RGA

Fraud Red Flags for Life Insurance

December 2017

Underwriting/New Business

- Signatures on application and paramed exam are not consistent.
- Inconsistencies in height, weight, physical descriptions, license numbers or social security numbers.
- Blatant material misrepresentation on the application.
- Employment address is a P.O. Box.
- Money Order (or other cash equivalent) used to pay initial premium, particularly large single premium.
- Premiums exceed the client's apparent means.
- Premium being paid by someone other than the insured or owner.
- Premiums financed by unapproved premium finance program.
- Applicant states they do not know how premiums will be paid.
- Financial information provided on the application is false or cannot be verified.
- Applications with multiple carriers in short period of time, particularly for large face amounts with ADB.
- Applicant is a recent arrival to the U.S.
- Applicant resides, works, or spends a great deal of time in a foreign country. Applicant cannot provide driver's license or other identification or has a temporary or recently issued form of identification.
- Applicant overly interested in claim procedures or is unusually familiar with insurance terminology or procedures.
- Beneficiary does not have an insurable interest.
- Owner does not have a relationship to the insured.
- Initial premium is not valid, i.e., checking account information is not valid, rejected due to insufficient funds, or credit card payment rejected.
- Pattern of producer closing out cases due for lack of requirements, then immediately submitting a new application on the same individual, particularly when the applications escalate in premium value.
- Producer submitting multiple applications on the same individual without explanation.
- Excessive controlled business submitted by producer.
- Pattern of producer writing identical product, face amount, and application information on multiple applicants (especially for products with limited underwriting requirements).

Inforce Processing

- Payments or surrenders via wire transfer from/to foreign parties.
- Beneficiary changed shortly after issue, particularly to someone with no insurable interest.
- Ownership changed shortly after issue.
- Repeated "free looks" by applicant or excessive number of "free looks" related to individual agent's block of business.
- Address changed immediately followed by withdrawal or surrender.
- Questioned signature on change of ownership, beneficiary, or assignment forms.

- Questioned signature on withdrawal or cash surrender request.
- Payee signature forged on check issued to customer.
- Signatures on reinstatement application inconsistent with other known signatures on file.
- Credit card or cash equivalent used for reinstatement premium.
- Reinstatement application backdated.
- Dollar amount or payee on check issued to customer has been altered.
- Customer knowingly cashes check after claiming it has been lost and requesting a stop payment and reissue of the check.
- Misrepresentation as attorney-in-fact under a Power of Attorney, guardian, or trustee of a minor or incompetent person.
- Ownership changes to Life Settlement Companies immediately after the policy hits its two-year anniversary.
- Change in face amount at or near the first policy anniversary.
- Change to direct bill shortly after issue of a large policy, then no subsequent premium payments.

Accounting – Misappropriation

- Vendor payment address does not agree with vendor approval application.
- Spending in excess of budgeted or normal amounts.
- Weekend or holiday dates on invoices.
- Submitting fraudulent expense reports (overstated or mischaracterized expenses).
- Altered or fictitious receipts for expense reports.
- Submitting fraudulent invoices from vendors.
- Abuse of corporate credit card.
- High volume of manual disbursement checks.
- Excessive number of voided transactions.
- Discrepancies between bank deposits and postings.
- Bank accounts not reconciled on a timely basis.
- Altered payee on legitimate payment.

Commissions

- Excessive non-issued cases.
- High debit commission balance (chargebacks exceed new sales).
- Low persistency (pattern of early lapses).
- Undisclosed controlled business.
- Pattern of early face decreases, particularly at one year anniversary

Claims - Death

- Foreign deaths, especially from less developed or emerging countries.
- Information concerning foreign travel is incomplete, inconsistent, or vague.
- Conflicting descriptions of illness or accident.
- Insured is a homicide victim, and the beneficiary is suspected of involvement in the death.

- Significant amount of other life insurance, particularly if acquired just prior to death and ADB included.
- Blatant material misrepresentation on the application.
- Brief interval between onset of disease and death on a contestable claim.
- Death occurs shortly after the contestable period has expired.
- Death occurs shortly after an increase in coverage or reinstatement.
- Fake death certificate.
- Absence of verifiable documents, i.e., medical records, police report, coroner's report.
- Application or payment backdated to precede date of loss.
- Use of alias or bogus TIN by insured or beneficiary.
- Insured reported as missing, not deceased.
- Beneficiary knowingly provides false, incomplete or misleading information as part of claim submission.
- Beneficiary changed in close proximity to the date of death.
- Beneficiary change dated or postmarked after the date of death.
- Beneficiary change contested before or after date of death.
- Beneficiary has no insurable interest.
- Beneficiary is unwilling to provide an authorization or makes alternations to the authorization provided.
- Beneficiary is unable to produce an original death certificate.
- Incessant calls from the beneficiary or others regarding the status of the claim.
- Overly aggressive in attempt for quick payment of claim, threatening to contact insurance commissioner, attorney, or superiors.
- Unexplained delay in providing notice of death.
- Beneficiary provides excessive documentation not requested as part of the claim.
- Age discrepancy on suspected STOLI case.

Claims - Disability

- Failure to sign an authorization or altering the authorization provided.
- Disability coincides with the date of layoff, plant closing, or job termination.
- Signature of attending physician is similar to the claimant's signature.
- Claimant provides inconsistent accounts of disability or accident.
- Claimant frequently cancels medical appointments or refuses to submit to an independent medical examination.
- Disability stems from subjective complaints such as back pain, strain, headache, depression, or soft tissue injury.
- Claimant is near retirement age.
- Length of disability extends normal length of time for that condition.
- Claim is submitted shortly after contestable period has expired.
- Difficulty reaching claimant at home or claimant is reached at work while disability is being claimed.
- Attending physician continually extends disability each time forms are sent.

- Pressure from claimant for quick decision and immediate threats of complaints to the insurance commissioner, attorney, or superiors.
- Claimant uses P.O. Box and refuses to provide a physical address.
- Claimant is self-employed.

Claims – Long-Term Care

Provider

- Provider/PH with same name or address
- Billing at the top of the daily limit
- Rates change with policy inflation or are unusually high
- Paying claims without a break in billing
- POC changes result in increased rates for service
- Refuses to participate in telephony check-in process
- Not available during verification calls
- Manual edits to telephony system notes
- New/updated documentation shortly after a denial
- Revised, copied, whited out, pre- or post-dated notes

Agent

- Listed as POA/Family member
- Referred PH to provider
- Commits Bankers to claim payment by giving inaccurate information
- Involved in claim or complaint

Policy triggers

- All ADL's are documented as services received: bathing, dressing, toileting, transferring, eating, continence, mobility
- ADL assistance does not align with diagnoses/condition
- Subjective diagnosis

ROB

- Maxed Policy paying premiums
- Chronic illness not likely to improve
- New or concurrent condition
- Leaves and re-enters the facility