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THE
State Auto Group

Your Business
Insurance Specialists

Risk Control Services

Insurance Fraud Awareness

Workers Compensation

Much research has been done about insurance fraud committed in the processing of a claim, qualifying for insurance or creating an artificial insurable interest. Insurance fraud occurs when a person intentionally lies to obtain a benefit or advantage to which he or she is not otherwise entitled. By the same token, fraud also occurs when a person knowingly denies a benefit that is due and to which a person is entitled.

In the processing of a claim, there are phases during which a person could knowingly misrepresent information to the insurance company in order to obtain a benefit. For instance, during the initial investigation phase of an automobile accident, a person could lie about: the type of accident he or she may have been involved in, the circumstances, the hour, the location, the types of damages sustained and the extent of damages sustained, the number of people involved and the number of vehicles involved.

In qualifying for insurance, there are also phases during which a person could knowingly misrepresent information to the insurance company in order to "qualify" for an insurance program or a specific coverage of interest. For instance, during the processing of the application a person could lie about their personal information—age, health, address, telephone number, and Social Security number, date of birth, place of work, previous driving history and previous insurance history.

Creating an insurable interest could also be construed as fraud. Insurable interest exists where there is a legal or equitable relationship between the insured and the object of the insurance such that the insured benefits by the safety or is prejudiced by the loss of that object. It is unlawful for anyone to take out an insurance policy when there is no insurable interest at the time of applying for the policy.

All suspicious claims, though they may have to be paid for lack of conclusive evidence of fraud, should be referred to a SIU—Special Investigations Unit.

The following are general indicators of insurance fraud which may apply to more than one type of fraud scheme; at any given time, multiple forms of fraud may appear in a single claim. For example, in a slip and fall claim there may be indicators or evidence of medical fraud and lost earnings fraud.

This is a review of three phases of insurance fraud that affect the insurance industry and could directly affect you or your business: Workers Compensation, Property and Casualty."

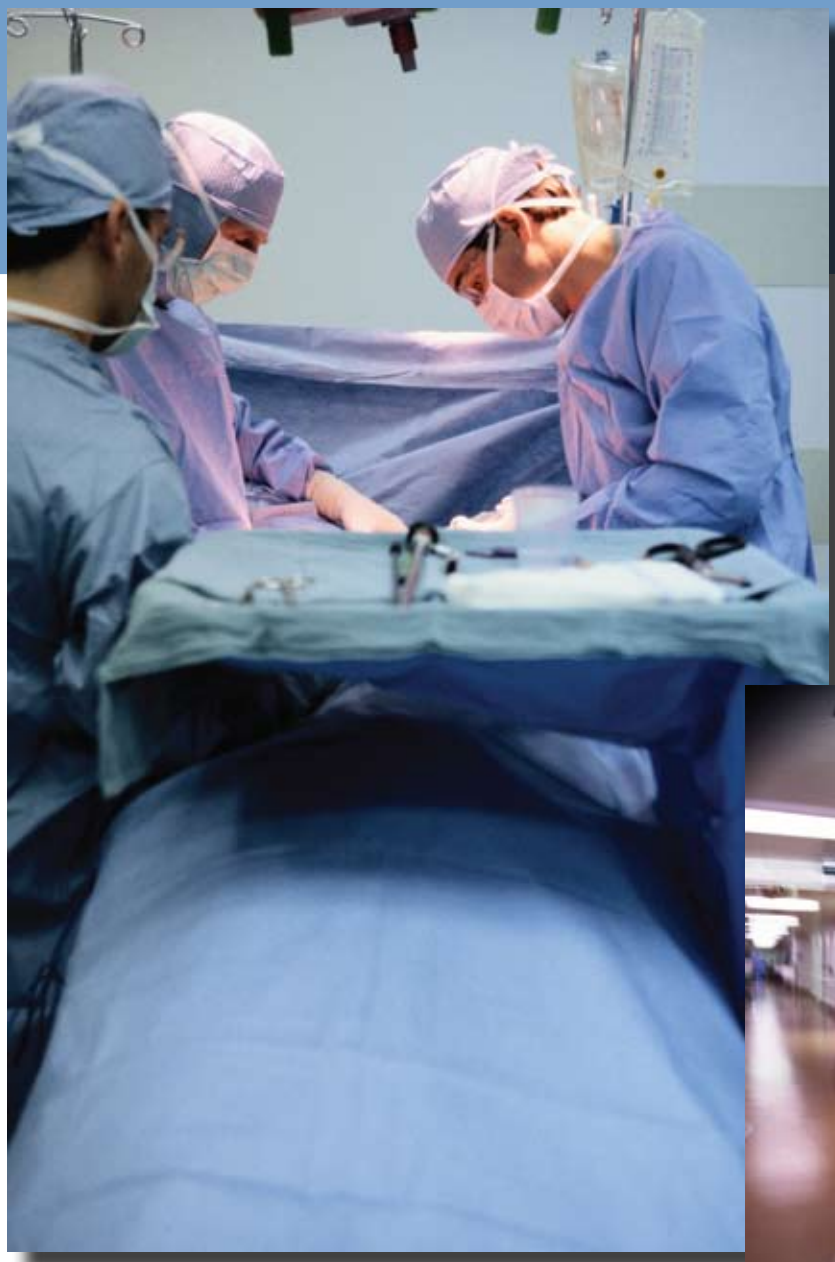
Indicators of

workers compensation fraud

- Injured worker is disgruntled, soon to retire, or facing imminent firing or layoff.
- Injured worker is involved in seasonal work that is about to end.
- Injured worker took unexplained or excessive time off prior to claimed injury.
- Injured worker takes more time off than the claimed injury seems to warrant.
- Injured worker is nomadic and has a history of short-term employment.
- Injured worker is new on the job.
- Injured worker is experiencing financial difficulties.
- Injured worker recently purchased private disability policies.
- Injured worker changes physician when a release for work has been issued.
- Injured worker has a history of reporting subjective injuries.

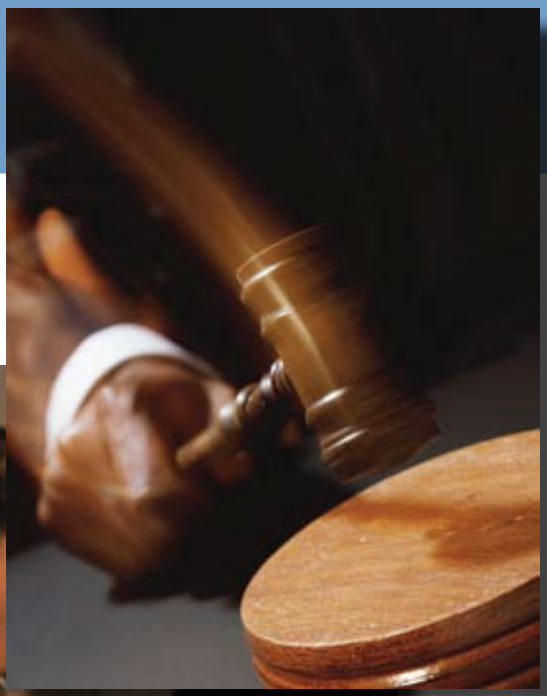
Questionable workers compensation accidents

- Accident occurs late Friday afternoon or shortly after the employee reports to work on Monday.
- No witnesses were present at the time of the accident.
- Claimant alleges injury occurred at off-the-clock hours – i.e., lunch hour or during break.
- Other employees give indications of rumors that the accident was not legitimate.
- The accident occurs in restricted areas.
- The accident occurs outside the scope of claimant's employment functions – i.e., office worker lifting a heavy object on a loading dock.
- The accident occurs just prior to a strike, or near the end of the claimant's probationary period.
- The details of the accident are not clear – difficult to ascertain the precise cause.
- The accident report summary differs from the medical report summary.
- The accident is not promptly reported to management or security.
- Surveillance shows that the alleged totally disabled worker is currently employed elsewhere.
- The injured worker is difficult to locate at home – either answering machine on or no answer at all.
- Other members of claimant's family have no knowledge and direct all communication via the claimant.



Questionable medical treatment

- The diagnosis is inconsistent with the treatment.
- The physician has a reputation of handling suspicious claims.
- The diagnosis is inconsistent with the medical findings and injuries alleged.
- The medical records are identical to other reports filed by the same physician.
- Double billing – both the workers comp and the health carrier are billed simultaneously.
- Very slow medical recovery in spite of positive findings on medical records – the claimant is not released.
- Medical bills submitted without dates or descriptions of office visits.
- Summary medical bills are photocopies of originals.
- Extensive, unreasonable and unnecessary treatment for minor, subjective injuries.
- Multiple referrals for treatment and/or testing to other facilities close by.
- Injuries are all subjective – i.e., pain, headaches, nausea, inability to sleep, nervousness, stress, etc.
- Treatment dates occur on time and dates outside of normal business operations for the facility.
- Injured worker cancels or refuses to submit to diagnostic procedures to confirm or evaluate the injury.



Questionable factors involving the injured worker's attorney

- The attorney has a reputation for handling suspicious claims and becomes involved on the date of loss.
- The attorney appears to have a close working relationship with a doctor or medical facility.
- The attorney immediately refers the claimant to the medical facility for evaluation.
- The attorney immediately files a lien for his fees and/or medical treatment being rendered.
- The attorney threatens further legal action unless the claim is promptly settled.
- The attorney is interested in a settlement early in the life of the claim.
- The attorney is never in the office and all negotiations are handled by paralegals.
- The claimant complains that his attorney is drawing the claim too long and that he is never available.

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