



Barry Zalma

Zalma's Insurance Fraud Letter



The Essential Resource For The Insurance Fraud Professional

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Quote of the Issue

"I have never let my schooling interfere with my education."

Mark Twain



Compliance With Conditions Must Be Proved

Failure to Prove Compliance With Conditions & Answer Investigative Questions Defeats Claim

If insurance fraud is suspected and the insurer demands examination under oath and production of documents it is the obligation of the person insured to cooperate fully. A suit against an insurer requires that the insured prove the contract and that the insured complied with all the conditions of the contract. In *Lisa Fletcher v. Progressive Casualty Insurance Company*, No. C066145 (Cal.App. Dist.3 10/03/2011) the Court of Appeal granted a non suit because of the failure to prove the contract of insurance and compliance with the policy conditions.

Lisa Fletcher challenged the trial court's order dismissing her claim for breach of contract against her automobile insurance carrier, Progressive Casualty Insurance Company (Progressive). Fletcher sued to recover the value of her 2003 Land Rover, which had been found burned. Progressive considered the circumstances of the vehicle's loss to be suspicious and denied Fletcher's claim after she refused to produce financial documents.

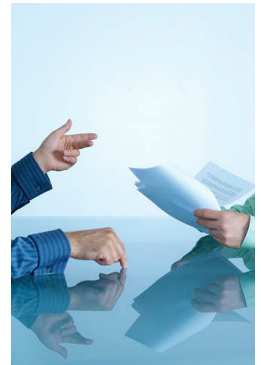
Fletcher contended that the trial court erred by (1) granting Progressive's motion for non-suit, (2) denying her motion to file a supplemental complaint, (3) denying her motion to amend her complaint to conform to proof adduced at trial, and (4) denying her motion to tax costs based on a bad faith settlement offer by Progressive made pursuant to Code of Civil Procedure Section 998.

Factual and Procedural History

Fletcher's Claim and Progressive's Denial

At 1:44 a.m. on May 22, 2006, the Sacramento Fire Department received a call about a fire. When the fire department arrived at the scene, they found Fletcher's Land Rover fully engulfed in flames. On May 23, 2006, Fletcher met with Rita Sharma, a fire and theft claims adjuster for Progressive. Fletcher asserted that the Land Rover had been stolen and presented a claim for the vehicle in the amount of \$50,719.44.

In June 2006, Sharma discussed the claim with her supervisors because it seemed suspicious. Sharma's supervisors, Kelly Dobbins and Eric Snitzler, agreed that some red flags appeared in Sharma's investigation. The claim raised suspicions for several reasons, including Fletcher's past due payments on the vehicle, her attempts to sell the vehicle prior to its loss, the condition of the vehicle when it was located, and the lack of tampering with the vehicle's ignition. Moreover, Progressive's initial investigation revealed several misrepresentations by Fletcher. Fletcher first denied any attempt to sell the Land Rover, but later admitted listing it for sale during a 10-day period. Progressive discovered that the vehicle had been advertised for a lower price than Fletcher reported. Fletcher stated that she called the police



immediately after she discovered the vehicle missing, but her cell phone records indicated that the call had been made “much later.” And, Fletcher’s account of discovering the vehicle to be missing differed from what Progressive learned during its initial investigation.



Sharma and her supervisors reached the conclusion that Progressive needed to investigate Fletcher’s claim further. Thus, Sharma called Fletcher on June 23, 2006, to explain that a field investigation would be conducted. Dobbins referred the claim to Progressive’s coverage counsel, Teresa Starinieri, for additional investigation and to take Fletcher’s examination under oath. Starinieri requested some financial documents but Fletcher’s attorney refused to provide them. Consequently, Progressive was unable to complete its investigation of the claim. Progressive supervisors discussed Fletcher’s claim and concluded that it should be denied.

On January 2, 2007, Progressive mailed to Fletcher’s attorney an 11-page letter in which it denied the insurance claim. Among the grounds listed for the denial of the claim were Fletcher’s material misrepresentations to Progressive and her refusal to provide the requested financial documents.

In May 2009, Fletcher filed a complaint alleging a single cause of action for moneys due under an auto insurance policy.

Progressive’s Motion for Non-suit

A jury trial commenced on July 20, 2010. After calling Sharma and Dobbins as witnesses, Fletcher rested her case. Progressive moved for non-suit on grounds that Fletcher had not proven an element of her cause of action, namely that she performed all the conditions of the insurance policy. Progressive argued that Fletcher’s refusal to produce financial documents at Progressive’s request violated the express terms of the auto insurance policy. Fletcher’s counsel opposed the motion but acknowledged, in an amazing blast of truth, that Fletcher “didn’t live up to the duties of the policy, and that’s fair enough.” The trial court then granted Fletcher’s motion to reopen her case.

Fletcher testified on her own behalf, recounting that she and her husband had been on vacation in Canada from May 14 to 21, 2006. On the evening of May 21, their son picked them up from the airport. The next morning, Fletcher discovered that her Land Rover was missing. The vehicle was gone despite the fact that both sets of keys were still in her kitchen drawer. Thinking that she might have left the Land Rover at her place of employment, she drove one of her husband’s trucks to check. When she did not see the Land Rover at her workplace, Fletcher immediately reported the theft to the police. Fletcher acknowledged that her cell phone records listed no call to the police but asserted that the records did show a later call to the Yuba County Sheriff’s department.

Fletcher admitted that she and her husband filed for bankruptcy in November 2009. However, she claimed that her attempt to sell the Land Rover in 2006 was not motivated by financial necessity. Following her testimony, Fletcher rested her case a second time.

Progressive again moved for non-suit. The court indicated its inclination to grant the motion as follows: “[T]here’s been no dispute that there were records that, and I’m not talking about records in possession of the third party, I’m talking about records in the possession of [] Fletcher that she did not provide before her [examination under oath]. She, apparently, based on the testimony, she — they weren’t provided after the [examination under oath], and there was an ongoing objection, and she relied on advice of counsel, which this case says that you cannot rely on advice of counsel in this context. And the coverage — or the claim was subsequently denied. There was no additional information given after the denial.”

At the court’s request, the parties submitted written briefing on the motion for non-suit. After a hearing, the trial court granted the motion for non-suit.

At some point Fletcher moved for a new trial and Progressive opposed the motion. The trial court denied the motion for new trial on the same grounds as its granting of Progressive’s motion for non-suit.



Analysis



When testifying on her own behalf, Fletcher admitted that “the policy provides that it authorizes the insurance company to have access to your business and personal records as often as the insurance company reasonably requires.” Fletcher also acknowledged that the policy stated, “We may not be sued unless there is full compliance by you or an insured with . . . all the terms of this policy.”

As part of Progressive’s investigation, its coverage counsel requested that Fletcher bring specified financial documents with her to her examination under oath. Fletcher’s attorney objected on grounds of privacy and relevance. After Fletcher’s examination under oath, Progressive again requested the financial documents. The parties never resolved the dispute over production of Fletcher’s financial information. Fletcher conceded that she also did not “provide anything to Progressive after [she] got this letter [denying her claim] and before [she] filed the lawsuit against the insurance company two or two and a half years later.”

The trial court granted the non-suit because plaintiff was unable, despite being permitted to reopen her case, to demonstrate an element of her cause of action, cooperation in the investigation of her claim by the carrier and cited to *Abdelhamid v. Fire Ins. Exchange* (2010) 182 Cal.App.4th 990.

“The duty to cooperate with the carrier’s investigation was a condition precedent to the commencement of the action, i.e., an element of the cause of action. Under *Abdelhamid*, the carrier was entitled to request the financial documents the plaintiff refused to produce, and, under that case, reliance on advice of counsel in refusing to cooperate does not obviate the refusal to cooperate. The relevant period for determining whether there was evidence of cooperation is the period during which the claim was being evaluated, that is, before it was denied. Because plaintiff refused to cooperate with the carrier, she failed to establish that element of her cause of action.”

The trial court granted the motion for non-suit based on Fletcher’s failure to introduce evidence showing her compliance with the insurance policy’s requirement to cooperate with an investigation of a claim. A plaintiff’s compliance with the terms of the insurance policy constitutes an element of the breach of contract claim asserted by Fletcher. The standard elements of a claim for breach of contract are: (1) the contract, (2) plaintiff’s performance or excuse for nonperformance, (3) defendant’s breach, and (4) damage to plaintiff therefrom. Based on Fletcher’s noncompliance with the terms of the insurance policy, she could not prove the second element of her breach of contract claim.



In *Abdelhamid*, a similar case involving a law suit by a policyholder for breach of contract after the insurance carrier denied a claim for loss of a house that had been subject to arson, this court upheld the insurance carrier’s denial of a claim based on the policyholder’s non-cooperation in the investigation of the claim, including the policyholder’s refusal to submit a completed claim form, answer material questions, and produce requested financial information. As this court explained, an insured’s compliance with a policy requirement to submit to an examination under oath is a prerequisite to the right to receive benefits under the policy. A refusal of the insured to answer material questions at an examination under oath (provided for in the policy), shows a failure to give to the insurer that degree of cooperation required by the provisions of the policy and is a violation of the agreement of the insured to submit to such examination under oath.

Where the insurer has reason to suspect arson, it is relevant and material to inquire into the financial condition of the insured because an insurer is entitled to develop circumstantial evidence of the insured’s involvement in the suspected arson.

As in *Abdelhamid*, the plaintiff in this case failed to satisfy the insurance policy condition to cooperate with an investigation of a claim for loss. The trial court correctly noted that Fletcher’s own testimony established her inability to prove that she satisfied the policy requirement to cooperate with an investigation by Progressive. On the witness stand, Fletcher conceded that the insurance policy required her cooperation, that Progressive repeatedly requested her financial information, and that Fletcher’s attorney refused to hand over the documents. This testimony established Fletcher’s failure to prove an element of her breach of contract claim, i.e., her performance of all terms of the insurance policy. (*Abdelhamid, supra*, 182 Cal.App.4th at p. 999.) For lack of proof, the trial court correctly granted Progressive’s motion for non-suit.



Fletcher attempts to distinguish *Abdelhamid* on grounds that the prejudice in that case was not present here. The documentation that the insurer sought with respect to plaintiff’s claimed losses was essential to a determination of the extent of her claim. The insurer’s requested documentation and queries regarding her financial status were, however, even more fundamental. The financial information sought went to the heart of its investigation of whether there was circumstantial evidence of plaintiff’s involvement in the arson of her Land Rover or whether there was a reasonable explanation for the many suspicious circumstances uncovered by the insurer’s investigation. This addressed the very validity of her claim.

The Court of Appeal rejected Fletcher’s attempt to distinguish *Abdelhamid* by asserting that Progressive did not conclude she was complicit in the vehicle’s loss. Progressive was unable to conclude anything about the loss because it was unable to complete its investigation. Fletcher’s refusal to cooperate with Progressive’s investigation constituted the obstacle. Her financial condition was directly relevant to the investigation and was called into question by her own misrepresentations to Progressive and by the “red flags” surrounding the vehicle’s loss.

Fletcher recovered nothing in trial or on appeal because the deficiencies in plaintiff’s proof of loss were a far cry from minor defects and no reasonable trier of fact could conclude she substantially performed her obligations or complied with the condition of her insurance contract requiring her to provide a proof of loss with supporting documentation.

An insurer’s offer to consider additional evidence in a denial letter did not “reopen” the door to its obligations and duties under the policy by making this offer. On the stand, Fletcher admitted that she had not given Progressive any additional evidence since the denial of her claim. Thus, Progressive had no reason to reevaluate the claim after its thwarted investigation.

The order dismissing Lisa Fletcher’s case was affirmed. Progressive Casualty Insurance Company shall recover its costs on appeal.

By refusing to cooperate in Progressive’s investigation of her claim, a condition of the insurance policy, Fletcher cannot allege all the elements for a breach of contract action. Fletcher’s attempt to file a tort cause of action in a supplemental complaint fails because the action is time barred. Similarly, Fletcher’s motion to amend her complaint to conform to proof at trial fails because the additional allegations for her contract cause of action did not excuse her non-cooperation in Progressive’s investigation of her claim and her attempt to add a



tort-based cause of action is time barred. Finally, Fletcher's appeal of the trial court's denial of her motion to tax costs is deemed forfeited for lack of an adequate appellate record.

Lessons

When faced with a suspicious claim insurers are required to conduct a thorough investigation which is required by the California Fair Claims Settlement Practices Regulations and California law to include a demand for production of relevant documents, a demand for a sworn statement in proof of loss and the examination under oath of the insured. If the insured refuses to provide the documents demanded or answer questions at examination under oath that are material to the investigation, the claim should be denied.

Zalma on Insurance



The Blog, [Zalma on Insurance](http://zalma.com/blog), is now available with a daily commentary by Barry Zalma, Esq., CFE. *Zalma on Insurance* will provide comments and opinions about insurance from an internationally recognized insurance, insurance claims handling, insurance fraud, and insurance bad faith expert. You can read articles on the blog now.

It is Mr. Zalma's intent to include items at least five days a week and he would appreciate comments on the reports. Go to my blog at <http://zalma.com/blog>. At the right column is a link to allow you to subscribe to the blog and receive notice of each new entry.

Some of the articles on the blog include Coverage Denied, From the Supreme Court of Canada, No Inequitable Apportionment of Loss, Claims Made Policies, Good Faith Settlement Destroys Insurer's Indemnity Rights, No Right to Interest on Deposit Premium, Texas Eliminates Tort of Bad Faith for Most Workers' Compensation Claims, Ignorance Can Be Cured – Stupid is Forever, and Catastrophes, Fraud, and Avoiding Liability.

Insurance Fraud Fails In Washington State

Bullivant Secures Jury Verdict, Court Awards Judgment under Counterclaim for First-Party Insurance Fraud



By John A. Bennett, Stuart D. Jones, Matthew E. Hedberg, Andrew E. Passmore, Attorneys, Bullivant Houser Bailey PC

Following a two-month trial, Safeco Insurance Company of Oregon was awarded \$9.977 million on its counterclaim for insurance fraud against a former insured, Sohail Masood.

An August 2008 fire destroyed Mr. Masood's West Linn, Oregon house. Shortly after the fire, Safeco made a number of payments to the insured under the various coverages of the homeowners insurance policy. In part, Safeco paid the limit of liability, \$3.8 million, for personal property lost in the fire; it paid the limit of liability for the dwelling, \$4.9 million; and, it agreed to pay a single lump sum in settlement under the Loss of Use coverage, \$1.35 million.



Mr. Masood filed two lawsuits in Oregon (Clackamas County) Circuit Court against Safeco on his homeowner's insurance policy. The first lawsuit alleged that approximately one week after the fire, Safeco entered into an agreement with Mr. Masood to pay the insurance policy's Extended Dwelling Coverage--without requiring Mr. Masood to replace the damaged property. The Extended Dwelling Coverage provided up to 50% of the dwelling limit, if needed, to replace the home, and Mr. Masood demanded the full 50% (approximately \$2.45 million). Safeco disputed that it had agreed to relieve Mr. Masood of this condition of the insurance policy. The second lawsuit alleged that approximately \$3 million in personal property was stolen from an outbuilding on the property in a separate incident. The lawsuits were consolidated into a single proceeding.



During Safeco's investigation and adjustment of the fire loss, Mr. Masood represented that he had spent millions remodeling the house and that he had furnished the house with antiques and artwork. Prior to trial, Safeco discovered evidence that Mr. Masood exaggerated the value of claimed dwelling components lost in the fire, including chandeliers, a built-in stereo/AV system, and kitchen cabinetry. Safeco amended its pleadings to assert that the policy was void and added a counterclaim for return of amounts already paid.

At trial, a forensic document expert testified that certain documents Mr. Masood presented to support his claim were forgeries. The builder of the home, the cabinetmaker and several subcontractors who were involved in original construction identified their own work from photographs taken shortly before the fire of rooms that Masood claimed had been remodeled. Experts contradicted Mr. Masood's representations regarding the quality and value of the light fixtures and the stereo system in the house at the time of the fire.

After three days of deliberations, the jury returned a verdict finding that Mr. Masood intentionally misrepresented the value and quality of the dwelling components at issue. The jury also found that Mr. Masood failed to prove that a theft of property from an outbuilding occurred after the fire. Mr. Masood's attorneys argued that the finding of misrepresentations in the adjustment process would not affect either the amounts claimed under the Extended Dwelling Coverage, pursuant to the agreement reached one week after the fire, or the amounts Safeco had paid prior to the earliest date the jury determined Safeco had relied upon misrepresentations.



On August 22, 2011, the trial judge ruled that, based on the jury's finding that the insured intentionally misrepresented his property loss and exaggerated the values, the insurance policy was void, and Mr. Masood was required to repay Safeco. The court wrote: "[i]t is clear from state statute, case law, and simple logic that a financial sanction to the insured is the intended penalty for misrepresentation before or after a claim of loss. Since the only way a financial penalty can come about under the language of the insurance policy is if the contract is deemed void. . . It follows that all payments made by Safeco on the fire loss claim, except those made under the Loss of Use settlement agreement must be restored to Safeco as damages."

After weighing the competing public policies of encouraging settlement of disputes and that of discouraging insurance fraud, Circuit Judge Norby concluded that enforcement of the Extended Dwelling Coverage agreement was contrary to the public interest expressed in ORS 742.208 to "discourage insurance fraud 'before or after a loss.'"



John A. Bennett, Esq.

Safeco was represented by Bullivant Houser Bailey's John Bennett, Stuart Jones, Matthew Hedberg, and Drew Passmore

Related Article with detail: bit.ly/bullivant-client-awarded-judgment

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ZIFL adds its congratulations to Mr. Bennet, Bullivant Houser Bailey PC and SAFECO for its courage to take on the fraud attempted by the insured and obtaining a judgment – probably collectible – against the insured so that he does not profit from the fraud the jury found.

Zalma on Insurance Nominated for LexisNexis Top 50

Each year, LexisNexis honors a select group of blogs that set the online standard for a given industry. LexisNexis notified me that blog [Zalma on Insurance](#) is one of the nominated candidates for the LexisNexis Top 50 Insurance Law Blogs of 2011, featured on the [LexisNexis Insurance Law Community](#).



LexisNexis is inviting Insurance law practitioners to comment on our list of nominees. I respectfully request that readers of [Zalma on Insurance](#) support its nomination. Please comment on the announcement post on the LexisNexis Insurance Law Community.

To "talk up" [Zalma on Insurance](#) you will need to be a registered Community member and be logged in. If you have not registered previously, create a new registration or use your sign in credentials from your favorite social media site. Registration is free! Go to <http://www.lexisnexis.com/community/insurancelaw/user/createuser.aspx>. Once you are logged in, scroll all the way to the very bottom of this page.

To submit a comment, visitors need to log on to their free LexisNexis Communities account. If you haven't previously registered, you can do so on the Insurance Law Community for free. The comment box is at the very bottom of the blog nomination page. The comment period for nominations ends on October 7, 2011. The Matthew Bender Insurance editors and the LexisNexis Insurance Law Advisory Board will then give strong consideration to the comments received when they review all of the nominees and select the Top 50 Insurance Law Blogs of 2011 next month by going to <http://www.lexisnexis.com/community/insurancelaw/user/createuser.aspx>.

Add a comment in the box at the bottom of the page to vote or nominate your favorite blog, and that's it! If you are having problems registering, click here, or please contact us at ted.zwayer@lexisnexis.com. As a Community Manager, Mr. Zwayer wants to make sure that everyone gets to vote and I would like you all vote for *Zalma on Insurance*.

I would also appreciate your help with spreading the news about the LexisNexis Top Blogs campaign. Please tell your colleagues and your online groups and networks that our Insurance Law Community is seeking nominations and comments for the Top 50 Insurance Law Blogs so that they can participate in our recognition event. After all, it's only through input from others that LexisNexis can continue to maintain the value and quality that the LexisNexis Insurance Community relies upon when it searches our Top Blogs for insight and information.

I am honored to have been nominated and appreciate your comments.

California Funds Auto Fraud Fight

Insurance Commissioner Jones Announces \$23 Million in Grant Funding to Battle Automobile Insurance Fraud



California Insurance Commissioner Dave Jones on October 4, 2011 announced \$23 million in grants to California District Attorneys that will aid in the battle against automobile insurance fraud. Grant funds totaling \$15.2 million were distributed to 35 counties

for the regular auto insurance fraud grant program and \$7.6 million were distributed to 10 counties for their Organized Auto Fraud program. These funds will assist the District Attorneys with the investigation and prosecution of automobile insurance fraud.

The Commissioner distributes the grant funds to District Attorneys who participate in insurance fraud investigation and prosecution efforts. The

grant funds that are distributed come from statutory authority granted to the Commissioner which allows the collection of assessments from insurance companies based on the number of vehicles they insure.

The breakdown to individual counties is as follows:

Regular Auto Insurance Fraud Program FY 11/12 Grant Awards

County	Amount	County	Amount	County	Amount
Alameda	\$872,426	Monterey	\$352,666	Solano	\$113,738
Amador	\$80,000	Napa	\$34,974	Sonoma	\$106,691
Butte	\$115,000	Orange	\$1,402,843	Stanislaus	\$191,079
Contra Costa	\$417,457	Riverside	\$580,000	Tehama	\$50,000
El Dorado	\$298,957	Sacramento	\$532,567	Tulare	\$200,000
Fresno	\$365,468	San Bernardino	\$637,495	Ventura	\$345,955
Humboldt	\$43,307	San Diego	\$1,500,000	Yolo	\$152,423
Imperial	\$45,122	San Francisco	\$250,000		
Kern	\$324,556	San Joaquin	\$329,185	Total	<u>\$15,259,000</u>
Kings	\$121,636	San Luis Obispo	\$64,128		
Los Angeles	\$4,306,309	San Mateo	\$278,605		
Marin	\$94,171	Santa Clara	\$785,000		
Mendocino	\$27,646	Santa Cruz	\$90,771		
Merced	\$85,513	Shasta	\$63,312		

Organized Auto Fraud Interdiction Program

County	Amount	County	Amount	County	Amount
Alameda	\$695,675	Orange	\$428,340	San Bernardino	\$225,218
Fresno	\$366,640	Riverside	\$417,318	San Diego	\$1,196,166
Los Angeles	\$2,741,147	Sacramento	\$369,930	San Francisco	\$246,290
				Santa Clara	\$956,693
				Total	<u>\$7,643,417</u>

ZIFL is pleased that money is being issued to the fight against fraud but wonders if the \$23 million would have been used more efficiently if the Attorney General of the state of California was asked to create, for \$23 million, a staff of professional auto insurance fraud prosecutors to work directly with the Fraud Division investigators and prosecute all cases of auto insurance fraud in the state.

World Risk and Insurance News Launches

With Video News Report for Monte Carlo RendezVous

Zalma's Insurance Fraud Letter and I are pleased that Mr. Zalma has been allowed to participate in wrin.tv and ask that you click on the link, watch the initial programming and continue to check in for new programs including those relating to insurance fraud. WRIN.tv is an online video network that ushers in a new era in news, communication and education for the global risk and insurance industry.



Insurance Broadcast System, Inc. announced today that it has resumed broadcasting its video news network for the global risk, insurance and financial services industry with the launch of World Risk and Insurance News (WRIN.tv), available online at www.WorldRiskandInsuranceNews.tv (also www.WRIN.tv)

World Risk and Insurance News offers late-breaking video news for the millions of professionals worldwide who make up the global risk, (re)insurance and financial services industries.

In its first report, WRIN.tv previews the annual RendezVous in Monte Carlo and includes an interview with Christopher Klein, Head of Guy Carpenter's Sales Operations and Market Relationships in London, and a special presentation from Dr. Robert Hartwig, CPCU – President of the Insurance Information Institute in New York on the impact of September 11.

In addition to late-breaking news and insightful interviews, regular programming, including some from your author, will feature forward-thinking panel discussions surrounding industry issues and in-depth coverage directly from industry meetings and catastrophic events. Currently, WRIN.tv is producing a weekly video news report throughout the remainder of 2011. The network plans to grow to 5 days per week in 2012 as it expands its coverage around the globe.

Dennis Richard, Chief Executive Officer of Insurance Broadcast System, Inc. said: "We are pleased to bring back live video news and high-quality insurance programming at a time when technology facilitates a more immediate and comprehensive service to a global audience."

"We now have in place a worldwide team of correspondents to report on news that affects the healthcare, commercial insurance and financial services industries around the world," says Richard.

About IBSNewsDirect.com

World Risk and Insurance News (WRIN.tv) is the online video-based insurance news network delivering late-breaking and relevant business-to-business information, analysis and forward-thinking programming for the global risk, insurance and financial services industries. WRIN.tv works closely with news outlets, research firms, industry analysts, trade associations and subject matter experts around the globe to deliver relevant and valuable information, news and special programs. WRIN.tv uses a unique blend of streaming video and integrated social media to connect professionals in the global risk and insurance community through its website at www.WRIN.tv.

For more information:

For sponsorship opportunities and to become an industry alliance partner with WRIN.tv contact Sandra L. Masters at Sandra.Masters@WRIN.tv

Submit press releases and story ideas for WRIN.tv to Media@WRIN.tv



Man Bites Dog

An Effective Deterrent to Insurance Fraud



Insurance fraud has been estimated to take between \$80 billion and \$300 billion a year from the insurance industry in the United States. Every state has a statute making insurance fraud a crime including the federal crimes of mail and wire fraud and the Racketeer Influenced and Corrupt Organization Act (RICO). RICO can also be a civil action which allows for treble damages or punitive damages.

Some insurer victims of insurance fraud have become proactive. In *State Farm Mutual Automobile Insurance Company; State Farm Fire and v. Arnold Lincow, D.O.; Richard Mintz, D.O.; Steven Hirsh; 7622 Medical*, No. 10-3087 (3d Cir. 09/16/2011) the Third Circuit dealt with an appeal from State Farm's successful trial against some doctors and clinics who defrauded it and those it insured.

Facts

After a four-week jury trial plaintiff State Farm successfully convinced the jury that defendants, a number of health care providers (“Defendants”), engaged in various schemes to defraud State Farm by billing it for medical services that were either not provided or provided unnecessarily, and were illegal under RICO, fraud statutes, and common law fraud. Following trial, Defendants filed motions for judgment as a matter of law or, in the alternative, for a new trial or, in the alternative, to alter or amend the judgment. The District Court denied Defendants’ motions in their entirety.



Plaintiff alleged that Defendants were members of a conspiracy that sharply inflated the costs of medical care for car accident victims by prescribing tests and treatments, as well as prescriptions and medical equipment – whether medically necessary or not – and then routinely billed State Farm for additional treatments that were never provided. At trial, State Farm’s proof of Defendants’ fraud consisted of State Farm’s claim files and testimony of patients, physicians at Defendants’ medical facilities, Defendant physicians, and experts.

After a four-week trial, the jury awarded Plaintiff over \$4 million against all Defendants jointly and severally, and individual Defendants were found liable for punitive damages totaling \$11.4 million. The jury also found in favor of Plaintiff on Defendants’ counterclaims for unpaid bills for services.

Analysis

The Third Circuit’s reviews a district court’s order granting or denying a motion for a new trial for abuse of discretion unless the court’s denial of the motion is based on the application of a legal precept, in which case the review is plenary. A new trial may be granted on the basis that a verdict was against the weight of the evidence only if a miscarriage of justice would occur if the verdict were to stand.



State Farm noted that RICO is distinct because the members of the association-in-fact enterprise include all the defendants, there is a complete identity between the enterprise and the defendants and, therefore, no distinctiveness among the defendants. As the District Court noted and State Farm urged, the intracorporate conspiracy doctrine is not universally accepted, and it is questionable whether the Defendant’s version is completely accurate.

The defendants argued that State Farm failed to prove: (1) the elements of an association-in-fact enterprise; (2) that defendant Mintz conspired with the other Defendants to defraud, as § 1962(d) requires; (3) that Mintz’s actions proximately caused State Farm’s injuries; (4) that Mintz’s conduct fulfilled the elements of common law fraud; and (5) that Mintz’s conduct fulfilled the elements of statutory fraud under Pennsylvania law. The Third Circuit rejected all of Mintz’s claims to the contrary and held that the weight of the evidence supports the jury’s finding against Mintz and the other defendants. Therefore, the Third Circuit concluded that to let the verdict stand would not result in a miscarriage of justice.

The Third Circuit agreed with State Farm’s assertion that a violation of the Insurance Fraud statute is a civil tort and that, as the jury found and the District Court upheld, the Defendants together contributed to State Farm’s injuries and are thus jointly and severally liable. Moreover, as the District Court correctly noted, there is no requirement for district courts to instruct juries to award damages against each defendant separately and individually. Because State Farm elected to receive treble damages the Third Circuit had no reason to address the contention that the punitive damages award should be reduced.

Lesson

Insurers who are the victims of fraud cannot rely on police agencies to investigate and prosecute perpetrators of insurance fraud. Prosecutions are few and far between. As readers of Zalma’s Insurance Fraud Letter, available FREE at <http://www.zalma.com/ZIFL-CURRENT.htm>, know prosecutions are increasing but are still anemic and those who are prosecuted and convicted usually receive minor punishments. By being proactive insurers can recover from the fraud perpetrators, like the doctors involved in this case, the insurer can recover what it lost, a bonus of three times the compensatory damages, and actually deter insurance fraud by hitting the perpetrators where it hurts them most, in their wallet.



It is time that insurers emulate the actions of State Farm and the few other insurers who are using civil suits to defeat insurance fraud by taking the profit out of the crime.

Zalma’s Insurance Fraud Letter

Zalma’s Insurance Fraud Letter (ZIFL) ends its fourteenth year of publication dedicated to those involved in reducing the effect of insurance fraud. ZIFL is published 24 times a year by ClaimSchool. It is provided free to clients, friends of the Law Offices of Barry Zalma, Inc., clients of Zalma Insurance Consultants and anyone who provides an e-mail address in the space provided on my web site.

**ZIFL IS FREE
FOR THE ASKING**

The comments made are for information only and are not intended as legal advice. If you need legal advice, Barry Zalma practices law as the Law Offices of Barry Zalma, Inc., 4441 Sepulveda Boulevard, CULVER CITY, CA 90230 or at 310-390-4455, fax

at 310-391-5614, Cell Phone: 310-738-6818 or E-Mail at zalma@zalma.com. Zalma's Insurance Fraud Letter can also be read on the web at <http://www.zalma.com>.

Mr. Zalma serves as an expert witness or consultant in insurance coverage, claims handling, insurance bad faith and fraud. Mr. Zalma's law practice is limited to the representation of insurers and those in the business of insurance. He is available to provide advice and counsel concerning insurance fraud, first and third party insurance coverage issues, bad faith and first party insurance appraisals.

Recipients of Zalma's Insurance Fraud Letter are authorized by ClaimSchool and Barry Zalma to make as many copies as needed to pass to your friends and staff as long as you do not copy for resale.

If this has been forwarded to you and you want to be on the FREE mailing list as a subscriber to ZIFL please go to <http://www.zalma.com> and insert your e-mail address in the box indicated and you will be automatically subscribed to the text version of ZIFL. If you want to be removed from the list click on the link at the end of the ZIFL and your subscription will be deleted. ZIFL will be posted for a full month in pdf and full color at <http://www.zalma.com>.



[Arson For Profit](#) – Serialized Novel

This story is based on a real case involving a member of Russian/Armenian organized crime, real insurers, investigators, lawyers, fire fighters, and insurance brokers. The names, descriptions, and identities of the people involved have been changed to protect both the guilty and the innocent.

You can purchase the novel as an e-book at <http://www.zalma.com/ArsonforProfit.htm>.

Chapter 29

Cooperation to Stop Fraud



Bill Mack met Campizi at Tommy's Famous Burgers on Beverly Boulevard, near downtown Los Angeles. They sat down on an outdoor bench with fifteen napkins each consuming, with pleasure, the messy, greasy and delicious chili burgers for which Tommy's is famous. Pigeons, looking for handouts circled above and brazenly landed at their feet hoping for an occasional french-fry or bit of hamburger bun.

Wiping off the last of chili burger off his moustache, Campizi laughed as he watched Bill Mack try to hold his burger together. The patty, greased by the chili, kept slipping from the bun.

"Anyone who can eat a Tommy's burger without losing some is a genius. You, Bill, are obviously gourmet eating challenged."

"I still see a pile of fourteen chili soaked napkins at your side, Campy." Bill responded. "Your moustache is holding more of the chili than your stomach."

"O.K.. We're even. No one I know can eat here neatly."

"Hell, Campy, if it was neat, it wouldn't taste so good."

"No question."

"So why did you invite me to this high-class meal, Campy?"

"I took your Levonyan case to the D.A. and asked that he file a felony insurance fraud. It's one of the best cases I have ever seen and he turned me down flat."

"Nothing unusual." Mack responded.

"I know your clients are facing a big claim. I wanted you to know you have no chance of seeing the man arrested. You can't rely on us. The D.A. just doesn't think it's a crime to cheat an insurance company unless you kill a firefighter doing it."

"Thanks, Campy. It's good of you to let me know."

"That's not the end, Bill. My Captain is as pissed as I am. He asked me to contact you and ask if your client is as set on fighting a false claim all the way as you told me when we first met."

Mack, wiping his face with a napkin that he had wet with his lemon-lime soda and drying his face with a second napkin looked at Campizi for some hint of the purpose behind his comment. For the last 20 years Mack had (from both sides) come across the unwritten rule that police and arson agencies share nothing with private investigators. The meeting seemed to presage a change in attitude. Finished with his toilet, Mack threw the greasy napkins in a nearby trash barrel and responded. "The Lloyd's Underwriter, Richard de Camp, has instructed us and counsel to 'take no prisoners.' He believes he has been defrauded and refuses to pay any tribute. He will, he says, spend every pound he has before he will pay the claim."





“Bill, if that is the case, my Captain has authorized me to open my files to you and to help you in any way I can.”

Mack was struck speechless. Arson-for-profit schemes must be rampant in Los Angeles. He had personally investigated four arson fires in the last year. Campizi must have investigated more. The D.A.’s office, the largest law firm in the country, only assigned one prosecutor to the arson units in the County. He picked his cases carefully and never prosecuted a case unless there was a death or serious injury. Arson-for-profit schemes, even when evidence is available as strong as that gathered by Campizi and Mack, just don’t have enough sex-appeal to gain the interest of the D.A.’s office. Usually, the private investigator, and his client was left alone and naked to fight the false claim. Campizi was offering to throw a blanket of evidence over his shoulders and help produce the evidence needed to prove a civil

fraud case.

“I don’t know what to say.” Mack Stammered. “Thank you, Campy.”

“If you’ve finished your lunch, let’s go to the office. The clerical staff should have finished copying my entire file. I have had prints made of all of our photographs and the video tape we got from the L.A. County F.D. helicopter and the Channel 2 video copter that both recorded the first fire and the fight to extinguish it.”

“You have video?”

“Yes. In fact, the Channel 2 video shows a car, without lights going down the hill and passing the fire engines as they came up.”

“Were you able to identify the car?”

“No. It looked like a Camaro, a Firebird or a Mustang.”

“The eldest son, Levon Levonyan, has a black ‘87 Camaro.”

“I know. You’ll find in the file the registration on the car. The D.A. didn’t even think it was interesting unless I could read the license plate off the video tape.”

“Well, civil counsel only has to establish fraud by a preponderance of the evidence, not beyond a reasonable doubt. Sam Hazan can work with that kind of evidence to cause a jury to draw an inference that is much harder for a prosecutor.”

“Bill,” Campizi added as they drove to the Arson Unit offices, “is there something I can do to help you more than the documents in my file?”

“Yes. Did you get the gas chromatography reports?”

“Sure, they are in the file. They show 87 octane unleaded gas.”

“Any particular brand?”

“ARCO Oil. Unfortunately, ARCO sells to fourteen different local stations and independents who market the fuel under their own brand name.”

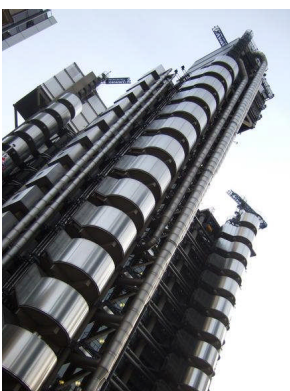
“Levonyan has an ARCO station, you know.”

“Of course I know. But the machine can’t pin the fuel down to a specific location. The gas could have come from any one of 1500 stations in L.A. County.”

“Seems to me there are a lot of coincidences pointing to the Levonyan family.”

“More than that, I did contact some friends I have in Customs – guys I served with in the NIS – who tell me that two days after the fire Levon Levonyan left LAX for Rome. There is no record that he has returned.”

“They didn’t get a surveillance tape picture of him, did they?”



“You know, I forgot that they told me, they photograph each person leaving and entering the country. There must be a photo.”

“Can you get it?”

“I think I can.”

“Please, contact your friends. I would bet he has bandages on his hand and face or some evidence that he was injured.”

“I’m just a poor civil servant. I can’t afford to take a sucker bet like that.”

“The information will help Sam Hazan when he continues the examination under oath.”

“Anything else I can do to help you?”

“I’m sure there is but I can’t think of anything right now. I’ll study the file materials you are providing to me and

get back to you.”

“Don’t let them get away with this crime, Bill.”

“Campy, I’ll try my best. I have some information which will help the Underwriters and Imperial work to avoid paying Levonyan’s claim. If the Underwriters and Imperial stick to their guns, they are facing hundreds of thousands of dollars in investigation and lawyers’ fees. Even the most aggressive lose some of their backbone when they pay out \$100,000 to a lawyer.”

“Keep their backbones stiff and I’ll get you all the evidence you need.”

“I could use your help, Campy, with a witness.”

“How?”

“Remember I told you Nathan Krooner, the auctioneer, wrote an appraisal the Underwriters relied upon.”

“Yeah, I remember. Wasn’t he convicted of receiving stolen property?”

“That’s the man.”

“What can I do to him. He didn’t light the fire, did he?”

“No. I don’t think he did anything except take \$500 for blank appraisal papers.”

“Blank appraisals?”

“Yes, Levonyan told him that his son was an ‘A’ student in typing and that he would type up Krooner’s notes and save the expense of a professional typist.”

“He might as well have handed the man a signed, blank check.”

“He did. When I met Krooner, he thought I was a cop. He didn’t read my private investigator’s license. He gave me information I can’t use openly.”

“Do you think he will give me more?”

“Yes. If you show him a real badge. Tell him he is under investigation as an accessory to an arson-for-profit or insurance fraud (which carries the same penalty as if he did the crime himself) he will do anything you ask to avoid jail. I need a signed, and sworn statement from him that tells the truth about the appraisal.”

“I can do that.”

“Great, just remember – so we can use it in civil court – have him sign his name above the words: ‘I declare under penalty of perjury according to the laws of the state of California, that the forgoing is true and correct.’ He does that and I will take it to MOM and Sam Hazan with recommendations that they deny the claim and fight any suit filed all the way to the California Supreme Court.”

“I’m ready and authorized to work with you to perfect this investigation.”



E-Books from Barry Zalma

[E-Books from Barry Zalma](#)

Do you have a book reader like the Kindle, the Nook from Barnes and Noble, the Sony Reader, an IPAD or any computer that can read Adobe pdf files? If you do, you can read any of Barry Zalma’s e-books.

The e-books available include: *Zalma on Insurance*, *Zalma on Rescission of Insurance In California*, *Zalma on Diminution of Value Damages*, *Arson for Profit*, *Insurance Fraud, Cases and Materials on Coverage*, *California Claims Regulations*, *The Truth, The Whole Truth & Nothing But the Truth – II*, *Murder & Insurance Fraud Don’t Mix* and *Heads I Win, Tails You Lose*, at [Zalma Books](#).



[Zalma on Insurance](#)



Every lawyer retained to prosecute or defend a civil suit should begin the representation with efforts to find insurance coverage for the benefit of the client. Indeed, a lawyer that does not know the law of insurance is litigating with duct tape firmly placed across his or her mouth.

Every civil lawyer should understand that a major part of the law firm’s income comes, directly or indirectly, from insurance. Since insurance is an important source of funds for success of a civil law practice it is imperative that every lawyer have a basic understanding of the law of insurance. Similarly, prosecutors or criminal defense lawyers dealing with the crime of insurance fraud must understand the law of insurance to properly represent the state or the defendant. Indeed,

the lawyer who is ignorant of the law of insurance cannot adequately serve his or her clients.

The E-book was designed to provide the law student, the practicing lawyer, the insurance lawyer, and insurance professionals with a complete survey of property and casualty insurance with the full text of insurance-related decisions of the United States Supreme Court, the US District Courts of Appeal, state appellate courts, and foreign courts that have molded the law that governs insurance transactions in the United States. It is updated daily by the blog, [Zalma on Insurance](#).



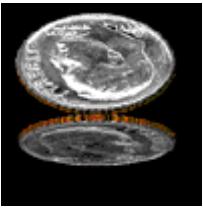
Those who are new to the subject of insurance will find this book a resource and a starting point for research. It can also be used as a basic training course for those who are just beginning the practice of insurance law or the claims business; for those representing insurers, those representing those who are insured; or for those litigating against insurers the book can be used in conjunction with, or as a supplement to, the author's books *Insurance Claims: A Comprehensive Guide*; *Mold: A Comprehensive Claims Guide*, *Construction Defects: Litigation and Claims* available from [Specialty Technical Publishers of Vancouver, BC](#), Canada and other e-books described below.

The E-book, in more than 1100 pages, begins with a history of insurance starting with a 1776 decision of the British House of Lords that established the existence of the implied covenant of good faith and fair dealing and pushing through to issues relating to interpretation of insurance contracts, remedies available to insurers and the policyholder, and the litigation of issues with the full text of definitive cases and analysis by Mr. Zalma, an internationally recognized insurance coverage, insurance claims handling, insurance fraud and insurance bad faith expert and consultant. It also has appendices including the full text of the California Standard Fire Insurance Policy, a glossary of insurance terms, and some insurance fraud statutes from across the country.

["Murder & Insurance Fraud Don't Mix"](#)

A new Novella from Barry Zalma involving an insurance fraud that goes terribly wrong when the perpetrator finds it necessary to murder the only possible witness to the crime. Follow the actions of MOM, the insurance company investigator who discovers the fraud and helps the police bring the killer to justice. Now available at <http://www.zalma.com/zalmabooks.htm> for only \$5.00.

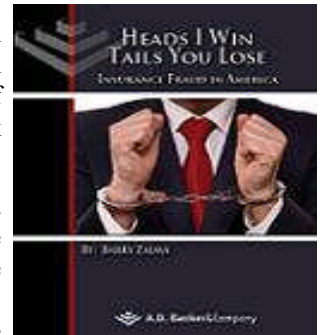
[Updated – "Heads I Win, Tails You Lose – 2011"](#)



This book started as a collection of columns I wrote and published in the magazines "Insurance Journal," "Insurance Week," and "The John Cooke Insurance Fraud Report" insurance trade publications serving the insurance community in the United States. Since the last edition I have added more stories that were published in my twice monthly newsletter, Zalma's Insurance Fraud Letter which is available free to anyone who clicks the link.

The title, "Heads I Win, Tails You Lose" is meant to describe insurance fraud as it works in the United States. It means that whenever a person succeeds in perpetrating an insurance fraud everyone who buys insurance is the loser. If the fraud succeeds the insurer must charge more premium to cover the expense of defending the fraud and payment of funds to the fraud perpetrator. If the fraud fails the insurer must charge more premium to cover the expense of defending the fraud. Everyone, except the lawyers, lose.

Heads I Win, Tails You Lose-2011 is available for only \$24.99."Zalma on Rescission of Insurance in California" Barry Zalma has produced the only detailed resource on the remedy of rescission of insurance in California. In 832 pages Mr. Zalma provides the full text of almost every decision of the California courts of appeal and the federal courts that deal with rescission of California insurance policies. It is published as an e-book in Adobe Acrobat pdf format.



Rescission is an equitable remedy as ancient as the common law of Britain. When an insurer or the insured discovers the existence of a factual basis for rescission they have the opportunity, but not the duty, to exercise the remedy of rescission. In California the remedy is available to both parties to the contract of insurance whether the party deceived believes the deceit was the result of a fraud or an innocent misrepresentation of a material fact. To do otherwise would be to make a gift to the person who deceived the insurer of rights not available to the truthful.

["Zalma on California Claims Regulations - 2011"](#)



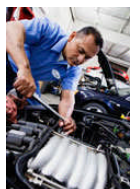
Every person who deals with claims in California must be trained annually after September 1, 2011 on fulfilling the Fair Claims Settlement Practices Regulations. Failure to train all personnel may cause insurers to face excessive fines from the California Department of Insurance.

The E-Book is available for only \$25 at <http://www.zalma.com/REGS.htm>. Every insurer doing business in California must prove to the California Department of Insurance that all personnel (whether employed or independent) have been trained to understand their obligations under California law.

["Zalma On Diminution of Value Damages"](#)

In this new 663 page E-Book you will find explanations of how diminution in value is handled across the country with cases (including the full text of many) from each of the fifty states, Guam, the District of Columbia and all federal courts.

Since 2001 when the Georgia Supreme Court decided *State Farm Mutual Automobile Insurance Co. v. Mabry*, 274 Ga. 498, 556



S.E.2d 114 (Ga. 11/28/2001) every person insured with a policy of insurance that promised to pay only the cost to repair or replace the property with material of like kind and quality, appraisers, adjusters, and lawyers. The book is a necessity for every person who is required to deal with property damage as an adjuster, appraiser, investigator or lawyer.

[Insurance Fraud Novel "Arson For Profit"](#)



From Barry Zalma an E-Book novel.

The book explains how an insurers refusal to pay a fraud took the profit out of an attempted arson for profit. Published as an e-book it is available for only \$5.00 at Zalma on Insurance.

Details available from the author at zalma@zalma.com.

Details on the other e-books are available at <http://www.zalma.com/zalmabooks.htm>.

WISDOM

"Socialism in general has a record of failure so blatant that only an intellectual could ignore or evade it." - **Thomas Sowell**

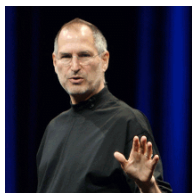
"Some cause happiness wherever they go; others, whenever they go." - **Oscar Wilde**

"Education is a progressive discovery of our own ignorance." - **Will Durant**

"If you attack the establishment long enough and hard enough, they will make you a member of it." - **Art Buchwald**

"Friends may come and go, but enemies accumulate." - **Thomas Jones**

"If the government gets into business on any large scale, we soon find that the beneficiaries attempt to play a large part in the control. While in theory it is to serve the public, in practice it will be very largely serving private interests." - **President Calvin Coolidge**



"Man is worthy of being called Man only if he's charitable." - **Yalkut Reuvaini**

"Simple can be harder than complex. You have to work hard to get your thinking clean to make it simple. But it's worth it in the end because once you get there, you can move mountains." - **Steve Jobs**

"What would life be if we had no courage to attempt anything?" - **Vincent van Gogh**



Good News



<http://www.InsuranceFraud.org>

* **A father-son team ran crooked pain-management clinics and a voracious pharmacy** that illegally dolled out millions of dollars worth of addictive pain pills in the Tampa area. The busts are among the biggest such busts ever in Tampa, officials say. The lead pharmacy, VIP, dispensed more oxycodone than any other pharmacy in America. VIP bought more than 1.5 million doses from wholesalers in 2009 — more than 13 times Florida's average and more than 20 times the national average. VIP sold nearly 2.7 million oxycodone pills in a 17-month span at \$2-\$7 a pop. Witnesses saw wads of cash bundled with rubber bands in shoe boxes, and technicians fabricating prescriptions and patient profiles. One witness saw a U-Haul box truck pull up to an affiliated pain clinic and spill out people from Ohio. The pain clinics sold or bartered blank prescription pads — forging them with names, signatures and DEA registration numbers of docs. Ringleaders Louis Fernandez Jr. and son Louis III pleaded guilty Wednesday. They face up to 20 years in federal prison when sentenced.



* **Larry Duran has created a new business model for fraud: Bring Congress in on the act.** The Miami man masterminded one of the largest Medicare cons in U.S. history. He submitted 866,000 dirty claims worth more than \$205 million for worthless mental-health treatment. He hauled in \$87 million. Duran bribed halfway homes, assisted-living centers and others up to \$400,000 a month to funnel patients to his clinics. Doctors frequently faked records or signed off on charts without seeing any patients. Patients often suffered from Alzheimer's, dementia or other conditions unsuited for therapy. They were often left to urinate or defecate on themselves while waiting for treatment that never came. Duran kept his con going by lavishly lobbying Capitol Hill. Flush with stolen Medicare loot, he set up an advocacy group called the National Association for Behavioral Health to front for him in Washington. Its goal was to convince Congress to allocate more money to Duran and make it easier for his clinics to operate. His front group spent more than \$750,000, holding fundraisers for legislators, staging "fly-ins" on Capitol Hill and advising group members how to get around Medicare denials. But all that elbow rubbing in Washington couldn't keep law enforcement



from knocking on his door. Duran said he pleaded guilty because he feels remorseful. The court appeared unswayed. Duran will have to feel remorseful in a federal prison cell for a long time; he received a cool 50 years.

* **Robert Wood skied down a slippery slope to a fraud conviction.** The Washington State man filed a comp claim for a lower-back injury he claimed he suffered while doing masonry work. Wood began receiving time-loss benefits, but was caught working as a ski instructor who zoomed down expert and advanced slopes. He also worked as a sales consultant, and as a deckhand on an Alaskan fishing boat. No word on sentence.

* **The taxpayer health program for the poor made Debora D’Anna rich.** She was CEO of a Detroit-area clinic before it shut its doors. But D’Anna kept the clinic’s state Medicaid patient list and medical IDs of two docs who’d worked there. She then made thousands of Medicaid claims on her own, as if the clinic still was in business. D’Anna hauled in \$3.3 million. She used the loot to buy a luxurious home in Florida, undeveloped land, a Mercedes sedan, Cadillac Escalade, jewelry and other goodies. She was busted when one of the documents noticed the Medicaid billings made with his ID. D’Anna faces up to 20 years in prison when sentenced October 27.

* **Knucklehead of the Week: Trying to fake his death for insurance payola,** UK agent Anthony McErlean impersonated his wife and claimed he was run down by a cabbage truck in Honduras. Except for one problem: McErlean’s fingerprints were on his own death certificate. The court wasn’t amused, and slapped him with six years in prison.

* **A Philadelphia body-shop owner masterminded a staged-crash ring that stole \$300,000** from auto insurers. Phillip Sessa’s workers at Philly Collision vandalized or damaged vehicles that were parked on city streets or stored at the shop. The shop then submitted bogus repair claims. The gang also staged crashes and had cronies hand over cars. The drivers then reported them as stolen. Sessa also had corrupt public adjusters produce false or inflated damage estimates. Sessa’s 12-person organization made at least 22 claims worth more than \$300,000, officials say. He and his gang used the money to pay gambling debts and car loans. Investigators had a sense of humor, dubbing the two-year probe “Operation Little Body Shop of Horrors.” Sessa pleaded guilty this week. He could serve up to 62 years in prison when sentenced.

* **An irate client blew the whistle on a young Colorado agent who stole more than \$50,000 in premiums** without buying his clients their promised coverage. Hartland Clubb wanted to help agent Joshua Amelang start up his new career, and stayed a customer when Amelang bought an established agency. But Clubb found he didn’t have a policy with his insurer despite paying the Grand Junction man the premiums. Amelang had no explanation when Clubb confronted him. Clubb knew other clients had similar problems with Amelang, so he went to the authorities. Amelang even scammed Pete Tarr, the agent from whom he’d bought the business. Tarr’s home, farm and all of his autos were insured through Escalante Insurance, but every time he asked Amelang for copies of his policies he kept getting excuses. Amelang received 10 years of supervised probation Monday.

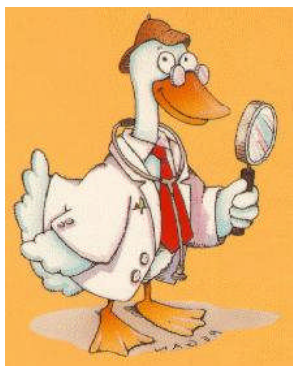


* **Leading a ring that dolled out addictive painkillers has earned Tony Navarro 11 years in Connecticut state prison.** Navarro somehow got ahold of the security paper that doctors use for writing prescriptions. The Hartford-area man began writing prescriptions using computers and printers. People paid Navarro \$150 for fake prescriptions, and had to give him half of the pills they obtained. When police raided his home, they found a large number of computers, printers, material for faking prescriptions, and a large quantity of oxycodone.

* **Fraud News Weekly normally covers U.S. cases, but a fatal arson disaster in Toronto** begs for attention: John Magno burned down his building supply store on Christmas Day for \$3.5 million (Canadian) in insurance money 10 years ago. But the scheme went fatally awry. The fire exploded, sending residents fleeing from their nearby homes. More than 170 firefighters and dozens of trucks toiled to control the fire. About 50 families spent Christmas Day huddling inside buses for temporary shelter. The blast caused millions of dollars of damage to adjacent buildings. Arsonist Tony Jarcevic’s burned body lay in the basement for weeks before workers found him. Co-arsonist John Paskalis suffered severe burns over most of his body and spent months in a coma before receiving a seven-year jail sentence. Magno is the last member of the conspiracy to face justice, receiving 12 years in jail last Friday.

Health Insurance Fraud Convictions

33 Months For Medicare Fraud



Bassey Monday Idiong, 32, of Humble, Texas, the owner and operator of a Houston durable medical equipment (DME) company was sentenced October 12, 2011 in Houston federal court to 33 months in prison for his role in a Medicare fraud scheme, announced the Department of Justice. Idiong was sentenced by U.S. District Judge Vanessa D. Gilmore. In addition to his prison term, Idiong was sentenced to two years of supervised release and was ordered to pay \$527,023 in restitution.

Idiong pleaded guilty on March 1, 2010, to one count of conspiracy to commit health care fraud and five counts of health care fraud. Idiong owned and operated **B.I. Medical Supply LLC**.

According to court documents, Idiong paid patient recruiters kickbacks in exchange for the names of beneficiaries for whom bills could be submitted to Medicare. B.I. Medical billed Medicare for expensive, rigid orthotics and braces that were packaged together and referred to as an “arthritis kit,” at a cost of approximately \$4,000 per kit. B.I. Medical then supplied the beneficiaries with different, less expensive products that were not medically necessary. Court documents indicate that in one instance, B.I. Medical billed Medicare for an arthritis kit that

included two knee braces for a beneficiary who had only one leg. In total, B.I. Medical submitted approximately \$846,000 in fraudulent claims to Medicare.

Pill Mills in Florida Result in Multiple Convictions

Jeff George ran lucrative prescription drug mills. **Theodore Obermeyer's** ordered doctors to "Keep the patients happy." The favored amounts - 180-240 oxycodone per month - would keep customers from deserting them for competing pill mills that offered more generous supplies of the powerful painkillers, federal prosecutors on Wednesday said Obermeyer told physicians.



If the doctors, often recruited on Craigslist, were stingy, Obermeyer would badger them to prescribe more. Faced with stacks of evidence of the key role he played in the illicit operation, the 30-year-old West Palm Beach man pleaded guilty in federal court to one count of racketeering conspiracy. George, who tapped him to manage clinics in West Palm Beach and Hallandale, pleaded guilty to the same charge last week. In return, prosecutors dropped three other felonies against them.

George and Obermeyer also face charges in state court in connection with the multi-million-dollar operation that prosecutors said is linked to more than 50 deaths. George pleaded guilty in August and Obermeyer will soon plead guilty to state charges according to his attorney.

However, unlike George, who pleaded guilty to second-degree murder in state court, Obermeyer faces multiple drug trafficking charges. While the charges carry a maximum 200 years in prison, he is expected to get far less. Obermeyer faces 20 years in prison and \$250,000 fine when he is sentenced on the federal charge January 6.

According to a deal George made with prosecutors, he will serve less than 20 years in prison on both the state murder and federal racketeering charges. While 16 of the 32 people arrested in August as part of "Operation Oxy Alley" have accepted plea deals. Two doctors, who are among 14 physicians charged in the operation, joined Obermeyer in federal court Wednesday.

Dr. Jacobo Dreszer, 70, of Aventura, pleaded guilty to conspiracy to commit wire fraud. He worked at **American Pain**, which had clinics on Dixie Highway in Lake Worth and Federal Highway in Boca Raton. In addition to prescribing large doses of oxycodone without medical justification, he lied on documents to pharmaceutical suppliers to keep the drugs flowing, prosecutors said. He faces five years in prison and a \$250,000 fine when he is sentenced Jan. 6.

Dr. Robert Meek, 36, pleaded guilty to conspiracy to commit money laundering. Meek, of Davie, worked at **Executive Pain**, prescribing a "predetermined cocktail" of drugs, including oxycodone, the anti-anxiety drug Xanax and the muscle relaxant Soma to patients at the clinic on Okeechobee Boulevard in West Palm Beach. He faces a maximum 10 years in prison and a \$250,000 fine when he is sentenced Jan. 6.

Dr. To Serve One Year and 3 Months for Treating Dead Patients



Dr. Robert Williams, 77, an Atlanta doctor who admitted filing more than \$2 million in bogus Medicare and Medicaid claims, asserting he treated patients who turned out to be dead and others he never saw, was sentenced October 12, 2011 to 1 year and 3 months in federal prison.

Williams also was ordered to serve three years' supervised release and to pay nearly \$1 million in restitution – \$771,596 to Medicare, and \$227,846 to Georgia Medicaid, according to a news release from the U.S. Attorney's Office. Williams pleaded guilty June 6 to federal health care fraud charges.

From about July 2007 through October 2009, the doctor contracted with a medical services company to provide group psychological therapy to elderly nursing home patients in the Atlanta area, authorities said. During that time, more than 55,000 claims were submitted to Medicare using Williams' provider number. Williams sought more than \$2 million in reimbursement, and Medicare ultimately paid him more than \$750,000. At the same time, more than 40,000 Medicaid claims using Williams' provider number caused Georgia Medicaid to pay out more than \$225,000.

An investigation by the FBI, Georgia Medicaid Fraud Control Unit and the Inspector General's Office of the Georgia Department of Community Health showed, however, that in many cases the patients were dead, or were hospitalized at the time of service and therefore could not have received care at a nursing home, as Williams had claimed.

Feds Collect \$995,000 In Civil Damages from New York Doctor and Hospitals

On October 5, 2011, Manhattan U.S. Attorney Preet Bharara announced the simultaneous filing of a Complaint and a settlement of the charges in a civil health care fraud lawsuit against the **Trustees Of Columbia University** ("Columbia"), **New York Presbyterian Hospital** ("Presbyterian Hospital"), and **Dr. Erik Goluboff** ("Dr. Goluboff").

Dr. Goluboff is a urologic oncologist, former Director of Urology at the Allen Pavilion of the New York Presbyterian Hospital, and former Associate Professor of Clinical Urology at the College of Physicians and Surgeons of Columbia University. The Complaint alleged that between 2003 and 2009, Dr. Goluboff violated Medicare regulations by conducting medically unnecessary diagnostic tests and then seeking improper and excessive reimbursement amounts from Medicare. Moreover, Dr. Goluboff was charged with submitting bills for a number of daily procedures that the Complaint alleges he was physically unable to achieve.



The Complaint did not solely single out Dr. Goluboff but further alleged that rather than having been unwitting participants in this scheme, Columbia and Presbyterian Hospital were aware of his fraudulent practices, failed to stop those practices, and caused his claims to be submitted to Medicare. Pointedly, an internal Columbia memo characterized Dr. Goluboff's conduct as "alarming compliance issues." Despite having known or at least having been on notice of these alarming issues, it does not appear that substantive steps were taken by the hospitals to shut down any of the cited fraudulent practices. Consequently, it is alleged that Columbia and Presbyterian Hospital benefitted financially from the fraud.

The settlement, approved by the federal court on October 4th, required Columbia to pay \$995,000 in civil damages under the False Claims Act

Medicaid Fraud to Buy a Mercedes Results in Guilty Plea



Joye Strong, a Charlotte, NC woman pleaded guilty to defrauding Medicaid through her company in order to purchase a Mercedes. U.S. Attorney Anne Tompkins announced that 43-year-old Strong faces a maximum of 10 years in prison and fines of up to \$250,000 per count in the case. In total, she was charged with eight counts of health care fraud and two counts of money laundering.

Strong's company, **Advocating for America**, provided mental and behavioral health services in the Charlotte area. For about five months in 2009, Strong fraudulently billed Medicaid for services the company never performed. Prosecutors say the claims resulted in \$83,000 worth of fraudulent payments, which Strong used to buy a Mercedes and make a large cash withdrawal from the company.

Guilty of 25 Counts of Medicaid Fraud

Deborah D'Anna, 57, of Ocala, Florida, the former medical director of **Palmer Health Center** in Detroit, Michigan was found guilty in Ingham County Circuit Court of 25 counts of Medicaid fraud and one count of racketeering for her role in a Medicaid fraud scheme.

Deborah D'Anna, 57, of Ocala, Fla., submitted thousands of fraudulent Medicaid claims and collected more than \$3.3 million of taxpayer dollars to finance a lavish lifestyle in Florida.

Court documents showed that D'Anna used her access to Palmer Health Center records to bill Michigan Medicaid for millions in services never actually rendered by its clinics in Detroit and Romulus, which had closed 2005. Until 2005, Palmer Health Center had been a legitimate medical clinic that employed doctors to provide services to Medicaid beneficiaries, including children in the Wayne County juvenile system. But D'Anna, who had been Palmer's CEO, continued to bill Medicaid on her own.



In 2006, after the clinic had shut its doors, D'Anna maintained the list of provider identification numbers — or PINs — for two doctors who had been employed at the clinic and a list of Medicaid beneficiaries that the clinic had formerly treated. The PIN numbers and beneficiary list allowed D'Anna to continue to submit fraudulent Medicaid claims on behalf of Palmer Health Center as if the clinic were still open.

In Ocala, D'Anna used the stolen money to buy a luxurious home with cash, undeveloped land, a Cadillac Escalade, a Mercedes sedan, as well as jewelry and other merchandise. The scheme was unearthed when one of the physicians previously employed by Palmer Health Center reported Medicaid billings being submitted under his PIN for services he did not provide.

D'Anna is expected to be sentenced October 27. She could receive a maximum sentence of 20 years.

Pharmacist to Spend 51 Months in Federal Prison



John Love, a former Terre Haute, Indiana pharmacist was sentenced to more than four years in federal prison for his role in an Indiana Medicaid fraud investigation. Love pleaded guilty in March to filing false claims for prescriptions that were never given to patients. In October Love told Judge William Lawrence that he wants to make restitution for the \$3.5 million he used to purchase property, vehicles and for personal expenses.

Love admitted to defrauding the government from 2006 through September 2010 when state and federal investigators seized records at the **Terre Haute Prescription Shop** on South Seventh Street as part of their investigation. Judge Lawrence sentenced Love to 51 months in prison, followed by 3 years of supervised probation, and ordered him to repay the \$3.5 million. Love has forfeited property, vehicles and other assets to the government to pay back a portion of the funds taken.

133 Months in Prison for \$4 million Medicare Fraud

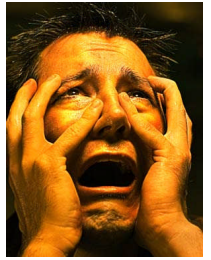
Alfredo Rasco, 52, of Pembroke Pines, Florida, was sentenced to almost 11 years in federal prison for his role in a scheme to defraud Medicare of more than \$4 million through a Broughton Street clinic.

Rasco must serve 133 months in prison followed by three years on supervised release and faces deportation for the period of supervised release, U.S. District Judge William T. Moore Jr. ruled in October. Rasco must report by 2 p.m. on October 28 to a prison facility to be designated by the U.S. Bureau of Prisons for his custody.

Also sentenced to three years on probation was his wife, **Niurka Rasco**, 50. As part of their sentences, the Rascos must forfeit \$1.3 million and

the 42-foot yacht “Thank You, God,” seized by investigators in the case.

Alfredo Rasco pleaded guilty August 30, 2010, to charges of conspiracy to commit health care fraud and aggravated identity theft by unlawfully using a doctor’s identification in April 2006. His wife pleaded guilty to a lesser charge, a misdemeanor that she filed document claiming to be owner-operator of United Medical which her husband owned.



Prosecutors said Rasco received some \$4 million in Medicare payments, pocketing \$2.5 million, for services that were not provided as billed, not medically necessary and not entitled to reimbursement by Medicare. The indictment charged he billed Medicare \$5.6 million in fraudulent claims for therapy not provided between September 2005 and April 2008.

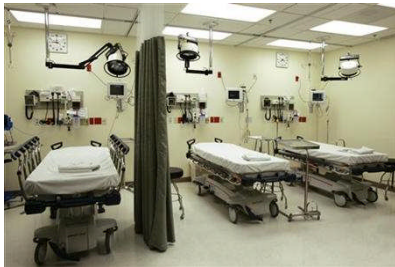
Two Guilty of Medicaid Fraud

Mustafa Mussa and **Stephen Rondestvedt** both pled guilty to stealing hundreds of thousands of dollars from Medicaid through a scheme where they billed the government for care that was never provided. Federal prosecutors say so far, they have recovered more than \$700,000.

Mussa faces a mandatory two-year prison term, while Rondestvedt -- a former lawyer who was previously imprisoned for stealing from his clients -- could face up to 10 years.

New York Downtown Hospital agreed to pay \$13.4 million to settle Medicaid fraud and kickback charges, reports the New York Post yesterday. Downtown Hospital allegedly paid healthcare firm and co-defendant Special Care Hospital Management for referrals and then admitted the same patients multiple times to its unlicensed inpatient detox program. The hospital submitted more than 2,000 Medicaid claims worth more than \$9.15 million, according to the article.

Hospital Agrees to pay \$13 Million



Downtown Hospital, in New York, knowingly submitted false and fraudulent claims to Medicaid from 2002 to 2006. Amy Held, special assistant for the state Attorney General medical fraud control unit, said in the 2008 complaint. It also allegedly paid a monthly fee of \$38,500 to Special Care for patient referrals, violating anti-kickback laws.

The United States and the state of New York have reached agreements in principle to settle these actions as to defendants **Special Care Hospital Management Corp.**, Robert McNutt [its CEO] and **New York Downtown Hospital**, according to Richard Hayes, assistant U.S. attorney for the Eastern District.

Downtown Hospital knowingly submitted false and fraudulent claims to Medicaid from 2002 to 2006, Amy Held, special assistant for the state Attorney General medical fraud control unit, said in the 2008 complaint, reports the Post. It also allegedly paid a monthly fee of \$38,500 to Special Care for patient referrals, violating anti-kickback laws.

Last month, the Centers for Medicare & Medicaid Services (CMS) issued a Medicaid final rule, in which it would specifically target Medicaid fraud, waste, and abuse with the goals of saving an estimated \$2.1 billion over the next five years.

Other Convictions

14 Years + and 6 Years Respectively for Arson for Profit and Manslaughter

Victor Barriere and **Olga Barriere**, a Long Beach California couple were sentenced to state prison on October 12, 2011 for the death of a handy man they paid to burn down their Long Beach home.

The couple initially faced a charge of murder in a special circumstance case that could have qualified for a death penalty prosecution, said Defense Attorney Jay Glaser. The evidence, however, showed the couple never intended for Thomas Trucios to become hurt, let alone die. Victor pleaded no contest August 31, to a charge of involuntary manslaughter and conspiracy to commit arson and conspiracy to commit insurance fraud.



As part of the negotiated plea deal, the 52-year-old was sentenced Tuesday to 14 years and four months in state prison. Olga was sentenced to six years. However, under the new sentencing guidelines for non-violent offenders her term will be served at the Los Angeles County Jail, the judge noted.

In addition to the criminal charge a civil case has been brought against the Barriere's in Trucios' death. The couple were charged with the deadly July 3, 2007, arson that killed Trucios and destroyed their house, located at 1090 Martin Luther King Jr. Ave.

Trucios died after he was engulfed in a fireball that erupted in the 600-square-foot house after Trucios used vast amounts of gasoline to spark the fire. So much fuel was used fumes built up to dangerous levels and when the explosion occurred residents for several blocks were jolted awake. The force of the blast left massive cracks in the sidewalks, the walls of the home and shattered all of the property's windows, investigators said.

Trucios suffered third-degree burns to more than 95 percent of his body. He died that day at USC Medical Center. Trucios was hired to burn the house down after the defendants realized they were unable to keep up with a \$315,000 mortgage on a home crippled with code violations, said Arson Detective Dennis Zigrang.

Jail for Workers' Compensation Fraud



Clifford K. Franklin of Village Mills, Texas to 180 days in jail based on workers' compensation fraud charges relating to \$1,453 in benefits he fraudulently received, according to Texas Mutual Insurance Company.

Franklin reported a job-related injury while working as an equipment operator for Odin Demolition and Asset Recovery, Inc. in Deer Park, Texas. He claimed he was unable to work as a result of the injury and received income benefits from Texas Mutual. Texas Mutual uncovered evidence that Franklin was working as an equipment operator for another employer while receiving income benefits.

Texas law requires claimants to contact their workers' compensation carrier when they return to work.

Jail for \$26,000 Theft from Dentist & His Patients

Summer Salm, 34, of Franklin, Ohio, who embezzled \$26,500 from a West Chester Twp. dental office will spend the next 15 months in prison.

Salm was sentenced by Butler County Common Pleas Judge Michael Sage in October after pleading guilty to two counts of theft by deception in August. Salm worked for Dr. Joel Koch in his dental offices as a billing clerk. When people paid their co-pays, Salm would enter the amount in the computer, give the patient a receipt and then erase the payment and pocket the cash.

The second prong to her "elaborate scam" was to bill her insurance for false medical claims for family members and then retain the 80 percent insurance payment.

Insurance Agent Pleads Guilty to Fraud

Guilty of Selling Fake Policies.

Christopher Purser, a Houston man pleaded guilty to a charge related to selling fraudulent insurance policies, including one to a company that owned a tour boat which capsized in a New York lake in 2005, killing 20 tourists. Federal officials reported that Purser pleaded guilty in Houston federal court to a charge of conspiracy to commit wire fraud.

Unsuspecting businesses around the U.S. paid millions of dollars in premiums for liability coverage, only to discover the policies were fake. The national scheme began in 2000 when Purser sold fake liability insurance policies to nursing homes, supposedly underwritten by Maryland Casualty Company. Purser also sold worthless policies to apartment complexes and condo associations through a "benefit association" in Belize called **International Property Owners Association**. The Texas insurance department finally booted Purser out of the insurance business, but he kept selling fake insurance to apartments, condos, bars and restaurants. He laundered the stolen premiums through bank accounts in the Bahamas, Canada, Hong Kong, Liechtenstein, Nicaragua, and St. Kitts and Nevis.

Authorities say Purser sold fraudulent policies from 2004 to 2006 in Texas and across the U.S. One of the policies he sold was to Shoreline Cruises Inc., which operated the Ethan Allen, a boat that tipped over on Lake George in northern New York in October 2005. Officials say none of the claims made against the policy could be paid. Purser faces up to 20 years in prison when sentenced Jan. 19.



Edmund Hugh Benton, 63, of Scottsdale, Ariz., pleaded guilty to the federal felony offense of conspiracy to launder money before U.S. District Judge Sim Lake in Houston. Benton's Oct. 7 plea followed a similar one in the case two days earlier by Houstonian Christopher Purser.



Benton admitted to conspiring to launder the proceeds of a fraud scheme that sold fake liability insurance policies to a "benefit association" operated from Texas called Global Property Owners Association Inc. (GPOA), the U.S. Attorney's Office for the Southern District of Texas said. Benton obtained liability insurance for GPOA members in 2003 from Heritage Mutual Surety Limited (Heritage), a company in the Caribbean island of St. Vincent. Heritage was controlled by a fugitive in Barbados through another St. Vincent entity called **Tri-Continental Exchange Ltd.**

Benton admitted knowing that GPOA was not licensed or authorized to sell insurance in Texas, that Heritage did not have the ability to pay claims, that Tri-Continental Exchange Ltd. was subject to cease and desist orders from insurance regulators and that the fugitive, "Robert Lewis Brown," was not using his real name. Benton also acknowledged receiving proceeds of the fraud in an account

he maintained in the Bahamas.

Benton faces a maximum of 10 years in federal prison without parole to be followed by a maximum three years of supervised release, a fine of up to \$250,000 and an order to pay full restitution to victims.

Guilty of Receiving Stolen Property as Part of Insurance Fraud Scheme

Reginald E. Lee, Jr., 38, of Elizabeth, New Jersey pleaded guilty October 3 to second-degree receiving stolen property before Superior Court Judge Paul M. DePascale in Hudson County. Lee was charged in a June 3, 2011 state grand jury indictment. Judge DePascale scheduled Lee's sentencing for November 10. Under the plea agreement, the state will recommend that Lee be sentenced to five years in state prison.

In pleading guilty, Lee admitted that between Aug. 15, 2006 and Oct. 16, 2006, he was in possession of stolen vehicles valued at a total of approximately \$243,645, knowing that the vehicles had been or believed to have been stolen. The stolen vehicles included: a 2001 Honda Accord; a 2006 Kawasaki ZX636 motorcycle; a 2003 Dodge Ram 50; a 1998 Land Rover Discovery; a 2003 Ford Econoline Conversion Van; a 1998 Toyota 4Runner; a 2004 Ford Econoline Conversion Van; a 1999 Mercedes Benz E430; a 2002 Subaru WRX; a 2005 Infiniti FX35; a 2006 Dodge Charger; a 2004 Chrysler Pacifica; a 2004 BMW M5; a 2004 Ford Explorer; and a 2006 Audi A3.



Also **A'Jon D. Rogers**, 26, of East Orange, pleaded guilty to third-degree receiving stolen property. The charge was contained in a separate June 3, 2011 state grand jury indictment. In pleading guilty, Rogers admitted that on Nov. 1, 2006, he was in possession of an Infiniti FX 35, knowing that it had been stolen. Judge DePascale scheduled Rogers' sentencing for Nov. 10. Under the plea agreement, the state will recommend that Rogers be sentenced to three years of probation.

The charges against both defendants were the result of an undercover investigation by the Office of the Insurance Fraud Prosecutor into a stolen vehicle ring. The investigation involved detectives from the Office of the Insurance Fraud Prosecutor working in an undercover capacity to purchase stolen vehicles.

Six More Sentenced to Prison in Texas for Insurance Fraud

Idaleen Sanchez, 43, of Edinburg Texas - 12 months and one day in prison and \$48,852 in restitution

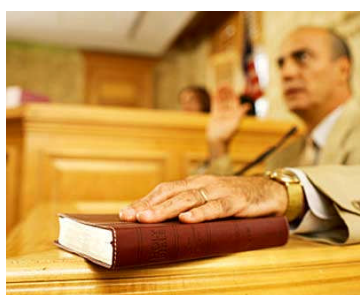
Valerio Ramos, 55, of Edinburg, Texas - 12 months and one day in prison and \$49,850 in restitution

Rigoberto Ramirez, 30, of Edinburg, Texas - 12 months and one day in prison and \$67,375 in restitution

Eddie Guerra, 35, of Alamo, Texas - eight months in prison and \$22,240 in restitution

Jose Guerra, 47, of La Joya, Texas - six months in prison and \$19,597 in restitution

Norma Sanchez, 40, of Edinburg, Texas - six months in prison and \$20,660 in restitution



The six defendants pleaded guilty in July 2011 to one count of wire fraud, admitting that they engaged in fraud as a policyholder under AFLAC's Accident-Only Insurance Plan. Specifically, from 2007 through 2009, the defendants routinely delivered lists of fake accidents and injuries to two physicians in Reynosa, Tamaulipas, Mexico. The physicians prepared an "accident report" for each fake injury in exchange for a cash kickback of approximately \$15 per accident report. In each report, the physicians falsely claimed they had provided treatment and prescribed medicine to the defendants for their purported injuries. Over time, the defendants faxed approximately 1,623 false injury claims and accident reports (purportedly certifying the fake injuries) to AFLAC in Columbus, Ga. The six defendants received various amounts of money from AFLAC totaling \$192,864.

All were allowed to continue on bond and voluntarily surrender to a Bureau of Prisons facility to be designated in the near future.

The 22 others who have pleaded guilty and are pending sentencing this fall for their roles in the scheme are: **Lucila Alcala**, 40, **Lilly Perez**, 32, **Desiree Rodriguez**, 34, **Jose D. Rodriguez**, 34, **Steven Betancourt**, 39, **Rachel Betancourt**, 42, **Maria C. Alaniz**, 39, **Patricia Cerda-Flores**, 44, **Dalia Cerda-Delgado**, 39, **Leonor Salinas**, 46, **Rebecca Castillo**, 41, **Ninfa Reyes**, 38, **Noemi Villareal**, 60, **Norma Flores**, 54, **Nora L. Palacios**, 53, **Georgina Flores**, 43, **Jessica Herrera**, 30, **Nancy Rodriguez**, 32, **Maria Cantu**, 56, **Denise Rendon**, 38, **Beatriz Carreon** 44, and **Minerva Murguia**, 43.

The investigation leading to the charges was conducted by the FBI. Assistant United States Attorney Greg Saikin is prosecuting the case.

60 & 45 Years Respectively for Life Insurance Fraud

Christian Allmendinger and **Adley H. Abdulwahab** the two principals of **A&O Resource Management** were sentenced to a combined 105 years in prison for their roles in a \$100 million scheme to defraud more than 800 investors in life insurance settlements — many of them elderly — across the United States and Canada. Allmendinger and Abdulwahab used the savings of their unsuspecting, often elderly, investors to live the high life — luxury houses, fancy cars, and even a 15-karat diamond ring, according to the prosecutors in a statement.



In September 2010, a federal grand jury returned the 18-count indictment against Allmendinger, Abdulwahab, as well as **David White**, 41, former president of A&O. Allmendinger was convicted at trial in March and Abdulwahab was convicted at trial in June. In June, White, and four others were sentenced to prison: White received 60 months; **Russell E. Mackert**, general counsel for A&O, received 188 months; **Brent Oncale**, former owner and founder of A&O, received 120 months; **Eric M. Kurz**, a wholesaler of A&O investment products, got 60 months; and **Tomme Bromseth**, an A&O sales agent, received 36 months in prison.

U.S. District Judge Robert E. Payne sentenced Allmendinger, co-founder and vice president of A&O, to 45 years in prison and sentenced Abdulwahab, part owner of A&O, to 60 years. The victims of A&O's scam were looking for a conservative investment, and they were



manipulated into believing A&O was a safe, secure, no-risk investment, according to the U.S. Attorney for the Eastern District of Virginia, in a statement. A&O "was a sham, a financial house of cards waiting to collapse."

It sold bonded life settlements by telling prospective investors of substantial returns enjoyed by previous investors, though "virtually none of A&O's investors made any money on their A&O life settlement investments because only one relatively small underlying life insurance policy matured during A&O's investment offerings according to the indictment.

Adley Abdulwahab was sentenced to 60 years in prison for his role in a \$100 million life insurance scam that claimed more than 800 victims in three dozen U.S. states and Canada. After hearing tearful testimony from several people whose life savings were stolen, a federal judge in Virginia sentenced the former Texas businessman in Richmond.

A Richmond jury in June convicted Abdulwahab on 15 counts of conspiracy, wire fraud, securities fraud and money laundering. Abdulwahab, 36, was one of the principals of companies called **A&O** that used investor funds to buy life insurance policies from individuals at less than face value. Investors were supposed to be paid

when the insured died, but **A&O's** partners spent the money on lavish lifestyles instead of safeguarding the investments and paying premiums. Policies lapsed, and investors lost their money.

Given a chance to address the court before sentencing, Abdulwahab suggested the value of insurance policies was incorrectly calculated, said prosecutors had declined to meet with him during the investigation, and blamed a co-defendant for encouraging him to join A&O.

The prosecutor, at sentencing, noted that some of the investors worked their entire lives to save \$50,000, while A&O's officers often rang up that much in credit card purchases in a month. Abdulwahab was sentenced a day after Payne sentenced A&O co-founder **Christian Allmendinger** of Houston to 45 years for his role in the scheme. Five other conspirators, including A&O co-founder **Brent Oncale** of Houston, previously pleaded guilty and received lighter sentences.

A federal financial crimes task force in Virginia coordinated the investigation. Several victims are from Virginia, and an A&O sales agent who pleaded guilty is from Richmond.

Probation Only for \$545,872.53 Insurance Fraud in Pennsylvania

Vincent A. LoCastro, a Canonsburg, Pennsylvania used car dealer in October pleaded guilty to charges in connection with his making a false insurance claim in November 2008. LoCastro was sentenced to 18 months of probation after pleading guilty to one count each of insurance fraud, theft by unlawful taking and forgery before Washington County Judge Janet Moschetta Bell. LoCastro also was fined \$500.

In October 2010, LoCastro was arrested by agents of the state attorney general's office for allegedly making a false insurance claim. He is accused of filing the false claim for a Cadillac Escalade that was involved in a crash in Pittsburgh. The vehicle was being leased by his dealership, **All Pro Auto Mall**, 108 S. Central Ave.

Payment of the claim never occurred, according to Deputy Attorney General Jerome Orie.

LoCastro will begin serving his latest sentence after he completes the 23 months of probation he is currently serving for unlawful business practices at the dealership from 2007 to 2009. LoCastro entered a guilty plea in that case in December. Also in December, LoCastro was indicted in federal court for allegedly using another person's personal information to obtain financing for nine luxury cars. He was charged with identity theft for allegedly using the name, date of birth and Social Security number of "a person known to the grand jury" to acquire loans that resulted in four banks losing thousands of dollars.

In June, LoCastro pleaded guilty and was placed on probation for 3 years. No fine was imposed, but LoCastro was ordered to pay restitution in the amount of \$545,872.53.

Courts in Pennsylvania seem kind to a serial fraud perpetrator and should place him in jail immediately if he does not pay the restitution in full. ZIFL guesses that the state of Pennsylvania will not see the restitution in due course. By committing the second crime he violated his probation for unlawful business practices and ZIFL can only wonder why he is not in jail.

Guilty of Attempting To Defraud BP Spill Fund

Gladys Douglas of Prichard, Alabama, a woman charged with submitting dozens of bogus claims for a fake catering business in the wake of the Gulf Coast oil spill last year pleaded guilty in October. The Mobile Press-Register reported that 42-year-old Douglas admitted that she submitted claims on behalf of **Smitty's Catering** that she said employed 45 people. Authorities say she made \$3,800 off of the scheme.

Authorities also charged four people that investigators said Douglas helped file fake claims with the Gulf Coast Claims Facility. All four have pleaded guilty in the case. The defendants in the case defrauded the government out of nearly \$65,000.

5 Year Nine Months for Arson-for-Profit Scheme

Niasha Marie King, a 30-year-old Reserve, Louisiana woman was sentenced to five years and nine months in prison for her role in 2007 fire at a public housing complex.



King pleaded guilty to setting her apartment in Reserve on fire to defraud her insurance company for payment on her personal property. Two men involved in the conspiracy also received federal prison sentences of 69 months and 30 months.

U.S. District Judge Carl Barbier on Thursday ordered King to serve three years of supervised release following her prison term.

35 Years in Prison for Crooked Contractor



Cecelia Slattery got to know her victims. She bought them lunch. She took them to church. She became a friend. Yet, Criminal District Court Judge Robin Pittman sentenced Cecilia Slattery to 35 years in prison for stealing more than \$200,000 from victims who paid for modular homes in New Orleans.

Wearing an orange jail jumpsuit in a New Orleans criminal courtroom in October the 61-year-old businesswoman begged for mercy. She received none. The sentence, in the form of seven consecutive five-year sentences, for bilking numerous victims in a post-Katrina modular home scam.

Slattery had agreed to a plea deal that would have kept her out of prison altogether, had she repaid the more than \$200,000 she stole from at least 10 victims who dropped down payments or paid in full for new homes. But when it came time to pay up at an August hearing, Slattery failed to show. Reached by phone from the courtroom, where several of her victims sat, Slattery claimed she was at a local bank, waiting for a wire transfer. The next day, she ditched court again. Then, she disappeared.

Slattery's promise of restitution, followed by skipping town, didn't help her request for mercy. Authorities grabbed Slattery in Florida. She was extradited to New Orleans and jailed on Sept. 29.

Slattery, who had assumed control of a company called **New Era Homes**, filed articles of incorporation under **JCV Homes** in 2008. The state revoked that residential license in May for failure to obtain insurance. Slattery has committed similar crimes elsewhere. The criminal case owed largely to Nikki Peterson, a former business associate of Slattery's who sniffed out her crimes and rallied victims. Yvonne Netters, 75, said Slattery went to communion with her and took her out for a lobster lunch as Netters wrote her a \$50,000 check for pilings, permits and other work on the property the widow had hoped to reclaim last year in eastern New Orleans. She ended up with a new pile of dirt on the property and nothing more, she said. Her calls to Slattery went unanswered. "She befriended me, hoodwinked me, bamboozled me," Netters said. "I had so much confidence in her."

Zalma's Insurance Fraud Letter

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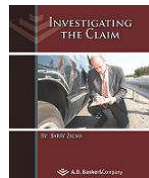
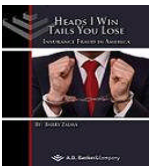
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Barry Zalma, Esq., CFE

Barry Zalma is an internationally recognized insurance coverage lawyer who has served the business of insurance since 1967. He practices as Barry Zalma, Inc., a sole practice law firm. The law firm was designed to take advantage of Barry Zalma's more than 42 years of insurance experience. Mr. Zalma emphasizes first party property and casualty insurance, third party liability insurance, insurance coverage disputes, claims handling, and the investigation of suspected insurance fraud.

Mr. Zalma is available to provide legal advice and counsel to insurers and those who are in the business of insurance. He is also available -- if there is no conflict of interest -- to provide legal advice and counsel to policyholders. Barry Zalma prefers to facilitate resolution of insurance disputes without litigation. If litigation becomes necessary Mr. Zalma will work with a litigator of the client's choice or refer the client to a litigator. Barry Zalma is licensed to practice law only in the state of California. He is also admitted to practice before the U.S. District Court, Central District of California and the Ninth Circuit Court of Appeals.



Barry Zalma, Esq.

Barry Zalma, as a "consulting attorney," can act as a lawyer consultant to the insured or the insurer. He can also serve as consultant or co-counsel (depending on the needs of the case). Mr. Zalma can provide the lawyer, the insurer or the insured coverage opinions, identify and explain the coverage issues, supply pertinent statutory and case law, and help his client deal with the issues.

Billing rates are all inclusive. The hourly fee takes account of all incidentals from telephone calls and postage to computer time and word processing. As for third-party costs, Mr. Zalma passes along all discounts and vendor savings. You pay what Mr. Zalma pays. Not a penny more.

Unlike major law firms with hundreds of lawyers, Barry Zalma, Inc. and its only lawyer, Barry Zalma, is dedicated to:

1. Be immediately responsive to the client.
2. Always be flexible.
3. Treat each client as if no other client required service.
4. Be easily accessible to clients.
5. Be independent.
6. Be efficient.
7. Encourage a personal and professional working relationship with each client.

Consultation with Mr. Zalma can make it possible for the insurer or policyholder to obtain the information necessary to successfully pursue a suit against an insurer and defeat a claim that the denial was based on a genuine dispute. If Mr. Zalma has no conflict with the insurer he can promptly and effectively enhance the probabilities of success of a policyholder or insurer in an insurance dispute.

In addition to his practice Mr. Zalma also writes ZIFL, the daily blog [Zalma on Insurance](#), and multiple books and e-books available at his [web site](#).