

CRIMINAL INVESTIGATIONS DIVISION

ANTI-FRAUD UNIT BEST PRACTICES

2024



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THE CRIMINAL INVESTIGATIONS DIVISION

The Criminal Investigations Division (CID) encompasses all law enforcement and forensic components residing within the Department of Financial Services. With this broad responsibility, the Division investigates a wide range of fraudulent and criminal acts related to:

- Insurance Fraud
- Workers' Compensation Fraud
- Public Assistance Fraud
- Fire, Arson, and Explosives
- Theft/Misuse of State Funds

Insurance fraud is one of America's costliest crimes. Conservatively, fraud losses across all insurance lines amount to at least \$308.6 billion annually. More specifically, property-casualty fraud equals about \$45 billion each year.¹ It is widely understood that insurance fraud depletes an insurer's resources and the losses incurred from fraud can impact consumers in the form of higher insurance premiums.

The Criminal Investigations Division believes insurance companies must treat investigating and reporting suspected fraud as a top priority. Any company that fails to dedicate the needed resources towards the fight against insurance fraud jeopardizes its financial stability which can create downstream effects in the way of increased rates charged to consumers.

In 2017, the Florida Legislature mandated the Criminal Investigations Division to create a best practice report for anti-fraud units and update it biennially. The report is to detail best practices for detecting, investigating, preventing, and reporting of insurance fraud and other fraudulent insurance acts for anti-fraud units doing business in Florida.

The report was compiled through extensive research as well as the collaborative input of industry professionals, state regulators, and compliance partners. It is expected that insurers maintain a flexible approach to adapt to the rapidly evolving issues of insurance fraud.

¹ Coalition Against Insurance Fraud, <https://insurancefraud.org/wp-content/uploads/The-Impact-of-Insurance-Fraud-on-the-U.S.-Economy-Report-2022-8.26.2022.pdf>

ESTABLISHING ANTI-FRAUD UNITS

The development and implementation of anti-fraud units should be handled in accordance with governing laws and administrative rules. However, it is important to note that legislative actions set only the required minimum standards expected of insurers in developing a process to investigate potential fraud. Section 626.9891, Florida Statutes mandates every insurer admitted to doing business in the State of Florida to establish and maintain an anti-fraud unit, to investigate and report possible fraudulent insurance fraud acts by insureds or persons making claims for services or repairs against policies held by the insured; or contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

Anti-fraud programs are expected to vary from insurer to insurer. However, creation of the structure, processes, and procedures is usually based on assessments of the unmitigated risk of fraud within the insurance products and services offered to consumers, with attention to:

- Market conditions, including the migration of ring and organized activity
- Data Trends; including number and location of insurance policies, and claims
- External influencers, such as catastrophe events or legislative changes
- Caseload per investigator
- Budgetary constraints

ANTI-FRAUD UNIT STRUCTURE

When developing and building a special investigations unit, one of the first things done is defining the anti-fraud unit's role and area of responsibility within the company. Usually determined by corporate leadership, some anti-fraud units are part of the organization, while others are contracted externally via third-party. They can be a separate division reporting to anti-fraud unit leadership or serve as an extension of the claims department. There appears to be no perfect or singular solution regarding the assignment or attachment within the organization. The anti-fraud unit is responsible for mitigating the risk of potential loss to the company by identifying and deterring insurance fraud. How the anti-fraud unit is integrated within the organization is critical to its overall success, so care must be given when assessing where it falls within the organizational structure.

ASSOCIATED COSTS

Management should consider these factors when budgeting or funding a successful unit:

- Personnel Costs - Salary & Benefits
- Relocation fees
- Employee selection costs - Advertisement
- Recruitment costs - Background, drug test
- Training - New employee orientation
- Equipment
- Office Space - Furniture, phone, etc.
- Transportation costs - Purchase, lease, rental, or mileage reimbursement
- Investigative software - Programs, licenses, and renewals
- State licenses - All lines, private detective, etc.
- Professional classifications

SELECTION OF PERSONNEL

Hiring the right person to work in a demanding and challenging anti-fraud environment is critical to the program's success. Anti-fraud managers should require some basic qualifications of potential new hires. It is strongly recommended that the selected member possess:

- A degree from an accredited college or university.
- A minimum of 3 years in special investigation of insurance claims or adjuster experience, investigative law enforcement experience, military, or private detective.
- A solid understanding of anti-fraud investigations or relevant claim processes, practices, and applicable laws and regulations.
- A professional certification designation in CFE, CIFI, FCLS, or FCLA.
- Strong interviewing and communication skills (verbal and written).
- The ability to work well both independently and in a team environment.
- A verifiable history of a consistently high level of performance and achievement.
- Strong critical thinking and analytical skills; ability to make deductions; logical and sequential thinker.

ESSENTIAL FUNCTIONS AND RESPONSIBILITIES OF ANTI-FRAUD PERSONNEL

Expectations of the personnel assigned to anti-fraud units will be defined based on the individual needs of the unit. However, members assigned to detect and investigate fraudulent acts are commonly expected to:

- Perform research investigation assignments as requested by examiners, clients, or legal counsel.
- Conduct thorough searches of both public and subscription-based database records.
- Conduct comprehensive background investigations, medical and other facility canvasses, social media searches, social media monitoring, geo-fencing, and other specialized research investigations.
- Document findings in a detailed, professional investigative report.
- Identify, document, and communicate red flag indicators and make additional handling recommendations as appropriate.
- Maintain proper documentation of all relevant facts and evidence pertaining to the case in the appropriate claim handling system(s) and ensure investigations are completed according to service expectations and industry best practices.
- Exhibit proper time management and possess the ability to prioritize tasks.
- Maintain technical competency and adherence to all applicable legal codes and statutes to ensure all investigations are conducted in a legal and ethical manner.
- Comply with deposition and courtroom testimony appearances as requested.
- Conduct training for new team members as requested.

MEASURING ANTI-FRAUD UNIT PERFORMANCE

When deciding how to evaluate the current unit's performance or implement performance standards for a newly formed unit, several things must be kept in mind. Some measurement standards will be concrete and easily tabulated. Other factors to be considered will be more unclear and intangible, but both are extremely important in rating the overall effectiveness of an anti-fraud unit.

A 2003 study on Special Investigation Units, conducted by the Coalition Against Insurance Fraud, found no consistency in how small, medium, or large anti-fraud units measure performance.² A similar study in 2023, had comparable results, but highlighted a shift from the anti-fraud management team being the primary evaluator to a more collaborative effort with senior management.³ Companies continue to operate differently by utilizing unique methodology, business practices, and trade secrets.

² Coalition Against Insurance Fraud, <https://insurancefraud.org/wp-content/uploads/Study-on-SIU-Performance-2003.pdf>

³ Coalition Against Insurance Fraud, <https://insurancefraud.org/wp-content/uploads/Coalition-Keys-Study.pdf>

According to the Coalition's 2023 study, some of the most common factors used to assess investigative teams are the:

- Number of referrals for suspected fraud
- Number of referrals accepted for investigation
- Number of claims referred for investigation that are mitigated
- Quality and accuracy of investigations
- Number of assists (non-fraud work) to the anti-fraud unit
- Number of claims referred that are denied
- Number of referred claims by the line of business
- Total economic impact per closed referral
- Percentage of claims investigated and sent to a state agency as required by statute

The measurement tools reported as most often used were the number of actual referrals received and the number of referrals accepted for investigation. This information is the simplest to track and tabulate, and to a large degree, provides a snapshot of how active the anti-fraud unit is overall within the organization.

DETECTING AND INVESTIGATING FRAUD

One of the most important issues facing insurance carriers and investigators is the development and implementation of a fraud control policy developed to serve as a consistent guide toward effective fraud detection and investigation.

DETECTING FRAUD

The identification of suspected insurance fraud remains a major part of the claim professional's job. Underwriting representatives evaluate the risk for policyholders seeking coverage. Adjusters and examiners investigate insurance claims, negotiate settlements, and authorize payments. They determine whether the customer's insurance policy covers the loss and how much of the loss should be paid to the insured and/or claimant. When fraud is suspected, the matter is referred to the anti-fraud unit whose primary purpose is the investigation and disposition of suspect claims and policies. Referrals to the anti-fraud unit are based upon industry-accepted fraud indicators, commonly referred to as "red flags." The presence of one or more fraud indicators is not evidence of fraud; it only means that the claim or policy should be referred to the anti-fraud unit for further investigation.

With the growing complexity of fraud, insurers need to put in place forward-looking fraud detection techniques that efficiently analyze data and help minimize fraud loss. Insurers tend to collect large amounts of structured, semi-structured, and unstructured data, which are seldom evaluated in fraud investigation operations. Combining analysis of data along with existing fraud detection techniques enables insurers to enhance the productivity of underwriting and claims processes to maintain a competitive advantage. As insurers move to analytics to detect fraud, specific policies should be considered regarding how data is compiled.

Working alongside underwriters and adjusters, analytics can collect and analyze structured and unstructured data and flag policies and claims for closer inspection. For this reason, insurers may leverage analytic solutions, such as predictive modeling, link-analysis, and rules-based algorithms. These solutions, typically based upon identifying indicators within data, increase the speed of detection and help expose known and unknown crime rings. Analytics can assist with compiling red flag indicators which include, but are not limited to:

- Excessive prior claims history
- Financial distress
- Policy inception
- Coverage inquiry
- Insured is overly pushy for a quick settlement

- Losses include total contents of business/home, including items of little or no value
- Handwritten receipts
- Property/Vehicle not available for inspection
- The vehicle has an unusual amount of aftermarket equipment

In addition to internal detection mechanisms, insurers would be remiss to disregard the public's desire to report suspected fraud. A direct line of communication, in constant operational readiness, should be established to facilitate immediate intake for consumer complaints of fraud and abuse. These usually involve implementing a toll-free telephone service available to the public; or an internet email/contact page.

INVESTIGATING FRAUD

The purpose of the anti-fraud unit's investigation is to examine and determine the veracity of an insurance application, claim filing, and/or allegations of fraudulent practices. The anti-fraud unit should establish, maintain, distribute, and adhere to written guidelines for the investigation of suspected insurance fraud. An investigation of suspected insurance fraud should include:

- A thorough examination of the claim file, application, or insurance transaction.
- Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
- Utilizing one or more industry-recognized databases identified by the anti-fraud unit as appropriate for use in fraud investigations involving the particular line of insurance in question.
- Preservation of documents and other evidence obtained during an investigation
- Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, is separate from any other document prepared in connection with the investigation, and includes the findings regarding the suspected insurance fraud and the basis for their findings. The summary should answer the following questions:
 - » 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 do they affect the claim or insurance 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?
 - » In addition, the summary should include a statement as to whether the investigation is complete.

BASIC PRINCIPLES OF EVIDENCE

Throughout the investigative process, information will be discovered that either proves or disproves the existence of fraud. This information, or evidence, is most commonly obtained through witness statements, documents, and “real” evidence, such as construction materials from a home.

Documentary evidence is generally used to prove a fact that is contained in the information it offers. Written documents, photographs, videos, sound recordings, and printed e-mails or web pages are all examples of documentary evidence. This evidence is typically presented at trial as an exhibit provided there is a legal foundation that explains what it is and where it came from.

PRESERVATION OF EVIDENCE

In Florida, the duty to preserve evidence relevant to a case may arise long before a complaint is filed. A party’s duty to preserve evidence is triggered once litigation is reasonably anticipated. The duty extends to any evidence that a party knows, or reasonably should know. The failure to preserve relevant evidence, also known as the spoliation of evidence, may result in the imposition of sanctions and a rebuttable presumption shifting the burden of proof in the underlying action.

ANTI-FRAUD EDUCATION & TRAINING

It is expected those involved in the handling of claims and policies are properly trained to facilitate the detection, investigation, and reporting of insurance fraud. This generally involves claims and underwriting representatives, but may extend to call centers, legal, and others within the insurance enterprise.

Florida law requires insurers to provide a minimum 2 hours of initial training to employees within the anti-fraud unit designed to assist in identifying and evaluating instances of suspected fraudulent insurance acts in underwriting or claims activities. Annually thereafter, an insurer shall provide such employees a 1-hour course that addresses detection, referral, investigation, and reporting of possible fraudulent insurance acts for the types of insurance lines written by the insurer.

Training can be internal and created by the insurer, or external facilitated by a variety of methods including antifraud conferences or webinars.

Training topics to consider include:

- CID fraud referral requirements
- Investigative techniques
- Fraud indicators
- Emerging fraud trends
- Legal and related issues
- Function and purpose of the anti-fraud unit
- Review of the anti-fraud unit's internal policies

Continuing education can be attained through a variety of methods, including:

- Certifications and designations that may be pursued through governing organizations, such as American Educational Institute: Fraud Claims Law Associate (FCLA) and Fraud Claims Law Specialist (FCLS)
- International Association of Special Investigation Units (IASIU): Certified Insurance Fraud Investigator (CIFI), Association of Certified Fraud Examiners (ACFE), and Certified Fraud Examiner (CFE).

Records of the anti-fraud training should be maintained, available for inspection upon request, and should include:

- The title and date of the anti-fraud training, instruction, or course
- The name, title, and contact information of the instructor(s), to the extent applicable
- Copies of the training, instruction, or course materials or, if the materials are unavailable, a description of the training, instruction, or course content
- The length of the training, instruction, or course
- The name and job title(s) of participating personnel

REPORTING INSURANCE FRAUD TO CID

Wherein, during the investigation of an insurance matter, it is determined that the elements of fraud are believed to exist, it is essential to report the matter to CID as mandated by Florida Statute and Administrative Code. Nothing precludes the reporting of fraud to other law enforcement agencies as well, but insurers should keep in mind the inefficiency involved with multiple law enforcement agencies separately investigating the same crime.

MANDATORY REPORTING REQUIREMENT

§626.989(6)(a), Florida Statutes

Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed shall send to the [Criminal Investigations Division] a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require.

§627.436(4)(i), Florida Statutes (related to automobile policies)

All claims denied for suspected fraudulent insurance acts shall be reported to the [Criminal Investigations Division].

F.A.C. 69D-2.003

Insurer Anti-Fraud Plans; Mandatory Reporting of Suspected Fraudulent Acts

Insurers or other entities or persons subject to mandatory reporting requirements of subsection 626.989(6), F.S., shall report suspected fraudulent acts electronically on Form DFS-L1-1691, <http://www.flrules.org/Gateway/reference.asp?No=Ref-09344>, Suspected Fraud Referral Form (Rev. 03/18), on the Division's website at www.myfloridacfo.com or via an electronic reporting interface that is linked to the Division (e.g. the National Insurance Crime Bureau or ISO sites). Form DFS-L1-1691 is hereby incorporated by reference. Insurers shall electronically provide the following with regard to reporting suspected fraudulent activity:

1. An acknowledgment that all reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.

2. An acknowledgment that the insurer or anti-fraud investigative unit shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.

While there are no mandated timeliness governing when a suspected insurance matter is reported to the CID, it generally should occur at the conclusion of the investigation. In some cases, it may be prudent for the insurer to report suspected claim fraud to the CID after the disposition of the claim.

SUBMISSION METHODS

There are several ways to report insurance fraud to CID. The Division maintains an insurance fraud reporting portal via the CID website (first.fldfs.com) used explicitly to receive fraud complaints from insurance companies, attorneys, citizens, law enforcement, and other governmental entities. Additionally, fraud reporting is received from member companies through the National Insurance Crime Bureau (NICB) portal, the National Association of Insurance Commissioners (NAIC), telephone, email, mail, and in-person.

QUALITY REFERRALS

The Criminal Investigations Division receives over seventeen thousand referrals annually. The Division investigates all insurance-related crimes including, but not limited to:

- | | |
|---|--|
| a. Auto Fraud | j. Workers' Compensation Claim Fraud |
| b. Arson | k. Workers' Compensation Premium Fraud |
| c. Application Fraud | l. Disability Fraud |
| d. Insurance Claim Fraud | m. Homeowners Fraud |
| e. Healthcare Fraud | n. Identity Theft Fraud |
| f. Life Insurance Fraud | o. Marine Fraud |
| g. Licensee Fraud - Insurance Agent, Bail Bonds, Closing Agent, Adjusters, Etc. | p. Warranty Fraud |
| h. Unauthorized Entity Fraud | q. Commercial Fraud |
| i. Insolvency Fraud | |

A regional supervisor receives and examines the referral for quality and content. If the referral is opened into a case, the referral is assigned to a sworn detective for follow-up. The Division opens over ten percent of referrals received annually into criminal investigations. Reasons for referrals not being opened into a case primarily involve insufficient evidence, lack of response from the reporting party, or those that fail to meet the investigative threshold.

Referrals opened into criminal cases are based on a triage system that utilizes case solvability factors in the Suspected Fraud Report Form. The absence of critical information or evidence could result in the referral being closed. A properly submitted suspected fraud form should indicate the existence of the following:

- | | |
|---------------------------|-------------------------------------|
| a. Known suspect(s) | h. Falsified Documents |
| b. Witness(s) | i. Photographs |
| c. Direct Evidence | j. Multiple Claims for Same Loss |
| d. Red Flags | k. Medical Reports Correspondence |
| e. Investigative Reports | l. Depositions/EUO Sworn Statements |
| f. Audio Tapes | m. Claimant Perjury |
| g. Conflicting Statements | n. Recognizable Method of Operation |

Referrals made to the CID fraud reporting portal must be clear, concise, accurate, detailed, and timely. Timeliness is critical to the success of criminal cases as crucial evidence can be lost or overwritten if the referral is delayed.

BRIEF SUMMARY OF CRIME

- ▶ Claim number
- ▶ Target/suspects
- ▶ Date & Location
- ▶ Amount of Loss
- ▶ Materiality Statement

EVIDENCE AVAILABLE

- ▶ Recorded Statements
- ▶ False Statements
- ▶ Documents - Bank, phone
- ▶ Video
- ▶ License Plate Readers

APPROPRIATE STAFFING LEVELS AND RESOURCES

Anti-fraud unit staffing levels should be determined by its demonstrated ability to establish, operate, and maintain a unit that follows administrative rules, statutes, and internal regulations. Factors that may be considered in staffing the unit include, but are not limited to, the number of policies written and individuals insured in Florida, the number of claims received with respect to Florida insureds on an annual basis, the volume of suspected fraudulent Florida claims currently being detected and other factors relating to the vulnerability of the Insurer to insurance fraud.

A successful anti-fraud unit should be composed of employees who have the knowledge and/or experience in general claims practices, the analysis of claims for patterns of fraud and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They should have the ability to conduct effective investigations of suspected insurance fraud and be familiar with insurance and related law and the use of available Insurer related database resources.

Companies should consider the following when determining appropriate staffing levels:

- Number of policies in effect
- Number of claims received
- Number of suspected fraudulent claims detected
- Need for staff to efficiently authenticate claims received
- Need for two (2) tier reviews for fraud referrals to ensure substance and validity
- Anti-fraud unit oversight

The use of technology in anti-fraud efforts is critical. Fraudulent claims which go undetected have a negative net effect on the insurance industry each year. With the use of technology, insurers can stay ahead of emerging trends and prevent all forms of attack from outside sources intending to make a profit from illegitimate claims. There is a wide variety of technology being used by industry professionals and professional organizations around the United States. The most commonly and widely used technology in anti-fraud units include:

- Automated red flag identification
- Predictive modeling /proactive fraud analytics
- Social media analysis
- Anomaly detection
- Data/Text mining
- Link analysis
- Data mapping
- Image forensics / Digital fraud detection
- Automated case management

MAINTAINING DATA & STATISTICS FOR MANDATORY REPORTING

Along with being statutorily mandated to report suspected instances of insurance fraud, insurers are also required to maintain and submit their anti-fraud plan and certain statistical information.

ANTI-FRAUD PLANS

The concept of mandating the submission of an insurer's anti-fraud plan was developed to encourage insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to combat fraud.

Section 626.9891, Florida Statutes, requires every insurer admitted to doing business in Florida to adopt an anti-fraud plan that must be submitted to CID annually and include:

- An acknowledgment that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer,
- An acknowledgment that the insurer has established procedures for the mandatory reporting of possible fraudulent insurance acts to the Criminal Investigations Division of the department,
- An acknowledgment that the insurer provides the anti-fraud education and training required by this section to the anti-fraud investigative unit,
- A description of the required anti-fraud education and training,
- A description or chart of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing, and
- The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

Anti-fraud plans are submitted at <https://antifraudportal.fldfs.com/Default.aspx>.

STATISTICAL DATA

Each insurer licensed in the state is required to report data related to fraud for each identified line of business written during the prior calendar year. The data shall be reported to the CID annually, by March 1, and must include, at a minimum:

- The number of policies in effect
- The amount of premiums written for policies
- The number of claims received
- The number of claims referred to the anti-fraud investigative unit
- The number of other insurance fraud matters referred to the anti-fraud investigative unit that was not claim related
- The number of claims investigated or accepted by the anti-fraud investigative unit
- The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that was not claim related
- The number of cases referred to the Criminal Investigations Division
- The number of cases referred to other law enforcement agencies
- The number of cases referred to other entities
- The estimated dollar amount or range of damages on cases referred to the Criminal Investigations Division or other agencies

In addition to providing information required above, each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1st of each year:

- The estimated dollar amount of losses attributable to workers' compensation fraud is delineated by the type of fraud, including claimant, employer, provider, agent, or other types.
- The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other types.
- The number of cases referred to the Criminal Investigations Division, delineated by the type of fraud, including claimant, employer, provider, agent, or other types.

Statistical data is reported at <https://antifraudportal.fldfs.com/Default.aspx>.

CARRIER TO CARRIER SHARING

The provisions within Section 626.989, Florida Statutes provide qualified immunity against civil actions (libel, slander) when sharing internal information, such as claim file documents, between carriers concerning suspected acts of insurance fraud, provided that:

- Those sharing information are on file with CID as designated employees whose duties include the investigation and disposition of claims relating to suspected fraudulent acts; and
- The information is related to persons suspected of committing fraudulent insurance acts (The information cannot be simply for establishing damages)

Information requests are generally made in writing after verbal contact with the designated employee to confirm they have records that are material to the investigation. The letter should contain their insured's name, claim number, date of loss, and name of the member assigned the investigation.

DESIGNATED EMPLOYEES

Section 626.989(4)(d), Florida Statutes identifies designated employees as those who are employed by insurers and whose responsibilities include the investigation and disposition of claims related to suspected fraudulent insurance acts. Designated employees may share information relating to persons suspected of committing fraudulent insurance acts with other designated employees employed by the same or other insurers provided that CID has been given written notice of the names and job titles of such designated employees prior to such designated employees sharing information.

CONFIRMING DESIGNATED EMPLOYEE STATUS

Currently, the only method to confirm the designated employee status of someone requesting information is to email the request to difsuiadmin@myfloridacfo.com. For those individuals employed by companies providing investigative services who are non-insurers it is important to also include the name of the insurer they are representing. CID will confirm the insurer contracts its investigative services with the company before confirming the individual's designated employee status.

THE FUTURE OF THE FIGHT AGAINST FRAUD

As fraud schemes continue to become more sophisticated, fraud fighters must continue to use every available tool to stay ahead, but as with so many initiatives, it takes human ingenuity and increased financial resources to be successful. Florida continues to be a leader in insurance fraud education and training of insurance professionals. Organizations such as the Florida Insurance Fraud Education Committee (FIFEC), the Florida Advisory Council on Arson Prevention (FACAP), the National Association of Insurance Commissioners (NAIC), and the Coalition Against Insurance Fraud are a few resources used to educate and share information on state and national platforms. Current monthly and quarterly meetings held by the National Insurance Crime Bureau (NICB), the Florida Workers' Compensation Fraud Taskforce, and the Florida Property & Casualty Taskforce have proven to be useful to personnel investigating acts of fraud. The forward-thinking strategies developed during these events and information shared by professional organizations are critical to the overall success of future fraud fighting endeavors.

REFERENCES

- [Association of Certified Fraud Examiners Insurance Fraud Handbook 2019](#)
- [Coalition Against Insurance Fraud](#)
- [NAIC Model Laws, Regulations, Guidelines, and Other Resources, Anti-Fraud Plan Guidelines Spring 2021](#)
- [SIU Today Spring 2019 How to Build a Major Case Unit](#)
- [New Jersey Anti-Fraud Prevention & Detection Procedure Manual 2016](#)
- [Law Governing Insurance - State of California](#)



The Florida Insurance Fraud Education Committee (FIFEC)



The Florida Property and Casualty Insurance Fraud Task Force



The Florida Workers' Compensation Fraud Task Force



The Florida Advisory Council on Arson Prevention (FACAP)



Coalition Against Insurance Fraud

Coalition Against Insurance Fraud

NAIC

NATIONAL ASSOCIATION OF
INSURANCE COMMISSIONERS

National Association of Insurance Commissioners (NAIC)

APPENDIX – 1

Criminal Investigations Division:

<https://www.myfloridacfo.com/division/cid/home>

Criminal Investigations Division SIU Information:

<https://www.myfloridacfo.com/division/cid/special-investigative-unit>

Criminal Investigations Division Referral Portal:

<https://first.fldfs.com/>

SIU Description/Anti-Fraud Plan Report Filing:

<https://antifraudportal.fldfs.com/Default.aspx>

Designated Employee Notification- Add/Delete/Status:

DIFSIUAdmin@myfloridacfo.com

APPENDIX – 2

INDEX OF RELEVANT FLORIDA STATUTES AND RULES

Florida Statutes 817.234

FALSE AND FRAUDULENT INSURANCE CLAIMS

- Defines insurance fraud elements.
- All claims and application forms must contain a statement.
“Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.”
This paragraph does not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.
- A contractor, or a person acting on behalf of a contractor, may not knowingly or willfully and with intent to injure, defraud, or deceive, pay, waive, or rebate all or part of an insurance deductible applicable to payment to the contractor, or a person acting on behalf of a contractor, for repairs to property covered by a property insurance policy.

Florida Statutes 626.989

INVESTIGATION BY DEPARTMENT OF DIFS; COMPLIANCE; IMMUNITY; CONFIDENTIAL INFORMATION; REPORTS TO THE DIVISION

- Defines insurance fraud related to the filing of a false insurance application or claim filing,
- Mandates the creation of fraud units,
- Requires reporting of fraud, and
- Provides qualified immunity for the report of fraud and sharing of information with others as designated by Statute.

FAC
69D-2

INSURER ANTI-FRAUD INVESTIGATIVE UNITS

- Mandates insurers must report the suspected fraud acts electronically using either the E-file Referral or the NICB interface site.
- Clarifies what constitutes an allegation of suspected insurance fraud.

Florida
Statute
626.9891

**INSURER ANTI-FRAUD INVESTIGATIVE UNITS;
REPORTING REQUIREMENTS.**

- Adoption and electronic filing of an anti-fraud plan.
- Minimum 2 hours Anti-Fraud Training to SIU (1-hour refresher yearly).
- Required Collection and Reporting.

FAC 69B-
220.201

**ETHICAL REQUIREMENTS FOR ALL ADJUSTERS AND
PUBLIC ADJUSTER APPRENTICES**

- Requires adjusters to subscribe to a code of ethics.
- Outlines ethical treatment of insureds to ensure fair dealings with their insurer.

Florida
Statute
627.711

**NOTICE OF PREMIUM DISCOUNTS FOR HURRICANE LOSS
MITIGATION, UNIFORM VERIFICATION OF INSPECTION
FORMS.**

- FS 627.711(6)(a) Prohibits inspectors from offering kickbacks, inducements, rewards, or referral fees to insurance agents, brokers, etc. for the referral of the homeowner to the inspector for insurance-related inspections.
- FS 627.711(6)(b) an insurance agent cannot accept a kickback, inducement, reward, referral fee from an inspector.

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