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Companion Life Insurance Company of California
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NAIC # 12285

2023 Special Investigation Unit (SIU) Policies & Procedures Manual

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Allied Universal Compliance and Investigations
Special Investigation Unit (SIU) Program

Allied Universal Compliance and Investigations f/k/a G4S Compliance & Investigations has a comprehensive Special Investigation Unit Program which includes a strategy designed to assist our claim professionals with preventing, detecting and investigating claims with suspected fraud. The Anti-Fraud Plan also intends to minimize claim exposures through enhanced information verification and intelligence capabilities.

The Allied Universal SIU was created to provide our corporate clients with an international investigative program managed and staffed by experienced professionals. Allied Universal provides Special Investigative Services to include but not limited to Surveillance, Database Investigations, Claim Investigations, SIU Complex Investigations, Documented Fraud Packages, Fraud Awareness Training and SIU Compliance and Reporting. This partnership, along with other innovative applications, will enable all our clients to achieve our objectives and differentiate our product and service among our competitors.

Allied Universal endeavors to detect and prevent insurance fraud through a systematic program of identification, investigation and resolution of suspicious claims and fraud. Further, Allied Universal commits to cooperate with all of the various organizations that are committed to control fraud including all Department of Insurance Fraud Divisions, National Insurance Crime Bureau, Law Enforcement and any other localized group involved in the detection, prevention and prosecution of insurance fraud.

The philosophy of Allied Universal Compliance and Investigations is to assist our clients to write legitimate business and settle legitimate claims. When abuse is identified in the process it is the position of Allied Universal to resist and defend those cases.

Listed below is a summary of key considerations and elements of Allied Universal Compliance and Investigations Anti-Fraud Program:

Fraud Problem

There are numerous studies and expert opinions that support the need for anti-fraud programs. In one recent report, the Insurance Research Council estimated that one-third of all auto bodily injury claims contained some element of fraud. The National Council of Compensation Insurance has estimated that 35% of all workers compensation claims had elements of fraud or exaggeration. Fraud is prevalent in all lines of insurance. Combating fraudulent or invalid claims is a client and industry expectation and mandate. The Coalition Against Insurance Fraud (CAIF) estimates the annual cost of insurance fraud to be more than 220 billion dollars and growing, with more than 50 billion dollars to the Property & Casualty markets alone.

Allied Universal Compliance and Investigations is committed to our obligation to protect the corporate assets of all our clients from fraud, not only because it is in our client's financial interest, but more importantly because we have a fiduciary responsibility to our clients to hold down their costs.

The Anti-Fraud Program must have structure to meet the regulatory requirements Promulgated by the states, but also must be flexible and diverse to adequately address

the ever changing face of insurance fraud. Allied Universal believes that its SIU Operations Manual meets both of these expectations.

Compliance with State Regulations

California Statute - 10 CCR § 2698.35 **Detecting Suspected Insurance Fraud.**
(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.
(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.
(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may indicate possible fraud.

The Allied Universal Compliance and Investigations Fraud Abatement Plan has been developed as a multi-disciplinary approach to the prevention, detection, investigation and prosecution of insurance fraud on behalf of our self-insured and insurance clients. Allied Universal has a six-prong approach to fighting fraud:

- **Fraud Prevention & Detection Procedures:** Procedures to prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage and external claim fraud.
- **Fraud Review & Investigations:** This part of the plan encompasses the review of claims for our clients in order to detect evidence of possible insurance fraud and procedures for investigating claims where fraud is suspected.
- **Referral of Fraudulent Activity to Law Enforcement:** Allied Universal has a systematic method of reporting fraud to the appropriate law enforcement agencies, fraud bureaus and designated prosecutor’s office, and will cooperate with the law enforcement and regulatory offices in the fight against fraud.
- **Remedies Against Fraud:** Allied Universal has developed plans and procedures dealing with restitution or other damages through either independent counsel or under criminal proceedings.
- **Fraud Detection Training Plan:** This portion of the Allied Universal SIU Fraud Plan includes all aspects of anti-fraud training including both internal and external programs.
- **Fraud Warnings:** Pursuant to the NAIC’s and/or CAIF’s standardized statements of warning, Allied Universal assists all our clients in developing their insurance claim documents that include “substantially similar” warnings to the effect of: *“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefit.”*

Fraud Prevention & Detection Procedures

Fraud Recognition – Allied Universal Compliance and Investigations believes that understanding fraud indicators will facilitate timely recognition of potential fraud claims. Early recognition greatly enhances the probability for successful resolution of suspected fraud. Therefore, Allied Universal has made fraud indicators an integral part of the detection procedures for claims personnel, medical rehabilitation specialists, customer service personnel and others. The most common way that claims adjusters are trained to detect fraud is through the recognition of certain "red flag" indicators. These potential signs of fraud may include such factors as claimants with no permanent address, claimants who claim lost wages, but are never home when called, or inconsistent and contradictory details of events, etc. Allied Universal will assist our clients to adopt fraud indicators promulgated by the National Insurance Crime Bureau and other generally accepted industry indicators of suspicious claims. The Policies & Procedures Manual shall be distributed to and maintained by all integral anti-fraud personnel and updated annually by the SIU.

Fraud Recognition Skills:

- Evaluate each claim individually.
- Do the facts of the loss make sense?
- Does the injury or damages make sense as reported?
- Evaluate the time line of events.
- Compare statements with first notice, medical reports, incident report, proof of loss, police report and other available statements and documentation.

Fraud detection technology – One of the most useful sources of help in emerging technologies are via the Internet and other electronic accessing of public records and industry claims information available to members of ISO and NICB. Allied Universal Compliance and Investigations has access to many of these industry recognized databases and may utilize them to assist our claims colleagues in their efforts to detect, investigate and prosecute fraudulent activities.

Internal Fraud – Allied Universal will work closely with the various operating units of all our clients in a proactive manner to prevent, detect and investigate insurance fraud. All investigations into suspicions and allegations of internal fraud will be directed and coordinated by our direct named contact with all our clients.

Public Awareness – Allied Universal Compliance and Investigations is a member of the Coalition Against Insurance Fraud (www.insurancefraud.org) and sits on the CAIF Privacy Task Force. CAIF is an industry organization of Insurers, Corporations, Fraud Bureaus, Consumer Protection Agencies, Prosecutors, Government Agencies and others involved in the fight against insurance fraud. CAIF participates in legislative development activity (including model bill development), public awareness campaigns through various forms of media, and industry activity dedicated to insurance fraud abatement.

The Allied Universal comprehensive referral guide of suspicious claim indicators outlines when to refer a claim to the SIU. Allied Universal will assist our clients in combating suspected fraud as well as in assisting with validating information that is important to a claim evaluation. From skip traces and a search for prior medical providers to surveillance

and field interviews and evidence collection, Allied Universal can assist the claim investigation process.

Once a suspicious claim is identified and further investigation is warranted, the client will submit a referral to Allied Universal through a specific referral process. The SIU will assign the investigation referral to a field investigator. The client and SIU will determine what resources and methods will be utilized to resolve the fraud issues and avoid payment of a fraudulent claim when possible. Regardless of the approach taken, the fraud investigation must be closely coordinated between the client and the SIU, completed in a timely manner and evaluated correctly for appropriate disposition.

Allied Universal believes that the SIU component must establish a careful balance between investigations of suspicious claims while ensuring that resources are not wasted on unnecessary matters. By providing structure to our anti-fraud program our clients will help maximize fraud control results while minimizing unwarranted cost and risk.

The Integral Anti-Fraud Personnel's Investigation Responsibility:

All integral anti-fraud personnel are responsible for identifying red flag indicators (suspected insurance fraud) during the handling of insurance transactions and referring it to the SIU as part of their regular duties. Be sure to document your file with the red flag indicators you identify and explain the reasons why you suspect insurance fraud when submitting a referral to the SIU to investigate. "Suspected Insurance Fraud" includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium, and application fraud. (See Red Flag Indicator Section).

- Identify and document suspected insurance fraud during the handling of insurance transactions
- Refer suspected insurance fraud to the SIU
- Ensure fair claims handling and ensure compliance with policy and state statutes
- Be aware of all indicators and profiles/follow up as required
- Be a claims professional / Confirm coverage, liability
- Be the Point of Contact on all matters regarding the reported claim
- Schedule, coordinate and conduct interviews and statements
- Develop an investigation plan
- Control claim (Diary, Follow-up, Consultation, and Resolution)
- Review prior claim history and policy information
- Review the results of the investigation and process the claim in a fair and appropriate manner
- Document the file with the comparison of any insurance transaction against patterns or trends of possible fraud, red flags, events or circumstances present on a claim, behavior or history of person(s) submitting a claim or application and other criteria that may indicate possible fraud

The SIU provides notice to all integral anti-fraud personnel of fraud indicators, guidelines for investigations, information disclosures, procedures for reporting to the SIU and DOI Fraud Division, statement-taking techniques, state statutes and regulations, as well as ever changing case law, and the extent and limitation of SIU authority.

The integral anti-fraud personnel specifically receive scenario indicators which can assist in the detection of fraud at all levels, from the application to the claims process. The integral anti-fraud personnel are advised that indicators are not conclusive of fraudulent activity but demand a higher level of scrutiny. All SIU and integral anti-fraud personnel are educated as to the value of the indicators and timely and accurate recognition of questionable claims. The integral anti-fraud personnel have been advised of the specific areas to review to determine the possibility of a fraudulent application. These areas include, but may not be limited to, previous claims history, a previously cancelled or non-renewed insurance policy and financial information on the insured to include bankruptcy, liens and judgments.

Underwriting Guidelines

The opportunity to detect and prevent fraud in the application process is the responsibility of The Company's underwriting department. Steps are taken in each line of insurance to verify the information supplied on the application. These procedures are periodically reviewed and refined to enhance the current workflow procedures and to ensure compliance.

Underwriters are instructed to contact Allied Universal immediately when suspicious occurrences are detected.

Employee Benefits

The Underwriting Department screens applications and renewals.

The following is an example of the steps taken to verify information submitted and, therefore, to control potential fraud in the application process.

A. Group must exist for reasons other than that of obtaining insurance and be financially sound (length of time in business). The individual who signs the application must be authorized to contract for the group.

B. The group must be located in the state in which the policy is issued. The group will assume responsibility for administrative duties such as: enrollment, premium collection and payroll deduction, remittance of premium, record keeping and assistance with claims.

C. Only active employees who receive regular compensation are covered. This may include but is not limited to partners, owners, and non-permanent employees.

The above underwriting steps are an illustration of some of the practices used to determine the accuracy of information submitted at the time of application and renewal. While they are not all inclusive of the investigation done to reduce application fraud potential, they are routine and show the commitment of the Company to maintain the integrity of policies. Underwriters are instructed to contact Allied Universal immediately when suspicious occurrences are detected.

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, underwriters are expected to review all applications for possible fraud.

Determining the "fraud potential factor" of any application is facilitated when the underwriter is familiar with various fraud indicators.

These indicators should help isolate those applications which merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that a fraud is being committed. Indicators of possible fraud are "red flags" only, not actual evidence.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, subsequent referral to Allied Universal for further review may be appropriate.

Agents & Brokers Guidelines – Effective January 1, 2023

The opportunity to detect and prevent fraud in the application process is also the responsibility of the Company's Agents & Brokers. Steps are taken in each line of insurance to verify the information supplied on the application. These procedures are periodically reviewed and refined to enhance the current workflow procedures and to ensure compliance.

An agent or broker who reasonably suspects or knows that a fraudulent application is being made on behalf of the Company, shall, before placing an insurance application within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the California Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application.

All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously.

In addition, an agent or broker who, after an insurance application has been placed with The Company reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the Company's special investigative unit, Allied Universal Compliance and Investigations. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to Allied Universal upon request and shall otherwise assist and cooperate with Allied Universal. An agent or broker shall also furnish all papers, documents, reports, or other facts or evidence to the CDI upon request and shall otherwise assist and cooperate with the department.

Allied Universal Compliance and Investigations
Best Practices

The priority mission of Allied Universal Compliance and Investigations is to provide value-added service to all our clients in the Claims, Underwriting and Legal Divisions as well as their client companies.

Allied Universal is committed to taking a leadership role in providing expert consultation, training and superior investigative services to all our clients in order to achieve operational excellence.

Allied Universal will leverage available resources to provide the highest quality of investigative, training and consulting services to all our clients.

Allied Universal shall establish, maintain, distribute and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application or insurance transaction that includes consideration of factors indicating insurance fraud.
(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
(3) Utilizing one or more industry-recognized databases to assist in all SIU investigations when appropriate for use during the investigation specifically relating to the particular line of business and suspected fraud.
(4) Identification, collection, safeguarding documenting and preserving all evidence and documentation obtained during the investigation.
(5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings. The Summary will be a separate report from any other document prepared in connection with each investigation.

Special Investigation Unit Objectives

1. To thoroughly investigate all suspicious or unlawful activity directed at our clients and our client's corporate assets.

2. To review, investigate and report factual information in a prompt and expedient manner of suspicious claims referred for surveillance and/or investigation. This will be accomplished in compliance with applicable laws, regulations, company procedures, policies and objectives.

3. To abide and comply with the provisions of the IFPA and the regulations found within Subchapter 9 Insurance Fraud - Article 2 Special Investigative Unit Regulations - Section 2698.

Best Practices Defined

Best Practices is a movement from a standards-driven measurement to a result-based organization that focuses measurement on the outcomes of investigative methods that prevent, defeat and deter insurance crime.

Purpose

Investigation Best Practices shall serve the Special Investigation Unit (SIU) in carrying out its objectives. Allied Universal commits to:

1. Providing a valuable service to all our clients greater than our cost.

2. Providing value-added tools to all our clients in their efforts to deter fraud efficiently and effectively.

3. Facilitating teamwork with our clients that promotes mastery of proactive strategies that further the SIU's effectiveness, efficiencies and performance.

4. Maintaining a reputation for professionalism, ethical behavior and dedication that results in our clients being an undesirable target of fraudulent activity.

Assignment Referral - Best Practices

Referrals for investigation assignments can be made by any of our client's claims professionals, Legal Divisions and Underwriting Divisions.

Referrals may be received from the above via PartnerLink, E-Mail, or Phone.

Referrals shall be properly documented.

All necessary information shall be included to evaluate the referral for appropriate field assignment, the adjuster's objectives, case budget planning, scheduling and personal identifying data of the subject of the investigation.

Assignment Receipt – Best Practices

Allied Universal shall provide an electronic written acknowledgement of the assignment to the referring claim representative within 24 hours of receipt.

Upon receipt of the referral Allied Universal shall review the information with the referring adjuster and develop the assignment objectives and any specific action plan, which may be required.

Upon receipt, Allied Universal will make the appropriate assignment to a SIU staff investigator or to an approved Vendor.

The investigator will perform a thorough analysis of the claim file, application or insurance transaction by reviewing every document within the file.

The referral must be assigned to an investigator to be performed within the standard due date or on the dates provided by the specific instructions for the assignment.

Communication – Best Practices

Allied Universal shall provide fraud awareness, prevention, detection and investigation training to all our clients.

Allied Universal shall encourage and engage all of our client's integral staff including the claim representatives, legal staff and underwriters in participating in the objectives and strategy of the investigation.

All communication shall be timely and consistent between the SIU and our clients or other internal customers.

All communication shall be timely and consistent between approved Vendors, Allied Universal and our clients.

Allied Universal Compliance and Investigations will provide a totally electronic method of delivering the surveillance investigative report, color snippets, and video evidence to the referring claim adjuster on all work performed by the SIU staff investigator.

All of our clients will have access to a 24 hour secure Internet site to obtain status of investigations performed by a staff investigator of the SIU. This site will also give our clients access to color snippets, full-length streaming video evidence and the complete investigative report of the surveillance or investigation.

The SIU will encourage approved Vendors to provide an electronic transmission of the investigative report, at minimum.

Documentation – Best Practices

Allied Universal and/or approved Vendor will ensure that:

- Information is legally secured, verified and documented
- Identification of relevant witnesses and quality statements are secured from those witnesses who may provide information on the accuracy of the claim or application
- Relevant and referenced quality photographs and/or video are secured and
- Physical evidence is identified, collected, safeguarded, documented and preserved

Investigating Suspected Insurance Fraud – CA Best Practices

An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction that includes consideration of factors indicating insurance fraud by reviewing every document within the file.
(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application. SIU will ensure quality statements are secured from those witnesses who may provide information on the accuracy of the claim or application.
(3) Utilizing one or more industry-recognized databases to assist in all SIU investigations when appropriate for use during the investigation specifically relating to the particular line of business and suspected fraud. (See Pages 19-20 for full list of databases used by the SIU).
(4) Identification, collection, safeguarding documenting and preserving all evidence and documentation obtained during the investigation.
(5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings. The Summary will be a separate report from any other document prepared in connection with each investigation. (See below for Workflow for SIU Investigations).

Workflow for SIU Investigations:

- Initial Referral comes into the SIU.
- SIU referral is accepted or rejected by SIU depending on suspected fraud.
- If red flags are present, we will classify as a SIU referral. All referrals to SIU will be classified as a SIU referral if the referring party clearly identifies the fraud indicators.
- If no red flags are present or other non-suspect reason for a referral, we will classify the referral as an SIU assist investigation, also known as a claim assist investigation.
- SIU will thoroughly analyze the insurance documents and determine the proper investigative steps needed which may include interviews of potential witnesses who may provide information on the accuracy of the claim or application, surveillance or utilizing databases and will conduct an effective investigation to determine if reasonable belief is established or if the red flag indicators can be resolved.
- On all referrals that come to the SIU with red flags present, SIU will write a clear and concise summary of the findings noting they have either substantiated reasonable belief or ruled it out.

The Clear & Complete Summary will include answers to all of the following questions:

(A) What facts caused the reporting party to believe insurance fraud occurred or may have occurred?
(B) What are the suspected misrepresentations and who allegedly made them?
(C) How are the alleged misrepresentations material and how do they affect the claim or insurance transaction?
(D) Who are the pertinent witnesses to the alleged misrepresentation if there are pertinent witnesses?

(E) What documentation is there of the alleged misrepresentation, if documented?
(F) In addition, the summary prepared shall include a statement as to whether or not the investigation is complete or if further investigation is needed.

Each investigation of suspected insurance fraud shall include performing at least the procedures specified pursuant to subdivision (a) of this Section 2698.36, to the extent they are applicable.

The SIU shall investigate each credible referral of suspected insurance fraud that it receives from integral anti-fraud personnel, including automated or system-generated referrals via. PartnerLink. Note: SIU will only identify a referral as an SIU assignment only if credible referral of suspected insurance fraud is one that includes a red flag or red flag events. In the event that upon a preliminary review the SIU determines that it is reasonably clear that the red flag or red flag events contained in the referral is not or are not the result of suspected insurance fraud, the SIU will not open an investigation and the SIU file shall be documented for the reasons supporting its conclusion that the red flag or red flag events contained in the referral is not or are not the result of suspected insurance fraud.

- If reasonable belief was established, an eFD-1 will be filed within 60 days for all lines of business. If red flags are resolved by the investigation, a clear and concise summary will be written and the SIU file closed. The eFD-1 will be submitted at the conclusion of the SIU investigation if reasonable belief has been established effective January 1, 2023. Note: The Summary of the investigation will be written at the case level, not the individual task assignment level as the summary must address the SIU investigation in its entirety regardless of individual objectives and must include a statement as to whether or not the investigation is complete or further investigation is needed.
- Effective January 1, 2023, the 60-day time limit on filing an eFD-1 begins after the completion of an SIU investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring. The 60-day time limit does not start at the time an adjuster, underwriter or other individual notes red flags and does not start at the time the red flags are initially reported to the SIU.

Action plan results shall be communicated in a timely, relevant and factual report. All written reports to our clients shall be professional and supported by relevant documents that are logically organized and all evidence will be properly saved and preserved. Necessary follow-up investigations shall be aggressively pursued and reported in a timely manner.

Allied Universal Compliance and Investigations
Surveillance – Best Practices

- The SIU will provide electronic confirmation after receipt of your assignment.
- The SIU will work full days if the claimant is confirmed at home.
- The SIU will break off the surveillance if the claimant cannot be confirmed at home at the half-day mark. Other investigative techniques may then be utilized depending on the circumstances of the assignment. These techniques and services may include variation of surveillance times to establish the claimant's routine schedule, neighborhood canvas for information on activity levels, background checks, etc.
- The SIU will begin surveillance at 6:00 a.m. on the first day of a new assignment (unless directed otherwise). Follow up starting times may be varied depending on the case results, or developed information, which implies potential activity during a different time frame.
- The SIU will maintain surveillance on an active claimant even if the authorized budget has expired for that day.
- The SIU will work consecutive days or work cases in the same week, when possible.
- The SIU will immediately contact the client if the investigator is directly compromised by the claimant during the course of the investigation.
- The SIU will not exceed two hours to re-establish contact with a claimant that has been lost during a mobile surveillance.
- The SIU will maintain continuous product quality and evaluation process to assess a "Performance Grade" to each day of surveillance thru the program.
- The client will receive electronic status updates during the investigation.
- The client will have access to immediate status updates via the PartnerLink system.
- The client will have access to the full investigative report, color snippets, and full-length streaming video evidence via a secure Internet connection on all assignments worked by the SIU staff; (not available for Vendor work).
- The client will typically receive the investigative report, snippets, invoice and video within 21 days of assignment. The SIU standard product delivery system is based on a fully electronic transaction process.
- The SIU will tailor our investigation to fit your individual needs.

Allied Universal Compliance and Investigations
SIU / Claim Investigations – Best Practices

- The SIU will acknowledge receipt of the assignment within 24-hours.
- The SIU will review the assignment and provide an investigative game plan (as required) within 48 hours of receipt.

An investigative strategy is a careful plan or method designed to achieve a goal. The goal of the investigation is always the pursuit of information which leads to the truth. Sometimes that information will be inculpatory (incriminating) and other times it will be exculpatory (exonerating). However, unless a thorough plan for obtaining information is formulated, vital pieces of information can be overlooked or not investigated at all. No strategy should have the sole focus of developing evidence to prove fraud. The strategy should be designed to pursue the factual aspects of all information that will satisfy the questions who, what, where, when, why, how and how much of the claimed loss.

As a part of the investigative plan, the Investigator will discuss with the insurance professional the identification and interviews of any potential witnesses who may be able to provide additional information surrounding the claim or application.

- The case will be assigned to an investigator within 48 hours of receipt.
- The client will receive a report within 21 days, if the case is complete. If the assignment is not complete, an interim update will be provided followed by additional status updates every 7-14 days until the case is concluded.
- The client will always have access to PartnerLink for status updates of investigative activity on assignments performed by the SIU to include work history, completed investigative reports, photographs and any obtained videotape of a loss scene.
- The SIU will provide transcription services (at an additional cost) if required by the adjuster's objectives.
- The SIU will maintain all original evidence/ recording media on assignments performed by the SIU (and copies of Vendor's reports & video) unless directed to forward directly to our client.
- The SIU, or assigned Vendor, will maintain a copy of all obtained documents and forward the originals to our client.
- The SIU requires a recently signed authorization for credit, medical, employment, and financial record procurement.
- The SIU will conduct interviews upon our client's request; however, we will not knowingly make direct contact with a represented person without permission from that person's attorney.

Assigning a Case to the SIU

The SIU will maintain a secure Internet Web-site and 1-800 toll free numbers for the receipt of our clients' surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. Cases may be assigned via one of the following methods:

1. Allied Universal PartnerLink® (preferred) - https://partnerlink.cni-aus.com
2. Phone 800-927-0456, and report to a SIU Manager (immediate/rush cases)
3. E-mail request to cases@aus.com

Once a referral and/or a suspicious insurance act is made to Allied Universal, the SIU Case Manager consults with the referring party and reviews the facts of the loss and investigation objectives. A plan is formulated to ensure timely investigation of the areas of concern on each referral to the SIU. In instances of suspected fraud during the underwriting process the Company staff reports the suspected insurance transaction to the SIU. The appropriate SIU staff member consults with the reporting party and determines the investigative support to resolve the suspicion, and/or take appropriate follow-up action.

The referral is assigned to a SIU field investigator within 24-48 hours. The SIU field investigator reviews the assignment and objectives and consults with the claim or underwriting professional on any issues still in question. The investigator makes arrangements to meet with the claimant, insured, or other involved parties to conduct interviews, and obtain written or recorded statements, where warranted.

The file will document interviews with the insured, claimants, applicants, and any witnesses or other involved parties. The investigation may include photographs, videos, and diagrams of the loss site or individuals involved, as well as any police or other governmental report available. On liability or workers' compensation claims involving a personal injury, there will be an adequate medical investigation done on claims that warrant such.

There will be an investigation as to whether the injuries were directly related to the incident giving rise to the claim. If such injury investigation is referred to the SIU, the file will include copies of medical reports and treating doctors' records to verify treatment patterns, and when needed, will attempt to determine if treatment is reasonable and necessary.

Pre-surveillance Preparation

Once a decision is made to investigate a claim, the SIU's professional team will immediately begin our assigned task. A pre-surveillance work-up will be conducted including, but not limited to, various database searches to establish current and last known addresses, owned vehicles and tag numbers (when available) and current telephone number.

Along with database searches, the SIU and/or staff investigator will contact the referring claim representative, or other source as directed, to develop additional information.

Assignment to the Field

Upon completion of the pre-surveillance investigation, the SIU will assign the most appropriate investigator to work the case, taking into consideration the geography, specific requirements and overall goals of the assignment. All assignments will be performed by the staff investigators of the SIU unless otherwise directed by the client, based upon a formal contract.

Allied Universal Compliance and Investigations' goal is to schedule and complete surveillance and minor claims investigations within 21 days, unless otherwise specified in an individual client agreement. However, in claim investigation assignments, the availability of the claimant, insured or other involved parties will dictate the actual time-frame that the assignment will be completed. The investigator will also make appropriate action plans based upon investigative priorities to complete all facets of the field investigation that may be required.

Communication

Each new surveillance and claim investigation assignment will receive a verbal or electronic confirmation from the SIU indicating a thorough understanding of the client's objectives and budget parameters.

The SIU staff investigators are required to electronically submit their narrative report after each day of investigative activity. Investigators transmit "highlights" of investigative activity for claim investigation assignments each day. Complete surveillance reports of the day's case are transmitted each day. Every investigative report is reviewed by a SIU Manager. The claim representative is updated either verbally or via e-mail, within 24 hours of any activity on their file. Same day and field updates by the investigator are available upon request.

Effective and timely communication is essential in that it brings the claim representative into the investigative loop. By creating this "team" approach, the SIU can react instantly on information and alter our investigative game plan based on a mutual understanding.

Assignments being performed by a SIU approved Vendor have similar requirements that the investigator update the claim representative **AND** the SIU after each day of surveillance activity. Same day updates from the field investigator are also available upon request. Email updates are preferred unless there is significant information that must be discussed with the claim representative and the SIU.

Interim & Final Reports

The Final Report is usually completed by the field investigator within 24 hours of concluding the investigation on assignments performed by a staff investigator. The investigator electronically transmits the report to the SIU Manager and emails all "attachment documents." The Manager will review and approve the Final Report and the "attachment documents" will be uploaded to each file. The report and all attachments will be electronically transmitted to the referring client.

The staff investigator will upload all original documents, photographs, and video according to standard protocols. The original documents will be retained in the master file for future retrieval by the client.

At the conclusion of the initial surveillance assignment (2-day/3-day etc.), and at the conclusion of any additional days of surveillance requested by the claim representative, the SIU will process and proof the investigative report, edit the video, and produce color snippet prints highlighting key video sequences that are digitally extracted from the video. The SIU Manager will ensure a quality assurance review of the entire package prior to the final product being prepared for delivery to the client. The Interim and Final report, color prints and video evidence may be accessed by the client on the Internet, via PartnerLink. The Final Report, Color Snippets, and Invoice may be transmitted to the requester via E-mail. The video evidence may be produced on disc or SD cards.

Overnight delivery to the client is also available.

Approved Vendors performing work through the SIU will Email and/or mail their Investigative Reports, Photographs, Video Evidence, and attachments directly to the client. The Vendor shall also provide a copy of said materials, at the same time, to the SIU.

The Vendor Invoice for services will only be sent to the SIU.

Technology

The SIU automation strategy is to provide the fastest, safest and most professional product available in the industry today. To accomplish this, the SIU uses state-of-the-art technology to enhance our communications capabilities so we can provide information in a way that works ***best for you***.

At Allied Universal, we have taken several steps to ensure that both our internal system and our web site are secure and virus free. Allied Universal uses secure technology to protect your information from intentional and unintentional access as it traverses the Internet.

Each SIU staff field investigator is equipped with a laptop computer so they can receive electronic case assignments and updates from their Case Manager and each evening transmit their investigative report for that day's activity.

The SIU is capable of electronically transmitting your updates, Surveillance & Investigation Reports, Color Snippets, and Invoices directly to your email. All our clients may access their Investigative Reports, Color Snippets and full-length video evidence directly from the SIU secure PartnerLink site.

Fraud Detection Technology - Instruction on the Utilization of Industry Recognized Databases

The SIU utilizes numerous web-based electronic solutions for accessing information from public records and subscription databases. The SIU utilizes various sources of intelligence and data to support and assist the claim examiners in their efforts to detect, investigate, and prosecute fraudulent activities.

In addition to direct access into various local and state governmental record repositories, the SIU utilizes various subscription databases to obtain legally permissible information and public record information from a variety of sources, including but not limited to:

Accurint
Lexis Nexis (Risk Management Solutions)
Verisk ISO Claimsearch
Choicepoint/Orderpoint
Criminal Record Check.com
Denspri
Edex
Records Research
Pacer
FACIS
Carfax
Transunion/TLO
Various state DMVs (AR, CA, IN, KS, NV, NJ, NY, NC, OR, PA, SC, UT, VA)
Social and Professional Networking sites
Various social media searching web crawlers
Miscellaneous resources of the Internet via Search Engines

Comprehensive Nationwide Background Investigation: The Comprehensive Background includes verifying existing or developing new information regarding current employment, 7 year Criminal & Civil History in current County of residence and up to (3) additional counties identified in a Comprehensive Profile Search, public records check for Bankruptcy, Liens & Judgments, State Driving Record and Vehicle Registrations (where available), Statewide Professional Licenses, a statewide Real Property Ownership Asset Search and a Comprehensive Profile Report.

Skip Tracing: Individual Locate – Allied Universal database researchers use a variety of public and private databases in addition to other investigative methods to locate that individual that just doesn't want to be found.

Real Property Search: Statewide / Nationwide – This comprehensive search for Real Property (real estate) owned by an individual involves a thorough check of Tax Assessor and Deed Transfer records available online. The subject's full name and social security number, at minimum, must be provided. This search can be done for a single state or as a nationwide search of available records.

Social Security Number Search: - A comprehensive search of databases including credit headers, consumer databases, etc., that will return names of individuals associated with the social security number, addresses, phone numbers, and other related information.

Various state DMVs (AR, CA, IN, KS, NV, NJ, NY, NC, OR, PA, SC, UT, VA) – Motor Vehicle Registration records searched by subject's name or by address. Returns information on file with the state DMV and usually includes year, make, model, VIN, owner name and address, and on occasion provides the vehicle tag number, owner's phone number, and lien holder information. (Available in most states)

State Driver's History Record: Transcript of a subject's state motor vehicle driving record. Available in most states.

Social and Professional Networking sites - Social Media Investigations include a search of multiple social networking sites for subject activities and interests, address verification, a civil and criminal records search, a motor vehicle record search and report documentation.

Miscellaneous resources of the Internet via Search Engines.

Client Management Reports

Allied Universal has developed the industry leading and proprietary Case Management Program that we have named PartnerLink. Through PartnerLink we have been able to create a variety of detailed Client Management Reports.

The Client Management Reports provided by the SIU allows our client personnel to track the measurements of investigator performance and sort by a host of criteria including, but not limited to: Investigator, Claim Representative, Insured, Claim Office and Date of Service.

These reports provide the following information:

- Claims office
- Adjuster/SIU name
- Claimant name, injury, physical location
- Claim number
- Date assignment referred/received
- Date assignment worked
- Date final report transmitted to the requestor
- Hours worked
- Budget expended
- Investigator's name
- Case Grade assigned to EACH day worked
- Brief summary results of each days activity

Invoicing

The SIU is flexible to meet the invoicing needs of all our clients. The normal practice of the SIU is to electronically transmit the invoice for service on each assignment to the client representative that made the referral by email. The Invoice for service may also be mailed to the claim representative.

Invoice payment is preferred within 15 days, and expected within 30 days, of receipt of the invoice for services.

The Allied Universal Accounting Department is available to answer any questions concerning invoices or payment. They may be contacted at (800) 927-0456.

SIU Quality Assurance

Internal Evaluation

The SIU has taken a leadership role in developing industry standards for measuring investigative effectiveness. The SIU will utilize these tools to measure our performance and the performance of Vendors performing work for all our clients.

The SIU will evaluate and measure the performance every day of every assignment for our staff investigators. This daily performance measurement allows the SIU to quickly identify and react to trends, target training, and seek innovation to continuously improve our performance. Allied Universal is truly a performance-based organization. Each employee is held accountable for measured results and is constantly provided with performance feedback.

The SIU will also evaluate the performance of all Vendors conducting surveillance and investigations for all our clients. These evaluations will occur on an assignment basis and the results made available to our client's management team.

External Evaluation

Internal measurements are essential for quality improvement; however, without external claim representative satisfaction, true improvement is not possible. The client will have the opportunity to complete an Evaluation Survey Form on every assignment worked by a SIU staff investigator and assignments worked by Vendor's investigators. These easy-to-use Satisfaction Surveys are available via PartnerLink.

Total Quality Service Guarantee

Allied Universal provides a written guarantee to all our clients for quality service and performance on all work performed by the staff of the SIU.

"Our guarantee to our clients is customer satisfaction by providing a total quality service. If you are not satisfied, with our services, we will refund, credit or re-work the assignment immediately to ensure that you are completely satisfied."

The SIU will insert the same guarantee statement in all Vendor contracts.

Allied Universal SIU management will work cooperatively with all our clients to resolve any service or billing issues and concerns in a prompt and professional manner.

Physical Security

The SIU maintains a secure and protected office and computing environment. We are a lock-down facility that requires card-key access at all times. After hours and weekend entry has additional protection of a central station monitored alarm for unlawful entry, vandalism, fire, smoke and water.

Computer Security & Disaster Recovery

The SIU's automation strategy is to provide the fastest, safest and most professional product available in the industry. To accomplish this, the SIU uses state-of-the-art technology to enhance communication capabilities while providing information in a way that works best for our clients.

All Allied Universal systems are deployed utilizing industry-leading virtualization technology and have a paired replication for redundancy. Each host server is configured with RAID 10 for maximum redundancy and protection. All Allied Universal systems are backed up on a daily basis to offsite storage, using 256 bit encryption. Databases are backed every 15 minutes resulting in an RPO and RTO of 15 minutes. All Allied Universal systems align with NIST, OWASP and ISO 27001.

SIU – Comprehensive List of Services

The SIU provides a host of professional investigative services to our clients, including but not limited to:

General Investigation Solutions
AOE / COE - Compensability
Auto Bodily Injury
Casualty Investigations
COD / Disability Investigations
Document Retrieval
Beneficiary Review
Theft Investigations
Subrogation Investigations
Mediation Representations
Travel Claim Investigations
Life & Annuity Investigations
InVue Video Interviews

Surveillance Solutions
Surveillance
Unmanned Surveillance
Activity Checks / Canvass
Wellness Checks / Alive & Well Checks

Loss Adjusting Solutions
Daily Adjusting
Commercial Adjusting
CAT Adjusting
Heavy Equipment, Machinery and Trucking
Marine Adjusting
Loss Control / Roof Inspections
ClaimScope for remote inspections

Fraud Compliance Solutions
Regulatory Reporting
Fraud Reviews
Audits
Anti-fraud Training
State Fraud Referrals
SIU Consulting
Documented Fraud Reports
Suspect Claim Investigations
Desktop SIU Investigations

Research & Database Solutions
Social Media Investigations
Background Investigations
Civil & Criminal Checks
Skip Tracing Individual Locate
Social Security Number Verification
Real Property / Asset Check
State Driver's History Record
Work Comp State Records Check
National Individual Profile Report
Litigation Search
Business Search
Police Report
Hospital / Pharmacy Check
Death Certificate
Vehicle Title History
Professional License Search
UCC Filing

COVID-19 Solutions
COVID-19 Initial Claim Insight
Initial Claim Insight
Social Distancing Social Media Monitoring
Unemployment Investigations
Business Interruption Investigations
Virtual Inspection Program

Law Enforcement Request For Insurance Information

SIU employees responding to a law enforcement request for claim file, investigative file, ISO ClaimSearch, and/or other data services information must justify release of the information based on a legitimate need by law enforcement with a regard to an active criminal investigation and whether the information provided would benefit the investigation.

The request for information must be in writing and should cite specific state or federal immunity statutes covering the release of information.

Once justification has been established, the employee shall first obtain an approval of a Branch Manager or executive level management, before conveying the information to the requesting law enforcement agency. The Branch Manager or executive level leader may want to discuss the claim file and the law enforcement request with the SIU.

In some specific situations it may be necessary for law enforcement to obtain a subpoena for the requested information.

All requests for information, and any subsequent release, must be documented in the file.

Liaison With Law Enforcement Officials

Allied Universal will ensure all our clients are aware of their corporate responsibility to actively cooperate with and assist federal, state and local law enforcement and fire service authorities to combat insurance fraud. The SIU and our client will coordinate with DOI Fraud Bureaus, Law Enforcement, Fire Service, and other government entities. The SIU may be requested to assist by providing professional investigative, consultation and training assistance. All decisions to provide actual service will be approved by our client.

Mandatory Reporting Statutes

Allied Universal believes it is prudent to establish formal guidelines for compliance with mandatory reporting statutes enacted by state law or insurance department regulation.

It shall be the policy of all of our clients to utilize the SIU to comply with state statutes and insurance department regulations mandating reporting of suspicious claims.

The SIU will make individual reports to the various states that have the mandatory fraud reporting statutes.

CA Mandatory Reporting Statutes

It is the SIU's responsibility to document in the file the suspected insurance fraud identified by the insurance professional (i.e., red flag indicators). The SIU is then responsible to conduct an effective investigation to determine if reasonable belief is established by confirming if the red flag indicators are still present or if the red flag indicators were resolved. If the red flag indicators remain after the investigation, the SIU has now established "reasonable belief." When the SIU has confirmed "reasonable belief" that a person has committed insurance fraud, the SIU will file the eFD-1 to the CDI and/or applicable District Attorney's office within 60 days of discovery for all lines of business.

CCR §2938.37(c) points out that referrals shall be made within the period specified by statute. The specific statutes are located at *California Insurance Code (CIC) Sections* 1872.4 (all insurance except for Automobile and Workers' Compensation), 1874.2 (Automobile) and 1877.3 (Workers' Compensation). These insurance code sections address when a referral must be made to the Fraud Division (and district attorney, when applicable):

- *CIC Section 1872.4 & 1877.3* requires a referral within 60 days of determining reasonable belief for all lines of insurance.

CA Insurance Code 1872.4

(a) Any company licensed to write insurance in this state that has determined, after the completion of the insurer's special investigative unit investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring shall, within 60 days after that determination by the insurer, send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances regarding the alleged insurance fraud and person or entity that may have committed or is committing insurance fraud, as specified in Section 2698.38 of Title 10 of the California Code of Regulations. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, claims, application, or other insurance transaction, the commissioner shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, the commissioner shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the Fraud Division the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Fraud Division, when so requested, and shall otherwise assist and cooperate with the division.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Fraud Division information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

CA Insurance Code 1872.41

(a) An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made shall, within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application. All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

(c) An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the department upon request, and shall otherwise assist and cooperate with the department.

(d) (1) For purposes of this section, 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 and is not the employee of an insurer.

(2) An agent or broker is not considered a "contracted entity" or "integral antifraud personnel" pursuant to Section 2689.30 of Title 10 of the California Code of Regulations.

CA Insurance Code 1872.51

(a) An agent or broker who furnishes written or oral information pursuant to Section 1872.41, or an authorized governmental agency, or its employees, that furnishes or receives written or oral information pursuant to Section 1872.41 or assists in an investigation of a suspected insurance fraud violation conducted by an authorized governmental agency, shall not be subject to any civil liability in a cause or action if the insurer, authorized agent, agent or broker, or authorized governmental agency acted in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained by reasonable efforts.

(b) This chapter does not abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, agent or broker, licensed rating organization, or any authorized governmental agency or its employees.

CA Insurance Code 1874.2

(a) Upon written request to an insurer by an authorized governmental agency, an insurer or agent authorized by that insurer to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency that the insurer may possess relating to any specific motor vehicle theft or motor vehicle insurance fraud. Relevant information may include, but is not limited to, all of the following:

(1) Insurance policy information relevant to the motor vehicle theft or motor vehicle insurance fraud under investigation, including, but not limited to, any application for a policy.
(2) Policy premium payment records that are available.
(3) History of previous claims made by the insured.
(4) Information relating to the investigation of the motor vehicle theft or motor vehicle insurance fraud, including statements of any person, proof of loss, and notice of loss.

(b) (1) When an insurer knows or reasonably believes it knows the identity of a person whom it has reason to believe committed a criminal or fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim or has knowledge of the criminal or fraudulent act that is reasonably believed not to have been reported to an authorized governmental agency, then, for the purpose of notification and investigation, the insurer, or an agent authorized by an insurer to act on its behalf, shall notify the local police department, sheriff's office, the Department of the California Highway Patrol, or district attorney's office, and may notify any other authorized governmental agency of that knowledge or reasonable belief and provide any additional information in accordance with subdivision (a).

(b) (2) When an insurer provides the local police department, sheriff's office, Department of the California Highway Patrol, or district attorney's office with notice pursuant to this section, it shall be deemed sufficient notice to all authorized governmental agencies for the purpose of this chapter. Nothing in this section shall relieve an insurer of its obligations under Section 1872.4.

(b) (3) Nothing in this subdivision shall abrogate or impair the rights or powers created under subdivision (a).

(c) The authorized governmental agency provided with information pursuant to subdivision (a) or (b) may release or provide that information to any other authorized governmental agency.

(d) An authorized governmental agency shall notify the affected insurer in writing when it has reason to believe that a fraudulent act relating to a motor vehicle theft or motor vehicle insurance claim has been committed. The agency shall provide this notice within a reasonable time, not to exceed 30 days. The agency may also release more specific information pursuant to this section when it determines that an ongoing investigation would not be jeopardized. The agency may require a fee from the insurer equal to the cost of providing the notice or the information specified in this section.

(e) An insurer providing information to an authorized agency pursuant to this section shall provide the information within a reasonable time, but not to exceed 30 days from the day on which the duty arose.

CA Insurance Code 1877.3

1877.3. (a) Upon written request to an insurer or a licensed rating organization by an authorized governmental agency, an insurer, an agent authorized by that insurer, or a licensed rating organization to act on behalf of the insurer, shall release to the requesting authorized governmental agency any or all relevant information deemed important to the authorized governmental agency that the insurer or licensed rating organization may possess relating to any specific workers' compensation insurance fraud investigation.

(b) (1) When an insurer or licensed rating organization knows or reasonably believes it knows the identity of a person or entity whom it has reason to believe committed a fraudulent act relating to a workers' compensation insurance claim or a workers' compensation insurance policy, including any policy application, or has knowledge of such a fraudulent act that is reasonably believed not to have been reported to an authorized governmental agency, then, for the purpose of notification and investigation, the insurer, or agent authorized by an insurer to act on its behalf, or licensed rating organization shall notify the local district attorney's office and the Fraud Division of the Department of Insurance, and may notify any other authorized governmental agency of that suspected fraud and provide any additional information in accordance with subdivision (a). The insurer or licensed rating organization shall state in its notice the basis of the suspected fraud.

(d) An insurer or licensed rating organization providing information to an authorized governmental agency pursuant to this section shall provide the information within a reasonable time, but not exceeding 60 days from the day on which the duty arose.

Title 10 of the California Code of Regulations. Section 2698.35 Detecting Suspected Insurance Fraud

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may indicate possible fraud.

Title 10 of the California Code of Regulations. Section 2698.37 Referral of Suspected Insurance Fraud.

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and as required, district attorneys.

(b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

(d) The SIU shall complete as much of its investigation as is reasonable prior to the time the referral is made to the Fraud Division. Each referral of suspected insurance fraud shall indicate whether the investigation is complete or further investigation is needed.

(e) The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act.

(f) The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation.

Insurance Carrier Request for Insurance Information

Specific state and federal immunity statutes will strictly govern the release of insurance information to other insurance carriers. No file information may be released to another insurance carrier absent specific immunity statute language authorizing the legal release or exchange of information between insurance carriers.

The request for information must be in writing and must cite the specific state or federal immunity statute that allows the legal release or exchange of information.

Any request for information on a file must be discussed with the client representative handling the file or their manager prior to release.

Prohibition Against Firearms & Other Weapons

Allied Universal Compliance and Investigations do not allow its employees to carry firearms, or other weapons designed for the purpose of offense or defense, while on company time, on company premises and in company vehicles for any reason.

Allied Universal further prohibits any Vendor performing work for our clients to allow their employees to carry firearms, or other weapons designed for the purpose of offense or defense, while engaged in work.

Safety Awareness

The SIU employees, and approved Vendors performing work for our clients, must develop and maintain safe work habits, use common sense when performing work-related duties, and immediately report unsafe conditions to the appropriate supervisor and company management. SIU employees should consult their manager and/or proceed with caution in instances of uncertain risk.

SIU employees may assist our clients in retaining experts by providing information and technical support within established guidelines.

SIU employees and Vendors shall always use appropriate safety equipment when conducting field investigations for all our clients.

Media Contact

All media inquiries, including requests for information and/or interviews, shall be directed to the SIU Marketing Department for review and approval.

Credit Bureau Reports

Allied Universal is concerned about the privacy of individuals involved in an insurance claim. Allied Universal has a strict policy regarding obtaining and access to a consumer report on an individual.

The SIU, and others performing work on behalf of all our clients, may only obtain a Consumer Credit Bureau report if there is a valid, dated, and signed authorization

in the file from the subject on whom the report is being obtained, and it is being requested for a permissible purpose.

All Allied Universal employees and any Vendor performing work for our clients must be in compliance with the Fair Credit Reporting Act.

Physical Evidence

To achieve the maximum benefit from physical evidence, there must be clear and established guidelines for the proper documentation and safeguarding of physical evidence from the time of collection to the time that it is presented in court.

The total accounting for evidence is what is known as the chain of possession or the chain of custody. This chain is made up of those individuals who have had custody of the evidence since its acquisition by the field investigator.

The number of persons handling the evidence from the time it is found, safely stored and introduced into a court proceeding should be limited.

All original video evidence, photographs, and sound recordings will be maintained by the SIU. Only copies of the evidence will be released to the client for review and evaluation purposes.

Recorded Interviews

Field Investigators must utilize proper interview techniques at all times and adhere to established procedures. Field Investigators must ensure that statements conform to legal and ethical standards of conduct. Should an interviewee request a copy of their statement the investigator will ensure that the SIU is aware of the request for a copy of the recording or a copy of the interview transcript.

The investigator will document in their report that a recorded interview has taken place. The field investigator will provide a brief synopsis of the significant and important information learned during the interview. The interview tape(s) will be maintained in the investigative file of the SIU. If the interview was conducted by a Vendor then a copy of the recorded interview shall be provided to the client and the SIU. The original recording shall be maintained by the Vendor as evidence.

Audio of each recorded interview (RI) shall be submitted as an “additional attachment” via. PartnerLink. **Interviews will only be transcribed when specifically authorized by the client.**

Upon approval from the client, recorded interviews shall be transcribed for any file that is referred to outside counsel for litigation defense and for any file referred to law enforcement for prosecution.

Privacy and Confidentiality of Non-Public Information

The SIU agrees to maintain the confidentiality of any nonpublic personal information consistent with and as defined by the provisions of the Gramm-Leach-Bliley Act (Pub.L. 106-102, 15 U.S.C 6802-3) ("GLBA"), Section 262 of the Health Insurance Portability and Accountability Act, P.L. 104-191 ("HIPAA") and applicable state law. Any confidential nonpublic personal information furnished to the SIU pursuant to this agreement is furnished exclusively to the SIU and for the SIU's use in connection with performing its obligation pursuant to this agreement. The SIU shall not use or disclose the confidential nonpublic personal information for any other purpose. The SIU may utilize an approved panel of Vendors to provide surveillance and/or investigative service on a small number of assignments (as directed by client preference), and in the event the SIU makes an assignment to an approved Vendor, consultant or any other person or entity to assist it, the SIU shall have in place an agreement binding such Vendor to the privacy and confidentiality standards applicable to the SIU under this agreement. The SIU agrees to negotiate in good faith to revise this agreement, the means of performing this agreement and any Vendor agreement as needed to conform to the requirements of the GLBA, HIPAA and applicable state law.

Surveillance Management
Standards for Private Surveillance Vendors

These are recommendations offered by the Special Investigation Unit for the use of the selected and approved private investigation firms (Vendors) for the purposes of surveillance, for Workers' Compensation, Liability, Disability, PIP, or any other purpose.

A. Quality Assurance Standards

1. All approved Vendors shall hold an insurance policy for Liability, Errors & Omissions, Workers' Compensation, and shall provide a copy of the Declarations page for said policy. The policy is to include the above coverage in the amount of not less than two million dollars ($500,000 workers' compensation). Allied Universal Compliance and Investigations, Inc. shall be listed as an Additional Insured on the certificate for the Vendor's policy. (See Vendor's Contract)

2. A Hold Harmless – Indemnification Agreement shall be required from all approved Vendors prior to conducting any type of investigation on behalf of our clients.

3. All Vendors shall be duly licensed and in good standing with the state Licensing Board in all states in which the Vendor conducts business. All personnel that are required to be licensed within the firm, must be licensed. A copy of all licenses shall be submitted to the SIU prior to any work.

4. Vendors who receive assignments from the SIU will utilize only regular, properly licensed employees of the Vendor to conduct the surveillance and/or investigation. It shall be required for all Vendors to submit a brief profile to the SIU on all investigators who conduct investigations for all our clients. Vendors shall submit an updated Profile List of Investigators upon any change, and that Profile will remain on file with the SIU.

5. Vendors who receive assignments from the SIU shall, at no time, reassign or contract the work to any outside firm or independent contractor. Vendors who violate this provision of the Standards or their Contracting Agreement will have their Agreements and approved status immediately voided. **(ABSOLUTELY NO SUBCONTRACTING)**

6. All Vendors and their investigative staff shall at no time during any investigation conducted on behalf of the SIU represent or appear to represent any action or activities that are illegal, unlawful, or are perceived to be illegal or unlawful. All Vendors and their investigative staff shall, at no time during the investigation, use misleading or illegal "pretext", or a pretext that "entraps" or causes an individual to react differently than they would without the pretext.

7. All Vendors and their investigative personnel shall be aware of and give full respect to the "privacy" or "perceived privacy" of an individual and/or individuals during the course of an investigation.

8. All Vendors and their private investigative staff shall be aware of the privacy, trespassing and stalking laws and regulations for the jurisdictions in which the

investigation is being conducted, and should at all times abide by all laws of the state, municipality or jurisdiction.

9. All Vendors and their investigative staff shall not make contact with a claimant who is represented by an attorney for any purpose. The only contact permitted would be a telephone call to verify that the claimant is at the location when surveillance is being performed.

10. All Vendors and their investigative staff shall not possess or carry any firearm, or other weapon designed for the purpose of offense or defense, of any sort while in the exercise of their duties on any assignment. Any possession will result in immediate termination of any existing agreement and any liability or action arising from the carrying of said weapon will be the responsibility of the Vendor.

11. The consumption of alcohol and/or the use of controlled substances by any Vendor or their investigative staff during the course of an investigation conducted for Allied Universal is strictly prohibited.

12. Vendors must constantly be aware of the fact that during the course of an investigation they are representing the interest and professional reputation of Allied Universal. Their conduct shall always be of a professional nature and high standards shall be maintained. During the course of any investigation or conversation with any person, the Vendor (and employees) shall not hold discussions or permit any actions that would hinder or damage the reputation of any person. All Vendors and their investigative staff shall not use any tactics that could be considered to be illegal or harassing.

B. Quality Video Standards

1. All equipment used by Vendors shall adhere to a minimum standard that the video equipment shall be commercial grade surveillance equipment with appropriate lens configuration and magnification to provide quality film for the purpose of the investigation.

2. Vendors shall ensure that their investigators who conduct video surveillance shall have completed a training program that demonstrates proper techniques and competence when using video equipment and techniques. Further, the training program shall properly train the investigators on the legal guidelines of surveillance, including statutory and case law. The issues of privacy, trespass, harassment, stalking, wiretap, Unfair Claims Practices, and Bad Faith should have been properly addressed during the training. Documentation of said training shall be provided to our clients.

3. All video evidence must clearly illustrate the subject of the video in order that a positive identification can be made. Any and all activities involving the subject of the investigation must be recorded and documented. The client must be able to positively identify the subject beyond a reasonable doubt and must provide clear and convincing evidence.

4. Labeling Video Discs. As a general rule, a minimum of one disc per case per day is to be utilized on surveillance cases. If the subject’s activities are such that

warrant the use of multiple discs the investigator will utilize the appropriate number of discs required to capture the activity. Each disc will be labeled utilizing a felt tip marker.

5. Labeling SD Cards. Unlike DVD's, the SD cards will be utilized over and over again. The video department will download all original files, and then send the blank card back to you ready for use. Therefore, label each card and its case with your first initial and last name (J. Doe), and then assign a number to each individual card (#1, #2, #3, …#15). Use only one card, per case, per day. For example, a three day case will have three separate cards, one for each day. In like manner, three different cases worked on one day will also have three separate cards. When mailing the SD cards, you must place each individual card into an envelope before placing it into the FedEx package.

6. Residence Only (RO) Video. Residence only (RO) video is defined as video that contains no claimant activity at all. It consists of hourly integrity shots only.

7. Activity Video. Activity video is defined as video that contains any amount of claimant activity.

8. Covert Video. Covert video is defined as video of the claimant which was obtained through the use of a video device other than standard video camera (iPod, Pinhole, Smart phone, etc.). Covert video is to be copied to a separate SD card than normal 'Activity' video.

9. The video evidence shall include date and time stamp during any filming. The Vendor shall ensure that their investigators shoot 15-30 seconds of film immediately upon commencement of any surveillance and shoot at least 15 seconds of video every hour during the surveillance. The investigator will shoot 15-30 seconds of video at the conclusion of the surveillance day just prior to departing the surveillance location. The quality-control video will be taken regardless of the level of activity, or inactivity, of the claimant.

10. It shall be understood that all video evidence submitted by the Vendor will be with the report and will be reviewed for its content, clarity, and methodology. Those videotapes that do not meet the standard will be rejected by the SIU and returned to the Vendor who produced it, without payment. It will be understood by the Vendor that this discrepancy shall be remedied of the defect, upon the request and approval, on a "Rush" basis, at no extra cost or reimbursement to the Vendor by Allied Universal.

11. Video-disks will be properly packaged for delivery and/or shipment to ensure that the video will arrive undamaged. The Vendor will adhere to the strict standards and appropriate handling of evidence.

C. Still Photography Evidence Standards

1. Still photography must be clear and relevant to the investigation being conducted. It is required that photographs contain date and time stamp.

2. Any still photographs submitted which contain the subject of the investigation must be clear and convincing, and the subject of the investigation must be positively identified as the individual who is the subject of the investigation.

3. All still photographic evidence will be reviewed for its clarity, relevancy, and usability by the SIU. Those photographs that do not meet our standards will be returned to the firm without payment, and the firm will be required to correct any defect without additional cost to Allied Universal or the client.

4. Photographs are to be identified, and labeled, which is to be included as an attachment to the investigative report.

D. Investigative Report Standards

1. Investigative reports shall contain only facts learned during the course of the investigation. Reports shall not contain or reflect the personal opinions or assumptions of the Vendor or their investigator. Allied Universal requires an accurate, readable and legible report containing only factual information.

2. The first page of the investigative report should contain a brief synopsis/summary detailing the result of the entire investigation. The investigative report must reflect and include the date, the day, and the beginning and ending times for each period in which work was completed during the course of the investigation. The report must reflect the total amount of mileage traveled by the investigator for each day of activity.

3. The investigative report shall also include the name of the investigator who actually conducted the surveillance investigation. Allied Universal requires that the name of the investigator be clearly indicated on every report.

4. Vendors and their investigators will refrain from using words like "pain" when making reference to the physical condition of a claimant or insured, as this is opinion, and only factual information can be, and should be, contained within the report. Vendors and their investigators will refrain from using words or phrases that provide the opinion that the subject of the investigation is involved in or committing fraud. Allied Universal wants and needs an unbiased report of the facts.

5. Vendors shall refrain from making recommendations other than additional investigative efforts and/or strategies. Any information that could be construed to be a lead or information that Allied Universal and our client would need to know for the purpose of considering any further action in the adjustment of the claim should be included within the body of the report, well documented.

6. All reports are to be submitted in duplicate. The report will be electronically transmitted to the client with a copy to the SIU. A copy of the video evidence will be sent to the client and to the SIU on a disk.

7. The invoice for service from the Vendor will only be sent to the SIU. The Vendor SHALL NOT send a copy of the invoice to the adjuster.

8. Should the Vendor be authorized by the client to secure any recorded statement, a summary of the facts will be required with each recorded statement. The Vendor shall not transcribe the recorded interviews unless specifically authorized by the SIU. All recordings become the property of the client. The Vendor shall retain the original recording tapes as potential evidence. A copy of the recordings shall be provided by the Vendor and submitted with any report.

E. Surveillance & Investigation Assignment Procedures

1. The SIU requires that any Vendor provide a written acknowledgement of every assignment referred to them. The acknowledgement may be made via E-mail and must be received by the SIU within 24 hours. The SIU recommends that all assignments be initiated within 3-5 days from the assignment date, unless other specific requirements of the case have been established. All assignments shall be completed and the report and video evidence submitted on or before the due date.

2. The field investigator for a Vendor shall provide a verbal progress report on any assignment in which significant activity is occurring. The investigator shall telephone the SIU and adjuster, from the field, immediately if the investigator believes they may have been compromised or the claimant is aware of the surveillance. The Vendor or their investigator must update the SIU and adjuster by email on all surveillance efforts within 24 hours of completing that day of surveillance activity. It is preferred that the email be received by 8 a.m. the day following the surveillance efforts.

3. The Vendor shall provide a detailed and professional written report of their completed investigation within 17 days. The report should be submitted according to the guidelines provided.

4. The Vendors shall be in strict compliance to any budget, special instructions, or service requirements and objectives provided prior to the commencing of the investigation, and that the budget is not to be exceeded without the documented written authorization of the SIU.

F. Investigative Evidence Standards

The Chain of Custody

1. It is imperative that the integrity of the evidence be controlled in a proper fashion and that chain of custody forms be established and strictly complied with.

2. Original video surveillance should be maintained in compliance with proper investigative standards; that the video tape be secured in a safe holding area with considerations given to the protecting of the video evidence from fire, heat and moisture.

3. The Vendor shall not produce, distribute or share any copy of any video tape, or portion thereof, without the express permission from the client.

4. When still photographs are obtained, only relevant photographs should be submitted.

5. Recorded statements (the original disk) should be maintained in a secure holding place. No copies of any disks are permitted without the express permission of the client, and the disk should be held in a secure fashion, giving consideration to protecting against damage by fire, heat and moisture.

6. Any and all evidence secured during the course of the investigation becomes the property of the client and should be held in strict compliance with all evidentiary rules and procedures.

7. All evidence should be held in strict compliance with the rules of evidence, and a chain of evidence must be maintained to ensure its appropriate and proper use in the courtroom at a later time.

G. Investigative Expense Standards

1. The invoice for service from Vendor will be sent to the SIU only.

2. The SIU will only be billed for actual hours performed. An itemized bill will be provided, outlining the hours and date of the investigation and the investigator conducting the investigation.

3. The pre-surveillance database searches required prior to any surveillance must be documented in the investigative report. The flat-rate charge provided in the Vendor Agreement may be listed on the invoice for the amount agreed.

4. Investigation, travel, and related expenses will be considered for reimbursement only according to the Vendor Contract pricing schedule.

5. The cost of still photographs for investigative assignments will be reimbursed according to the pricing schedule. Photographs and video taken as part of a surveillance assignment are considered part of the daily flat-rate surveillance pricing and not reimbursed as a separate cost item. The client will maintain the right to pay for only photographs relevant to the investigation, and to control and limit the numbers of photographs.

6. Certified court documents, public records, police reports, accident reports, and other reports requested by claims representative will be reimbursed at actual cost. All documents will be maintained in strict compliance with the rules of evidence and the chain of custody will be preserved. Any violation of this procedure will result in non-payment by Allied Universal and requirement that the service be performed again, and in strict compliance with our standards.

7. No special or unusual investigative equipment will be used during the course of an investigation unless so authorized by the SIU, and all costs must be outlined prior to use of any said equipment.

8. The utilization of more than one investigator on an assignment must be authorized by the SIU, prior to the commencement of the work. All requests for multiple-

investigator surveillance must be supported by the facts and said requests must be in writing.

9. Approval for additional investigators and equipment will be provided in writing by the SIU.

H. Lodging & Meals

1. Lodging is reimbursable at the contract price per night, and only when pre-approved by the SIU. Meals are not an authorized expense reimbursable by the client.

I. File Costs

1. All Vendors must incur their own expenses and overhead in the normal course of operating their business. The client will not reimburse any time required to organize their file, train personnel, prepare billings, etc.

2. Allied Universal reserves the right to inspect any bill, and any bill that is inappropriate or improper will be returned before payment. No payment will be tendered until all discrepancies have been resolved.

Responsibilities of The Vendor

The Vendor shall be responsible for all investigators and support personnel under their direction. The Vendor is responsible for the timely and professional completion of all surveillance and claims investigations assigned to the Vendor and their investigators.

The Vendor shall ensure that all policies and procedures are adhered to by their assigned investigators and support personnel.

The Vendor shall ensure that their investigators and support personnel conform with SIU Best Practices and abide by reasonable standards of care while performing assignments.

The Vendor should conduct performance appraisals of their personnel to ensure only properly trained and performing investigators are conducting surveillance and investigative work for Allied Universal.

The Vendor should strategically place investigators within their area of the operation so as to provide for efficient and timely completion of all cases assigned to the Vendor by the SIU.

Vendor is responsible for reviewing, evaluating and correcting all written reports and documentation of surveillance and investigations performed by their personnel.

Vendor is responsible to select, hire and train individuals who are experienced in conducting surveillance and investigations. The Vendor shall not assign any unqualified and/or unlicensed investigator to perform surveillance or investigations for Allied Universal.

Vendor shall collect and maintain information on all assignments referred to the Vendor by the SIU. The vendor shall provide the SIU a monthly report of all assignments referred to the Vendor, including date of assignment, date work performed, date report/video delivered to the client, number of hours performed, total amount invoiced for each day of activity, name of investigator performing the work and a brief synopsis of investigation results.

Allied Universal Compliance and Investigations
Guidelines for Investigators

*** The following guidelines apply to both the SIU and Vendor's investigators while conducting business for all our clients.**

1. Confidential Information

During the course of their investigations, Investigators will receive confidential information about our clients, along with individuals who have made claims, including claimant's names, addresses and other personal information. Investigators must keep this information confidential.

2. Neighborhood Investigations

The object of a neighborhood investigation is to obtain information about an insured's reported loss, including information about the insured's background and any other information relevant to the claim investigation.

If asked for identification, the Investigator should state, "'I am doing field work on behalf of _____________ insurance company. I'm here to verify some information about his reported loss."

[Note: Independent contractors do not technically work directly for the client]

Do Not

- Do not make negative comments about an insured, claimant, any witnesses, or the loss in general. The objective of the investigation is to learn information about the loss, or background of the claimant/ insured - if relevant. The investigator must always remain unbiased and true to the objective of gathering facts.
- Do not offer specific information concerning the loss. The purpose of an interview is to get information, not give it.
- To avoid risking potential liability for defamation, an Investigator should not make any statement, direct or indirect, that implies that an insured/claimant is a "fraud" or that the insurance claim is fraudulent.

3. Investigation in Gated Communities

Entry to gated communities is generally restricted to authorized persons who must pass through guarded gates. Only owners of property within a gated community and their invitees are generally authorized to enter into the community. An Investigator may risk liability for trespass if he misrepresents the purpose for which he seeks admission into a gated community and thereby gains access to the community. Thus, all investigators MUST contact the SIU before attempting to conduct an investigation in a gated community.

4. Pretext Interviews and Good Faith Claims Investigations

An Investigator seeking to engage in pretext interviews must obtain advance approval from the SIU and the Client Representative. Once approval is secured, an Investigator must comply with the following guidelines:

- Conduct any pretext interviews in a reasonable and unobtrusive fashion in order to avoid civil or criminal liability. Never harass a subject or enter onto a subject's private property without permission.

- Pretext may not be utilized to make direct contact with a claimant in order to obtain information about the subject's personal information and information about the claim. **Pretext with a claimant may be utilized to confirm them at home only.**

- Be objective. An Investigator is retained by the client to provide it with an accurate and honest appraisal of an insured's/claimant's reported loss or a subject's potential credibility. An Investigator must report objectively what they learn during the investigation.

- Do not enter a person's private property without permission in order to conduct an investigation.

- Do not use false pretenses or pretext to gain access to a person's home or other private place where the subject of the investigation/interview has a reasonable expectation of privacy.

- It is not proper to invade the subject's privacy by filming or peering through doorways or windows or by using a hidden camera to film the subject in the privacy of his or her own home.

- Never impersonate a police officer, fireman or other government official, a postman or social worker, an employee of any local utility company, a member of the clergy or an employee of any real company.

Allied Universal Compliance and Investigations

Red Flag Indicators of

Suspicious Claims

Identifying a Claimant for Covert Surveillance

- The claimant has a history of malingering in prior claims
- The claimant has discontinued medical treatment for extended periods but still claims total disability
- The medical provider Rehab reports indicate a healthy-looking claimant with no current medical complaints
- Medical providers fail to provide an objective basis for the disability
- The claimant has detailed knowledge of the insurance claims process
- The claimant can never be directly reached at home
- Tips received from neighbors, co-workers, and friends that the claimant is exaggerating their medical condition
- The claimant was employed in an industry or company experiencing current lay-offs and/or downsizing
- The claimant's time to reach maximum medical improvement is beyond the standard without any objective medical rationale
- The claimant's demands for payment and or lump sum settlement are excessive and/or premature
- The claimant refuses to provide a home telephone number and only utilizes a cellular phone and or pager for adjuster contact
- The claimant only provides a P.O. Box for receiving mail and refuses to provide a physical street address
- The claimant's occupation is a seasonal type of job and the active labor season is coming to a close
- The claimant is disgruntled with their current employment, facing disciplinary action or imminent termination, or is retiring in the near future
- The claimant is facing disciplinary action and/or revocation of their professional licensing
- Adjuster receives conflicting medical opinions from medical providers as to the claimant's disability and/or extent of restrictions
- Claimant recently purchased new disability policy or had recently increased the coverage limits
- The claimant has multiple disability policies
- The claimant has more than one active workers' compensation claim pending at the same time that arise from different incidents
- The treatment being provided the claimant is inconsistent with the report diagnosis
- The claimant is utilizing a medical provider and/or attorney with a reputation of handling suspect claims
- The claimant's medical provider is providing "boiler plate" or "template" medical reports and findings
- The claimant is receiving immediate referrals for "psychological counseling" and/or stress at the on-set of the disability
- Information is learned that the claimant is possibly engaged in active employment although they claim a total disability
- The claimant is actively involved in a physical sport or hobby although they claim their disability prevents them from engaging in sedentary employment

Application/Underwriting Fraud Indicators

Most applicants for insurance coverage are trustworthy, but some are dishonest. Therefore, it is appropriate for the agent to review all applications for possible fraud. Determining the "fraud potential factor" of any application is facilitated when the agent is familiar with various fraud indicators.

These indicators should help isolate those applications which merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that a fraud is being committed. Indicators of possible fraud are "red flags" only, not actual evidence.

Suspicious applications may have to be accepted for lack of conclusive evidence of fraud; however, the underwriter should be made aware of the agent's suspicions, and subsequent referral to the appropriate State Department of Insurance Fraud Bureau (if applicable) or local, state or federal law enforcement agency for further review may be appropriate.

General Indicators of Application Fraud

- Unsolicited, new walk-in business, not referred by existing policyholder
- Applicant walks into agent's office at noon or end of day when agent and staff may be rushed
- Applicant neither works nor resides near the agency
- Applicant's given address is inconsistent with employment/income
- Applicant gives post office box as an address
- Applicant has lived at current address less than six months
- Applicant has no telephone number or provides a mobile/cellular phone number
- Applicant cannot provide driver's license or other identification or has a temporary, recently issued, or out-of-state, driver's license
- Applicant wants to pay premium in cash
- Applicant pays minimum required amount of premium
- Applicant suggests price is no object when applying for coverage
- Applicant's income is not compatible with value of vehicle to be insured
- Applicant is never available to meet in person and supplies all information by telephone
- Applicant is unemployed or self-employed in transient occupation (e.g. roofing, asphalt)
- Applicant questions agent closely on claim handling procedures
- Applicant is unusually familiar with insurance terms or procedures
- Application is not signed in agent's view (e.g. mailed in)
- Applicant is reluctant to use mail
- Applicant works through a third party
- Applicant returns the completed application unsigned
- Applicant has had driver's license for significant period, but not prior vehicle ownership and/or insurance

Indicators Associated With Coverage

- Name of previous insurance carrier or proof of prior coverage cannot be provided
- No prior insurance coverage is reported although applicant's age would suggest prior
- Significant break-in coverage is reported under prior coverage
- Question about recent prior claims is left unanswered
- Full coverage is requested for older vehicle
- No existing damage is reported for older vehicle
- Exceptionally high liability limits are requested for older vehicle inconsistent with applicant's employment, income or lifestyle

Indicators Associated With Applicant's Vehicle/Business

- Vehicle is not available for inspection
- Photos are submitted in lieu of inspection
- Vehicle does not appear to be appropriate for claimed address or income (e.g. a luxury vehicle in a low income neighborhood)
- Vehicle has unusual amount of aftermarket equipment (e.g. wheels, high priced stereo, CB radio, car phone)
- Vehicle inspection by agent uncovers discrepancy between VIN listed on title/bill of sale, VIN plate on dashboard and/or manufacturer's sticker on door
- No lienholder is reported for new and/or high value vehicle
- Vehicle title or authenticated bill of sale cannot be produced
- Applicant is seeking new business coverage and has never been in any, or this type of, business in the past
- Sound financial backing for the business to be insured is not apparent
- Loss payee is not a legitimate lending institution (e.g. bank or finance company)

General Fraud Indicators

General Fraud Indicators

- Recently increased limits
- History of claims activity
- Familiar with insurance claims terms and procedures
- Refrains from using the mail - conducts business in person
- No police report or on-scene police report
- Aggressive demands for quick settlement, sometimes for less than full value
- Threatens to contact higher company authority to push demands
- Recently issued policy; walk-in business
- Photocopies of supporting documentation
- Subject reports P.O. Box or Private Mail Box [PMB] as home physical address
- Unreasonable delay in reporting loss
- Refuses to give recorded or written statement
- Self-employed in vague occupation; reluctant to produce tax records
- First notice of claim and/or immediate representation by attorney
- Recent changes in coverage/inquiries with agent
- Loss occurs immediately before or after policy renewal/inception dates
- Claimant is experiencing declining financial conditions
- Discrepancies exist between official reports of incidents and statements made by insured/claimant
- Lifestyle inconsistent with observations and facts
- Insured/claimant wants a friend or relative to pick up check
- Over-documentation of loss
- Insured/claimant has no phone
- Claimant is transient or out-of-towner
- Loss occurs after recent uninsured loss
- No witnesses to accident
- No police investigation
- Single car accident
- Accident involving an unidentified third party
- Claimant's witness overly enthusiastic
- Loss reported by claimant, third party, or attorney
- Property repaired or disposed of before CR's inspection
- Documentation provided as photocopies

Disability Fraud Indicators

Claimant Indicators

- Extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent

Claim File Indicators

- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend

Dental Care Indicators

- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year
- Padding to reimburse co-payments or deductible clause
- Billing for services not rendered; bill for crown and bridge work, root canal performed

Treatment Indicators

- Treatment unrelated to or inconsistent with diagnosis
- Consecutive dates of treatment
- Treat family members who were not involved in accident; particularly in mental health claims
- Treatment on days just prior to policy termination date
- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities

Prescription Drug Indicators

- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed

Medical Bill Indicators

- Different/overlapping billing dates from same date of service
- Dates in doctor's notes do not match dates of serviced on bill
- Office visits not itemized by date and type of service
- Duplicate of unbundled procedures
- Inconsistent type-styles or handwriting on one bill

- Services billed but not rendered
- Bills for multiple providers who are not specialists
- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals
- Durable Medical Equipment
  - rental fee exceeds actual cost of item
  - billed for upgrade, but a lower quality item provided
  - electric/no electric wheelchair
  - TNS (tens) unit quantity padded:
- More diabetic, hosiery, orthodontics, etc. than provided

Altered Documents

- Dates changed
- Writing or typing inconsistent
- Signatures altered or obliterated
- Poor quality photocopies
- Claimant is approaching retirement age would like to retire is ill
- Financial obligations in arrears; taxes, payroll, loans, etc.
- Renovation loan approved before loss, but work not begun

Wage Loss Fraud Indicators

Employee Indicators

- Employment began shortly before the date of the accident
- Self-employed claimant
- Income level incompatible with claimant's standard of living
- Other sources of claimant's income not documented
- Tax returns not provided by claimant
- Claimant filed no tax return

Employer Indicators

- Employer is a small or unfamiliar business
- Business address is a P.O. Box, mail drop or residential area telephone number answered by a machine or service
- Employer cannot provide claimant's most recent W-2 (Form 1099 claimant's FICA statement for the last fiscal quarter

Wage Documentation Indicators

- Documentation is not on employers letterhead provided in a form letter provided by claimant's attorney poorly written or typed on a blank sheet of paper on poor quality business stationery not centered on a page and/or misspellings, grammatical errors, etc.
- Dates include weekends, holidays, plant closures, etc.

General Liability Fraud Indicators

- Any anonymous phone call or letter alleging possible fraud
- Any law enforcement inquiry regarding the validity of any part of the claim
- Any false statement willfully made with the intent to deceive
- The insured refuses to cooperate with our investigation
- The first notice (letter or phone) from an attorney is on the day of the accident
- Three or more ISO ClaimSearch returns in the past two years involving the claimant
- The claimant's address and/or phone number are returned as ISO ClaimSearch 'hits" with names of other persons reporting the same or similar type claims and injuries (especially if within relatively short period of time)

General Indicators

- Claimant is having serious financial difficulties
- Claimant refuses to mail information to office but insists on bringing in-person
- Claimant possesses unusual knowledge of insurance terminology and procedures
- Claimant lives at a P.O. Box or hotel and states no physical address exists
- Claimant address provided as physical address actually returns to private mail box, non-existent address or jail/prison facility
- Claimant frequently changes phone number for them to be contacted
- Claimant is never at home or spouse/roommate always states claimant "just stepped out"
- Claimant obtains medical evaluation and "estimate" of charges if they have surgery but never returns to doctor or follows through with forecasted medical treatment
- Claimant can't (or refuses to) produce valid government issued Identification
- Claimant is accompanied by an adult (friend or relative) that cannot (or refuses to) produce government issued ID
- The insured has no knowledge of accident or injury
- Claimant's accident description on day of loss differs from the account on the medical history or future interviews
- Insured raises questions about the suspicious nature of the claim
- Background noise on phone calls to the residence suggest it is not a "residence" phone
- Claimant has disability policies which were recently obtained
- No police report exists for an alleged assault with injuries reported to have occurred on insured's property

Accident Indicators

- Accident details from the claimant are vague with no specifics
- The accident is not reported promptly to the insured
- Claimant or attorney refuses to provide complete accident or injury information
- Claimant alleges fall in liquid spill yet their clothes/shoes not wet from substance
- Claimant alleges fall on wet/slippery area where there is no source of spill identified
- Claimant states the accident was unwitnessed
- Witnesses or video surveillance contradict facts presented by claimant
- Accident occurs in an area where the claimant should not be
- Accident is type claimant should not be involved in (claimant climbing store shelving or ladder to reach product they could not reasonably lift anyway)

Cyber Fraud Indicators

- Access privileges are beyond those required to perform assigned job functions
- Exception reports are not reviewed and resolved
- Access logs are not reviewed
- Production programs are run at unusual hours
- Lack of separation of duties exists in the data center
- Data Center does not use anti-malware software
- Operating system does not update regularly
- Operating system not updated with latest security patches
- Untested programs are placed on the server
- Boot-up allowed from a removable device
- Opened email attachments from non-trusted sources

Health Insurance Fraud Indicators

Medical Provider Indicators

- Billing for services or supplies never received by insured
- Billing for services outside the provider's scope of practice
- Upcoding or unbundling of billing codes
- Frequency or duration of treatment inconsistent with injury/illness
- Billing for non-emergency services on weekends or holidays

Claimant Indicators

- Extensive medical/insurance knowledge
- Claimant difficult to reach at home
- Claimant receives mail at post office box or address different than address on policy or application
- Claimant uncooperative or evasive
- Injury duration appears longer than normal for extent
- Income seems inconsistent with occupation

Claim File Indicators

- Disability claimed inconsistent with injury or illness
- Independent medical examination contradicts illness or injury claimed
- Details of illness or injury are vague or difficult to comprehend
- Employer downsizing, planning layoff, or closing a plant or office around the time of the claim

Dental Care Indicators

- Preexisting Temporomandibular Joint Syndrome (TMJ)
- TMJ claim not supported by medical records
- Chiropractic care for TMJ but no other symptoms
- Billing different calendar years; assures coverage is not maximized in one year

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- Medical or rehabilitation reports reference muscle tone, calluses, tanning, etc., indicating physical activities

Prescription Drug Indicators

- Number of prescriptions or quantity is unusually large
- Many prescriptions for scheduled controlled substances identified in the Physician's Desk Reference (PDR)
- Drugs not directly related to injury or illness
- Pharmacy in different geographical area from home/work
- Phoned prescriptions, but doctor has no record of calls
- Generic drugs dispensed; brand name drugs billed

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- Services billed but not rendered
- Bills for multiple providers who are not specialists
- Bills addressed to claimant's attorney
- Photocopies submitted instead of originals
- Durable Medical Equipment
- rental fee exceeds actual cost of item
- billed for upgrade, but a lower quality item provided
- electric/no electric wheelchair
- TNS (tens) unit quantity padded:
- More diabetic, hosiery, orthodontics, etc. than provided

Altered Documents

- Dates changed
- Writing or typing inconsistent
- Signatures altered or obliterated
- Poor quality photocopies
- Claimant is approaching retirement age would like to retire is ill
- Financial obligations in arrears; taxes, payroll, loans, etc.
- Renovation loan approved before loss, but work not begun

Medical Billing Fraud Indicators

Regarding Attorney Involvement

- Attorney is listed as the insurer on the medical bill
- Legal representation is contacted/obtained immediately after the accident/incident is reported
- Medical bills and narrative reports are sent from the attorney's office
- The same attorney appears in all BI/WC cases involving a particular medical provider

Regarding Claim

- Damages/losses presented by one or more parties are inconsistent with facts of loss/accident (lack of injury/damage causing mechanism, etc.)

Regarding Diagnosis

- A test or series of diagnostic imaging tests is given to all patients at a clinic or medical office regardless of injury
- Alleged injury relates to a pre-existing injury or health problem
- Bills for diagnostic imaging are submitted without supporting documentation such as reports
- Commonly refer patients for a "second opinion"
- Comparison diagnostic tests are ordered by provider (e.g. performing a diagnostic test on an uninjured joint so the results can be "compared" to the diagnostic test results from the injured joint)
- Diagnosis in the bill is not supported by other documentation
- Diagnostic imaging is not consistent with the nature of the injury or treatment
- Diagnostic imaging is performed on several separate visits rather than one
- Diagnostic testing (X-rays, EMG testing, MRIs, etc.) is performed often and early in the treatment
- Diagnostic testing is billed repeatedly without a report of a worsening condition in objective findings or a report of a new injury
- Discrepancies exist between the locations of diagnostic imaging testing (and other types of tests) and the person interpreting the test
- EKGs are administered to patients with no complaints or conditions
- Evidence exists of payments/commissions from a diagnostic test provider to the ordering practitioner
- Injuries are subjective (e.g. pain, headaches, nausea, inability to sleep, depression, dizziness and soft tissue)
- Insured questions the amount of diagnostic imaging tests ordered
- Medical records do not explain excessive, expensive medical testing/treatment
- Mobile unit performs neurological or other tests, which are read at remote locations
- Multiple diagnoses are indicated
- Multiple diagnostic procedures are billed with separate CPT codes when there is a CPT code that includes all of the billed procedures
- Patient does not know the result of the diagnostic test(s)
- Patient's account of diagnosis process is inconsistent with the actual test
- Range of motion (ROM) tests are conducted frequently

- Specialized equipment is required for diagnosis but the injured person cannot describe the equipment or procedure
- Surface EMGs (SEMG) are used for diagnoses

Regarding Facility/Operation

- Claims representative receives a sudden flood of medical bills from one new center/clinic
- Clinic/Center was recently incorporated
- Contact with clinic/center is difficult
- Equipment and treating facility is out-of-date, broken or inconsistent with treatment billed
- New or unknown diagnostic clinic/center
- No request, reports, or any indication the treatment was needed or conducted prior to receiving the medical bill
- Office/building has no furniture
- Ownership of clinic is questionable
- Provider utilizes established and trusted files, members, insured, patients, and doctor's information without their knowledge
- Telephone for the clinic/center is not listed on the medical bills
- The Tax ID number provided is real, but medical identity theft is suspected
- The building is too small to operate a clinic/center
- The clinic/center address is a P.O. Box number
- The date(s) of medical service(s) is prior to the date the clinic/center was established
- The location of the clinic/center is in a deteriorating or unsafe part of town
- The physical address of the clinic has inadequate, inconvenient, or no parking for patients and staff
- The word "Diagnostic" appears in the name of the facility submitting the medical bill

Regarding Incident

- Vehicle has numerous passengers claiming the same type of injuries

Regarding Medical Bills

- 1500 Bill does not show the injury as auto accident or workplace related
- A physician bills out of multiple offices on one day (treatment time is more than possible for one day)
- Amounts billed for are much more than other providers (of the same specialty) charge
- Billing for daily treatment for an extended period of time
- Bills are submitted by billing or medical finance companies and not the provider
- Bills are submitted in "bulk" just before the time deadline
- Bills are submitted months after treatment is rendered
- Bills are submitted without appropriate supporting documentation (e.g. PT worksheets or diagnostic imaging reports)
- Bills are templates or prepared forms that do not document the actual facts of a patient's case
- Bills for E&M provide little or no detail but the CPT code billed reflects an office visit of high complexity, comprehensive history/exam, etc.

- CPT codes are billed for the treatment which is usually not associated with the particular diagnosis/ICD code
- Continuous billing for comfort modalities for an extended period of time
- Contradictions are revealed when comparing the bills to other documents or sources of information.
- DME billed for multiple patients is the same
- Duplicate bills for same type of treatment with a different procedural name (e.g. electrical stimulation and TENS unit)
- Durable medical equipment (DME) bill shows charges for equipment not in the doctor’s order or patient’s receipt
- Durable medical equipment (DME) bill shows markups for equipment in excess of your state’s standards for such markups
- Emergency services are billed by providers (providers say they provided services on a day when their office is routinely closed)
- MRI bills appear early on in the treatment and repeated again in later treatment
- Medical bills accrued for the injury have a higher dollar value compared to the other providers treating patients for similar injuries
- Medical bills are not on a standard HCFA form or CMS 1500 form
- Medical provider bills for new patient visit, but insured/claimant advised that the doctor only spent a few minutes with them or they didn’t see the doctor
- Multiple providers in one office all treat the patient on the same day
- Multiple time-based modalities are billed for the same treatment session, resulting in the patient being in treatment for two or more hours (including acupuncture and massage)
- Patient cannot describe the physical aspects of items appearing on the bill (e.g. ROM test exercises)
- Patient indicates the provider listed on the bill is not the same person providing treatment
- Patient is quoted a treatment price but the bill shows a much higher amount
- Patient refutes charges
- Provider bills a referral fee for medical services that were never rendered
- Provider bills cancellation charges for office visits that were not originally scheduled
- Provider bills for an examination and treatment when in fact no treatment was provided
- Provider bills for medical supplies that were not used
- Provider bills for medical tests or evaluations that were not conducted
- Provider bills for office visits that were not made
- Provider bills for treatment that was not provided
- Rehabilitation or physical therapy bills are not supported by worksheets showing the who, what, when, where, effectiveness of the treatment program, and/or modification if not successful
- Repeated billing by the medical provider for extensive established patient visits (e.g. repeated bills for X-rays on a soft tissue injury)
- Summary medical bills are submitted without dates and descriptions of office visits and treatments, or treatment extends for a lengthy period without any interim bills
- TENS unit bills are very expensive (often billing for more advanced units without attempting treatment with basic, less expensive units first)

- TENS unit bills include frequently billed supplies such as electrodes and batteries (charges may also be excessive)
- The physician's bill and report, regardless of the varying accident circumstances, is always the same
- The treatment requires a licensed medical professional, but the provider is not licensed

Regarding Medical Fraud/Claim Inflation

- Boilerplate and matching reports from providers are present in claim file during review
- CPT codes appear "inflated" or "up-coded"
- Clinic has continued billing or treatment irregularities
- Clinic/Medical facility does not have patient sign-in sheets or patient signatures appear to be signed all at one time
- Doctor's notes contain no indication of checking the patient's treatment progress/improvement of symptoms
- Injured party's address is located unusually far from the clinic/center
- Medical bills indicate routine treatment being provided on Sundays, holidays, or other days that facilities would not normally be open
- Minor accident produces major medical costs and often lost wages, household help, transportation and unusually expensive demands for pain and suffering
- Narrative reports submitted appear to be templates
- No changes in treatment plan after several treatment sessions have been rendered and extensive diagnostic testing (EMG, NCV, MRI etc.) is performed
- Office visits extend daily for more than five consecutive days or continue for more than one week
- Patients are at or near the age of eligibility for Medicare when they are first injured and begin treating
- Patient is unable to describe the doctor or office location
- Patient's residence is not near treatment facility
- Reports for initial exams, follow-ups, consultations, etc. provide little or no detail, but the CPT code billed reflects high complexity, comprehensive history/exam, etc.
- Same treatment prescribed for all patients in spite of different accident facts
- Significant lapse between when the alleged service was provided and when the medical bill is received
- The date(s) the medical service(s) was provided is on a weekend or holiday or during hours the clinic is not open
- The patient decides to go back to work on their own despite the doctor classifying them with a total disability
- The patient's signature appears several times on the same sign in sheet
- Treatment extends for a lengthy period without interim bills

Regarding Medical Treatment

- Chiropractic treatment extends beyond the typical number of visits (approx. 30-34) for simple soft tissue injuries
- Claimant is receiving treatment from a "known" medical provider
- Clinic treats injured family members on different days
- Clinic treats several or all of the claimants on same day
- Doctor's initial exam reports are "fill in the blank" boilerplate reports

- Durable medical equipment (DME) given to all injured persons is the same regardless of diagnosis
- Durable medical equipment (DME) is dispensed without instructions for use
- Injury progression is atypical and seems to require extended treatment (often extending beyond estimated
- “discharge date”)
- Medical treatment is given by receptionists or other non-medical personnel
- Minor injury results in a network of treatment providers, diagnostic procedures, and treatments
- Multiple treatment procedures are billed using separate CPT codes when there is a CPT code that includes all of the billed procedures
- No referral is made to another specialist for evaluation when no progress is made after four weeks of treatment
- Pain management protocol is not modified (treatment is continued) even when not effective
- Passive treatment modalities are used exclusively without encouraging use of a home program of exercises/activity
- Patient is seen multiple days in a row
- Patient’s account of the treatment process is inconsistent with bill
- Patients are seen only by a chiropractor on the initial visit, yet proceed to get treatment and multiple modalities (acupuncturist, physical therapist, neurologist, etc.) before seeing a medical doctor
- Patients in one claim all receive the same treatment (same treatment dates, same examination/progress reports, etc.)
- Patients who are members of the same family are treated on different days
- Pharmaceutical bills indicate repackaging or compounding on the part of the treating provider
- Provider only treats patients that are represented by an attorney
- Provider repeatedly uses x-rays, ultrasounds, nerve conduction tests, or spinal video fluoroscopy to check treatment progress
- Same type of treatment is given to children and adults
- The employee/individual is unaware of or has no recollection of receiving the medical treatment being billed for
- The frequency or number of therapy modalities does not decrease after four weeks of treatment
- The treatment plan does not change over time (especially if additional diagnostic tests have been done)
- Time dependent procedures don’t match what was billed (more treatments than possible in a 24 hour day)
- Treatment begins prior to the accident date
- Treatment continues with no changes in plan
- Treatment dates on the bill indicate the start of treatment is delayed by more than four weeks from the loss date
- Treatment is ended when the policy’s monetary limits are reached
- Treatment is extended, without re-evaluation or outcome assessment
- Treatment is not consistent with usual standards of care
- Treatment plan exceeds 90 days with no evaluations during the 90-day period
- Treatment prescribed for the various injuries resulting from differing accidents is always the same in terms of duration and type of therapy

- Treatment provided is not usually associated with this type of injury
- Treatment requires specialized equipment, but the injured person cannot describe the equipment or procedure
- Treatment shows more than three therapy modalities in a single treatment session

Regarding Professional Issues

- Attorney/Medical provider is not located near the claimant/insured's residence
- Business/Contractors/Cleaning company are not licensed or are newly licensed
- Clinician has multiple locations and bills indicate regular or frequent treatment at one location
- Provider/Clinic doesn't allow a clinic inspection to be conducted or makes scheduling an inspection appointment very difficult

Regarding Slip & Falls

- Emergency medical responders were not called to the scene of the slip and fall
- The claimant did not receive medical treatment at an emergency room after the slip and fall

Regarding Specific CPT Codes

- Acupuncture, first 15 minutes (97810 or 97813) billed numerous times per visit
- Acupuncture, subsequent 15 minutes (97811 or 97814) billed more than twice per visit
- Biofeedback (90901) is performed on all of a provider's patients
- Chiropractic manipulation (98940-5) routinely billed in conjunction with an E&M visit without documentation of a separate office visit where treatment was required beyond normal pre and post manipulation assessment (should be billed with a -25 modifier)
- Community reintegration training (97537) billed repeatedly
- Consultation (99241-5) billed for own patient
- Davis series (72052) charge with fewer than seven images or reports
- Digital analysis of electroencephalogram (97957) routine appearance on bills
- E&M codes, complex/severe (992x4-5) billed for every visit until discharge
- E&M codes, complex/severe (992x4-5) billed for problem of relatively low severity
- E&M new patient (99201-5) billed every visit
- E&M, new patient (99201-5) billed for by provider in the same medical group where the patient has previously received treatment within the past three years
- E&M, prolonged services (99358), routine appearance on bills
- ESI (62310 or 62311) separate charge for drug and supplies (e.g. syringes, gloves, alcohol, etc.)
- ESI (62310 or 62311) billed more than three times in one calendar year
- Electric stim (97014) with modifier -50
- Interpretation hours (90887), billed with little detail in report
- MUA (22505) manipulation under anesthesia billed by a chiropractor (may also bill for assistant surgeons and standby assistant)
- MUA (22505) manipulation under anesthesia in conjunction with (23700 and 27194)
- MUA (22505) manipulation under anesthesia performed early in treatment
- Manual therapy (97140) routine appearance of charge
- Mechanized traction (97012), routine appearance of charge

- Modifier -51, routine appearance on bills
- Modifier -52, routine appearance on bills
- Modifiers - frequent use
- Muscle testing (95831) billed for each muscle rather than each extremity
- Muscle testing (95831) billed in conjunction with E&M codes (e.g. 99201-5)
- Needle EMG (95860 single extremity) multiple times per visit
- Needle EMG (95864) all four extremities (without justification documentation)
- Nerve conduction (95900 and 95903) on the same bill for the same nerve (95903 includes 95900)
- Nerve conduction tests (95900 and 95903) billed multiple times for the same nerve
- Nerve conduction tests (95900 and 95903) show the same results across patients
- Neuromuscular re-education (97112) billed in connection with a soft-tissue injury without nerve damage
- PDD (62287, Percutaneous disk decompression), routine appearance on bills
- Psychological test interpretation time (90887) is billed along with administration time (96101) without supporting documentation
- Psychological testing (96101) report is without detail
- Range of motion testing (95832) frequent
- Range of motion testing (95832) is billed for each muscle tested
- Range of motion testing (95832) is billed in conjunction with 95831
- Range of motion testing (95832) is billed in conjunction with E&M (e.g. 99201-5)
- Self-care/home management training (97535) billed repeatedly
- Subcortical/cortical mapping (95961 and 95962), routine appearance on bills
- Therapeutic activities (97530) billed in conjunction with 97112
- Therapeutic procedure with- 51modifier
- Unbundling of CPT Codes
- Unlisted codes (ending in 99)
- Unlisted modality (97039) routine appearance on bills
- Unlisted procedure (97139) routine appearance on bills
- Unlisted rehab (97799) routine appearance on bills

Durable Medical Equipment (DME) Fraud Indicators

Applicant/Claimant/Insured Indicators

- Patient denies ever receiving the DME or receiving less or different DME than the insurer is billed for
- Patient questions the amount of DME that is prescribed

Diagnosis Indicators

- Diagnosis in the bill is not supported by other documentation

Facility/Operation Indicators

- Bags of identical DME pre-labeled with patient names seen in the medical clinic
- Reminder notices in doctor's office to give out DME in pre-determined sets

Medical Bill Indicators

- Billing the insurer for DME component parts instead of as a complete unit as provided by the manufacturer
- Billing the insurer for defective medical equipment or for equipment that exceeds utilization or lifespan guidelines
- Billing the insurer for duplicate orders of DME or unnecessary amount of DME
- Billing the insurer for more expensive items than those actually shipped
- Billing the insurer for new DME when used and/or refurbished DME has been provided to the patient
- DME bill shows charges for equipment not in the doctor's order or patient's receipt
- DME bill shows excessive rental charges for equipment (e.g. rental of equipment cannot exceed 125% of the cost to purchase equipment)
- DME bill shows markups for equipment in excess of your state's standards for such markups
- DME billed for multiple patients is the same
- Invoice lists inexpensive products commonly available at local drugstores (e.g. over the counter – OTC) such as back massagers, heat lamps or neck braces, and billed under cryptic or fictitious model names and numbers or as customized equipment
- Mis-billing DME with multiple functions, such as hot/cold therapy units and billing as separate pieces of equipment
- Provider bills for medical supplies that were not used

Medical Treatment Indicators

- DME given to all injured persons is the same regardless of diagnosis
- DME is dispensed without instructions for use
- Inappropriate expensive medical equipment prescribed for minor injury

Professional Indicators

- Altering medical records to justify unnecessary DME
- DME prescriptions are written by DME suppliers rather than the patient's physicians
- Evidence exists of payments/commissions from a DME supplier to the ordering medical provider

- Evidence of patient lists being provided to the DME supplier
- Failing to credit the insurer for DME that is returned by the patient
- Improperly licensed/certified individual(s) prescribing/providing/administering DME
- Provider is a recent graduate with a high student loan debt
- Provider prescribes two types of DME items for patients at the same time
- Provider prescribing the DME may also be the owner or has an ownership interest in the DME company who manufactures and ships the DME
- Providing false or misleading information, such as offering of "free" equipment when they are actually billing the insurer
- Supplier ships DME to patients prior to obtaining a physician's order, certificate of medical necessity, or prescription

Surety Insurance Fraud Indicators

- The company has a history of being sued
- The company has several claims filed under previously obtained bonds
- The contractor has low profitability
- The company has poor working capital
- The contractor did not provide all relevant financial documents, including current tax returns and financial statements prepared by a qualified accountant
- The company did not provide information concerning the corporate structure of the business, information about principles, employees, and policies and procedures
- The company did not provide information concerning the particular contract or job that the contractor is seeking to be bonded for
- The bond company name was not on the indemnity agreement and the bonds provided
- The surety is not registered on the U.S. Treasury Circular 570, which lists each surety's contact information, Treasury limit, and the states in which they are licensed

Surety Agent Fraud

- The bond form is completed by hand (the only thing more unprofessional is if they used a crayon)
- The bond does not include a power of attorney (All corporate surety bonds have a power of attorney attached which authorizes the agent to execute or bind the obligation)
- The power of attorney is invalid (check to make sure the information on the power of attorney is correct and makes sense – date matches the bond date, name is the same as the person signing, company seal present)
- The bond does not have the surety's corporate seal

Surety Fraud Schemes

- There is no bond agent involved (most sureties only work through their licensed agents – if the surety seeks out directly, proceed with extreme caution as this is the MO of most unauthorized sureties)
- There is little or no underwriting process for a large bond
- The bond premium is very high (most sureties use rates ranging from 1%-3% of the contract amount)

Financial Guaranty Fraud Indicators

- Paying for independent reviews that “monoline” insurers used to do by themselves
- Bad loans re-coded to appear okay
- W-2s logged as “stated loans” borrower just claims his income without documentation and the W-2 contradicted what the borrower had states
- Using income of one borrower and the credit rating of the other borrower, such as husband and wife
- Default rate is intentionally difficult to define

Legal Insurance Fraud Indicators

- An unscrupulous agent collects premiums from a customer without delivering the insurance policy to the company
- Reporting the date of the claim as something other than the date it happened to avoid paying the fee before you need it. Moral hazard – most companies have a waiting period so people do not sign up until they actually need it
- The claim is made a short time after the inception of the policy
- The insured has a history of many insurance claims and losses
- Handwriting or signatures are similar on different receipts/invoices

Indicators of Crime and Fidelity Insurance Fraud

- Incomplete or undetailed bookkeeping/accounting records.
- Missing or altered documentation in financial reports
- Excessive/unexplained journal entries
- Sloppy records or out-of-balance accounts
- Employee provides copies of invoices rather than original documents
- Unexplained adjustments to accounts receivable of accounts payable
- Large unexplained inventory shortages
- Frequent cash shortages/overages
- Employee provides unreasonable explanations when questioned
- Personal employee financial problems
- Employees living beyond their means
- Staff working excessive, unexplained overtime
- Customer/vendor insisting on working with only one employee
- A history of filing claims
- A new claim filed shortly after the policy is in force, similar to a claim they filed before cancelling their last policy
- An insured who increases their coverage just before submitting a new claim
- An insured who’s unemotional and unflustered when submitting a sizeable claim
- No police report
- Damage or theft of items, for which it’s nearly impossible to establish an accurate value

- Handwritten or otherwise suspicious receipts provided for repairs or replacement of damaged or stolen property. Be especially aware of photoshopped receipts and documents.
- An applicant who already has coverage, but wants another policy
- Delayed reporting of a claim

The typical red flags concerning commercial theft and commercial property damage may apply based on facts of the crime or fidelity claim.

Common Carrier Insurance Fraud Indicators

- All transactions were conducted in person; claimant avoids using the telephone or the mail
- Claimant or insured is excessively eager to accept blame for an accident or is overly pushy or demanding of a quick/reduced settlement
- Claimant or insured is unusually familiar with insurance terms and procedure, medical or vehicle repair terminology
- One or more claimants or insured lists a post office box or hotel as address
- Claimant is transient or an out-of-towner on vacation
- Claimant threatens to go to an attorney or physician if the claim is not settled quickly
- The kind of accident or type of vehicles involved are not typical of those seen on a regular basis
- Claims to be self-employed but is vague about details; won’t provide specifics which can be verified
- Efforts to verify lost earnings statement with employer raises doubts about employer’s legitimacy or actual employment
- Insured has lived at residence less than six months or been with current employer less than six months

Life Insurance Fraud Indicators

- The policy's effective date is close to the date of death
- The deceased is not well-known by relatives
- There are many small policies with coverages that are available in mass offerings, *i.e.,* in magazines and mail-in and television advertisements
- The agent's "loss ratios" are unusually skewed considering the size of the market and the types of people insured
- There are numerous life insurance policies purchased on the deceased
- There were different carriers used in securing coverage for no apparent reason
- The coverage amount is excessive considering the social position of the deceased
- The claim is made shortly after the expiration of the contestability period
- Any indication that the insured did not know about the policy
- Death in another country, especially with death certificate and related documentation in another language
- Increase in coverage amount shortly before death
- Change of beneficiary shortly before death
- Death certificate shows a home address that is a great distance from the deceased's place of work.
- Any death within a contestable period
- Any death with no body recovered
- Any accidental death under less than open and shut circumstances
- High dollar policy
- Policies without investigative confirmation of income
- Any discrepancies in any document
- Excessive documentation provided
- Any doubts about the cause of death
- Multiple policies not requiring an exam
- Any possible suicide motives
- Roommate or boarder arrangements
- Marital problems – separation or divorce
- Financial issues
- Legal issues
- Group insurance - Employer records show Date Last Worked is the same as date of death, if inconsistent with circumstances of death (cancer diagnosis; died in a nursing home)
- Group insurance - Deceased's occupation on the death certificate is inconsistent with employer records.

Indicators of Stranger-Originated Life Insurance (Stoli)

- The insured is between the ages of 65 and 85 years old
- The beneficiary is changed immediately after the contestable period
- The address and premium payer change immediately after the contestable period
- The insured or policyholder is not the one making the initial premium payments
- The same agent or agency force has a significant number of policies that are sold to a Settlement/Viatical company shortly after the contestable period

- The same exam company or physician administered the exam for a significant number of policies which are sold to a Viatical/Settlement company shortly after the contestable period
- The same Viatical/Settlement company is showing up on a significant number of policies shortly after the contestable period
- The Viatical/Settlement company is not licensed in the state where the insured resides
- The Viatical/Settlement Co. initiates the sale
- Not having a transparent transaction about how many parties received commissions and how much was paid out in undisclosed fees
- See all of the indicators for application fraud

Allied Universal Compliance and Investigations - Code of Ethics

"All services that we provide must be conducted in a legal, reasonable and unobtrusive manner that will never compromise the claimant's individual rights."

- We do not sell results, but provide facts
- We provide an honest investigation without bias
- We are licensed in the states in which we work
- We abide by all regulatory, state and federal laws
- We do not conduct any electronic surveillance
- We do not carry weapons
- We will not misrepresent ourselves in any illegal manner
- We will not enter onto any property that is posted or is secured by a privacy fence without permission
- We will not run any credit reports without proper authorization
- We will not utilize any illegal sources to obtain information
- We will not videotape a claimant where reasonable expectation of privacy exists
- We will not entrap, harass, stalk or otherwise compromise the claimant's rights
- We may edit reports for grammar so they are court-ready
- We provide a chain of custody for all evidence
- We maintain all tapes and reports for three years or for a longer period of time when mandated by a state
- We will provide the original tape for all judicial proceedings
- We will conduct our investigations in a professional and ethical manner
- We will testify to the facts