INSURANCE CONTINUING EDUCATION

ETHICAL DILEMMAS FOR INSURANCE PROFESSIONALS

STATE-APPROVED CONTINUING EDUCATION
for
CALIFORNIA INSURANCE LICENSEES

BOOKMARKEDUCATION

BookmarkEducation.com
(800) 716-4113

ETHICAL DILEMMAS FOR INSURANCE PROFESSIONALS

Printed in the United States of America.
▪P2▪

All inquiries should be addressed to:
Bookmark Education
6203 W. Howard Street
Niles, IL 60714
(800) 716-4113
BookmarkEducation.com

Table of Contents

CHAPTER 1: WHY BOTHER WITH ETHICS?

This course makes the assumption that you, an experienced insurance professional, probably don't need to be lectured about what's right and what's wrong. You've known the basics of good and bad since childhood, and no continuing education course is likely to have a major impact on your concept of morality or turn a "bad" person into a "good" person.

However, good-intentioned adults can still benefit from some time and space to contemplate why they believe what they believe, how they make ethics-related decisions and how the basic lessons of right and wrong can be applied in specific business scenarios. Many of us are likely to discover that the truly hard choices in life aren't clear ones between something that is obviously wrong and something that is obviously right (for example, stealing money from a client vs. keeping the client's money safe). Rather they are the cases in which we notice two or more legitimate choices that could be made, all of them having merit but none of them likely to fully please everyone.

With this in mind, perhaps it's appropriate to consider a definition of "ethics." Definitions for this term are numerous enough to fill their own book and could include statements like, "the direction of your moral compass," "how you treat the people who you don't know" and "how you conduct yourself when no one is watching." For our purposes here, let's be guided by a paraphrased, three-pronged definition from former insurance professor and columnist Peter R. Kensicki, who proposed the following theories:

- Moral decisions involve deciding whether an act is right or wrong.
- Legal decisions involve determining whether an act is legal or illegal.
- Ethical decisions involve choosing between two or more right AND legal options.

Viewing ethics in this proposed way can be helpful to licensed insurance producers because it acknowledges that we are, of course, expected to treat people with kindness, compassion, honesty and skill but are also required to follow laws and rules set by federal and state governments. Our instincts to help a consumer or a colleague must be reexamined if our assistance might violate our legal obligations.

The Need for Ethics in Business

Strong cases can be made for acting ethically in order to increase business. Consider the successes you've had in your insurance career thus far and whether they would really be possible if you hadn't shown respect, humility and other positive and seemingly selfless traits to your customers, colleagues or even your competitors.

Building Our Business With Ethics

For most insurance producers, the most common source of new business opportunities will be referrals. By putting yourself in a position to be recommended by your current customers to their friends, their family and their business associates, you help yourself stand out from the thousands of other alleged insurance experts in your community. Your workday will also be more efficient because you'll be allowed to spend less time following cold leads and contacting strangers for business and more time helping people via legitimate, thoughtful sales.

Whether we realize it or not, each referral comes with a built-in level of trust that we should honor and appreciate. Because the referred person trusts the individual who sent him or her to us, that prospect feels a bit more comfortable talking to us about insurance needs than to one of our competitors. Because the referred person is more likely to trust us by extension of our relationship with the person's friend, family member, etc., we are more

likely to get honest answers from the referred party about his or her needs, goals and everything else related to the person's insurance situation. The built-in trust allows the referred prospect to let his or her guard down just enough to focus on the possible insurance transaction at hand rather than remaining tight-lipped and wondering about our motives. Less time is wasted, and more time is spent doing important, profitable work. But of course, those positives associated with dealing with a referral are only possible if we treat our existing clientele in an outwardly ethical way.

Protecting Our Business With Ethics

None of us will have a career completely free of struggle. Sometimes, but hopefully not too often, we will need to lean on our reputation during tough times and have confidence that our track record of good service will ultimately keep us afloat.

If we've laid the groundwork properly and maintain a bit of luck, some clients will remain loyal to us even as we notice heavy competition for them from a new and aggressive competitor. Similarly, if we have done our best to position ourselves as ethical insurance professionals, we will increase our chances of being forgiven for an occasional and admittedly inevitable work-related mistake, assuming, of course, that we quickly own up to our errors and work hard to fix them.

Due to our status as imperfect human beings, we must assume that mistakes will happen. We may misplace an important document. Or maybe we lose sight of an important deadline related to a client's coverage. Or perhaps we have a bad day, aren't as smooth in a sales presentation as usual and inadvertently mischaracterize how an insurance product works to a customer who buys it and then has a bad claims experience due largely to our poor setting of expectations.

No matter the specifics of our mistakes, maybe our strong ethical behavior with the impacted party will allow us to keep that important relationship intact. Or at the very least, perhaps our good behavior from the past will produce enough mercy within the harmed person to at least not make him or her take serious action against us, such as by contacting a regulator or involving us in a costly, time-consuming lawsuit.

Improving Workplace Relationships With Ethics

Our relationships with customers and clients can sometimes be influenced, directly or otherwise, by the quality of our relationships with other insurance professionals. Whether the other professionals are underwriters in a back office at an insurance carrier or a claims adjuster out in the field after a natural disaster, those peoples' decisions can make insurance consumers either very satisfied or very unhappy with us.

Consider, for example, the relationship that can exist between an insurance salesperson and an insurance underwriter. Although direct communication between salespeople and underwriters is more common in certain lines of insurance than others (more likely in property and casualty, less likely in life insurance), good underwriters will acknowledge that what they do is both a science and an art and that their decisions are driven not only by numbers but also by carefully considered instincts. In those scenarios in which an underwriter must decide whether to issue a policy for a borderline risky applicant or perhaps whether to order an inspection that will slow the transaction down, trust in the producer who is associated with the application can, in fact, be one of the deciding factors. In these cases, underwriters might ask themselves the following questions:

- Am I familiar with this producer and his or her work?
- Is this producer's work typically accurate and usually as complete as possible?

- Does this producer have a reputation of knowing our underwriting guidelines?
- Is this producer quick to respond when we have questions or need clarification?

Certainly, an insurance producer should not attempt to pressure or incentivize underwriters or claims adjusters in order to receive special treatment for themselves or their clients. However, workplace ethics should involve a goal of making hard-working people's jobs a bit easier (where possible) rather than more difficult.

Helping Our Industry With Ethics

When we treat the public with honesty, professionalism and respect, we increase the likelihood of them reaching out openly to members of the insurance community and becoming more forthcoming with us in subsequent transactions.

As much as we might believe that our insurance customers are personally happy with us, we should recognize that most people have a negative opinion of our industry as a whole. For example, a 2016 Gallup poll gave respondents a list of roughly 30 professions and asked whether people in those professions tend to have high ethical standards. Nurses, pharmacists, doctors, engineers and dentists scored highest in the poll, whereas insurance salespeople were tied for third from the bottom (along with advertising practitioners), only scoring better than car salespeople and members of Congress.

Such discouraging numbers aren't the fault of a single insurance professional (let alone the licensed producer who is reading this course material). Nor are they likely to be reversed by a single act. However, we likely do ourselves a disservice if we fail to acknowledge the data and refuse to admit that people have an unpleasant idea of who the stereotypical insurance salesperson might be. Perhaps that stereotype brings to mind someone who is overly aggressive in sales, never knows when to listen rather than talk, flings business cards left and right and is focused almost robotically on just making a deal.

By keeping that stereotype in mind and doing everything reasonably within our power to act against it, we can make the public more likely to listen to our important messages about risk and, perhaps, make our clients and prospects more willing to accept our recommendations. Those recommendations might be as complex as adding a series of nearly iron-clad endorsements to a business owner's unique insurance portfolio. Or they might be as simple as suggesting that a young person with a small life insurance policy meet with us on a yearly basis to assess the death benefit's continued suitability.

CHAPTER 2: APPLYING ETHICS TO BUSINESS

Some common life lessons, such as "Tell the truth" and "Treat others the way you'd want to be treated," seem so simple on their own terms yet can become much more complicated in the real world, particularly when an insurance producer must balance ethical obligations to consumers along with ethical obligations to insurance companies (and even a few ethical obligations to ourselves and our families). Let's spend some time exploring how those admirable teachings might become less clear in difficult business situations.

Tell the Truth, the Whole Truth and Nothing But the Truth?

To start, let's examine our presumed duty to tell the truth to insurance buyers. Without thinking too hard about it, this duty might be exemplified by not making promises that our products can't keep. It might mean making important disclosures about costs and exclusions. And it might mean acknowledging to ourselves and others that there is no such thing as an absolutely perfect insurance product and no such thing as an absolutely perfect insurance company. A product will always have exclusions and costs associated with it and

will almost certainly have dollar limits on benefits. Similarly, at the company level, there will always be a balance between the organization's breadth of product options, its pricing, the knowledge of its salespeople and its approaches to claims handling and customer service. We shouldn't feel ashamed for disclosing all the positives of a product or its parent company, as long as we have also been careful to mention those possible drawbacks.

But is this approach really so easy or totally practical? Consider the following scenario:

- The Smiths visit an insurance agent and tell him they want to be protected while their new home is under construction this winter. Their agent is a captive agent and can only sell insurance from one company. They say to the agent, "We're insurance illiterates, and we don't know what we're doing!" The agent says, "I'll get you the best coverage available from my company. In fact, I bought the same policy when I was building my house. You can sleep at night knowing you'll be adequately protected. Just be aware that it doesn't cover a few things like floods and earthquake damage." The Smiths follow the agent's advice and purchase the recommended coverage. During construction, a major snowstorm causes the Smiths' roof to collapse. Losses are not covered by their policy, and the agent is sued. In court, the agent says his company always excludes collapse caused by snowstorms for buildings under construction and that the Smiths would've known about the exclusion if they'd read their policy. However, he admits that most of his competitors sell policies and/or endorsements that would've insured against this type of loss. Did the agent do anything wrong?

Of course, the agent in our story did something wrong, but let's look deeper into the story and see if we can give him a small, partial benefit of the doubt.

As a captive agent, the agent can only sell insurance from one carrier. Therefore, advising the Smiths to go elsewhere might have technically violated a contractual agreement between the agent and the company. However, some captive agents in this situation have found that sending a prospect to an appropriate competitor in an effort to truly address the prospect's needs can actually benefit all parties. Even if the agent's carrier loses business on this one occasion, the prospect who received an honest referral to a competitor might remember the agent's professionalism, appreciate the transparency and come back to that agent when other insurance purchases must be made. By letting go of a customer carefully in the short term, the agent and the parent company might actually gain a loyal customer in the long term.

Alternatively, perhaps the captive agent could have projected honesty to the prospect while still maintaining the expected company loyalty. We might all agree that the agent had an obligation to disclose that his company's products didn't cover collapse during construction, but would it have been acceptable to frame the disclosure in a company-friendly way by saying something like, "Our products don't cover an important risk that might arise during the winter, but that allows us to offer the lowest price to cost-conscious homeowners"?

Insurance sales professionals have an ethical (and in some cases) legal obligation to disclose all material facts related to an insurance product. But are there cases in which there can be some debate regarding whether a particular fact is truly a material fact? When meeting with an impatient prospect who is only willing to give you a few minutes of his or her time, are you forced to make quick decisions about what to disclose and what can't be addressed in such a quick conversation? And shouldn't consumers share some responsibility for reading their policies and educating themselves about what they've purchased?

Yet we must face the reality that buyers are highly unlikely to read their policies, other than perhaps to check that the appropriate address and coverage amounts are listed on the declarations page. And in our specific case study presented here, we must be mindful of the facts and the couple's upfront admission that they know nothing about insurance and don't feel confident in their judgment. If there ever was a time for an agent to comfortably spend significant time going through all the coverages and exclusions in an effort to educate a buyer, this might be it.

Our special knowledge about insurance might put some nervous buyers at ease. At the same time, however, we need to be careful with our power to soothe our prospects in an attempt to reduce their worries. Providing overly broad reassurances, such as, "You can sleep at night knowing you'll be adequately protected," doesn't serve the public well because it disregards all the intricacies of a product's terms, conditions and exclusions. Rather than making these types of emotion-focused statements, our desire to provide calming answers to a buyer's questions about a product should always be tied to the policy language, including what is really covered and what really isn't.

Do You Really Treat Everyone the Same?

Next, let's examine our assumed responsibility to treat the insurance-buying public equally with regard to our attention and offerings of services. Our first instinct might be that we already abide by this principle consistently and that we are equally professional to everyone without playing favorites. But in the real business world, it's probably impossible to not prioritize some customers over others on occasion.

When this occurs, are we simply doing something wrong? Or are there ways to place one buyer above another and still justify it as an ethical choice? Consider the following scenario:

- You're a health insurance professional specializing in group benefits. With a few minutes to spare before a very long meeting, you decide to check your voicemail and are alerted to two messages. The earliest message is from a business owner who has no experience with insurance. You can tell she's in a panic about some administrative paperwork related to her group's health plan. You're fairly certain that her "problem" isn't really a problem at all and that she just needs some reassurance. However, you know it will take some time to explain things and calm her down. The more recent voicemail is from one of your firm's most important clients. He, too, doesn't seem to have a major problem that should really require immediate attention. But this client has constantly made it clear that his time is extremely valuable. You can tell by the tone of his voice that he expects you to personally resolve his issue as soon as possible. Your meeting will last the rest of the day, and you only have time to return one of the calls. What do you do?

Many readers will automatically react by claiming they'd find some way to return both calls, such as by missing their meeting or by staying late. But for the purpose of the exercise, let's force ourselves to make a choice and ask ourselves how we arrived at it.

If you choose to return the first person's call, your ethics-based decision might focus on the fear heard in the person's voice and your compassionate desire to alleviate it as soon as possible. Another reason to speak to the first person might be that this is a new customer who is still learning to trust you and therefore deserves a sign of your attention in order to strengthen the relationship. Or maybe you do it because you simply believe in the unwritten rule of "first come, first served" and will return her call because she was essentially at the front of the line.

A few brave readers might admit, albeit silently, that they'd return the call from the second client, who is much more demanding and who likely has a much bigger influence on a salesperson's professional success. Even if you might personally want to dismiss the second caller and help the first, you might have a supervisor who overrules you.

Modern technology might provide a reasonable solution by allowing you to call the supposedly more important client but also send a quick text message or email to the first caller, letting her know not to worry, that you care about her concerns and that you will ultimately be in touch to address her problem during the next business day as soon as possible.

If nothing else, this scenario offers a reason for all of us to review our outgoing voicemail messages and determine whether what we say on them actually sets reasonable, achievable expectations for anyone who calls, including big clients and small ones.

Do You Stand Up For Yourself?

Let's not forget that, in addition to having ethical obligations to the public, our peers and our supervisors, we also have ethical obligations to ourselves. Despite not being able to be entirely thin-skinned and dismiss every difficult person we encounter, we all must have limits to prevent ourselves from unreasonable intimidation, bullying and unhealthy influences. In other words, we must have a threshold beyond which we will be willing to stick up for ourselves and say, "No."

But can't this obligation to ourselves create tremendous stress, particularly if the person causing problems has a direct impact on our ability to earn a living? Consider the following scenario, which, believe it or not, is based on actual events:

- You work for a financial services firm as a sales manager. Your new supervisor tells you about a popular sales seminar called "Annuity Boot Camp" and insists that you and your team attend. At the seminar, you're surprised to hear the speakers make the following recommendations:
    - "There are real answers, and then there are answers for senior citizens. Oversimplify the information to move the sale forward."
    - "Seniors struggle making their own decisions. Make up a scary problem and then act like your product is the only solution."
    - "Talk in technical terms about Medicare, Medicaid and estate taxes. The more you can get people to worry about losing their assets, the more money you'll make."

  You can understand how the various presenters' techniques might work. You also know that you have a team of producers who depend on you for experienced, ethical leadership. What do you tell your team members who have attended the seminar with you? What do you tell your boss upon returning to the office?

To avoid creating panic among our team, we may want to huddle together, solicit immediate feedback from the group, advise them that they should be proud of working for an ethical company that doesn't engage in such self-interested tactics, and tell everyone that you will talk with your supervisor about some concerns.

The more challenging aspect of the scenario is, of course, how to handle the supervisor. If the supervisor is new and unfamiliar with how the seminar's tactics might impact the company's relationships with consumers, the conversation is likely to be less scary and should be focused on some tactful education about what you do and why you think the

seminar's recommendations aren't valid. If, on the other hand, the supervisor is fully aware of what the suggested sales pitches are intended to accomplish, the honest and hard next step for us might unfortunately involve polishing off our resume and considering new employment.

Supervisors who demand that their workers engage in unethical behavior are unlikely to protect those workers when faced with a regulatory complaint. Never forget that the only person who can truly protect your ability to make a living is you.

What Kind of Boss Are You?

The same logic and need for self-protection might apply in cases where we are in a supervisory role and notice a subordinate doing something terribly inappropriate. In those cases, how much mercy and compassion are we required to exhibit? How firm and cold might we need to be in our correcting of the situation so that the bad behavior doesn't cause serious harm to us and our business? Consider the following scenario:

- You run a mid-sized life insurance agency and are ready to congratulate your newest employee on his first sale. While approaching his desk, you notice he has the client's application in front of him and is forging the client's signature. When you confront him, he casually says he forgot to get the applicant's signature in one spot. He didn't want to inconvenience you or the client by admitting the mistake or asking for another signature. Instead, he informed another employee, who said it wasn't a big deal. How do you respond?

We can debate whether this action by a new employee should be dismissed as a "rookie mistake" or a terrible judgment call worthy of a firing. However, maybe our even bigger concern relates to the unacceptable culture at the very workplace where we are supposed to lead. If, in fact, a more experienced employee advised the new person that forgery was "no big deal," our next steps might include a company meeting where we make proper procedures clear to everyone in a forceful manner. And though we might not all agree about whether the new employee should lose his job over the forgery, perhaps we are closer to all agreeing that if anyone deserves to lose a job, it should first be the allegedly experienced person who gave the terrible advice.

Handling Difficult Conversations at the Workplace

If we are worried about whether a difficult conversation might escalate between us and someone else at the workplace, a few strategies can be employed to increase our chances of a positive outcome:

- Maintain a low-key tone that doesn't make it seem as though you are morally or ethically superior to the other person.
- Have a conversation in a one-on-one setting in order to prevent public embarrassment for either party.
- Attempt to communicate some positives about the situation, the person or his or her goals before making any negative comments.
- Use non-accusatory language rather than personalizing your concerns, and talk about your observations and feelings rather than voicing assumptions about the other person's motives.

CHAPTER 3: MANAGING CARRIER RELATIONSHIPS

We all have ethical duties that are owed to insurance companies. This goes for those of us who are acting as agents of those companies and those of us who are acting more in a brokering capacity and working for the consumer. Whenever you're bringing two parties together as part of an insurance transaction, you're expected to be doing it only in good faith.

Disclosure to Carriers

Earlier in this course, we mentioned telling the truth. When we discuss ethics in business, we tend to think of honesty as something that is owed to consumers. We're taught that if you're misleading someone into making a purchase, you're unethical or a bad person. But the core values that were mentioned in the previous chapter—such as honesty—should also be practiced when we interact with insurance companies. Consider the following scenario:

- You're doing a life insurance presentation in front of a middle-aged man at his home. He has filled out an application and has indicated that he doesn't smoke. However, the home has a faint odor of cigarettes. You ask the man whether he lives with anyone else, and he says he lives alone. How should you handle the situation?

Some producers who have been confronted with this situation have found that mentioning the discrepancy in a tactful way can help reduce application fraud. For example, after being verbally reminded in a non-accusatory manner that inaccuracies on an application could lead to a policy being rescinded, the applicant might ask to review the application again and claim to have made a mistake.

Of course, not all applicants will be so quick to reconsider their actions. If they aren't, the producer might want to at least make a note of the discrepancy somewhere in the documents that will be submitted to the insurance company. This allows the producer to accept some responsibility for his or her actions but also leaves the door open for a potential sale if the matter is simply a major misunderstanding.

Given our proposed scenario, you might reason that misrepresentations regarding an applicant's smoking habits will be caught anyway by a medical test. This is a fair point, particularly in many life insurance transactions, where paramedical exams are relatively common. However, does the likelihood of a medical test release the producer from his or her responsibilities? Don't forget that insurance producers, along with claims adjusters, underwriters and others, have a responsibility to speak out about potential insurance fraud and that the producer is more likely than anyone else at the carrier to have an understanding of an applicant's character.

What about disclosure related not to an application but to knowledge of a loss? Does that change our duties to inform a carrier of potentially important information? Consider the following scenario:

- Your best friend, who is also one of your property insurance customers, has had a lot of bad luck. His roof was damaged in a hailstorm a year ago, and his house was burglarized last summer. Now an electrical problem has caused a small fire in his kitchen. He estimates that the amount of fire damage will be only slightly higher than his policy's deductible. Your friend says he doesn't want to report the fire because it might cause him to be non-renewed at the end of his policy term. You agree that non-renewal is likely. But you believe the carrier would want to know this information. What do you do?

Many producers who have been presented with this scenario admit to not feeling an obligation to inform the carrier. Perhaps their reasoning is based on a combination of not wanting to start telling consumers when and when not to file claims, as well as a sense that unreported losses like this one (or fender benders in auto insurance) occur on a regular basis and are already somehow factored into the price of insurance.

But let's assume a slightly paranoid stance for a moment and imagine what might happen if the problem that caused the small kitchen fire eventually returns and causes an even bigger loss. In that case, the agent in our story has hurt the carrier via nondisclosure and could seriously damage his or her relationship with the company if the nondisclosure is ever revealed. Suppose, when questioned about the bigger fire, our friend turns on us and says he was told by us not to mention the earlier problem. Hopefully, we will never be in such a situation, but it's worth considering our rationalizations for not disclosing everything to carriers and whether those rationalizations are appropriate.

Company Loyalty

Most of us probably have confidence in the products we sell. But what if we are required to sell something we don't fully believe in? Depending on our contractual relationship with an insurance carrier, we might be required to sell those products anyway, even if they aren't always what's best for a buyer.

Yet how can we ignore our ethical obligation to focus on a person's needs rather than being overly influenced by corporate pressure to sell, sell, sell? Consider the following scenario:

- You work for a large property and casualty insurance carrier that requires its agencies to satisfy a small annual sales quota related to life insurance products. This is the first year in which the quota is being enforced, and practically all the agencies that you help oversee have met this modest requirement. However, one agency that brings in more than $2 million in annual premiums hasn't come close to hitting the quota. You call the agency owner, who tells you she thinks your life insurance products are bad and that she's decided to focus instead on bringing in even more property and casualty business. You know these life insurance products are complicated and more expensive than what your competitors are offering. What do you tell the owner?

Before making a final decision, our first action should probably be to question the owner about her position. If we're lucky, she might merely be resistant to change and be capable of being won over to selling our life insurance products with more training about their best features. If, on the other hand, she has done her homework and truly believes selling our life insurance products is wrong for her customers, our situation becomes much harder. We don't want to force someone to do something that is against his or her principles, yet we do have an obligation to our company to enforce its rules.

Some producers might feel comfortable pairing the agency owner with another agent who is much more excited about selling the products and allowing the two of them to share credit for any life insurance sales so that the principled agent isn't punished. But since the world isn't always as big as we believe it to be, what might we do if word of our concession gets around to other agents who begrudgingly sold these life insurance products and didn't get similar treatment? Presumably, if we believe everyone on our team should be treated with basic equality, can we grant an exception to one agent without also at least considering the same exception for everyone else?

Handling Money

Some of the most serious ethical violations committed by producers against insurance companies involve improper money management.

Many states consider insurance licensees to have "fiduciary" relationships, either with the insurance companies they represent or with the consumer who hires them. Being in a fiduciary relationship essentially means that a producer is being put in a heightened position of trust. In the event of wrongdoing or negligence, a producer with fiduciary status will be held to stricter standards and is likely to be penalized more severely than someone without fiduciary status.

Traditionally, insurance agents have owed fiduciary duties to insurance companies, and insurance brokers have owed fiduciary duties to consumers. This traditional way of viewing insurance relationships has been modified or even abandoned in many jurisdictions. For example, unlike California, some states don't make a distinction between agents and brokers in their insurance laws. Meanwhile, some states have decided to restrict the kinds of situations in which an agent or broker is considered to have fiduciary status.

But even where fiduciary status and its accompanying duties have been limited, a producer might still be considered a fiduciary in regard to handling money. If collected premiums don't go to their intended recipient or aren't used for their intended purpose, the producer in charge of transferring them will have some serious questions to answer.

One example of unethical money management would be commingling of funds. Commingling occurs when you take money that's intended for one party or one purpose and mix it in with money that's intended for a different purpose. Commingling is discouraged—and often illegal—because it makes it easier for accountholders to pay their own bills with other people's dollars.

Not all businesses engaging in commingling have theft in mind. Some simply don't have the patience for accounting and believe keeping all their money in a single account makes life simpler for them. But commingling is a problem because it makes it significantly harder to keep track of which dollars belong to whom. If multiple members of the organization have access to the single account, it also makes it easier for a devious person to get away with making inappropriate withdrawals. Plus, if people keep all funds in one general operating account and end up having to declare bankruptcy, money belonging to someone else can become inaccessible to its rightful owner.

If you are collecting premiums from consumers, you probably need to put them in a carefully maintained "premium fund trust account." Each state is likely to have its own rules about where these accounts must be established, what types of funds can be deposited into them and how and when withdrawals are to be made. In general, these accounts are intended only as a holding place for money that will ultimately either be transferred to an insurer or refunded to a consumer. Because the money in them belongs to someone else, the accounts can't be tied to risky investments.

CHAPTER 4: ETHICAL SALES

An ethical approach to selling insurance is likely to require a carefully self-monitored combination of disclosure, analytical skills and professionalism. Your success depends on your ability to explain complex products, determine how they apply to a prospect's goals and convince people that you, out of all insurance professionals, are the right person to buy from. Your chances of nurturing a positive relationship with a new client start upon your very

first interaction with the person and continue as you learn more important information about the person's needs.

Before turning to the specifics of a particular product that might be worth purchasing, you have an obligation to clarify some basic facts for any prospect who you encounter. These basics include, but aren't necessarily limited to, the following items:

- Who you are.
- What you're selling.
- Which company or insurance entity you represent.

As a first step toward being clear about this information, think about what's printed on your business cards and email signatures. If you include any titles under your name that are meant to suggest a heightened level of insurance-related expertise, were they earned through successful completion of special courses or exams? If not, what is your rationale for including them? Although many people earn insurance designations in order to attract more business, unearned titles that are included for the sole purpose of luring new customers might confuse and ultimately alienate the very people you are hoping to attract.

If you have pride in your role as an insurance professional, you should have no problem clearly informing prospects that what you are selling is, indeed, a type of insurance rather than a mysterious-sounding financial tool. In the senior market, it is fairly common for producers to invite prospects to free seminars with the promise of a free meal and some tips about how to plan responsibly for retirement. In fact, many of these seminars are introductory sales presentations about annuities, yet the word "annuity" is often absent from the seminar organizer's advertising. Does the organizer leave out the word "annuity" because of a belief that recipients won't understand the term? Or is the lack of clarity an intentional form of deception, done under the assumption that less people will attend if they know an insurance product (such as annuity) will be discussed? Even if you engage in this type of advertising for what you believe are valid, well-intentioned reasons, it might be worth considering how others—including your audience and regulators—are likely to perceive it.

Being clear about the companies or other insurance entities that you represent can be particularly important in the senior market because of the link between various senior-focused products and federal programs such as Medicare and Social Security. As much as producers in this market might feel the need to emphasize the gaps in federal programs and the ways in which insurance can help fill those holes, your clients and prospects should never be allowed to think that you and your company are, in fact, affiliated with the state or federal government unless such affiliations are true.

Unfortunately, widespread misunderstandings about health insurance laws and government benefits have made it easy for scam artists to trick vulnerable citizens. For example, soon after passage of the Affordable Care Act in 2010, insurance regulators were already warning the public about real cases in which licensed producers falsely claimed to be from the government and conned people into purchasing bogus coverage. Such sad cases of deception help explain why states and federal departments tend to be very strict regarding the use of their names and their logos in advertising by private companies.

Disclosing Material Facts

Based on our own experiences when shopping for complex and relatively expensive products, we probably believe that consumers have a right to be informed of all material facts related to what we sell. But putting this belief into practice can be a challenge because the meaning of a "material fact" can differ from person to person, product to product and

transaction to transaction. When deciding what must be disclosed to a potential purchaser, ask yourself, “What pieces of information are likely to have an impact on this person’s decision to buy or not buy what I’m selling?”

More often than not, your answer will at least include the items on the following list:

- Price.
- Dollar limits.
- Major exclusions.
- Waiting periods or deductibles.
- Tax penalties or surrender charges (for insurance products with a cash value).
- Other issues that the applicant clearly cares about (based on your conversations with the person and your investigation of the person’s stated goals).

Many insurance policies include a “free-look period,” which allows a policyholder a set number of days (such as 10 or 30) to review an insurance contract after a purchase and cancel the coverage in return for a full refund of paid premiums. Although free-look periods are often mandated by law as a form of consumer protection, they should not be used as an excuse to avoid disclosure of material facts in advertising or in conversations with prospects. Since most insurance customers lack the time and the interest to actually read their policies, your role in educating your clients about the specifics of their insurance portfolio is immensely important.

Producers who advertise their products and services on social media platforms should be mindful of the ways in which these platforms can directly and indirectly put limits on the ability to disclose all required information. For example, some social media sites force users to keep all of their communications below a certain length. Other social networks might not have rules about the length of posts, but producers might instinctively compose short items online because of the internet community’s emphasis on shorthand communication.

Your commitment to disclosing material facts might be more obvious if you hold yourself to strict and consistent standards in all of your marketing campaigns, no matter if they are done via the mail, the phone or any corner of the internet. If a particular platform doesn’t allow you to make the kinds of disclosures that would be important to your audience, you might want to reevaluate your advertising plans.

Watching Your Language

If you spend most of your day talking about insurance, it’s very easy for the occasional vague word or unclear phrase to come out of your mouth. If you catch this happening to you, it might be appropriate to pause for a moment and then reframe the word or phrase so that your audience understands the content of your message. Since the average person knows so much less about insurance than a licensed producer, we might forget how easy it is for a consumer to misinterpret our language and how hard it can be for someone to put insurance information within the proper context.

Here are some words that, while not necessarily inappropriate, might deserve some clarification:

- “Unlimited.” (A health insurance product might have an “unlimited” benefit cap but might limit the insured’s choices in regard to networks of doctors.)

- "Comprehensive." (A product might be fairly "comprehensive" compared to similar products in the market but is still likely to have some important exclusions.)
- "Generous." (Who is to say what is "generous" and what isn't?)
- "All." (Insurance policies are complex legal documents. Words like "all" are often misleading because one broadly worded portion of a policy is often subject to exclusions found in another portion of the policy.)
- "Guaranteed." (This term can be particularly dangerous in regard to interest-sensitive life insurance policies. Whereas there might be a "guarantee" associated with a death benefit, there might not actually be a guarantee associated with cash values or dividends.)

Coping With Competitors

In an ideal world, you will have an extreme amount of confidence in your products and services and won't need to waste much time worrying about what your competitors are up to. Keeping quiet about other producers and other insurance companies in front of your clients can be both a sign of professionalism and a risk management tool that reduces your chances of making a libelous or slanderous statement. But, of course, we don't really live in that ideal world where everyone plays fairly.

Consider this scenario:

- You have invested a great deal of effort into a new prospect and are on your way to a meeting where you expect to finally win her business. When you arrive, the prospect apologizes and says she has decided to go with one of your competitors. You have a long history of losing business to this competitor, whom you believe is very quick to sign up new business but very slow to provide good service. Without being prompted to do so, the prospect reveals that she got a "great deal" from your competitor and tells you about "promises" that the competitor allegedly made. Based on the prospect's words, it's clear to you that something is wrong. She either has a clear misunderstanding of how her desired insurance product really works or was given bad information by your competitor in order to close the deal. Now, you're not only annoyed that you lost this business but also fearful that the prospect has made a very serious and potentially harmful mistake.

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- How is the prospect likely to respond if you imply that the competitor's offer is too good to be true?
- Since you can't prove what really happened between the prospect and your competitor, is it wise to take no action at all?
- What might happen if you were to say nothing about your suspicions to the prospect but raise the issue in a private phone call with the competitor?
- How would you respond if a competitor contacted you and raised concerns about your own business practices?

- If you believe you need more information about the situation in order to proceed, how can you obtain it while also being mindful of privacy concerns?
- If this were the first time that you'd suspected the competitor of unprofessionalism or bad behavior, would you be more inclined to ignore the situation?

High-Pressure Scare Tactics

Fear plays a central role in insurance. In most cases, in fact, it is the very thing that gets people to purchase insurance in the first place. We purchase life insurance because we worry about the impact our death might have on our loved ones. We purchase property insurance because we worry about fires destroying our home and all of our belongings. We purchase health insurance because we worry about getting into a serious accident or being diagnosed with a serious illness.

Fear, in and of itself, can be a positive motivator because it can force us to find solutions to problems that we'd otherwise prefer to ignore. You might even argue that part of your duty as an insurance professional involves instilling a healthy dose of fear into your clients and making them confront the very real risks that exist in today's complicated world.

But at what point do we risk crossing the line between providing people with a healthy dose of reality and scaring them in cruelly manipulative ways? Consider this scenario:

- A middle-class married couple meet with a life insurance salesperson. They agree that term life insurance should be purchased for each spouse so that if either one dies, the surviving spouse and their two young children will be able to maintain their standard of living. The salesperson is willing to help them obtain their requested type of insurance but also asks them whether they would be interested in buying life insurance on their children. The couple declines, but the salesperson continues to pursue the possibility with them. "The right policy can help them save for college," he says. "Plus, you never know. They might be healthy now, but if one of your kids is ever diagnosed with a serious illness, they might never be eligible for good coverage later on. So now would be a great time to buy some." Again, the couple expresses no interest, and the salesperson makes another attempt to persuade them. "You have two kids. If an accident were to happen, have the two of you thought about how you would pay for two funerals at the same time? I'm not trying to scare you. I just want to make sure that we're addressing all possible scenarios."

Now, carefully consider all of the following questions, keeping in mind that there might be more than one "right" answer:

- Was it appropriate for the salesperson to bring up the issue of life insurance on the children at all?
- Was it appropriate for the salesperson to pursue the issue in any way after the couple first expressed no interest in it?
- Was it appropriate to mention the possibility of the children becoming seriously ill or disabled?
- Was it appropriate to mention the possibility of the children dying?
- Does your opinion of the salesperson change if you knew that life insurance on the children would've netted him a large commission? What about a small one?

Focusing on Suitability

One seemingly obvious but not always easy step toward maintaining good relationships with clients is to give them what they need. If you have been in the insurance business for practically any length of time, you probably have noticed that what people need is not always the same as what they ask for. Although consumers need to make the final, ultimate decisions about what to buy, your ethical (and, in some cases, legal) responsibilities include making the appropriate disclosures about requested products and taking the time to understand each person's unique situation.

Even if a prospect seems to have a clear goal regarding his or her financial future, that person might not be capable of articulating it in insurance-specific terms. For a simple example, consider a prospect who claims to want a life insurance policy for short-term needs but then says he wants to achieve that goal by purchasing a variable life insurance policy. In that case, your instincts should lead you to ask more questions and provide some basic education about the differences between term life insurance and the various types of permanent coverage, including variable life insurance. In short, the best way to help people get what they really need is to know your customers.

In order to increase the likelihood of pairing their clients with truly suitable products, many insurance professionals use a checklist of questions that are asked to each and every person before a transaction or recommendation is made. If you've worked in insurance for a long time, this checklist might be a matter of second nature to you and might be committed to memory. If you have less experience or are at all concerned that you will forget to ask an important question, you might rely on a printed copy that you keep in front of you at each of your appointments.

Though your exact checklist will depend on the type of business you're in, here are some basic issues that are worth considering as part of determining suitability for certain insurance products:

- For variable life insurance or variable annuities:
    - Age.
    - Investment objectives.
    - Financial situation.
    - Tax status.

      Note that there might be additional factors that must be considered and documented in accordance with state laws. Also, since variable products are generally considered to be securities, producers selling these products should research their suitability obligations from the Financial Industry Regulatory Authority (FINRA).
- For any type of annuity (fixed, variable or indexed):
    - Age.
    - Income.
    - Financial situation.
    - Financial objectives.
    - Purpose of the annuity.
    - Existing assets.

- Liquidity needs.
- Liquid net worth.
- Tax status.
- Risk tolerance.

Particularly over the past decade, insurance regulators have been concerned about types of annuities that are difficult to understand or that jeopardize senior citizens' financial stability through steep surrender charges and market risks. As annuities become more complicated and more customized to meet the demand of niche audiences, careful explanations of these products takes on even greater importance.

- For long-term care insurance:
  - Applicant's ability to afford coverage.
  - Goals and needs with respect to long-term care.
  - Values, benefits and costs of other applicable insurance.

Affordability of long-term care insurance should be measured not only by current pricing and a prospect's current financial status but also by potential changes that could make coverage more expensive in later years. Despite the benefits of long-term care insurance for many people, insurers have struggled to price this product appropriately. Contrary to initial industry expectations, the amount of people who purchased some of the comparatively generous policies in the early days of the LTC market and cancelled their coverage before ever making a claim turned out to be fairly low. Then, due to shaky worldwide economic conditions in the early 21st century, LTC insurance carriers were unable to earn strong financial returns by investing their collected premiums. These and other factors caused many insurers to leave the LTC market entirely. Meanwhile, many of the companies that chose to stay in the market had little choice but to raise prices for new and even many existing policyholders. Therefore, if you are in a position to help someone choose a long-term care insurance carrier, you may want to conduct research regarding each carrier's financial stability and history of rate increases.

Suitability and Social Media

We touched on the topic of social media in regard to making necessary disclosures. This relatively new method of online marketing also deserves a mention in our discussion of suitability.

If a producer uses a social networking website in order to attract and communicate with a broad range of followers, any posts that a producer puts out on the social networking site should be written in ways that don't confuse readers into believing that a specific recommendation is being made.

Consider a producer who has 1,000 followers on a social media network and who posts a message to everyone that says, “Call me today to learn how universal life insurance can satisfy all of your estate planning needs.” While it is certainly possible that some among the 1,000 followers are, indeed, good candidates for universal life insurance, the producer’s post has the potential to mislead the rest of those followers and make them believe that universal life is a one-size-fits-all product.

Concerns about disclosure and suitability are at least partially responsible for the manner in which many of today’s major insurance carriers conduct their social media marketing campaigns. Instead of emphasizing the benefits of specific products and using sales-heavy language, most carriers use social media to educate the general public about risk and to engage current and potential policyholders in fun, light-hearted conversations. For example, instead of posting about how everyone should purchase auto insurance from them, carriers might use social media to pass along car maintenance tips to drivers. Instead of pushing followers to make changes to their homeowners insurance, a property insurance carrier might offer advice about what to do before and after a storm so damage can be minimized and claims can be paid quickly. Independent agencies might have more freedom to get personal on social media, which might involve posting about the local little-league team that the agency has sponsored or providing fun facts about the producers and office personnel who work there. Regardless of the specifics of a social media campaign, the emphasis tends to be on the subtle building of personal relationships rather than on selling.

Since most insurance advertising regulations were written prior to the widespread popularity of social media, the specific requirements for producers who market themselves online aren’t always clear. Even if your state has not specifically addressed acceptable types of conduct on social media, here are some basic tips that can help you maintain a good ethical reputation:

- When discussing a specific type of insurance, reserve some space for any important disclosures.
- Think before you type. Don’t risk making controversial statements as a result of anger or carelessness.
- Plan ahead so that you can discuss any ethical or legal concerns about your online advertising campaign with an attorney, compliance officer, supervisor or carrier.
- Treat online communications as seriously as hard-copy communications. If you have a system in place that involves careful proofreading and editing of items sent through the mail, use the same process for anything posted online.
- Keep your social media posts general and educational rather than product-specific.

Handling Web Rage

Despite its many positives, the internet also provides a forum where misplaced anger can be vented and used to harm people’s reputations. Think back to the comments section of a typical online article and recall how many of those comments were negative, spiteful and needlessly hurtful. Putting yourself online as a businessperson, while generally advisable, can open you up to those same risks of unexpected incivility.

If negative comments about your business appear online, no matter their level of fairness, how much should you engage with the person who wrote them? Consider the following scenario:

- Upon logging into one of your agency's social media accounts, you notice that a customer has posted an embarrassingly negative comment about your level of service. You believe encouraging an open dialogue on social media is important to staying in touch with clients, but you're truly shocked by the person's negative review. You're also worried that the comments will harm your reputation among any online visitors. What do you do?

In a heated moment, we might frantically type a reply for all the world to see and refute the person's negative comments. But we can't give in to the urge to escalate the confrontation, particularly when the fight can be seen publicly by other online visitors. Nor do we want to take the other extreme and completely ignore the situation, thereby sending a message to the online community that we really don't care about our customers' problems or criticisms.

Arguably the best route is somewhere down the middle of engagement and disengagement. For example, a comment left in the public forum such as, "I'm sorry you had a negative experience. Please call me, and we'll try to resolve your concerns," can showcase your professionalism without making the situation worse.

CHAPTER 5: TIPS FOR ETHICAL INSURANCE PROFESSIONALS

We've addressed unethical behavior and some of the consequences for consumers. But let's assume you're a very ethical person and always try to treat people well. What are some precautions you can take to avoid making a mistake or being accused of wrongdoing? The next few sections contain some simple pointers for you.

Analyzing Needs

To keep the consumer satisfied, you'll want to ensure that the products presented to a potential purchaser are suitable. When you meet with a new customer, you should conduct a needs analysis in order to determine the suitability of specific products. To perform a proper needs analysis, you must ask several questions and listen carefully to the answers.

Helpful questions might include:

- What are your needs and goals?
- What kinds of property do you currently own?
- What do you do for a living?
- Do you own your own business?
- Do you have a family?

In spite of the important information that can be learned from those questions, you should consider alerting the consumer that the answers won't have an impact on their eligibility for insurance (as long as that's the case). Depending on the kind of insurance and the state where you do business, certain factors (such as marital status) cannot be used to charge someone more or to limit a product's availability.

The needs analysis is important because no two people are exactly alike. Even in a broader context, what you'd sell to a senior citizen is probably going to be different from what you'd sell to an 18-year-old. Similarly, what you'd sell to the 18-year-old is probably going to be different from what you'd sell to a 40-year old.

If you're working with a senior citizen, the main insurance concerns might be estate planning and paying for health care. An 18-year old might need renters insurance if he or she has an apartment. Auto insurance would be needed, too, if the person has a car.

At 40, there might be a bunch of things that are needed because 40-year-olds are more likely to have dependents. Life, disability and homeowners insurance are all legitimate possibilities. So is extra liability insurance if the person has significant assets or has a pool or a trampoline in the backyard. The 40-year-old might also have a business, which opens up the door to a variety of commercial products. The list of possibilities could go on and on.

Assisting Elderly Customers

You'll want to use special care when working with clients who are elderly or disabled because there might be physical or mental impairments that can create a communication problem. The person might not be able to hear you or speak clearly. In situations like this, you might find it helpful to have one of the person's trusted family members in the room. But even then, you'll want to get a sense that the family member isn't the one making the decisions. Unfortunately, some caregivers don't always have people's best interests at heart and will engage in coercion.

Maintaining Documentation

No matter who you meet with or speak to, it's important to take and keep good notes. Taking detailed notes about all of your interactions with the public can decrease the likelihood of disagreements regarding what was said or not said in conversation or what kinds of financial advice were or were not provided. If you and an angry consumer continue to dispute the facts of a particular meeting or conversation, your notes can help defend you in the event of a regulatory complaint.

However, good note-taking shouldn't be an activity that is done only on occasion. In order to aid your credibility and for your notes to serve as an adequate piece of evidence, you may need to show that you take detailed notes in all similar circumstances.

The notes you take about client interactions should be contemporaneous rather than after the fact. The quicker you are to document something, the better chance you'll have at remembering all of the important details.

Some agents keep handwritten notes in client files. Others keep a continuous record in a computer software program. In either case, some sales professionals find it helpful to send an email to clients containing a summary of a conversation's key points. In addition to the summary, the email might ask the recipient, "Do you agree that this is what we discussed?" The client can then respond and clarify points where necessary.

In order to maintain a clear picture of your relationship with clients, and to protect yourself, here are some documents that you might keep in an organized, readily accessible fashion:

- Copies of completed applications.
- Copies of any written correspondence with clients.
- Copies of any written correspondence with insurance carriers.
- Notes from meetings.
- Notes from phone calls.
- Notes regarding all attempts to contact clients (for example, a note that you left a voice mail regarding an upcoming policy renewal).
- Notes regarding the timing of various mailings to clients or prospects.

A Note-Taking Case Study

In order to underline the importance of notes, let's go through an extended scenario, which was developed with the help of a former securities regulator. At the end of our story, you should also be able to see how consumer complaints of practically any kind can complicate matters for licensees.

Our story begins with a concerned daughter who has gone through her elderly mother's paperwork. After noting some suspicious documents, she discovers that her mother recently canceled a decades-old life insurance policy and bought a new one. Since the annual premiums were the same for both policies, the daughter is unsure why the replacement took place. After talking with her mother, she convinces herself that a slick life insurance agent tricked her mother into switching insurance for no good reason.

The daughter contacts her state's insurance department and is told to send copies of any relevant documentation to the local regulators. With her mother's consent, she sends copies of the new policy and the canceled policy, along with notes that the daughter took when the old policy was issued.

Upon receiving the documentation from the daughter, state regulators are able to identify the agent who sold the new life insurance policy and note that the agent has already had two similar complaints filed against him. Concerned that the latest complaint might represent a pattern, state regulators assign an investigator to the case.

At this point, the assigned investigator is concerned not only about the actions of the agent who sold a policy to the mother but also about the overall business practices at the agent's place of employment. In order to determine whether there is misconduct at the agency level, or perhaps a failure to supervise, the investigator writes to the agency's compliance officer and demands that all of the agency's records be readied for a visit. Because of the complaints against this one agent, ALL of the business's records (those related to the specific agent and those unrelated to him) will be subjected to scrutiny.

In response to the request by the investigator, managers at the agency start covering their tracks. They identify records proving that all agents have undergone ethics training, and they reprimand the agent in writing. Unfortunately for the agent, the agency managers are more concerned about protecting themselves than about protecting him.

Meanwhile, the daughter has hired legal counsel and has announced that she and her mother plan to sue the agent for damages. Since his managers don't seem willing to support him, the agent decides to hire his own attorney. Luckily for him, the agent has made a habit of keeping detailed notes during all of his client interactions and of all company meetings. Through those notes, he is able to show not only that replacing the life insurance policy had a tangible benefit for the mother but also that his managers emphasized the money-making potential of life insurance replacements to all agents in the organization. Based on the various headaches caused by the entire experience and lack of support, the agent determines that he will be happier working someplace else.

We could take this scenario even further, but the story's two key points should already be clear to you:

- Regulatory complaints, even those in which no wrongdoing actually occurred, can be a big problem and should be avoided when possible.
- Maintaining detailed notes is an essential element of risk management for insurance professionals.

Keeping Yourself Informed

The evolution of the insurance industry doesn't stop once you pass your licensing exams. In order to serve the public well and remain on good terms with insurance regulators, sales professionals must take some initiative and keep up with what's happening around them.

While employees at large insurers might receive comprehensive training and frequent regulatory updates from a compliance department, licensees who work either alone or at small agencies must work a bit harder to remain up to date. Let's look at a few simple tasks that can help you keep up with important changes.

Looking Online

As part of keeping up with changes in state requirements, you might consider checking the website of your state's insurance department on a regular basis. Most departments will post important updates online, and some have completely stopped sending important news by regular mail. State websites are also likely to contain links to relevant insurance laws and administrative rules.

Regular Reading

Trade publications can help inactive licensees keep track of important trends in the insurance community. Many respected insurance publications offer free online newsletters that are delivered on a monthly, weekly or even daily basis. Others might be included as part of your membership in an insurance trade organization.

Reviewing Company Guidelines

Active licensees should periodically review any company handbooks or agency agreements that they receive as part of their employment with various agencies and insurance carriers. In many cases, the licensee will be representing an insurance company as part of a transaction and must conduct business in a manner prescribed by the company. It's possible that a company handbook or agency contract will put restrictions on a licensee's conduct that are more strict than local laws or state rules.

If you are in a supervisory position and do not have a handbook, you might want to consider creating one. Having sets of procedures all in writing and all in one place can make it easier for your subordinates to respond to problems. Of course, you will want to ensure that workers who receive the handbook actually read it.

Note: *The remainder of this ethics course includes text written by the California Department of Insurance as part of mandatory anti-fraud training for agents and brokers. The text is taken directly from a video transcript provided by the Department of Insurance and is required to appear here verbatim without changes to wording, grammar or punctuation. As a result, the style, voice and formatting may differ from the rest of this course.*

As part of the course completion process, you will be required to affirm that you have read this material from the California Department of Insurance.

CHAPTER 6: CALIFORNIA INSURANCE AGENTS AND BROKERS ANTI-FRAUD AWARENESS TRAINING

Hello and welcome to the required one hour anti-fraud awareness training.

You are participating in this training because you are either working toward obtaining your agent or broker license in the State of California, or you already have your license and are in need of this requirement to renew it.

In the next hour, you will hear from Commissioner Ricardo Lara and several Enforcement Branch personnel as we walk you through who we are, what we do and what your obligations are if you suspect potential insurance fraud may be occurring.

Message From Ricardo Luna: California Insurance Commissioner

Hello and welcome to the California Insurance Agents and Brokers Anti-Fraud Awareness Training.

I'm California Insurance Commissioner Ricardo Lara.

As insurance agents and brokers you provide an essential service and serve as an important resource for homeowners, renters, drivers and consumers across the state.

You also play a key role in anti-fraud effort for the insurance industry as you are in a unique position to detect suspicious insurance applications, potential fraudulent transactions, and claims, and stop them before the fraud is committed.

Because of the change in state law, beginning in 2023, agents and brokers now have a duty to report suspected fraud. The new requirement will assist investigators in our Department to do our job to protect consumers.

To help you comply with this law, our Department of Insurance has put together this training.

This training is really aimed at helping you identify red flags for potential fraud so you can meet your reporting duty. In doing so, you are helping prevent fraudulent insurance transactions and sending a strong deterrent message.

Our enforcement team is the largest branch in the Department, with more than 300 staff dedicated to protecting Californians and stopping fraud. Our team includes Detectives, Investigators, and support staff who work everyday to meet the Department's mission of insurance protection for all Californians.

Fraud hurts all of us, but by working together to fight fraudulent claims we can better serve our consumers.

Thank you, thank you for choosing a career in insurance and doing your part to keep California's insurance marketplace the strongest in the nation.

Thank you again, Muchas Gracias!

Insurance Fraud in the United States

The Coalition against insurance fraud is a group comprised of 281 member organizations that include both private and public groups. The Coalition was formed in 1993 and has dedicated nearly 30 years of work and research in the fight against insurance fraud.

The Coalition conducted a massive study that concluded with a report issued in 2022. The results of the study indicate there to be at a minimum $308 billion lost to insurance fraud each year. And it is estimated that about 10 percent of losses in property and casualty involve some element of fraud.

For agents and brokers, this is a significant number and can impact your profitability.

For more information about the Coalition Against Insurance Fraud, please visit their website at www.insurancefraud.org.

The California Department of Insurance: An Overview

Here are some highlights of the California Department of Insurance. If I may draw your attention to bullet points number 2 and number 4 here. The CDI has roughly 1,400

employees and 30 percent of those work in the Enforcement Branch. That is a lot of resources dedicated to the fight against insurance fraud. In fact, of the 11 branches within the California Department of Insurance, the Enforcement Branch is the largest. In a few moments, you will see why those resources are needed and some of the phenomenal work that our branch does.

Checkpoint

Here is a quick checkpoint question, and this is the first of many. The Departments goal is to provide training and form a partnership with you.

To effectively do that, we wanted to ensure that certain elements throughout this course were being retained. So, this checkpoint question is – How many operational branches exist in the California Department of Insurance?

And the answer is 11. Remember, there are 11 branches, with the Enforcement Branch being the largest.

The CDI Enforcement Branch

Before we get into numbers, figures and the particulars of what the Enforcement Branch does, please allow me to first outline our structure.

The Enforcement Branch has two divisions and an administrative support section.

Today, you will hear from both the Fraud Division and Investigation Division. But as a quick summary, the Fraud Division handles fraud committed against the insurance industry, such as claimant fraud, while the Investigation Division handles fraud and misconduct committed by agents, licensed and unlicensed, brokers and insurers.

Our divisions and the administrative support personnel occupy nine regional offices within California.

As mentioned earlier, we account for about 30 percent of CDI employees, equaling 424 positions. The rest of our resources are broken out here. You can see we operate with a significant budget as well as handle the administration of tens of millions to County District Attorney offices to assist in our fight against insurance fraud.

Insurance fraud in California impacts all of us and we are pleased to have these resources available to work toward helping California consumers.

For the next several minutes you are going to hear from one of our Investigator Supervisors and a seasoned Fraud Division Detective. They will provide some insight on recent cases and how the resources provided to our Department are used.

The Investigation Division

The mission of the investigation division is to protect California consumers by investigating suspected violations of laws and regulations pertaining to the business of insurance and seeking appropriate enforcement actions against violators.

Effective enforcement of the insurance laws help to safeguard consumers and insurers from economic loss and eliminate unethical conduct and criminal abuse in the insurance industry.

The investigation division is charged with enforcing applicable provisions of the California Insurance Code under authority granted by Section 12921. The Division pursues prosecution of offenders through both regulatory and criminal justice systems. The Investigation Division employs over approximately 90 investigative and support staff that

are assigned to seven regional offices statewide to handle the large volume of complaints that are filed.

When appropriate, the Division will partner with a number of other state and federal agencies. Which include local law enforcement agencies, the Franchise Tax Board, the U. S. Postal Service and the FBI.

The Investigation Division Works These Kinds of Cases

The Insurance Commissioners priorities emphasize investigation and prosecution and in the following areas that concern the Investigation Division.

They include premium theft, senior citizen abuse, health insurance violators, illegal bail practices, unauthorized insurers and insurance transactions, deceptive sales and marketing practices, title insurance rebates, public adjuster violations, abusive acts committed by auto insurance agents and companies.

Investigation Division Case Work

In the last Fiscal Year, the Investigation Division opened 472 new cases, and working with the Departments Legal Division, obtained 236 administrative actions. The Investigation Division also made 20 criminal arrests while also carrying out the mission of protecting California consumers.

More Investigation Division Examples

Examples of case work done by the Investigation Division include agents forging documents and committing identity theft, premium theft, a broker or agent misappropriates premium payments and provides clients with phony documents as proof of coverage.

Material misrepresentations on life insurance and annuity policy applications in order to generate six figure commissions for the writing agent. Selling unregistered and non-existent investments to clients. Agents knowingly backdating an auto policy. Advance commission schemes and brokers and agents using unlicensed persons to issue quotes, bind policies and facilitate insurance policy transactions.

A Recent Investigation Division Case

Here is an example of an investigations case. Here we have a case that is joint between the California Department of Insurance and multiple federal and local law enforcement agencies against bail bondsman acting in bad faith and outside the law. These three defendants are charged with multiple felony counts of kidnapping with the use of a firearm, false imprisonment, residential burglary and misdemeanor counts of false arrest under color of authority, brandishing a firearm, acting as a fugitive recovery person as a convicted felon, acting as a fugitive recovery person while unlawfully carrying weapons and failing to notify law enforcement prior to arresting a bail fugitive.

Here is another recent example of investigative casework. In this case, a previously licensed agent stole identities of multiple individuals in a scheme to open a fraudulent insurance agency. His actions didn't stop there, he also used those stolen identities to attempt to open small business loans to fund his fraudulent insurance agency under the name of Cyber Access Insurance Agency.

Checkpoint

It's time for another checkpoint question.

This one asks, what is the focus of the Fraud Division within the Enforcement Branch?

Your options are fraud committed against the insurer, fraud committed against the consumer, fraud committed against elders/seniors, fraud committed by agents or brokers.

And the answer is A. Fraud committed against the insurer.

In looking at your other options here, fraud committed against the consumer do not meet the definition of insurance fraud. Fraud committed against elders or seniors also won't meet the definition unless the fraud includes an element of misrepresentation on an insurance policy where the insurance company is the victim. The final option, fraud committed by agents or brokers is not the responsibility of the Fraud Division, but rather the responsibility of the Investigative Division that you just heard about.

The Fraud Division

The Fraud Division is staffed by sworn personnel who conduct criminal investigations into various types of insurance fraud related violations. The Fraud Division is composed of four separate insurance fraud programs: Automobile Insurance Fraud, Workers' Compensation Fraud, Property/Life/Casualty Fraud, and Disability and Healthcare Fraud. Fraud Division detectives also provide assistance, as well as training for consumers, the insurance industry, and allied law enforcement agencies. The Fraud Division hosts several task forces with the mission to combat specific areas of insurance fraud, such as the Organized Automobile Fraud Activity Interdiction Program and regional worker's compensation anti-fraud consortiums. Fraud Division detectives may be assigned to various local law enforcement task forces such as auto theft, computer forensics, underground economy, pharmaceutical fraud, and disaster fraud. This pooling of resources and expertise has identified strategies to aggressively investigate and deter fraudulent behavior. Fraud Division detectives are also tasked with identifying emerging trends in insurance fraud in order to protect California consumers.

The Fraud Division: Penal Statutes

Within the four Fraud Division programs, detectives investigate crimes related to sections 549 and 550 of the Penal Code, and 1871.4 of the Insurance Code.

Additionally, there are many other criminal violations associated with insurance fraud found in the Penal Code, Insurance Code, Labor Code, and Business and Professions Code.

Oftentimes, detectives uncover related crimes during their investigations, such as conspiracy, human trafficking, grand theft, automobile theft, arson, forgery, and embezzlement.

The Fraud Division: Penal Code Section 549

Penal Code 549 addresses illegal referrals and solicitation in connection with insurance fraud. This code is often associated with illegal activities concerning automobile insurance, however, the code applies to any type of fraud that falls within Penal Code 550 and Insurance Code 1871.4.

Any firm, corporation, partnership, or association, or any person acting in his or her individual capacity, or in his or her capacity as a public or private employee, who solicits, accepts, or refers any business to or from any individual or entity with the knowledge that, or with reckless disregard for whether, the individual or entity for or from whom the solicitation or referral is made, or the individual or entity who is solicited or referred, intends to violate Section 550 of this code or Section 1871.4 of the Insurance Code is guilty of a crime…

The Fraud Division: Penal Code Section 550(A)

Penal Code 550 (A) delineates the various unlawful acts regarding any false or fraudulent claim. Subsections 3 and 4 specifically mentions claims associated with vehicles, however subsections 1, 2, and 5 apply to any false or fraudulent claim.

Subsections 6 through 10 cover unlawful acts connected specifically with health care benefits.

It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer, with an intent to defraud.

(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of a motor vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented, in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit that was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.(10) For purposes of paragraphs (6) to (9), inclusive, a claim or a claim for payment of a health care benefit also means a claim or claim for payment submitted by or on the behalf of a provider of any workers' compensation health benefits under the Labor Code.

The Fraud Division: Penal Code Section 550(B)

Penal Code Section 550(B) covers unlawful acts in connection with a claim or payment or other benefit pursuant to an insurance policy. This section can apply to an unlawful act committed in connection with a legitimate claim for a loss.

It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(3) Conceal, or knowingly fail to disclose the occurrence of, an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(4) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

Insurance Company Data

This chart shows a three year comparison of the total amount of insurance claims filed in California, the amount of claims referred to insurance carriers' Specialized Investigative Units, the amount of Suspected Fraudulent Claim referrals made to the Fraud Division, the amount of arrests made by the Fraud Division, and the amount of criminal convictions obtained by the various district attorney's throughout the state.

	2018	**2019**	**2020**
Claims in CA	209,800,209	68,197,096	103,976,124
Referrals to SIU	120,531	116,439	176,166
Fraud Referrals (SFCs)	23,341	23,723	20,203
Open Cases	1,341	1,828	1,817
Arrests	482	613	554
Convictions	430	386	400

A Recent Fraud Division Case

August 11, 2022 in San Bernadino, CA – Branden Heywood, 30, of Chino, was arraigned yesterday on 39 felony counts of insurance fraud after an investigation found he allegedly acted as the leader of a "paper collision" ring to collect over $80,000 in undeserved insurance payouts. In a "paper collision," the accidents never occurred and perpetrators use false documents to commit fraud.

This recent case involved an individual that functioned as a ringleader for a staged collision ring. The investigation revealed that the suspect was using his identity and others', including the identities of his minor children, to stage fake collisions by submitting fictitious medical records and altered California Highway Patrol collision reports to insurance companies in order to collect insurance payouts. The suspect recruited people on social media to say they had been passengers in the fake collisions. As a result, five additional suspects have been charged with felony insurance fraud.

A Recent Fraud Division Case

December 9, 2022 in Los Angeles, CA – Kenneth McDaniel, 32, was arrested yesterday on four felony counts of insurance fraud and assault with a deadly weapon after an

investigation found he allegedly caused a vehicle collision in order to receive an undeserved insurance payout. The suspect cut in front of the victim and then abruptly stopped his vehicle for no reason. The entire accident was captured on dash cam.

The type of alleged scheme in this case is called a swoop and squat and is used to force a victim to remain in their lane so a collision cannot be avoided. These types of intentional collisions are extremely dangerous, not only for those involved, but for anyone on the road. The Fraud Division not only investigates these types of collisions, they also conduct training with local and state law enforcement agencies on how to identify and investigate these types of violent crimes.

More Recent Fraud Division Cases

This slide details several more recent investigations conducted by the Fraud Division. These examples demonstrate how insurance fraud can take a variety of forms, from concealing hit and run collisions to doctors submitting fraudulent bills pursuant to workers' compensation claims.

- A hit-and-run accident involved a driver excluded from a driver's insurance policy. Suspects in this case misrepresented who was driving.
- A suspect claimed that a vehicle was stolen when it was instead driven to Mexico and left there.
- A company owner under-reported payroll to reduce the amount of his workers compensation premiums. The premium loss was $4,000,000. He also operated a second company for which he failed to report any payroll or secure workers compensation insurance.
- A doctor was charged with multiple counts of medical insurance fraud, workers compensation fraud and grand theft after allegedly submitting over $500,000 of fraudulent medical services reimbursement claims. For five years, this doctor allegedly orchestrated a fraudulent scheme of billing medical services never provided and "upcoding" of bills to illegally obtain a greater payout from the insurer.

I hope you enjoyed hearing a little bit about what we do here at the Enforcement Branch.

Next, I am going to cover compliance requirements.

We will start with insurance company requirements and then get into the specifics of what you, as an agent or broker, are required to comply with.

Please keep in mind, the requirements we are reviewing today only pertain to anti-fraud operations. Other units within the California Department of Insurance may have additional requirements for the groups listed here. If you have questions about statutes and regulations that are outside of scope of anti-fraud operations, I encourage you to review our public website to determine the best resources for your questions.

Each Insurer Must Have an Special Investigative Unit

Insurance companies admitted to do business in the state of California are required to comply with the Insurance Frauds Prevention Act and the California SIU Regulations.

One of the initial requirements is to establish what is called a Special Investigative unit, or SIU for short. This unit is required to be available to investigative suspected insurance fraud on behalf of the insurance company. The unit can be comprised of internal or external employees. If an insurance company decides to go external for this function, they are subject to additional requirements, which we will go over shortly.

Insurer Anti-Fraud Requirements

The requirements within the IFPA and California SIU Regulations can be subdivided into these four sections.

Staffing and Operations. This begins with the existence of the SIU itself. The unit must also be comprised of staff that is knowledgeable in claims practices, investigative techniques and detecting fraud. As mentioned previously, if this unit is contracted to an external company, then contractual obligations also fall in this category. An external company must have a contract in place with the insurance company that contains very specific verbiage. The external SIU must also comply with all provisions of the IFPA and the California SIU regulations. If they fail to be compliant, the insurer they contract with could be assessed penalties. Operations also covers response requirements if a law enforcement agency, such as ours, reaches out to get documents or conduct an interview.

SIU Annual Report. The SIU Annual Report is a report filed each fall by approximately 1,200 insurance companies operating in California. This report contains statistical data, structural outlines and names and contact information for insurance company SIU personnel. This is a confidential report and the data is not released outside the Department. It is an insurers responsibility to know this filing is required. Notifications are mailed on the last business day each June; however, even if a notification does not reach its intended target, the filing obligation still stands. Since the filing does contain several levels of data, you may get a request for information from an insurer you contract with seeking information. If this occurs, be sure you confirm who you are releasing information to and be certain you provide them with exactly what they ask for. Errors in data could result in penalties for them so it is important they be accurate.

Anti-Fraud Training. Training requirements for anti-fraud personnel comes in three levels. The first is training required to be given to newly hired personnel within 90 days of commencing their assigned duties. The training must cover specific criteria, some of which are the detection of fraud red flags or indicators and how to refer something to the SIU. The second level of training is an annual training for the integral anti-fraud personnel. This would be underwriters, claims adjusters, possibly premium auditors – basically anybody in a position to detect insurance fraud red flags. This training has similar topics to the new-hire training and is required to be given minimally once per calendar year. The third level of training is specific to the SIU personnel. SIU personnel are required to have five hours of continuing anti-fraud training annually and it must cover at least one of the topics of investigative techniques, communication with Fraud Division, legal and related issues, red flags or insurance fraud trends. Even though these training requirements do not apply to you as agents or brokers, be aware that some of this information is still needed for you to comply with reporting requirements. For example, in certain circumstances, you will need to know what the referral process to an insurance companies SIU is. So, even if you don't need the training, be sure you have the knowledge needed to effectively operate.

And finally, the detection, investigation and referral of suspected insurance fraud. This area covers a lot of requirements for both the integral anti-fraud personnel and the SIU personnel. It encompasses everything from how to detect red flags, how to refer those red flag files to the SIU, what investigative steps the SIU is minimally required to take, how to determine if and when a referral to the CDI Fraud Division is warranted and how to make that referral when it is required. Later in this training, we will talk more about when a referral is warranted to the CDI Fraud Division if you are an insurance company employee and if you are an agent or broker. While similar, there are key differences you'll need to know.

Recent Audit Finding: Communication With CDI

Within the area of staffing and operations, a common violation is failing to communicate with the CDI Fraud Division, California District Attorneys or other authorized governmental agencies within the timeframes specified by statute. Statute requires that insurers respond within 30 days to all lines other than workers' compensation and for workers' compensation insurers are allotted 60 days. Shown here is a recent violation that was written up by our SIU Compliance Unit. As you can see in column three, this company was significantly late on several communications. Violations such as this one hinders our ability to investigate and prosecute insurance fraud. As an agent or broker, you are also required to respond to file requests within these timeframes.

Agency	Line of Business	Number of Days Late
CDI	Workers Comp	84
District Attorney	Automobile	109
CDI	Automobile	96
CDI	Automobile	75
District Attorney	Workers Comp	100

Another Recent Fraud Division Case

Q'Orianka Kilcher, 32, of West Hollywood was charged with two felony counts of workers compensation insurance fraud. California law prohibits misrepresenting injuries to collect workers compensation insurance benefits. Yet the investigation found that Kilcher still worked on the television show "Yellowstone" during the time she told a doctor she had been too injured to work.

We put in this example of a recent case to highlight that nobody is exempt from having to be honest about workplace injuries or other types of insurance claims. This actress thought she could get away with working while collecting workers' compensation benefits. California law prohibits this and her status in Hollywood did not exempt her from being charged with insurance fraud. We feel examples like this one are important to highlight. Too often people get into a mindset that they are either entitled to something or exempt from having to follow rules or laws. When it comes to insurance fraud, we don't care who you are, what your title is, or who you know. If you commit insurance fraud, we will be there to set you straight.

Recent Audit Finding: Anti-Fraud Training

Another recent violation written up by our SIU Compliance Unit. This one is in the area of training, specifically the new-hire training. As you can see here, our SIU compliance unit reviewed training records for a total of 1,120 new hires for this company. In that review, which reflected both the hire dates as well as the training dates, the compliance unit found that this company failed to train 3 percent of their new hires within the 90 day timeframe and failed to train 96 percent of the new hires at all. That amounts to a 99 percent noncompliance rate overall. The penalty assessed on this violation alone was well over six figures and the company also earned a fairly quick follow-up audit to make sure they implemented proper steps to rectify this issue going forward.

Insurer Anti-Fraud Requirements: Penalties

Speaking of penalties, California has two types of penalties for anti-fraud violations.

Violations are either considered to be willful or inadvertent.

Inadvertent penalties has a $5,000 maximum. If something is considered inadvertent, we also combine like violations that are similar.

Willful violations carry a $10,000 maximum. In cases of willful noncompliance, the Department does not combine like violations and so that $10,000 figure can be assessed for each act of noncompliance.

For example: in the previous slide, I showed you a finding that included over 1,000 people that were either trained late or not trained at all. If this were an inadvertent penalty, we would assess up to $5,000 for the entire violation. As a willful penalty, the company can be assessed a separate $10,000 for each individual that was not trained or trained late. Using that math, you can see how we got to a six figure penalty very quickly.

It is important to note, that to be considered willful, all the company needs to do is be aware the statute or regulation existing. It is very rare to have a violation be considered inadvertent for this reason.

This is not to say that for every violation we go after the maximum penalty allowed by law. Since we do consider fighting insurance fraud to be a partnership with the industry, we take into consideration several factors when determining what exactly a penalty will look like.

Some of those factors are, how quickly did an insurer come into compliance, what does their prior compliance record look like if we've examined them before and what kind of corrective action are they putting in place to avoid it in the future.

Some years are better than others when it comes to how much we assess in penalties. We noted our 2020 figure of $924,000 on this slide. We did that to illustrate that penalties are significant and insurance companies should not consider violations and penalties to be simply a cost of doing business.

Checkpoint

Insurance fraud committed by this group is not a violation of law.

- Politicians,
- Actors/actresses,
- CEO's,
- None of the above, insurance fraud is a crime regardless of status or title.

And the answer is D. Remember the Yellowstone actress we talked about? Nobody is above the law.

Red Flags

- Not concerned about cost of coverage
- Asks detailed questions about types of claims that would be covered
- Asks questions about how long a policy has to be in force before coverage is effective

- Does not want a physical inspection of property or vehicle to be covered – offers pictures instead
- Pushing for immediate binding of the application
- U.S. P.O. Box only – refuses to provide a physical location
- Discrepancies in answering questions
- Paying cash for high premium policy
- Application completed in multiple visits with two or more people without a clear distinction of relationship
- Type of coverage (i.e. full coverage on a low value vehicle)
- No clear connection between insured and beneficiary
- Trying to buy a policy without interest in the object to be covered (house, auto, person)

Some of the most common red flags you may encounter are listed here.

They may include asking questions about specific types of losses that may be covered, asking about taking out a life insurance policy on a person they don't appear to have a direct connection to or attempting to purchase coverage on collateral they don't appear to have a connection to.

Any one of these, or combination, should be enough for you to pause and consider what your next steps should be.

Alright, picture this, a new customer calls and they want to insure a 1970 Pinto Station Wagon, and they want full coverage, meaning comprehensive and collision both included, they don't care what the policy is going to cost and they want to make sure the policy will be effective today. Sounds odd, right? I certainly hope so. While the scenario sounds somewhat entertaining, and perhaps you are even picturing this Pinto now, we would hope you stop, ask some additional questions and then decide if something is just isn't right.

That, of course, is an extreme example. What you will more likely encounter will just be someone who wants to take out a policy, doesn't want to have the collateral inspected or just seems to really want the policy to be effective immediately without really caring about cost.

Fraud Indicators

- Indirectly answering application questions
- Vague answers
- Hesitant to sign application
- Pushy behavior
- Walk-ins with no justification

Here are some of the more general indicators. Red flags tend to be specific, whereas indicators are not. If someone answers a question with hesitation, it could be a sign of potential insurance fraud, or it may just truly be a fuzzy memory.

For example: if I ask a potential client if they had a specific type of cancer in the last 20 years and they hesitate or respond in a non-committal way, it may not be someone trying

to commit fraud, it might legitimately be someone who did have cancer but truly can't remember if they were considered cancer-free 19 years ago or 21 years ago.

Walk-ins with no justification we get asked about quite a bit. Cold calling an insurance company for quotes does happen, but usually it is spurred by something specific. A person might be shopping for lower rates or they may be unhappy with their current agent, broker or company. Perhaps they were referred to you by someone that you made extremely happy. Asking the question, how'd you here about us? Or, what caused you to reach out to us today? can be simple, valuable and effective ways to determine if a person has a reason to be calling you, or if they are simply calling every broker or agent in the area to see who they can trick. Again, not saying cold calls don't happen, but we'd recommend taking a closer look to see if additional flags or indicators are present if you do get a call with no reasons behind it.

Fraud Trends in 2022

Over the last few years we've seen some new trends come about in the industry, much of which is centered around claims and telehealth in a virtual reality. For underwriting and agency fraud, not much has changed. We do see an increasingly higher volume of policies purchased online or through phone apps, but we were seeing that before the pandemic as well. So, for 2022, we settled on these three trends to bring to your attention.

The intentional concealing of information, this could be something such as not listing all the drivers in the household.

The misrepresenting of collateral. This could be the number of something that is owned, such as how many pieces of artwork does somebody have or it could be the condition of something that is owned.

We also included an item that our Investigative Supervisor mentioned earlier in this training, and that is theft of premiums by agents or brokers. This can be the use of money provided to purchase a policy that is ultimately pocketed by an agent or broker and the poor policyholder has no idea until they have a loss and there is no coverage.

Next Checkpoint

Next checkpoint. This question is, which of the following is not considered an insurance fraud red flag?

Inconsistent answers, refusal to allow inspection of collateral, wanting liability coverage on an old vehicle, insisting coverage be bound immediately.

And the answer is C. Wanting liability coverage on an old vehicle. California law requires all vehicles have liability coverage if they are registered and so this is not an unusual request. Now, if the person is seeking to add comprehensive and collision coverage to an older vehicle, that should cause you to want to ask questions and have a deeper conversation.

Available Databases

Here are a couple of databases that exist to help you identify red flags as well.

Insurance Services Office, better known to the industry as ISO. If you have access to ISO, you will be able to see past claim history, potential fraud indicators that other companies may have noted. There's really, truly, a lot of great information available through ISO. If you don't have access, consider asking the companies you are working with if they can provide you access.

We also have the Arson database, this database is maintained by the Department of Justice is also a good resource if you are doing property policies. If someone has been convicted of arson, they should show up here, and that would be a pretty big indicator that perhaps you should stop, and consider whether or not you want to write a policy for them.

Fraud Warning Language

Alright, let's talk about the California fraud warning language.

This statement, "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison," must be provided to insureds.

As an agent or broker in California, you are going to see this wording a lot. Or at least, you should. This wording is required to be on forms used to apply for a policy, make a change to an existing policy or within the claims process. So, you may see it on applications, endorsement pages, basically on anything used to apply for or change a policy.

This requirement is actually amended as of 2023. Prior to January 1, 2023, you would find this wording only during the claim process. It was expanded because the Department saw a need to ensure consumers seeking to get coverage or change coverage were aware that honesty matters at all points of an insurance transaction.

SB 1242

Senate Bill, or SB 1242 is the reason you are all listening to this. In this bill, a few things happened, but those pertinent to you at this moment are: the creation of this 1 hour anti-fraud training that as I mentioned at the opening you are either getting now because you are seeking to obtain a license or you have one renewing. The bill also creates specific reporting requirements for agent and brokers. There are two reporting requirements depending on the status of the policy. If the policy is in the application stage and has NOT been placed with a specific carrier then the agent or broker is required to report the red flag directly to the Fraud Division Consumer Portal. If the policy has already been placed, the agent or broker will report the red flag to the insurer's special investigative unit. Also on this slide, please note that an agent or broker is required to cooperate with the insurer's SIU or law enforcement. This is not actually new, but something that we wanted to point out as your interaction with us may increase with the implementation of these requirements.

It is important to know if you fall under these requirements.

An agent or broker is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5 1625.55, 1626 or 1758. 1. They are also not an employee of the insured.

For the purposes of the remainder of the of the California SIU Regulations, it is also important to know that the Enforcement Branch does not consider an agent or broker, as defined by these codes, as a contracted entity.

Lastly, but no less important, agents and brokers who refer to either a carrier or directly to the Fraud Division do have protections against civil liability as long as they were acting in good faith, without malice and reasonably believed that the action taken was warranted.

Checkpoint

And here is our next checkpoint. As it pertains to SB 1242, who is required to cooperate with law enforcement conducting a criminal investigation?

Brokers and agents, unlicensed agents, bail bondsmen, insurance company personnel.

And the answer is brokers and agents. The other listed individuals or groups here may have a duty to cooperate, but this question is specific to SB 1242, which applies to brokers and agents.

How Do I Fulfill My Obligation to Report Red Flags?

Over the next several minutes, I will walk you through how to access the consumer portal and what needs to be entered.

Keep in mind as we go through that this form is in the event of an unplaced policy. If you have placed the policy, refer the file to the insurance company SIU using whatever internal referral method they have created.

Getting to the Consumer Fraud Reporting Portal

We begin with the California Department of Insurance public website, which is located at www.insurance.ca.gov.

From the home page, you will find the word Fraud on the banner, this is located third from the right and we have it circled here in red.

When you hover over the word Fraud, it will produce a drop-down with several options.

Toward the bottom you will find an option that says “Report Fraud” and that is where you will click.

Clicking on Report Fraud will take you to this screen here, which has two options. The top option is for insurance company SIU personnel to report. As agents or brokers, you want to select the second option, which says Consumer Insurance Fraud Reporting Form.

Section 1: Person or Business Reporting Fraud

Clicking the link to open the Consumer Insurance Reporting Form will take you here and you will fill out the boxes as presented.

At the top, you will have a drop down giving you the options of individual, business or agent/broker. You will select agent/broker.

The next line down asks you if you wish to file anonymously. As agents or brokers you may not file anonymously. Statute does not allow for that. And the reason is, if the Fraud Division wants to open a case on this referral, we need to be able to reach out to you to get information or for the files.

The remainder of the form is fairly self-explanatory, please enter your name and contact information.

At the very bottom, you will indicate “yes” for being a victim of the alleged fraud. Even if you did not end up writing a policy because you detected the red flags and declined the business, you were still the victim of that fraudster trying to take advantage of you.

Section 2: Person or Business Reporting Fraud

The next section of the form is where you will enter the information of the person, or business, committing the fraud. More than likely in your case, it will be person.

To the right of the screen, circled in red here, you will find a button to create a suspect.

Clicking the create button will bring up a pop-up screen, so make sure pop-ups are enabled, and on that pop-up you will enter any data you have on the suspect.

Here is what that popup looks like.

At the top, it asks you who the person listed is. Your options here are going to be insured, claimant or other. Most likely, you will be selecting insured since you are not dealing with claimants under most circumstances and other would be reporting fraud perpetrated by providers, attorneys, medical personnel or similar individuals.

We do recognize that the term insured implies they are an insured of yours. In your case, this may not be wholly accurate. Reporting red flags through the consumer portal is for applicants who you have not placed business for and so they are not your insured at this point. That is ok, please select insured anyway. We will see that you are an agent or broker submitting and know that insured is potentially not a client of yours.

The remainder of the form, as you can see, will ask you for name, company name if applicable and address information.

When you save the information on that popup, you will see it populate under the line at the top of the screen shot where it now says “there are no records to display. ”

After entering the information, you will complete the rest of the section. For the location of the fraud, please be as specific as possible. This will help us ensure we get the referral to the right Regional Office for handling.

Section 3: Insurance Fraud Details

The next screen in the portal asks you write out what the suspected fraud details are. What you see here are the questions that appear on the form. Please do your best to answer these as thoroughly and accurately as possible.

The first question. Who are the persons committing the fraud?

When you answer this, be as specific as possible. What is their name? Full name preferably. Not just Sally. Also, not nicknames, provide the legal name. If someone goes by Bob, but their actual name is Robert, please enter Robert. If there is more than one person involved, enter them all. Don’t hold back, we need to know everyone who is part of the potential fraud.

The second question. When and where did the fraud occur? This one may be difficult to pinpoint. If someone called, you may not know exactly where they are calling from. If someone submitted something online, again, you won’t know from where. The easiest way to handle this question if you don’t have an exact location would be to use your office location. If a criminal case gets opened, our Detectives or Investigators will take on the task of confirming location for jurisdiction purposes.

The third question. What is the name of the insured, if different than the suspect? Now that is an interesting question, right? We do see a fair amount of fraud committed by someone other than the policyholder. Common examples include children taking out policies for parents. This could be property casualty policies and the parents don’t speak English, and so the children are there facilitating. This could be medical or life insurance where the children are intentionally misrepresenting medical history of elderly parents in order to take advantage of something. There are other examples as well, could be significant others, could be other relatives that are not children. Unfortunately, the opportunity to commit insurance fraud when you are not the policyholder is just as prevalent as if the fraudster were the policyholder themselves.

Next question, include names of others who can corroborate this information. Ok, let’s be honest, we could have written this easier. Simply put, what witnesses exist? The others that can be a potential witness range from family, friends, coworkers of the insured all the way

to other employees within your agency. Did this person talk to more than one person in your office? If they did, list it here.

Last question. Is anyone in the insurance industry aware of what is occurring? When this is answered by a member of the general public, they provide us names of people from insurance companies, such as adjusters or agents and brokers. When you are answering this from the perspective of an agent or broker, you will not need to list yourself. We know you are aware, that is why you are reporting it. What you may want to add here is whether or not anyone with a company you contract with is aware? Perhaps you called an underwriter for advice, ultimately ended up not writing the business, and still need to report it. That underwriter should be listed here. Or, are you a member of an agent or broker association and the suspect has been the topic of discussion? Let us know that. It helps us determine the scope of the fraudulent activity if we know that this suspect is known to an entire agent or broker group.

Referral Form Synopsis

Alternatively, you can answer these questions. So, what you are seeing here are the questions that an insurer is required to answer when they submit referrals in our portal. As agents or brokers, you are not required to answer these questions; however, we have found that following these questions gives you greater success at conveying to our Detectives what the misrepresentation was and what information you have to support the allegation.

Please note: choosing to answer the questions on the preceding slide versus this slide is not a matter of compliance. It is a pure choice. What we ask is that either direction you go, you provide us with as much information as possible.

You also will not see these questions populate automatically when you are in the form because they are not your compliance requirement. If you are considering answering these questions, you will need to know what these are. You are welcome to take a screen shot of this, or you can reach out to the SIU Compliance Unit and they can email it to you. Their contact information is on the Departments public website.

- What facts caused the reporting party to believe insurance fraud occurred or may have occurred?
- What are the suspected misrepresentations and who allegedly made them?
- How are the alleged misrepresentations material and how did they affect the claim transaction?
- Who are the pertinent witnesses to the alleged misrepresentation, if there are pertinent witnesses?
- What documentation is there of the alleged misrepresentation, if documented?
- Provide a statement as to whether the or not the investigation is complete.

Section 4: Other Referrals

Section 4 of the form is next and the final section you will encounter when you complete the referral.

Remember, if you have already placed a policy, your reporting requirement is to the insurance company where that policy is placed. If, for some reason, you wish to also notify us directly, you are welcome to do that. In those cases, you will enter which insurance company you reported to in the top box.

If your case involves workers' compensation, we also strongly recommend you notify the applicable district attorneys office for the county of where the fraud took place. If you do this, please note on line three, what District Attorneys office you sent it to.

The purpose of this section is simply you notifying us if you have also reported the suspected fraud to anyone else. This allows us to know who else might be working the case or other companies or agencies we can seek information from.

Referral Form Summary Tips

Here are some tips for writing summaries.

First, do not include irrelevant information. If the sky that day was grey instead of blue, unless it matters to the suspected fraudulent activity, we really don't need to know.

Secondly, please do not copy and paste the same information under each question. We do read each and every referral and when you do that, we spend a lot of time re-reading the same information over and over just looking to see if something is different between them.

Last, when you answer the questions, and this is whether you are answering the ones prompted on the form or choosing to enter the questions as insurers, please make sure you are complete, thorough and accurate.

Checkpoint

And it's checkpoint time. From the CDI website, an agent or broker will report suspected insurance fraud via what portal?

Agent portal, company reporting portal, SIU annual report portal, consumer reporting portal.

And the answer is D. Consumer Reporting portal. At this time, a specific agent or broker portal does not exist. Statute specifies that an agent or broker will use the consumer reporting portal. The other options listed are the company reporting portal, which would be where insurance company personnel report and the SIU Annual Report portal, which if you recall much earlier in this training is an annual obligation of an insurance company operating in California.

Referral to CDI

So now that you know your two referral options and how to refer through our consumer portal, you may be wondering if the requirement comes with a timeframe in which you must refer. The answer is yes, you are required to refer within 60 days.

Insurers referring also have a 60 day requirement as noted here. But you will notice that the level of belief of the insurance fraud to refer is different. An insurance company has to establish what is called reasonable belief of insurance fraud, which means they've done some additional investigation to the red flags that you've notified them of.

Your referral obligations is at the point of detection of the red flag itself. And again, you're either going to refer that to an insurance company if the policy is placed or, you are going to refer it directly to us here at the Fraud Division for policies that are not placed. That is calendar days.

The sooner the better, just to ensure you are never outside that window.

Checkpoint

We have another checkpoint.

What is the timeframe that an agent or broker has to report suspected insurance fraud to the CDI Fraud Division?

14 days, 30 days, 60 days, or none of the above because there is no required timeframe in statute

And the answer is B. 60 days. Please be mindful of this. It is 60 calendar days and so that does include weekends and holidays. As a best practice, it is suggested that you refer as soon as possible. Waiting 60 days not only delays our ability to review the referral and make a determination on how to handle it, but it also allows you to potentially forget specific details that may be necessary for us to know.

Cooperation With Law Enforcement

Earlier in this training, I noted that you also have a duty to cooperate with an insurance company SIU and law enforcement agent.

So, what exactly does that mean?

If you receive a call or email from a law enforcement officer, whether that is one of our Fraud Division Detectives or perhaps a District Attorney Investigator does not matter, just please remember you have a duty to cooperate.

You are required to provide files and documents upon request. You are bound by the same time standards as insurance companies, as a reminder that is 30 days for all lines of business other than workers' compensation and 60 days for workers' compensation.

Please be sure to respond to all calls and emails asking for clarifications or additional information.

Also, please know that statute provides law enforcement the authority to interview you. You may not decline an interview. If you are asked to be present for an interview, either on the phone or in-person, work with the law enforcement officer to establish a time and place and be sure to be available and present.

Checkpoint

Checkpoint question.

What is the timeframe that an agent or broker has to provide file information on a workers' compensation file.

14 days, 30 days, 60 days or none of the above

And the answer is 60 days. Requests for workers' compensation allow 60 days to respond to authorized governmental agencies asking for the release or documents.

And, one final checkpoint.

What is the timeframe that an agent or broker has to provide file information on a file for lines other than workers' compensation.

14 days, 30 days, 60 days, none of the above

And the answer is 30 days. You only have 30 days in which to respond to requests for file information for all lines of business other than workers' compensation.

Thank You

Thank you for joining us for the last hour as we took you through several aspects of the anti-fraud requirements for agents and brokers in the State of California. We look forward to working with you. Should you ever need information from the California Department of Insurance, please visit our public website at www.insurance.ca.gov to locate contact information for our various units.

BOOKMARKEDUCATION

CALIFORNIA INSURANCE CE

Satisfy your entire CE requirement.
Discount packages are available.

Choose a package
and SAVE!

Don't Delay, Enroll Today

Online:

BookmarkEducation.com

Phone:

(800) 716-4113