

## Insurance Fraud: Turning Adjusters Into Columbo

By Ellen Jean Brooke

Unlike the short-tempered, heavy-fisted television detectives of CSI and Law and Order, Columbo was a mild mannered, seemingly slow-witted police detective who rarely carried a gun. He was never rude or offensive, but thanks to his eye for detail and meticulous investigations, he always caught the bad guy. Too bad he doesn't work in claims.

The Federal Bureau of Investigations estimates that non-health care related insurance fraud costs the insurance industry more than \$40 billion dollars a year.<sup>1</sup> Some might shrug their shoulders and say, "Who cares? Insurance companies have plenty of money." But what folks might not understand is that an insurance company is like any other business. If it wants to stay in business it has to pass some of its increased costs onto its customers. Who cares? We all should because that \$40 billion a year results in increased premiums of \$400-\$700 a year for the rest of us.<sup>2</sup> In an economic climate where even the smallest sacrifice makes a big difference—a Starbucks Latte or Folgers from home—\$400-\$700 a year is nothing to sneeze at.

So what does all this mean for insurance adjusters who are on the front line? It means that it is more important than ever to be alert to the signs of insurance fraud, including inflation of legitimate claims, staged accidents, and incendiary fires. It means that adjusters must continue to provide the customer service insureds demand, while in accordance with the procedures of their company and the laws of governing state<sup>3</sup>, but that they must do it all while channeling their inner-Columbo.

Today, many insurance companies have a Special Investigative Unit dedicated to evaluating and investigating suspicious claims. Whether your company does or not, here are some basic investigative tools in every front line adjuster's detective kit:

1. From the start, be sure to ask probing questions politely and *listen to the answers* before going on to your next question. Individuals engaging in insurance fraud are likely to have **lots** of answers, just not to any of the questions you have actually asked them. If you have teenagers, you've had lots of practice. Q: What time did you get home last night? A: We were at Greg's house playing pool and his mom told the funniest story. Let them tell the story then come back around. A: And what time did you get home last night? Repeat as necessary.
2. Take a recorded statement of the insured as soon as possible. Statements made immediately after a loss have more weight in court, and they tend to hold more clues than statements made after the insured has had an opportunity to perfect her story. Don't try to catch the insured in a lie, just make sure you lock down the insured's story no matter how ridiculous it is—this is invaluable later on.
3. Ask for documents. Almost every insurance policy written—auto, homeowners, or renters—has a provision allowing the insurer to request documents and records in support

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<sup>1</sup> Federal Bureau of Investigations, <http://www.fbi.gov>, October 30, 2009. Insurance Fraud: A Basic Overview. The Coalition Against Insurance Fraud (CAIF) estimates that non-health care related insurance fraud costs as much as \$80 Billion a year, [www.insurancefraud.org](http://www.insurancefraud.org), November 11, 2009, Go Figure: Fraud Data.

<sup>2</sup> Federal Bureau of Investigations, <http://www.fbi.gov>, October 30, 2009. Insurance Fraud: A Basic Overview.

<sup>3</sup> The Missouri Insurance Code (20 CSR 100-1.040) and the Illinois Insurance Code (215 ILCS 5/154.5) set forth and regulate claims practices for insurers conducting business in the respective state.

of a claim, yet many adjusters are afraid to ask for them. Pertinent documents frequently requested include: documents which evidence the Insured's financial condition (i.e. bank records, utility records, payment history on the insured home or auto, tax returns) and/or motive (i.e. GAP insurance, foreclosure or repossession papers).

4. Document all the facts, and only the facts. Claim Diaries often end up as trial exhibits so it is important that they show a thorough investigation without suggesting it has been a prejudiced one. Avoid subjective statements like "Insured was uncooperative" or "Insured was hysterical" and opt for fact statements like "Insured would not answer questions about the fire" or "Insured was crying."

While these investigative tools are self-serving, they are also self-*preserving*, as most states have enacted legislation requiring insurance companies to fully investigate claims.<sup>4</sup> The failure to fully investigate a loss almost always comes up in the context of litigation. In lawsuits, insureds often claim the company did not fully investigate their claim. This leads to another big issue, timeliness. Many times adjusters feel overworked, pressed for time and under the gun. Add an insured or his attorney demanding payment, and it is no wonder fraudulent claims get paid.

So it is important to keep in mind that while most states require *timely* investigations, they also have protections allowing for *thorough* ones. All you have to do is follow the rules.<sup>5</sup>

1. Reserve Your Rights. Initial correspondence to the Insured should clearly and conspicuously reserve all rights and defenses under the policy and the law. All subsequent correspondence should too.
2. Acknowledge all Pertinent Communication. If the communication received from a claimant suggests that a response may be expected, then a timely response should be made; most states require a response within 10 days.
3. Timely Provide Claim Documents. Not only do you want them for your investigation, but you need to make sure the Insured has them. Most states require Insureds have claim documents in hand within 15 days.
4. Timely Claim Decision. Most states require a claim decision within 15 days of receiving the completed claim forms *unless* additional investigation is required. In which case, the company simply needs to, in writing, explain the reason why and continue to do so every 30-45 days until a decision is made. For example: "The company is unable to make a claim decision at this time as it is following up on information provided by you in your recorded statement. The company should be in a position to make a claim decision within the next 30 days. If it is not, it will inform you in writing."

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<sup>4</sup> The Missouri Insurance Code (20 CSR 100-1.040) and the Illinois Insurance Code (215 ILCS 5/154.5, require) insurers to timely and fully evaluate a claim prior to a coverage or claim decision, failure to do so can be used as evidence of vexatiousness under both Missouri and Illinois law.

<sup>5</sup> Check your state's Insurance Code which is almost always available online.

For Missouri see: <http://www.sos.mo.gov/adrules/csr/current/20csr/20csr.asp#20-100>

For Illinois see: <http://www.ilga.gov/commission/jcar/admincode/050/05000919sections.html>

For Kansas see: [http://www.ksinsurance.org/legal/regs\\_list.htm](http://www.ksinsurance.org/legal/regs_list.htm)

For Arkansas see:

<http://www.insurance.arkansas.gov/PandC/Insurance%20Code%20&%20related%20chapters/PCCode.htm>

And in the words of Columbo, “just one more thing...” Remember that you are not going to catch every instance of insurance fraud, but if you never launch an investigation, you’ll never nab your crook. While it is important to keep an eye on costs, if you are faced with a fairly substantial claim that smells funny, refer it out for an examination under oath. In the cases of fraud many claims simply go away or are withdrawn once an attorney gets involved. Many Insureds trying to perpetrate fraud get nervous about lying under oath and the threat of criminal charges. Other times, an examination under oath allows an attorney to delve into the issues and details adjusters do not have the time or training to broach. Be up front with your attorney of choice, if she has the requisite training and expertise, she will know how to formulate an investigation to your budget. It might be the only way we can protect against future increased premiums to honest policy holders.