:

- Amend the unauthorized insurance criminal penalty within the Texas Insurance Code to align penalties for this type offense more appropriately with the Texas Penal Code theft statutes.
- Amend the statute of limitations for unauthorized insurance from three years to five years. Extending the statute of limitations by two years will allow for proper investigation, referral, and prosecution of unauthorized insurance fraud activity.

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Legislative Recommendations, continued

Criminal Penalty
and Statute of
Limitations for
Unauthorized
Insurance,
continued

Proposed Draft Changes Relating to Unauthorized Insurance:

1. Texas Insurance Code

§ 101.106 Criminal Penalty

(a) A person, including an insurer, who intentionally or knowingly or recklessly violates Section 101.102 commits an offense.

(b) An offense under this section is: ~~a felony of the third degree~~

(1) a state jail felony if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any person or persons is \$1,500 or more but less than \$20,000;

(2) a felony of the third degree if the greater of (i) the value of property, services or other benefit wrongfully obtained or attempted to obtain or (ii) the segregate or aggregate economic loss suffered by any person or persons is \$20,000 or more but less than \$100,000;

(3) a felony of the second degree if the greater of (i) the value of property, services or other benefit wrongfully obtained or attempted to obtain or (ii) the segregate or aggregate economic loss suffered by any person or persons is \$100,000 or more but less than \$200,000;

(4) a felony of the first degree if the value of property, services or other benefit wrongfully obtained or attempted to obtain or (ii) the segregate or aggregate economic loss suffered by any person or persons is \$200,000 or more.

(c) It is a defense to prosecution under this section that Section 101.051 or 101.052, as applicable, by its terms does not apply to the person charged.

§ 101.107 Aggregation of Amounts Involved

When amounts are obtained in violation of Section 101.102 pursuant to one scheme or continuing course of conduct, whether from the same or several sources, the conduct may be considered as one offense and the amounts aggregated in determining the grade of the offense.

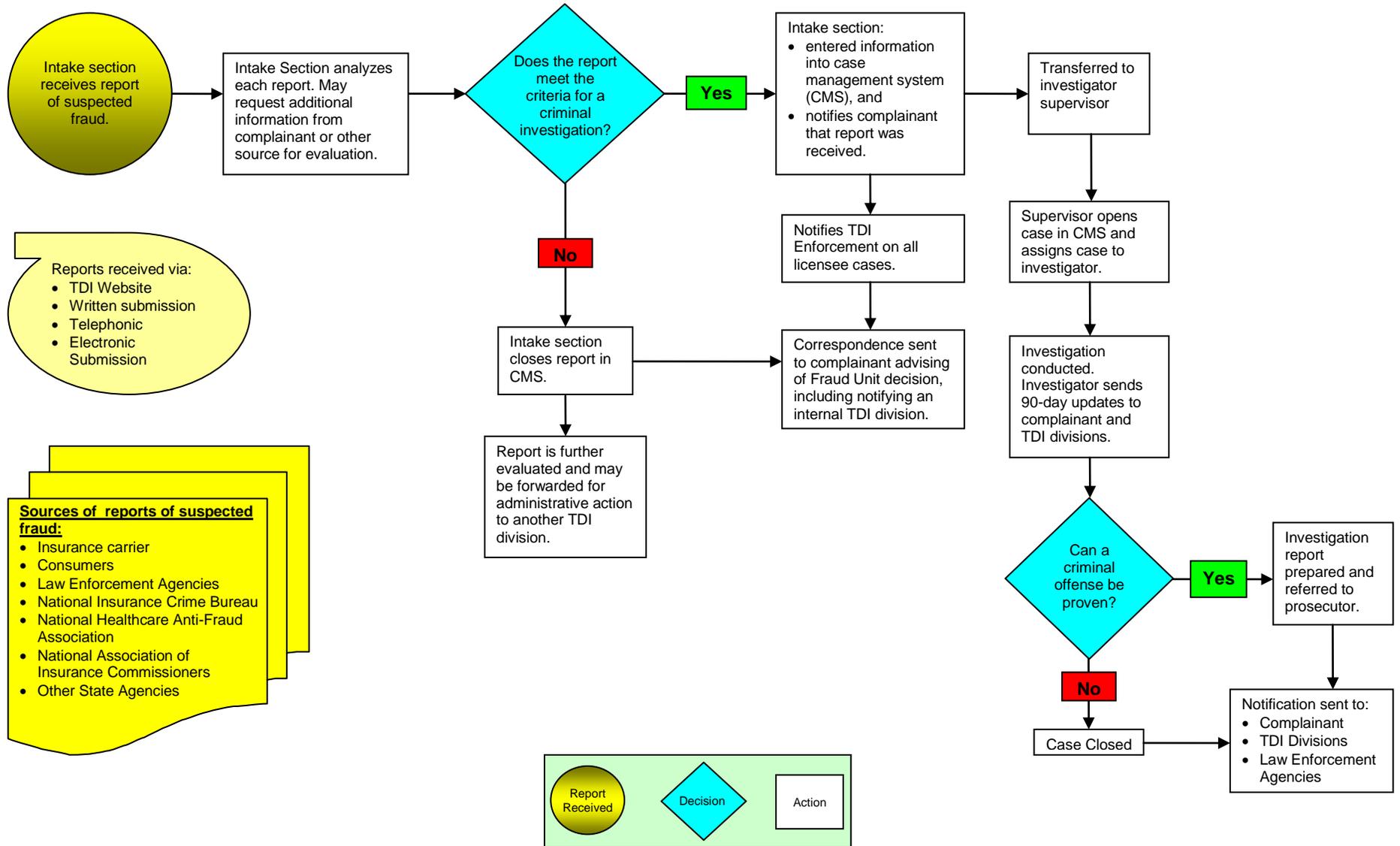
2. Code of Criminal Procedure

Chapter 12, Limitation and Venue

Art 12.01

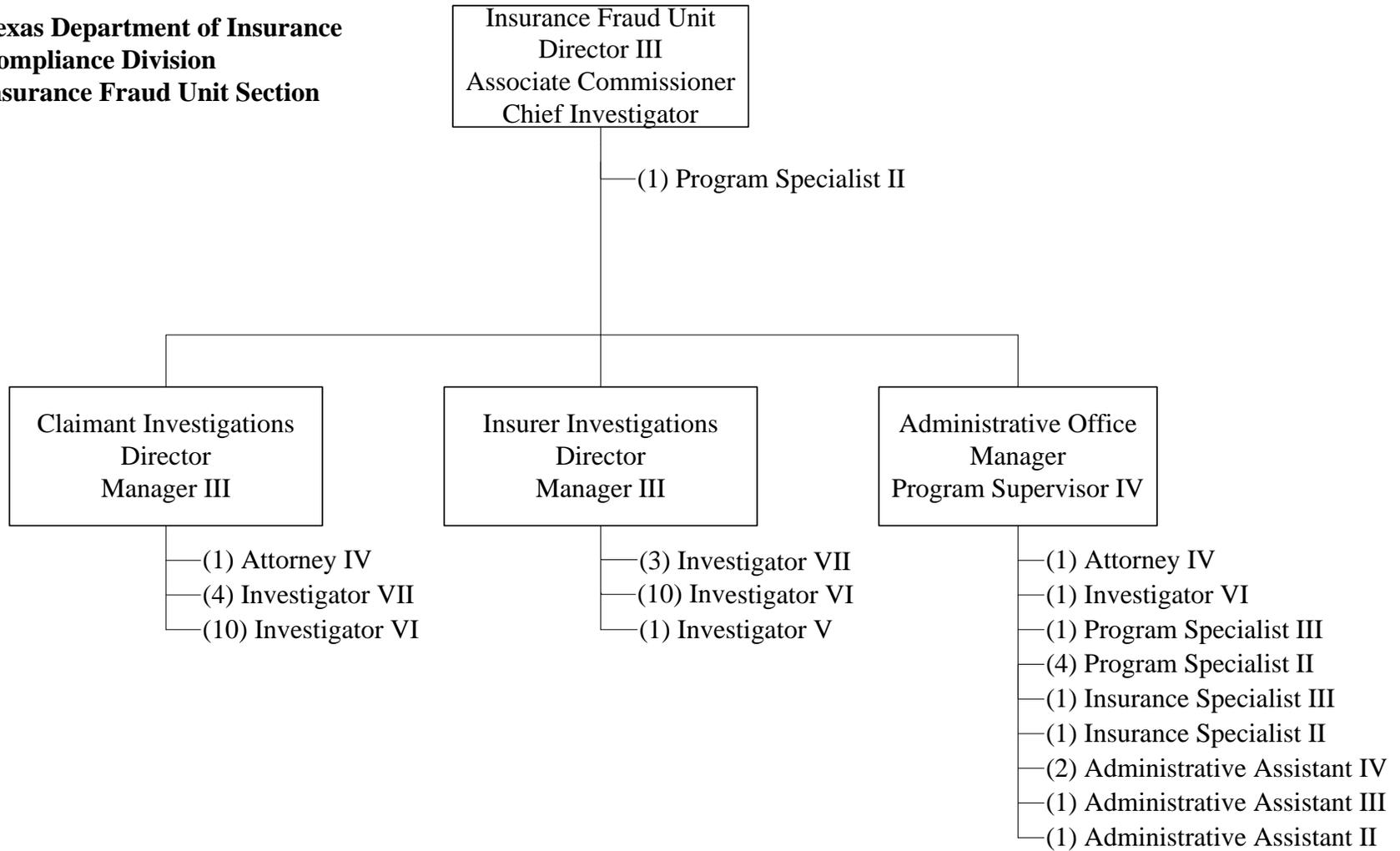
(4) five years from the date of the commission of the offense under Texas Insurance Code Section 101.102.

Attachment A: Fraud Report and Case Flow Process



Attachment B: Fraud Unit Organizational Chart*

**Texas Department of Insurance
Compliance Division
Insurance Fraud Unit Section**



* As of September 1, 2011