

TEXAS DEPARTMENT OF INSURANCE FRAUD UNIT



FY2009 ANNUAL REPORT

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PUBLIC DISTRIBUTION VERSION

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Overview

Annual Report Requirement

Texas Insurance Code §701.101 (c) (1) and (2) requires that the Insurance Fraud Unit 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.

This annual report complies with the above provisions and also contains insurance fraud trend data, noteworthy accomplishments and legislative recommendations.

Overview of the Fraud Unit

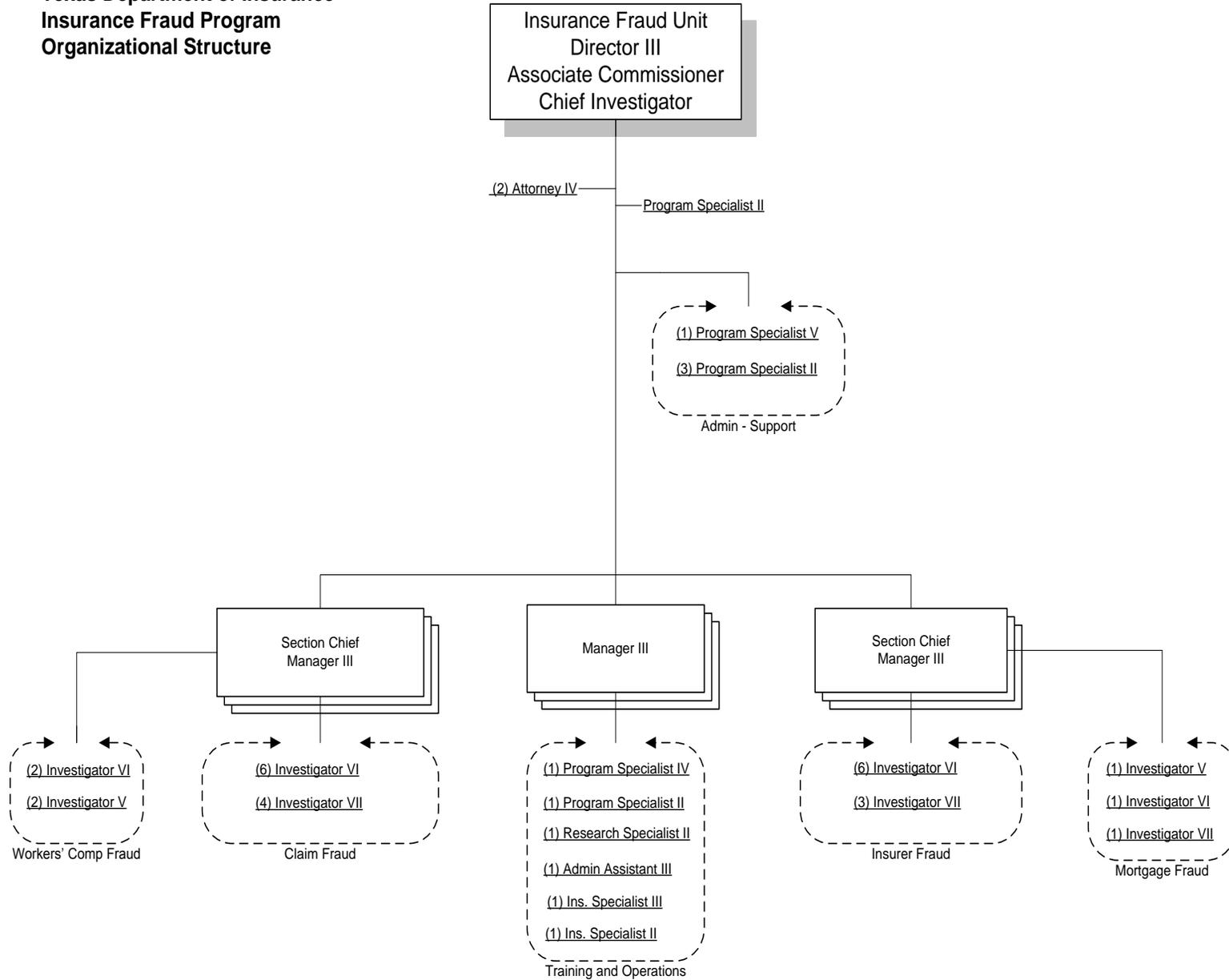
Texas Insurance Code §701.101(a) describes the purpose of the Texas Department of Insurance (TDI) Insurance Fraud Unit, which is to enforce laws relating to fraudulent insurance acts. The unit's responsibilities include receiving and reviewing reports of fraud, initiating inquiries, and conducting investigations when TDI has reason to suspect insurance fraud. In addition, the unit actively seeks criminal indictments, makes arrests, and assists in prosecutions to deter insurance fraud in Texas.

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:

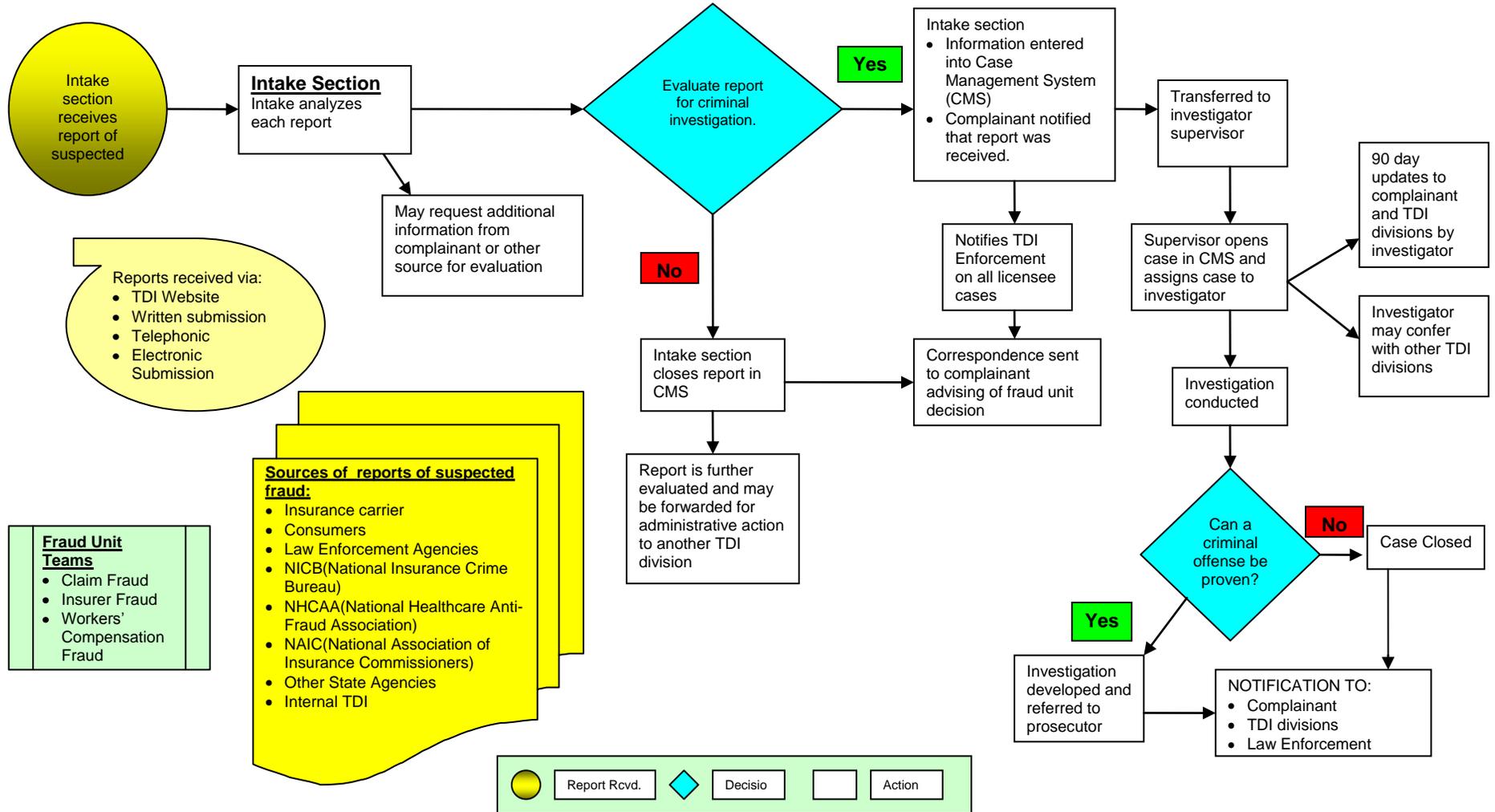
- claim fraud committed against an insurer
- fraud by TDI licensees against their company or the public
- insurance application fraud
- unauthorized business of insurance, including operating without proper authority or the sale of fraudulent insurance products
- workers' compensation, premium, claim 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. By statute, the Chief Investigator supervises and directs all peace officers and coordinates and oversees all investigations conducted by the Fraud Unit.

Texas Department of Insurance
 Insurance Fraud Program
 Organizational Structure



Fraud Report and Case Flow Process



Statistics

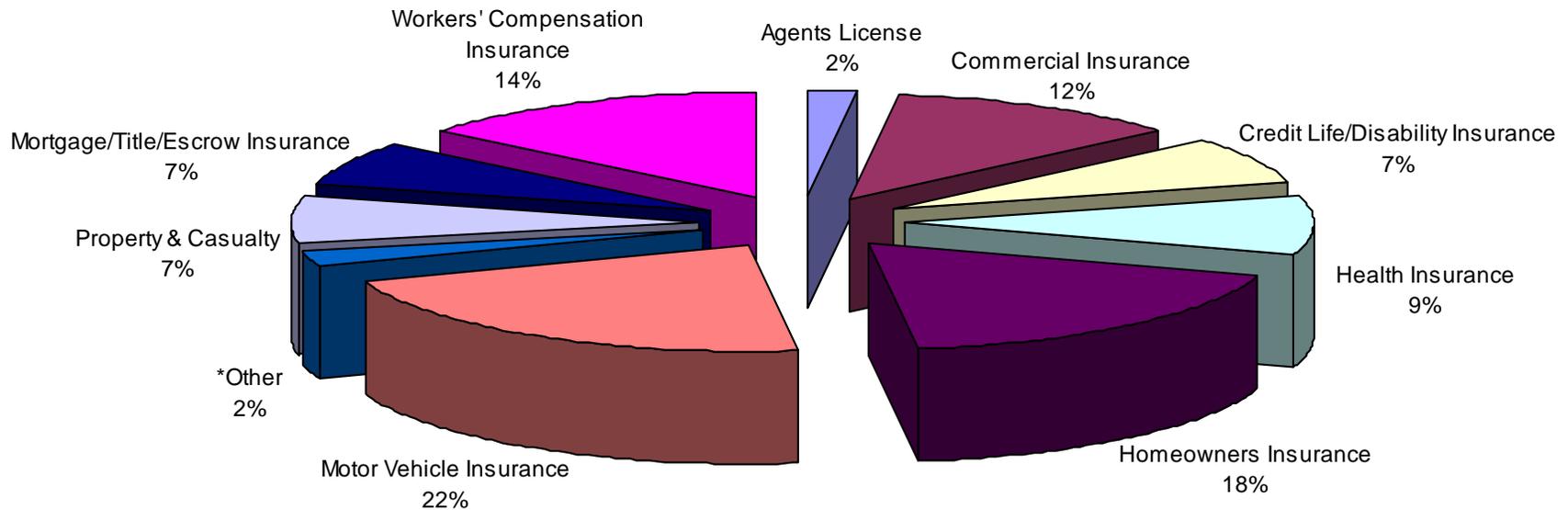
**FY 2009
Statistics**

Fraud reports received	11,021
Calls received via toll-free Insurance Fraud Hotline	5,451
Cases opened for investigation	637
Cases referred for prosecution	206
Amount of fraud identified in referred cases	\$18,079,013
Indictments resulting from investigations	148
Convictions from cases referred	116
Restitution assessed by courts on Fraud Unit cases	\$7,449,147
Subpoenas issued	439
Open records requests processed	145

Referrals by Fraud Type

FY 2009 Referrals for Prosecution by Fraud Type

206 Total Referrals



* Other (< 1% each):

- Life, Accident & Health Insurance
- Life/Annuity Insurance

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Referrals by Fraud Type, continued

FY 2007-2009
 Referrals by
 Fraud Type

Fraud Type	FY 2007 (188 Referrals)	FY 2008 (195 Referrals)	FY 2009 (206 Referrals)
Agents License	7%	2%	2%
Casualty Insurance (Plus For-Profit Prepaid Legal)	0%	1%	0%
Commercial Insurance	4%	7%	12%
Credit Life/Disability Insurance	14%	12%	7%
Health Insurance	9%	10%	9%
Homeowners Insurance	11%	3%	18%
Life, Accident & Health Insurance	0%	0%	1%
Life/Annuity Insurance	4%	2%	1%
Motor Vehicle Insurance	23%	30%	22%
Property & Casualty, Non-auto & Homeowner	4%	8%	7%
Title Insurance	5%	1%	7%
Unauthorized Health Insurance	0%	5%	0%
Unauthorized Property & Casualty Insurance	4%	1%	0%
Workers' Compensation Insurance	15%	18%	14%

Analysis of Trends

Six fraud types had significant variances between FY 2008 – FY 2009.

- **Commercial Insurance** – fraudulent claims filed against commercial businesses has increased significantly. Whether attributable to the economy or not, soft fraud, i.e. the padding of otherwise legitimate claims in an effort to increase payments from insurers, has contributed to this increase.
- **Credit Life/Disability Insurance** – The decline in referrals related to this fraud type is a result of the Fraud Unit focusing its efforts on cases associated with Hurricane Ike this fiscal year.

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Referrals by Fraud Type, continued

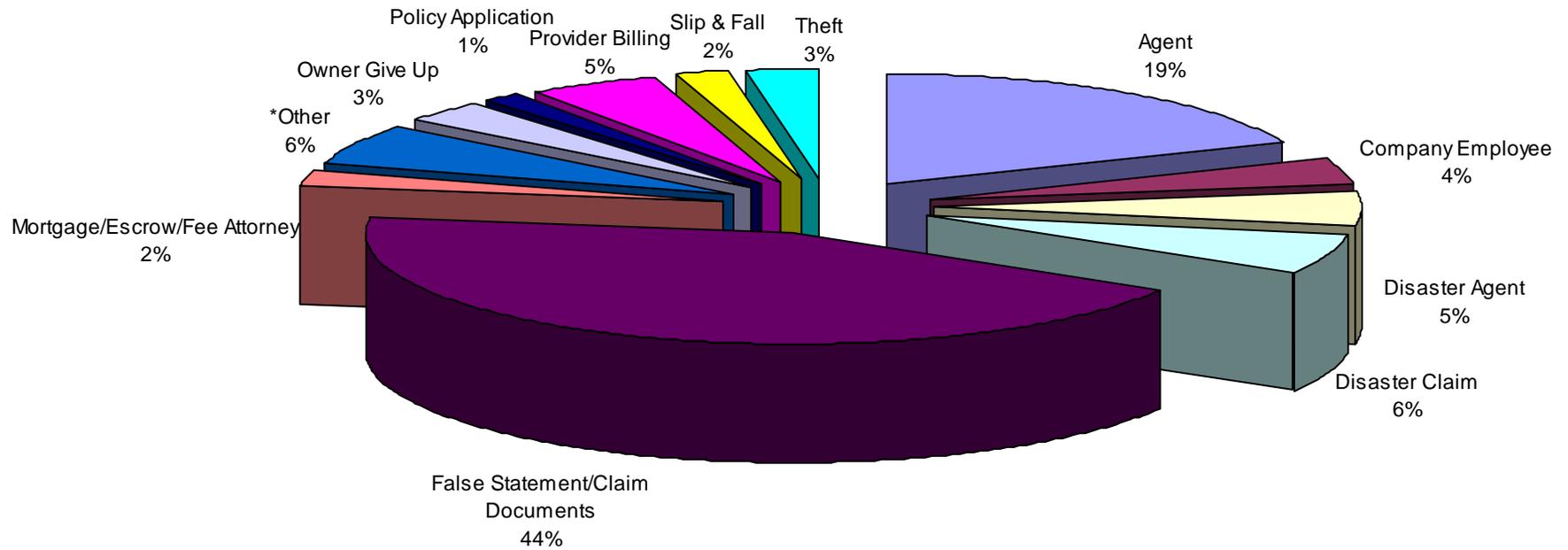
Analysis of Trends, continued

- **Homeowners Insurance** – this increase is somewhat similar to the increase in fraudulent commercial insurance claims and whether attributable to the economy or not, soft fraud, i.e. the padding of otherwise legitimate claims in an effort to increase payments from insurers, has contributed to this increase.
 - **Motor Vehicle Insurance** – this fiscal year, several reports of single theft autos that may have been investigated in the past were instead forwarded for investigation to the Auto & Burglary Theft Task Force in Dallas, thus allowing TDI investigators an opportunity to focus on other emerging fraud types.
 - **Title Insurance** – these investigations are associated with fraudulent mortgage transactions and generally require a year or more to conclude. The percentage increase from the prior fiscal year is associated with the conclusion of cases that have been under investigation for more than one fiscal year.
 - **Unauthorized Health Insurance** – the number of cases and reports of suspected fraud associated with this type of scheme have decreased for the past two fiscal years.
-

Referrals by Fraud Scheme

FY 2009 Referrals for Prosecution by Fraud Scheme

206 Total Referrals



* Other (< 2% each):

- Adjuster Fraud
- Auto Body Shop
- Auto Theft
- Arson for Profit
- License Application Misrepresentation
- Unlicensed Agent

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Referrals by Fraud Scheme, continued

FY 2007-2009
 Referrals by
 Fraud Scheme

Fraud Scheme	FY 2007 188 Referrals	FY 2008 195 Referrals	FY 2009 206 Referrals
Adjuster Fraud	5%	1%	1%
Agent Fraud	8%	15%	19%
Arson for Profit	0%	0%	1%
Auto Theft	0%	2%	1%
Company Employee Fraud	1%	3%	4%
Disaster Fraud	2%	0%	NA
Disaster Adjuster Fraud*	NA	NA	0%
Disaster Agent Fraud*	NA	NA	5%
Disaster Claim Fraud*	NA	NA	6%
False Statements/Claim Documents	63%	61%	44%
License Application Misrepresentation	7%	2%	1%
Mortgage Fraud	5%	1%	2%
Organized Crime	0%	2%	0%
Owner Give Up**	NA	NA	3%
Paper Accident	0%	1%	0%
Policy Application Fraud	1%	1%	1%
Provider Billing Fraud	2%	1%	5%
Slip & Fall	1%	1%	2%
Staged Accident	0%	2%	0%
Theft	1%	1%	3%
Unlicensed Agent	1%	2%	1%
Unlicensed Company	4%	4%	0%
Water Damage - HO	1%	0%	0%

* Data previously captured under Disaster Fraud, and refined in FY09

** Data previously captured under Auto Theft, and refined in FY09

Analysis of Trends

Five fraud schemes had significant variances between FY 2008 – FY 2009.

- **Agent Fraud** – for the past three fiscal years, the number of agent fraud cases referred for prosecution has increased. One of the factors contributing to this steady increase has been the economic downturn.
- **Disaster Agent Fraud** – this is a new statistic captured due to the number of reports received and cases investigated associated with Hurricane Ike. These are specific cases where the agent received premiums for homeowners insurance and never remitted the funds to an insurer.

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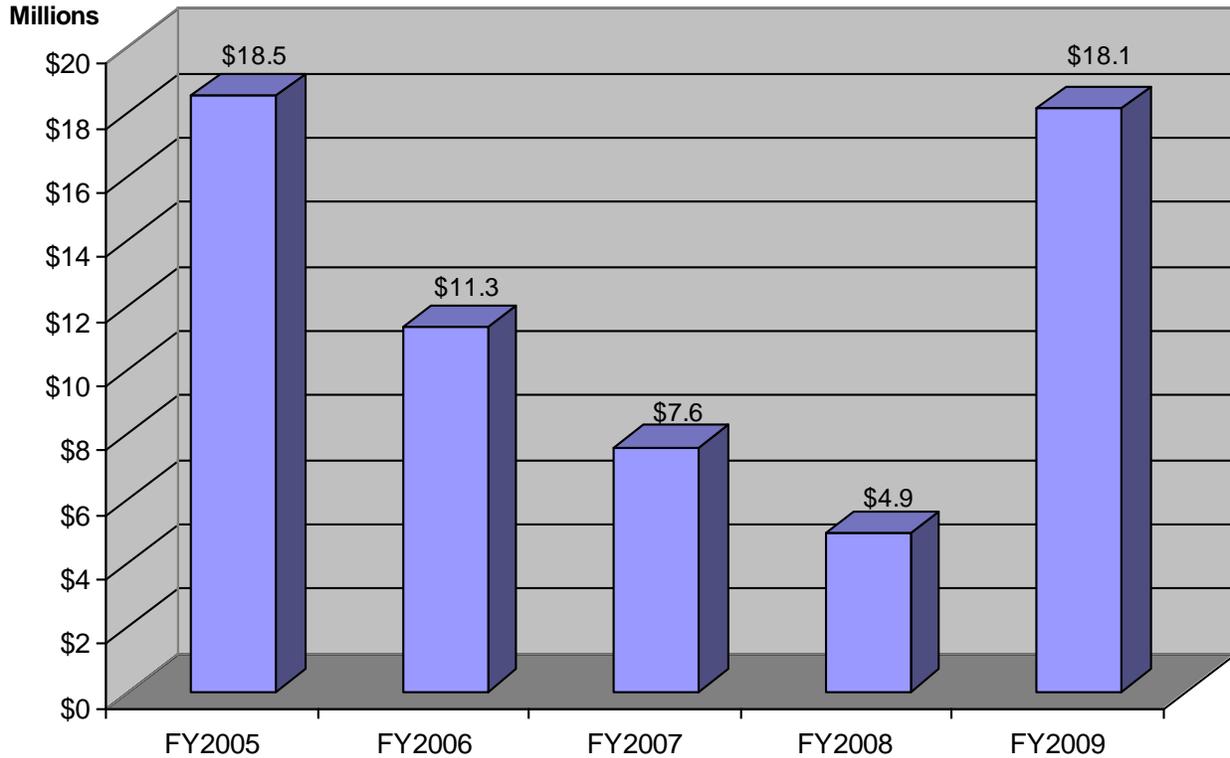
Referrals by Fraud Scheme, continued

Analysis of Trends, continued

- **Disaster Claim Fraud** – this is a new statistic captured due to the number of reports received and cases investigated associated with Hurricane Ike. These are specific cases where a legitimate storm related claim is inflated or a claim is totally fabricated.
 - **False Statements/Claim Documents** – the percentage decrease from previous years is attributable to the establishment of several new scheme categories that were previously calculated under this type of fraud.
 - **Provider Billing Fraud** – these cases are generally complex and document intense, and although the data shows a significant increase in FY 2009, a number of these referrals were under investigation in a prior fiscal year.
-

Amount of Fraud Referred for Prosecution

FY 2005- FY 2009 Dollar Amount of Fraud Identified in Referrals



Analysis of Trends

The size of a case 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 parties involved in an insurance fraud case.

Referrals and Court Actions

FY 2009 Referrals and Court Actions by County	County	Referred FY09	Indicted FY09	Convictions FY09
	Bastrop	0	0	1
	Bell	1	0	0
	Bexar	12	8	9
	Bowie	1	1	0
	Brazoria	3	0	0
	Brewster	2	0	0
	Burnet	1	1	1
	Callahan	0	1	1
	Cherokee	2	1	0
	Collin	10	5	1
	Comal	0	0	2
	Dallas	28	4	15
	Denton	5	5	1
	Ector	1	0	0
	El Paso	3	0	0
	Ellis	2	0	0
	Fort Bend	2	4	0
	Freestone	1	0	0
	Galveston	2	3	1
	Guadalupe	2	0	0
	Grayson	0	0	2
	Harris	51	54	38
	Haskell	1	0	0
	Hays	1	1	0
	Henderson	1	1	1
	Hidalgo	2	10	5
	Jasper	0	1	0
	Jefferson	2	1	2
	Johnson	3	4	2
	Liberty	1	0	0
	Live Oak	0	2	1
	Lubbock	3	3	0
	McLennan	0	0	1
	Midland	0	1	1
	Montgomery	1	2	2
	Nacogdoches	1	1	0
	Navarro	0	1	1
	Nueces	0	3	1
	Orange	2	0	0
	Parker	1	0	0
	Polk	1	1	1
	Potter	2	1	0
	Reeves	1	0	0
	Rockwall	0	1	1

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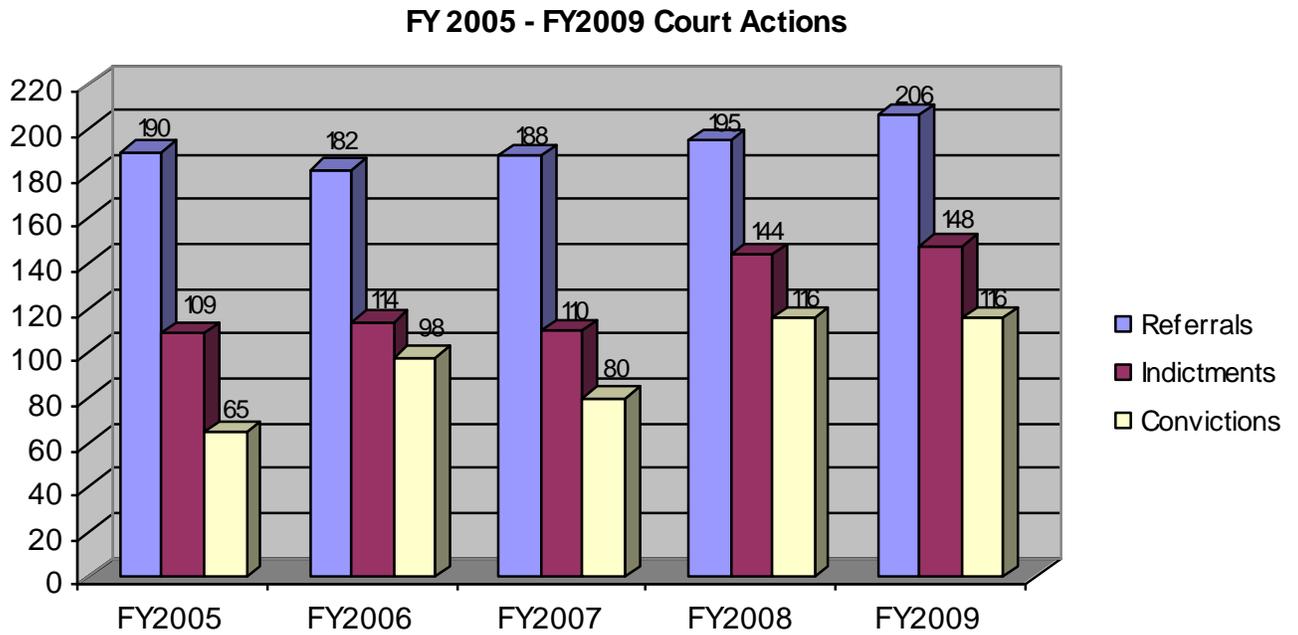
Referrals and Court Actions, continued

FY 2009 Referrals and Court Actions by County, continued	County	Referred FY09	Indicted FY09	Convictions FY09
	Smith	1	1	1
	Tarrant	13	1	1
	Tom Green	1	0	0
	Travis	22	17	12
	Van Zandt	0	0	1
	Victoria	0	1	1
	Walker	1	1	0
	Waller	1	0	0
	Webb	6	0	0
	Wichita	0	1	0
	Williamson	3	1	1
	Young	0	0	1
	Federal Courts	6	4	7
	Fiscal Year Totals*	206	148	116

* Data is a result of current referrals and prior year pending cases

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Referrals and Court Actions, continued



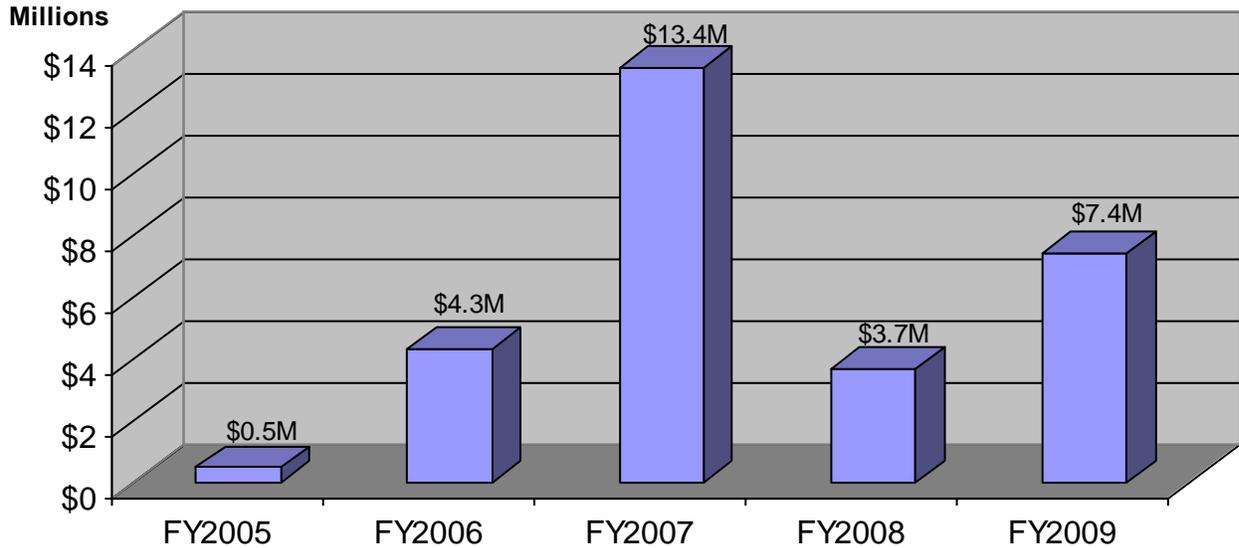
Analysis of Trends

Referral data during the previous five fiscal years varies only slightly each year and is primarily the result of individual investigator performance. Since staffing levels have remained stable, it is anticipated the outcome for fiscal year 2010 will be similar.

Indictment and Conviction data will vary from year to year since those actions are directly the result of actions by prosecuting agencies.

Restitution

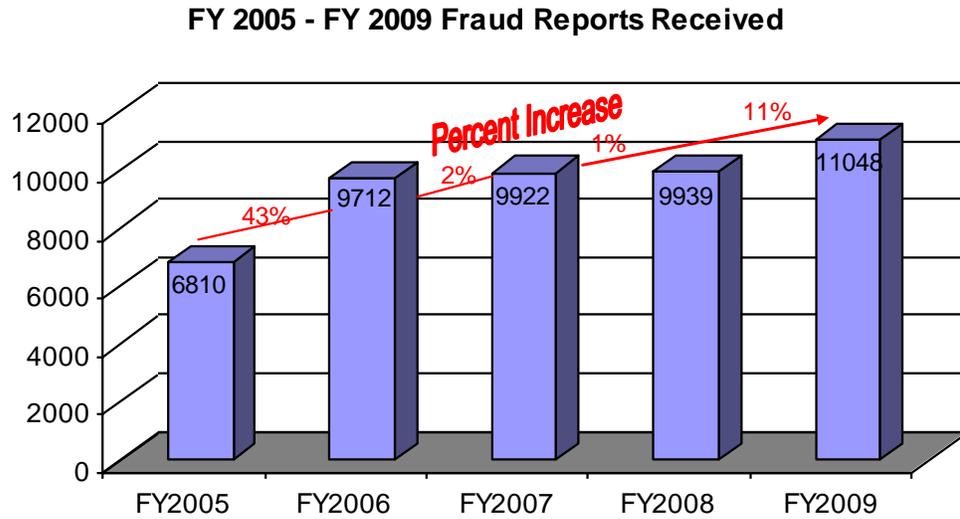
FY 2005 - FY 2009 Restitution Assessed by Courts



Analysis of Trends

Restitution in criminal insurance fraud cases is assessed by the courts, usually at the request of the prosecutor. The dollar amount of restitution will vary by year and is attributable to the total amount of fraud identified in adjudicated cases. The Fraud Unit strives to provide prosecuting entities with data that will allow the courts to appropriately assess restitution to victims of insurer fraud.

Fraud Reports



Analysis of Trends

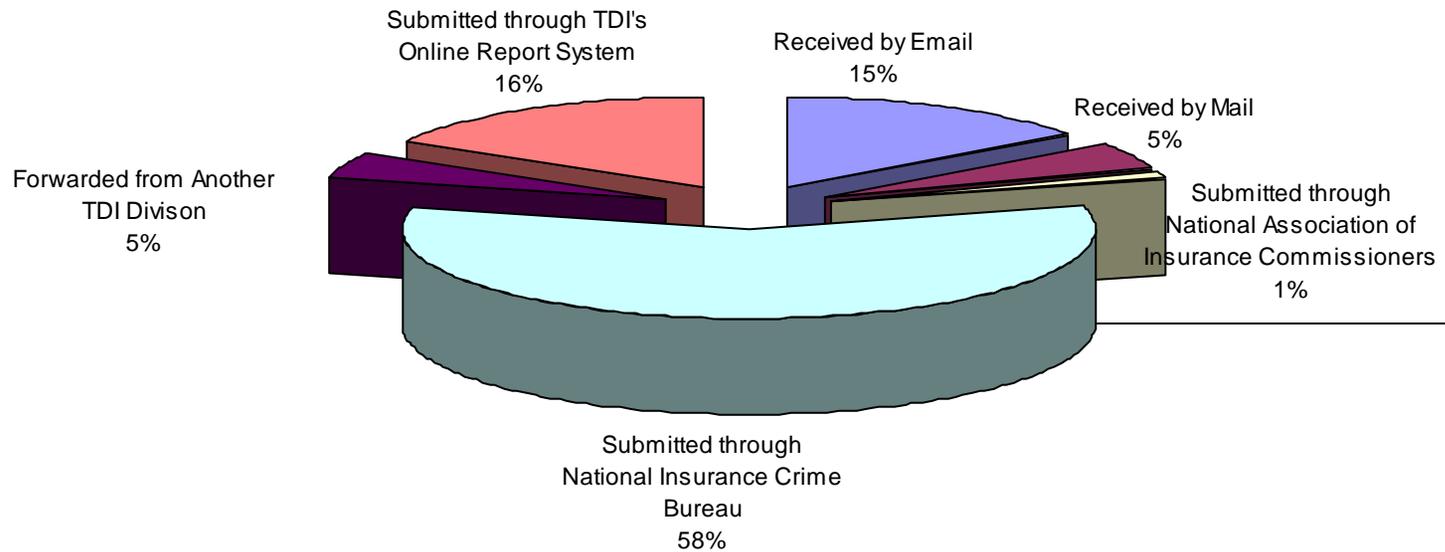
The significant increase between FY 2005 and FY 2006 was a result of changes to the fraud reporting statute during the 79th Legislative session. The increase between FY 2008 and FY 2009 is attributable to Hurricane Ike fraudulent claims and fraudulent insurance acts driven by the economic downturn. The Fraud Unit continues to promote investigator and consumer outreach liaison activities which have encouraged insurance fraud reporting by insurers and the public.

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Fraud Reports, continued

FY 2009 Fraud Reports Received by Method Reported

11,021 Total Reports



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Fraud Reports, continued

FY 2009 Reports by Fraud Scheme The Fraud Unit received 11,021 reports of suspected insurance fraud in FY 2009. Below is a chart that shows the different fraud schemes of the reports.

Fraud Scheme	Percentage
Adjuster Fraud	0.47%
Agent Fraud	3.71%
Arson for Profit	1.94%
Auto Body Shop Fraud	0.78%
Auto Theft	8.83%
Company Employee Fraud	1.02%
Company Officer Fraud	0.57%
Disaster Adjuster Fraud	0.21%
Disaster Agent Fraud	0.69%
Disaster Claim Fraud	3.91%
Escrow/Fee Attorney	0.17%
Faked Death	0.03%
False Billing	0.04%
False Claim Documents	44.02%
Fictitious Insurance Card	0.56%
Inflated Claim	2.81%
License Application Misrepresentation	0.02%
Mortgage Fraud	3.12%
Owner Give Up	3.52%
Paper Accident	1.06%
Policy Application Fraud	4.57%
Premium Fraud	1.08%
Provider Billing Fraud	7.96%
Runner/Capper	1.45%
Slip & Fall	1.47%
Soft Tissue Injury	0.94%
Staged Accident	2.72%
Theft	0.69%
Theft from Elderly	0.03%
TPA Fraud	0.01%
Unknown	0.75%
Unlicensed Agent	0.27%
Unlicensed Company	0.28%
Viatical	0.04%
Water Damage - HO	0.29%

A Decade Review

	FY00	FY01	FY02	FY03	FY04	FY05	FY06	FY07	FY08	FY09
Fraud reports received	2220	3065	3686	4490	5738	6810	9712	9922	9939	11021
Cases opened for investigation	489	264	320	325	265	294	448	400	379	637
Cases referred for prosecution	175	156	225	183	181	190	182	188	195	206
Amount of fraud identified in referred cases	*	\$4,642	\$17.2M	\$12.9M	\$7.4M	\$18.5M	\$11.3M	\$7.5M	\$4.8M	\$18M
Indictments resulting from investigations	84	81	74	100	102	109	114	110	144	148
Convictions from cases referred	85	62	69	69	66	65	98	80	116	125
Restitution assessed by courts on Fraud Unit cases	\$4M	\$4.7M	\$12.9M	\$13.5M	\$2M	\$500K	\$4.2 M	\$13.3M	\$3.7M	\$7.4M
Fines assessed by courts on Fraud Unit cases	\$136K	\$28K	\$42K	\$115K	\$52K	\$40K	\$80K	\$68K	\$73K	\$86K

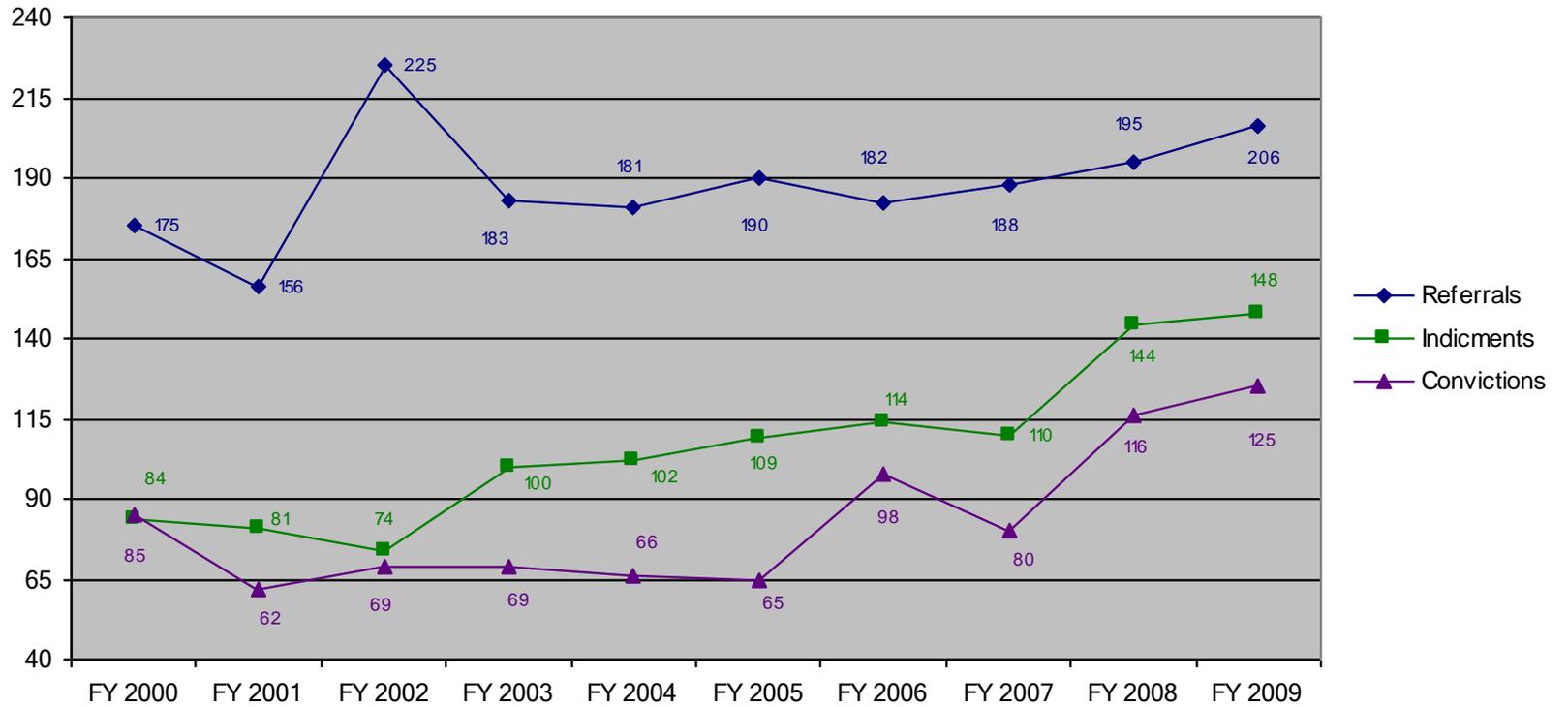
*This statistic was not recorded until FY 2001

Decade Analysis

The Fraud Unit has tracked above key statistics over the past decade. There has been a significant increase in the number of fraud reports received, which is attributable to a change in the fraud reporting statute, along with Fraud's outreach liaison activities. The number of open cases does not necessarily increase as reports increase. Each report is evaluated on its own merits to determine if a case will be opened. While the number of reports and cases opened may vary, the number of referrals remains consistent because the Fraud Unit has a finite number of staff who can investigate a finite number of cases at a time. The Fraud Unit's outreach/liaison initiative with prosecuting entities across Texas is contributing to a greater number of legal actions.

A Decade Review, continued

FY 2000 - 2009 Decade Overview



Workers' Compensation Four Years in Review

Workers' Compensation Statistics

On March 1, 2006, the Commissioner for the Division of Workers' Compensation delegated the responsibility for investigating suspected fraudulent worker's compensation acts to the Fraud Unit. Below is a summary of what the Fraud Unit has accomplished during the past four years.

	FY 2006	FY 2007	FY 2008	FY 2009
Fraud Reports Received	1,772	2,020	2,097	1,880
Cases Opened for Investigation	59	65	84	72
Cases Referred for Prosecution	5	28	33	28
Amount of Fraud Identified in Referred Cases	\$25,000	\$1,800,000	\$239,000	\$189,000
Indictments Resulting from investigations	0	6	25	22
Convictions from Cases Referred	0	3	11	20
Restitution Assessed by Courts on Fraud Unit Cases	0	0	\$101,000	\$4,200,000

Analysis

From FY 2006 to FY 2009, there has been a significant increase in the number of indictments and convictions. Court actions frequently are not concluded within the same fiscal years as the referral is made. This increase is attributable to cases referred in the previous fiscal years and the Fraud Unit's outreach/liaison initiative with prosecuting entities across Texas.

Fraud Unit Activities

**Noteworthy
Accomplish-
ments**

In Fiscal Year 2009, the Insurance Fraud Unit:

- Received and analyzed 11,021 suspected insurance fraud reports.
- Opened 637 cases.
- Through enhanced relationships with state-wide prosecutors, in addition to the efforts of the TDI Fraud Prosecutor, realized 148 indictments, 116 convictions for insurance fraud with restitution, fines, and penalties ordered of \$7.5 million.
- Answered 5,451 toll-free hotline calls for persons to report suspected insurance fraud, and provided additional assistance to callers reporting fraud related to Hurricane Ike and callers reporting fraud, waste and abuse at TDI.
- Hosted the 11th Annual Fraud Conference in February 2009 with 266 fraud investigators from state government, law enforcement and the insurance industry in attendance.
- Made 16 public presentations on insurance fraud.
- Fraud Unit investigators made 57 liaison contacts with law enforcement throughout the state.
- Updated Fraud's internet resource page.
- Participated in statewide task forces in several metropolitan areas, including Austin, Dallas, Houston and San Antonio.
- Participated in the Texas Committee on Insurance Fraud to address insurance fraud on a united front with industry, law enforcement, other state agencies, legislators and citizen advocate groups.
- Participated in Texas Residential Mortgage Fraud Task Force meetings.
- Renewed a memorandum of agreement with the Dallas County District Attorney's Office to continue the insurance fraud prosecutor initiative.
- All Fraud Unit attorneys and peace officers completed their legislatively mandated training requirements.

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FY 2009 Top Ten Adjudicated Cases

Paul Banks

Paul Banks pled guilty in federal court to Mail Fraud. Banks schemed to defraud six insurers by purchasing Equine Mortality Insurance and falsely reporting the purchase price for 18 horses. Banks created false bills of sale for each horse by increasing the actual purchase price by several thousand dollars. Claims were eventually filed on all 18 horses after they were found mysteriously dead. Banks collected approximately \$350,000 in fraudulent death claims. Banks was sentenced to 21 months confinement; three years supervised release; and ordered to pay \$217,500 in restitution.

Leslie Bennetsen-Hurley

Leslie Bennetsen-Hurley pled guilty in Victoria County to Insurance Fraud, a 3rd Degree Felony. Bennetsen-Hurley, a licensed insurance agent at the time, created a bogus company and submitted fraudulent policy applications to an insurer in order to receive approximately \$9,136 in advanced commissions. Some of the fraudulent policies were allegedly for children she claimed to have but did not actually exist. Bennetsen-Hurley also created fraudulent motor vehicle accident reports and hospital bills that she submitted claims to the insurer in the approximate amount of \$72,000. Bennetsen-Hurley was sentenced to 10 years deferred adjudication, a \$1,000 fine, and was ordered to pay \$83,701 in restitution.

Brenda Buckaloo-Merchant

Brenda Buckaloo-Merchant, a former claims adjuster, pled guilty in Dallas to 1st Degree Felony Theft for stealing \$1,208,316 from her employer. While using her position as a supervising adjuster for a major Dallas insurer, Buckaloo-Merchant schemed to approve claims and divert payment checks to a fictitious health care provider that was in reality, Ms. Buckaloo-Merchant. She used the money for personal purchases including foreign travel, gambling, gifts for friends and her local ministry. She was sentenced to twelve years in the Texas Department of Corrections and ordered to pay restitution of \$1,208,316 and fined \$3,000.

James D. Forrest

James D. Forrest pled guilty in Federal Court to Uttering a Counterfeit Security of a Private Entity, a violation of 18 U.S.C. 513(a). Forrest converted approximately \$292,591 in life annuities belonging to two individuals. Forrest forged loan and partial withdrawal requests from the victims' annuities without their consent or knowledge and had the money mailed to his home address or post office box. He endorsed the checks over to himself, and then deposited the funds into his personal bank account. Forrest eventually requested full surrenders from the annuities held by the victims, depleting all funds held in their accounts. Forrest was sentenced to an 18 month prison sentence, 36 months parole upon completion of the prison sentence, and was ordered to pay \$190,340 in restitution.

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FY 2009 Top Ten Adjudicated Cases, continued

Shamika Jones Shamika Jones, a former licensed escrow agent, pled guilty in Austin to 3rd Degree Felony Theft for diverting refund checks from various city and county taxing authorities. She schemed to divert 51 checks totaling \$33,067 to an account she controlled. Jones was sentenced to 10 years deferred adjudication, paid \$3,000 up front restitution and ordered to pay \$28,533 over the 10 years. She was also ordered to perform 200 hours of community service, and to not work in a job where she has direct contact with funds.

Sandra Moncrieffe Johnson Sandra Moncrieffe Johnson was convicted in Federal Court for the offense of Mail Fraud. Johnson worked as an adjuster for a Houston area insurer processing workers' compensation claims. Within eight months, Johnson and co-conspirators schemed to defraud her former employer out of approximately \$1.7 million in fraudulent claims. Johnson was sentenced to 12 months in federal prison and ordered to pay restitution in the amount of \$1,717,737.

Mary Kriegel Mary Kriegel pled guilty in Houston to the offense of 3rd Degree Felony Insurance Fraud for her part in filing over 370 fraudulent claim reimbursement requests for doctor visits from February 2006 to December 2007. A total of \$116,550 in claims were submitted to the insurer and resulted in the insurer paying out \$66,332. During the course of the investigation, Kriegel had reimbursed \$66,332 to the insurer. Kriegel was sentenced to 60 months deferred adjudication and 120 hours of community service.

Sylvester Lanre Ogundana Sylvester Lanre Ogundana pled guilty in Harris County to Misapplication of Fiduciary Property, a State Jail Felony. Ogundana received homeowner insurance premium payments during the closing process of home purchases. The money was intended for the purchase of insurance through the Texas FAIR (Fair Access to Insurance Requirements) Plan. Ogundana collected \$12,313 for FAIR Plan insurance premiums for nine separate home closings and failed to remit \$11,428 of those funds to the FAIR Plan. The investigation revealed that the proceeds were co-mingled with other accounts and were used for Ogundana's personal and business related expenses. Ogundana was sentenced to 36 months deferred adjudication, and was ordered to pay \$8,428 in restitution.

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FY 2009 Top Ten Adjudicated Cases, continued

Shaheen Sayyed Shaheen Sayyed pled guilty in Galveston County to Theft, a Class A Misdemeanor. Sayyed is part owner of a convenience store in Galveston, Texas. After Hurricane Rita made landfall, she reported to the police department that 2,900 cartons of cigarettes had been stolen from her convenience store and subsequently filed an \$80,000 claim with her insurer. A witness reported seeing Sayyed removing the cigarettes prior to the storm. The insurer denied the claim. Sayyed pled guilty to Insurance Fraud, was fined \$2,000 and sentenced to 12 months deferred adjudication.

**Brenda Alanis,
Gabriela
Castaneda,
Irene Santos,
Minerva Munoz
and Dalia Urbina** Brenda Alanis, Gabriela Castaneda, Irene Santos, Minerva Munoz and Dalia Urbina pled guilty in Hidalgo County to the offense of Theft, a State Jail Felony. These five individuals, along with a sixth who was convicted the previous fiscal year, all worked as support staff in a local medical office. They each schemed to submit fraudulent attending physician statements and medical bills to their insurer for payment of services that were not provided by a medical doctor. They each created false bills and used the doctor's signature stamp to certify services were rendered. Collectively, \$22,596 in fraudulent claims were submitted to the insurer. These individuals were sentenced from six to 24 months deferred adjudication and ordered to pay restitution to the insurer for each of their fraudulent claims which ranged from \$2,275 to \$3,455.
