Zalma's Insurance Fraud Letter

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Quote of the Issue

"Education Is That Which Remains, When One Has Forgotten Everything He Learned in School."

Albert Einstein

Allianz Subsidiary Pleads Guilty to Defrauding Investors

Prosecutors Also Brought Charges Against Three Former Allianz Employees, With Two Agreeing to Plead Guilty

One of **Allianz SE's ALIZF** investing divisions pleaded guilty to securities fraud and agreed to pay about $6 billion in penalties and restitution to investors who suffered losses when some of the subsidiary's hedge funds tanked during the March 2020 market selloff.

Allianz Global Investors U.S. admitted that it lacked internal controls and oversight for a series of private-investment funds and made false and misleading statements to investors, according to a plea agreement reached with the Manhattan U.S. attorney's office. The U.S. subsidiary also settled civil-fraud claims brought by the Securities and Exchange Commission.

The $6 billion will resolve the government's criminal and civil claims, as well as those from defrauded investors. The agreement is among the largest criminal resolutions between a financial institution and the Justice Department in recent years.

The settlements draw a line under one of the biggest early casualties of the market meltdown sparked by the Covid-19 pandemic. Investors, including pensions that managed the retirement plans of Arkansas teachers, Milwaukee city employees and New York City subway workers, lost billions on the funds.

Three former employees of Allianz Global Investors were also charged in the scheme. Two have pleaded guilty.

Gregoire Tournant, who ran the investment group responsible for the funds' steep losses, was indicted on several counts, including securities fraud and investment-adviser fraud. Mr. Tournant surrendered to authorities in Denver.

Trevor Taylor, Mr. Tournant's co-lead portfolio manager of the funds, along with a third money manager in the group, **Stephen Bond-Nelson**, agreed to plead guilty to charges of conspiring to commit securities fraud, as well as securities fraud and investment-adviser fraud. Mr. Bond-Nelson also agreed to plead guilty to a charge of conspiracy to obstruct justice.

The SEC also sued the three men and accused them of civil securities fraud.

The case centered on Allianz Global Investors' Structured Alpha funds, which bet heavily on stock options that effectively sold insurance to other investors that were hedging against a potential market selloff. The strategy had been profitable during the market's calm stretch, and Allianz managers had assured investors that they had hedged their own trades in the event that the markets turned volatile.

Mr. Tournant's Structured Alpha funds managed more than $11 billion in assets.

When the coronavirus swept around the globe and set off a market panic over the pandemic's effect on the economy. Stocks fell sharply, credit markets seized up and volatility touched a record high. As options contracts swung dramatically, Allianz managers scrambled to restructure their trades. They struggled to keep up; the stock market was spiraling lower at a pace the managers didn't expect.

The Structured Alpha funds lost more than $7 billion in March 2020, according to the government. On March 25 of that year, Allianz informed investors that two of its funds would be liquidated.

Allianz said it would transfer most of Allianz Global Investors' U.S. business to Voya Investment Management in exchange for a 24% equity stake in the combined money manager. Following the transaction, Allianz Global Investors would no longer operate as an investment adviser to U.S. mutual funds, a spokeswoman said. A separate unit will continue to advise on private funds in the U.S., she said. Allianz also agreed to distribute Voya's funds outside the U.S.

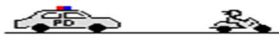
Allianz said its guilty plea would disqualify Allianz Global Investors from advising U.S. mutual funds and certain pensions. The firm said it expects the SEC to issue waivers on Tuesday that would ensure the agreement wouldn't affect Allianz Life or its other U.S. money manager, Pacific Investment Management Co.

Prosecutors said the Allianz scheme lasted from at least 2014 to March 2020 with Mr. Tournant reaping more than $60 million in compensation during that time. He and his team misled investors over the risks the funds were taking and how they were producing their returns, prosecutors alleged. The Structured Alpha managers also misrepresented the hedging strategies they had used to protect the funds' assets, prosecutors said.

The government also alleged that Mr. Tournant sought to obstruct the SEC inquiry into the losses by directing Mr. Bond-Nelson to lie to the regulator.

The SEC in its case alleged Messrs. Bond-Nelson and Tournant manipulated portfolio stress-test reports sent to clients that showed their estimated losses under certain dire scenarios. In one case, Mr. Tournant reduced the projected loss under a market-crash simulation from 42.15% to 4.15%. The men also misstated daily performance results sent to some investors, making returns look better than they were, the SEC said.

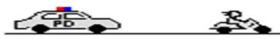
Allianz last week said it had set aside an additional $2 billion for legal expenses related to settlements with investors and discussions with the U.S. government. That came on top of the about $4 billion it had already provisioned.



Wisdom

"Where men cannot freely convey their thoughts to one another, no other liberty is secure." —**William Earnest Hocking**
"When people are presented with the alternatives of hating themselves for their failures or hating others for their success, they seldom choose to hate themselves." —**Thomas Sowell**
"The corporate grip on opinion in the United States is one of the wonders of the Western world. No First World country has ever managed to eliminate so entirely from its media all objectivity — much less dissent." —**Gore Vidal**
"If you want to see the poor remain poor, generation after generation, just keep the standards low in their schools and make excuses for their academic shortcomings and personal misbehavior. But please don't congratulate yourself on your compassion." —**Thomas Sowell**
"In the shadow of a lie is a forest of deceit." — **Jewish saying**

"Every book has been rewritten, every picture has been repainted, every statue and street and building has been renamed, every date has been altered... History has stopped. Nothing exists except an endless present in which the Party is always right." —**George Orwell**
"The more I study the history of intellectuals, the more they seem like a wrecking crew, dismantling civilization bit by bit — replacing what works with what sounds good." —**Thomas Sowell**
"Everybody is in favor of free speech. Hardly a day passes without its being extolled, but some people's idea of it is that they are free to say what they like, but if anyone says anything back, that is an outrage." —**Winston Churchill**
"Books won't stay banned. They won't burn. Ideas won't go to jail. In the long run of history, the censor and the inquisitor have always lost. The only sure weapon against bad ideas is better ideas. The source of better ideas is wisdom." —**A. Whitney Griswold**
"There is a certain enthusiasm in liberty, that makes human nature rise above itself, in acts of bravery and heroism." —**Alexander Hamilton**



Florida Proposes Changes to Reduce Fraud

Florida's lawmakers are concerned that property insurance for citizens of the state and intend to work to defeat or deter fraud and abuse by the means of insured's assigning benefits (AOB) to public insurance adjusters, roofers, contractors or lawyers. Florida's CFO Jimmy Patronis is leading the effort. Speaking alongside Florida's Citizens Property Insurance Corporation's CEO Barry Gilway, Patronis laid out five key areas for reforming Florida's property insurance marketplace.

Patronis and Gilway discussed what he believes is the major issue facing Florida's property insurance market is insurance fraud. Patronis listed his five desires are:

1) The setting up of three new anti-fraud homeowner squads that will "live and breathe property insurance fraud."
2) A $3 million funding for a fraud related public education campaign to help Florida's property insurance policyholders understand their rights when signing away a claim.
3) Amendments under qui-tam law, putting in place "a reporting mechanism that will incentivize the public to come forward and report the fraud taking place.
4) Incentivize people financially to call the Florida blocked Florida Fraud Fighter tip line.
5) Banning the bundling of these assignment of benefits claims.

On AOB, Patronis emphasized the fraud and abuse in the legal system he highlighted started with a policyholder assigning their benefits away to somebody else, to a fraudster. Florida, according to Patronis, cannot allow law firms and public adjusters to get into the business of bundling these AOB's and selling them the same way you would a security for a profit.

Florida wants to deter this feeding frenzy of bad actors going after consumers to sell AOB's on the open market, which again ultimately drives up rates, which drives carriers out of the state of Florida, because the environment allows that type of activity to exist in the first place.

Florida is currently dealing with insurance fraud resulting from a AOB's seems to be "a game of whack-a-mole", in trying to stop attorneys that move around and establish new companies to take advantage of the system, exploiting the statutes to use loopholes that enable their fraud.

Insurers and reinsurers are capital providers who want to see changes if Florida law to protect their assets from fraud perpetrators. The proposed changes will need to meaningfully move on providing effective defenses to litigated claims and quickly, if the state is to stabilize the insurance market.

Gilway of Florida Citizens agreed. Of course, these five areas of focus for the CFO of Florida still need to be adopted and codified into law through the Special Session of the Florida Legislature that Patronis proposed.

The five areas Patronis proposes all seem reasonable proposals for stemming the litigation tide. It is up to the Legislature and the Governor to make these suggestions law and for the state police and the three proposed anti-fraud homeowners squads and also fraud on other types of insurance fraud, to work to effectively prosecute and convict insurance fraudsters.


Free Insurance Videos

Barry Zalma, Esq., CFE has published five days a week videos on insurance claims, insurance claims law, insurance fraud and insurance coverage matters at https://www.rumble.com/zalma.

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 54 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.

Mr. Zalma is the first recipient of the first annual Claims Magazine/ACE Legend Award.

Over the last 54 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

See the more than 400 videos at https://www.rumble.com/zalma


North Carolina Judge Orders Lindberg to Give Up Control of Firms to Repay Insurers

Wake County Superior Court Judge Graham Shirley ruled that Lindberg intended to defraud the carriers after signing the agreement to stabilize them in 2019.

In issuing the order, Shirley said he was enforcing the agreement Lindberg signed when they were put under rehabilitation. **Greg Lindberg** was ordered to relinquish control of hundreds of his firms in a plan to salvage four of his insurance companies.

The judge in Wake County found that Lindberg committed fraud and failed to abide by a 2019 agreement after the North Carolina Department of Insurance took control of the insurers.

State Insurance Commissioner Mike Causey said the ruling is a big win for policyholders. The department "will continue to work to hold Mr. Lindberg to his promises and get the policyholders of these companies full access to their policies," he said, according to the Journal.

Lindberg is now serving a seven-year sentence in federal prison after being convicted of attempting to bribe Causey in exchange for favorable treatment for his insurance companies.

Lindberg had struck an agreement with a previous commissioner to allow him to invest as much as 40% of the carriers' assets into his affiliated companies. Causey, who took office in 2017, deemed the investment plan to be too risky. Lindberg attempted to influence Causey's decision, but the commissioner alerted authorities and recorded conversations with Lindberg, according to prosecutors.

Lindberg denied the charges but was convicted in 2020.

The case also ensnared a former North Carolina Congressman, **Rep. Robin Hayes**, who pleaded guilty in 2019 and was pardoned by former President Donald Trump just days before Trump left office in 2021.

On Wednesday, Lindberg lost control of most of his far-flung business enterprises. North Carolina Judge Graham Shirley said Lindberg had deceived and defrauded the insurance companies by investing even more than 40% of their assets in his other operations. After the state took control of the insurers under a 2019 agreement, Lindberg continued to withdraw more from the insurers than the stipulations allowed. His other operations had obtained millions of dollars in loans from the insurance companies but didn't turn over control of his operating companies as called for in the agreement, the judge said.

Most of Lindberg's businesses will now be put under control of a special overseer board, which will have the authority to sell the companies to repay the insurers money they were owed, which could be as much as $1.25 billion, the judge's order notes.

The insurance companies involved are **Southland National Insurance Corp., Bankers Life Insurance Co., Colorado Bankers Life Insurance Co.** and **Southland National Reinsurance Corp**. Many of Lindberg's affiliated companies were under the name **Eli Global**, which has since changed its moniker to **Global Growth Holdings.**

Revelations that Lindberg diverted insurance funds needed to pay claims into other parts of his business empire led North Carolina lawmakers to amend its code so that domestic insurers may invest in common or preferred stock, debt obligations and other securities of "affiliates or" subsidiaries in amounts that do not exceed 10% of the insurer's assets. Lindberg was able to take more than 10% of the insurers' assets before the change because the words "affiliates or" were missing from the code.

The ruling is the latest round of bad news for the entrepreneur, who once controlled hundreds of small and mid-sized businesses, including eye-care chains and software firms. Earlier this month, a federal judge ordered Lindberg to repay $524 million to a Puerto Rico insurance company whose assets were invested with a Bermuda-based insurer that has since collapsed.

Good News From the

Coalition Against Insurance Fraud

Scammers duped tens of thousands of patients into getting their insurers billed for more than $900 million of unneeded and over-priced compound pain and scar creams in a telemed-fueled scheme. Synergy Pharmacy (Palm Harbor, Fla.) hired a telemarketing firm called HealthRight to cold-call consumers, deceiving them into accepting the drugs and handing over their insurance info. HealthRight then bribed docs to authorize the scripts via its telemarketing platform — even though the docs never met or examined the patients. The docs relied solely on HealthRight's bogus patient screening to authorize the false scripts. HealthRight generated at least 60,000 scripts, fooling honest pharmacy benefit managers by misbranding the meds and disguising claims to con insurers into paying for the scripts. Telemed schemes are proliferating around the U.S. The arms-length technology has inspired some of the largest insurance schemes of the last five years. Several tried to gouge health insurers with more than $1 billion of false claims apiece. Seven schemers were federally convicted in Greenville, Tenn. in the latest insurance plot.

Romance novel writer Health Right's Nancy Compton-Brophy telegraphed her intentions when she published an essay, "How to Murder Your Husband." The Portland, Ore. woman shot her husband Daniel for $350,000 of life insurance. Daniel was a chef at the Oregon Culinary Institute. He was found dead with chest and back wounds in the institute's rear kitchen soon after he arrived at 7:30 a.m. Nancy claimed she was home all morning, yet surveillance cameras placed her downtown between 6:30 a.m. and 7:28 a.m. Just days after the shooting, Nancy asked detectives working on the case to send her a letter stating she wasn't a suspect. She wanted to give it to her life insurers and collect on the policies. The couple also earlier bought a Glock handgun. Nancy bought other gun parts on eBay, reassembled them on the gun then shot Daniel. Next she put the original gun parts back together so the Glock wouldn't match the shell casings connected to Daniel's murder. Nancy also penned numerous novels — including "The Wrong Husband." And she wrote an essay, "How to Murder Your Husband." She also bookmarked an article, "10 ways to cover up a murder," on an *iTunes* account she shared with Next, Daniel. Brophy was convicted and faces at least 25 years in prison when sentenced June 13.

Former Georgia insurance commissioner John W. Oxendine teamed with Dr. Jeffrey Gallups and others to submit fraudulent claims for medically unneeded pharmacogenetic, molecular genetic and toxicology testing, federal prosecutors allege in Atlanta. *The charges:* Docs associated with Gallups's practice were pressured to order medically unneeded tests from a lab in Texas. The lab company paid Oxendine and Gallups kickbacks of 50% of the net profit for eligible specimens Gallups sent to the lab for testing. In one charge, a doc held a meeting for other docs at the Ritz Carlton hotel in Buckhead. Oxendine gave a speech, telling the docs they needed to order the tests for patients. The lab made more than $2.5 million of billings for tests ordered by Gallups's practice. The insurers paid over $600,000 to the lab, which then paid $260,000 in kickbacks through Oxendine's insurance services business. He used some of the

kickback money to pay Gallups's debts, plus pay a $150,000 charity contribution and $70,000 in attorney's fees. Oxendine was last elected as Georgia insurance commissioner in 2006. He ran for governor in 2010 but lost. In 2009, the state also started investigating campaign finance violations after Oxendine accepted $120,000 from insurers. Then in 2015, an *Atlanta Journal-Constitution* investigation found that he never returned $50,000 from a campaign for governor, and spent some of that money on a house and cars. The state settled the remaining ethics case just last week.

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Matthew McCollister was found dead in his home in Twin Cities, Minn. He left behind his wife and three young children. McCollister was an acclaimed coach of the South St. Paul hoops team, in addition to his law practice. A chiro introduced McCollister to a confidential informant who was working with the Minnesota Commerce Fraud Bureau. The informant posed as a recruiter of supposed crash victims for bogus chiro treatment billed to auto insurers. McCollister met with the runner at the Red Cow restaurant, and asked him to find people who supposedly were injured. McCollister wanted the victims to get treated, with him representing the patients to bring the bogus injury claims against auto insurers. He offered to pay the pretend runner $300 or more for each person recruited. McCollister then unknowingly directed one of two undercover patients to be "treated" by chiro Huy Nguyen. McCollister kept an informal office at Nguyen's clinic, spending considerable time there. McCollister's fate was sealed when the undercover runner had lunch with McCollister, Nguyen and an MRI specialist named Quincy Chettupally in Minneapolis. The lunch was secretly video recorded, with the conspirators openly discussing the scheme. Even after being indicted, McCollister sent two letters to Liberty Mutual, demanding a $25,000 bodily-injury settlement for two bogus claims. This ring and others were broken up by Operation Back Cracker — an ongoing effort by the Commerce Fraud Bureau, FBI and U.S. Attorney's Office. McCollister stood to spend up to 16 months in federal prison.

Florida's special legislative session on property insurance concluded early on Wednesday with passage of a package of reforms available at the link.

The bill was signed into law by the Governor on Thursday. Among the new anti-fraud provisions contained in the law are:

- Attempting again to limit marketing efforts by roofing contractors and public adjusters, including mandatory warnings of felony fraud violations for waiving deductibles or submitting false claims.
- Mandating insurers to do physical roof inspections within 45 days of receiving a POL and to provide repair estimates to policyholders.
- Stopping the ability to use assignments (AOBs) to recover attorney fees by contractors or other third-parties and mandating those taking assignments hold harmless the persons signing away their policy rights.
- Bad faith claims now require proof of breach of the policy contract and not just a dispute over the amount the claim value. Attorney multipliers will also be severely restricted and insurers are now able to recover attorney fees if not given proper pre-suit notice of litigation**.**

For those involved in the investigation of insurance fraud should note the following from the new statute:

> It is insurance fraud punishable as a felony of the third degree for a contractor to knowingly or willfully, and with intent to injure, defraud, or deceive, pay, waive, or rebate all or part of an insurance deductible applicable to payment to the contractor for repairs to a property covered by a property insurance policy; and
>
> 3.It is insurance fraud punishable as a felony of the third degree to intentionally file an insurance claim containing any false, incomplete, or misleading information.

It also provides, to help insurers:

> When a claimant's suit is dismissed pursuant to subsection (5), the court may award to the insurer reasonable attorney fees and costs associated with securing the dismissal.
>
> (c) In awarding attorney fees under this subsection, a strong presumption is created that a lodestar fee is sufficient and reasonable. Such presumption may be rebutted only in a rare and exceptional circumstance with evidence that competent counsel could not be retained in a reasonable manner.

Embezzling $5.8 million has netted an insurer's controller four years in federal prison. Kevin J. Mix authorized & oversaw Chicago-based Insureon's accounting operations. He authorized 42 wire transfers into his personal bank accounts and the accounts of shell companies he created. Mix tried to hide the transfers by making false entries in the company's records, creating fake emails, and

lying to company reps. Mix used the stolen money to buy, among other things, several real estate parcels in the Chicago area and Ohio, Mercedes-Benz and Audi automobiles, multiple diamonds and gold bars, and membership in a private charter jet service.

A vehicle rammed Victor Robelet's police squad car from behind while he was stopped at an intersection in Crystal Lake, Ill. The collision caused minor damage to the vehicles, and was captured on video by a squad car camera. The vehicle that hit Robelet's car was traveling about 10 mph, yet Robelet told docs the vehicle was going 30-40 mph. First responders examined him at the scene, and he refused an ambulance to a hospital. Robelet drove his squad car back to the police department. No damages needed repairs and the vehicle stayed in service. Supervisors also sent Robelet to a doc as a precautionary measure. He was cleared, and returned to full duty for nine weeks. Robelet then started complaining his neck bothered him, he had trouble sleeping and had a concussion. He saw another doc without the department's permission. Robelet told fellow cops and supervisors the doc said he had a shoulder tear, and he couldn't even work light duty. Yet surveillance caught him lifting children and cases of water, power-washing his house and doing other physical tasks. Robelet also drove his personal vehicle while telling the department he was afraid to drive. He was paid full salary and collected insurance benefits while being treated by doctors and physical therapists, and taking prescribed meds. Robelet pled guilty, received two years of supervised probation and must repay more than $98,000. His 20-year police career is done as well.

***From our "Are We Next?" files:* Crime syndicates are taking out life and funeral insurance on people then killing them to make large claims, officials say in South Africa.** Syndicates are familiar with life and funeral policies. Rings also obtain paupers' corpses from mortuaries and stage hit-and-run accidents. And with insurers doing more to uncover the crimes, syndicates are using runners to do the work for them. One life insurer is warning South Africans with family members who abuse alcohol or drugs and/or live on the streets, not to let killers exploit them by getting their identity documents and taking out policies on their lives. Syndicates often buy insurance for people who are homeless, sickly, abusing substances or involved in gang or criminal activities. Fraudsters also use identification documents to create fake deaths or forge birth or marriage certificates and to buy life policies. One-off opportunists also are killing people, sometimes family members. In one case, insurance was bought a day before a mother and her daughter were shot in a field in the Eastern Cape. In another case, former policewoman Nomia Rosemary Ndlovu murdered her partner and five family members for life and funeral insurance.

Illinois Gov. Jay Pritzker signed HB 4493, which allows the Director of Insurance to request an insurer report factual information about suspected insurance fraud or arson. The director also can designate one or more data-processing organizations or government agencies to assist in gathering and compiling anti-fraud information — including establishing a fee insurers pay to cover the costs of data collection and analysis.

Patients visiting pain doc Andrew Berkowitz received a "goodie bag" — actually a tote bag — filled with prescription drugs for which the Philly man submitted pharmacy claims through his firm Bucks Philadelphia Medical Care Group. The "goodie bags" typically included a cocktail of drugs including topical analgesics, muscle relaxers, pain pills, plus anti-anxiety and insomnia meds. Insurers paid more than $4,000 for each bag by falsely asserting patients needed the stuff. Berkowitz also prescribed oxycodone to "pill-seeking" patients in exchange for their tacit approval that he'd submit excessive claims to the patient's insurer for the "goodie bag" and other medically unneeded services. He stole more than $4 million of insurance money. Berkowitz also obtained 20 years in federal prison and must repay the money.

Timothy W. Forester ran four pharmacies in the Pittsburgh area. They were drug emporiums that fed his own addiction. Forester ordered painkillers — mostly oxycodone and hydrocodone — from suppliers. He intercepted deliveries, falsified pharmacy inventories and took the drugs home to use. Forester also placed labels for brand-name drugs on bottles of generic drugs, and billed insurers and customers for higher-priced brand drugs. Finally, he changed the computer billing codes for drugs to falsely represent to payers that the drugs were brand-name, resulting in much higher insurance payouts. Forester received a year in federal prison.

Forced-placement insurance has led to a forced-fraud decision against two storage facilities in Sandoval County, N.M., the state insurance department says. Northern Boulevard Insurance and Armor Storage evaded state insurance-licensing requirements by falsely claiming their Customer Storage Protection Agreement wasn't an insurance product. The two firms' liability disclaimers imposing an insurance requirement and prohibiting an insurer's subrogation rights was "potentially unenforceable." It also was "unfair or deceptive" for the firms to force customers to buy the coverage. The statements on rental agreements being "bargained-for" was "unfair and deceptive." Nor is there a contractual provision for "force placed" insurance offered. Both companies were hit with hundreds of regulatory violations, plus acting as unauthorized insurers. They must pay a combined $120,000 in penalties.

An elderly client was defrauded by her trusted life and health agent. Koreasa Williams convinced the client to cash in several life policies worth $1.2 million in order to invest the proceeds in annuities. The Tucson, Ariz. agent then used almost $900,000 to pay victims of a separate annuity scheme to try to avoid criminal charges. Williams used the remaining $300,000 she obtained from her client to pay attorney fees for the unrelated fraud scheme, and to settle a civil suit brought by another client. Separately, Williams admitted she induced her client to dissolve a charitable foundation and place more than $124,000 in an entity Williams controlled. Williams never created the new entity and instead diverted more than $118,00 to her personal use. That person gave the money to Williams to purchase annuities between 2016 and 2018, but Williams diverted the funds for personal use. That victim has since died. Williams pled guilty to the primary scheme, and will receive up to 20 years in federal prison when sentenced. Williams agreed to repay her main victim $1.3 million, and $50,000 to the heirs of another victim. She earlier received 51 months for the $300,000 scheme.

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Traumatic brain injury from a fall supposedly killed Alexandra Hatcher in Newport News, Va. Her hubby Albert even posted an obit in the local newspaper. Sad, except Hatcher was quite alive. The couple faked her death to scarf payouts on two life policies. Albert sought a lump-sum payout, yet the insurers denied the claims because he had no certified death certificate. So, they forged a death certificate. Her family members also were concerned after reading the obit. They contacted the police. Albert gave them a confusing story that changed halfway through his explanation. The funeral home confirmed the death certificate was fake. Denied their insurance money, the pair went on a cross-country adventure to scam businesses out of luxury vehicles. They visited dealerships under the guise of buying a new or barely used car with fake or forged checks. The plot worked in Virginia, North Carolina, Washington, Ohio and Florida. The pair used the fake checks to buy pricy luxury vehicles before moving on to the next scheme. Once the cars were titled with the new fake names, the pair used the cars as collateral for loans and other cars. When that didn't work, Alexandra and Albert sold the vehicles to other dealerships for cash. Alexandra and Albert eventually pleaded guilty to a long list of charges.

Health Insurance Fraud Convictions

Sarasota Pain Doctor and Former Insys Sales Representative Convicted for Health Care Fraud

Dr. Steven Chun (59, Sarasota) and **Daniel Tondre** (52, Tampa) were convicted by a federal jury. Both were found guilty for conspiring to pay and receive kickbacks and bribes, in the form of speaker fees, in return for prescribing the fentanyl spray Subsys. They were both also convicted on five separate counts of paying and receiving kickbacks on specific dates. Tondre was also convicted of two counts of identification fraud in connection with the sham speaker events. Each faces a maximum penalty of 5 years in federal prison on the conspiracy count, and up to 10 years in prison for each substantive kickback violation. Tondre also faces up to 5 years' imprisonment on each identification fraud count. The United States is seeking a money judgment in the amount of the proceeds of the kickbacks. A sentencing date has not yet been set.

According to court documents, Chun was a doctor who owned and operated a pain management medical practice in Sarasota where he prescribed a large volume of Subsys, an expensive form of liquid fentanyl designed to be applied under the tongue (sublingual spray), allowing it to rapidly enter the bloodstream. Tondre was employed as a sales representative in Chun's territory by **Insys Therapeutics, Inc**., the company that manufactured and sold Subsys.

Insys, through its sales representative, Tondre, actively marketed Subsys to Chun by holding bogus and sham speaker events, and paid Chun $2,400 to $3,000 per speaker event in return for writing more and higher dosages of Subsys prescriptions. The sham speaker programs were often only attended by Chun's family and friends or repeat attendees and included many falsified or forged signatures of attendees. Insys also bribed Chun, a large Subsys-prescriber, by hiring his then-girlfriend to work as an Insys liaison to facilitate the approval of insurance forms for Subsys, including those submitted for Medicare patients. The sham speaker programs were designed to conceal and disguise kickbacks and bribes paid to Chun to induce him to prescribe Subsys.

According to evidence presented during the 10-day trial, Chun was paid more than $278,000 in illegal kickbacks and bribes from Insys in connection with the sham speaker programs over a period of less than three years. Chun was also employed as a consultant by a local pharmacy where he referred his patients to fill Subsys and other medications. Tondre earned more than $737,000 in salary and sales commissions over a period of two and half years. Medicare Part D paid more than $4.5 million for Subsys prescriptions written Chun.

Insys Therapeutics and other executives of Insys Therapeutics were convicted in the District of Massachusetts in *United States v. Gurry et al*., with the First Circuit Court of Appeals affirming their convictions.

San Francisco Physician to Pay More Than $1,000,000 To Settle Allegations of False Medicare Charges

Dr. Roger Wang agreed to pay $1,033,666.42 to resolve allegations that he violated the False Claims Act by charging Medicare for non-FDA-approved drugs and associated services.

According to the settlement, viscosupplements, such as Synvisc, Synvisc One, and Orthovisc, are FDA-approved drugs injected for the treatment of osteoarthritis pain. The United States has alleged that Wang, a rheumatology specialist practicing in San Francisco, purchased and injected into his patients versions of Synvisc, Synvisc One, or Orthovisc that were not approved by the FDA for distribution in the United States and therefore were not covered by Medicare, and billed Medicare for the drugs and injections. The settlement agreement resolves claims the United States might have brought based upon these allegations.

According to the settlement, the United States alleged Wang knowingly submitted thousands of false claims for reimbursement for non-FDA-approved Synvisc and Orthovisc and related procedures. Specifically, the United States alleged that Wang used non-FDA-approved drugs that were packaged and labeled for use in foreign

markets. At least some of the labeling, according to the settlement, was for additional uses not approved in the United States. In addition, the United States alleged that, from June 30, 2015, to December 1, 2019, Wang knowingly submitted claims to Medicare for reimbursement for non-FDA-approved Synvisc and Orthovisc, and for injection procedures, even though neither the non-FDA-approved drugs nor the injections of those drugs are covered by Medicare. Pursuant to the settlement, the United States agreed to resolve the government's claims resulting from Wang's conduct, including the government's claims under the False Claims Act, codified at 31 U.S.C. §§ 3729-3733, and certain other related claims, for more than $1 million.

The government did not file criminal charges against Wang.

Nurse Sentenced for Stealing Prescription Drugs from A Hospice Patient

Dana Aldinger, age 55, of York, Pennsylvania, was sentenced to one year probation and a $525 fine by United States Magistrate Judge Martin C. Carlson for theft in connection with health care. Aldinger also permanently surrendered her nursing license.

According to United States Attorney John C. Gurganus, Aldinger, a former Licensed Practical Nurse (LPN) and Administrator for a personal care home for senior citizens in York, stole and diverted controlled medications for personal use from nursing patients under her care. Aldinger diverted Oxycodone pills prescribed to a Medicare hospice patient on or about August 10, 2019. Aldinger also falsified medical records to conceal her diversion of the medications.

Defendants Sentenced in Tennessee for Multimillion-Dollar Nationwide Telemedicine Pharmacy Fraud

Peter Bolos and his co-conspirators, **Michael Palso, Andrew Assad, Scott Roix, Larry Smith, Mihir Taneja**, **Arun Kapoor** and **Maikel Bolos,** as well as various companies owned or controlled by some of these individuals, deceived pharmacy benefit managers (PBMs), such as Express Scripts and CVS Caremark, regarding tens of thousands of prescriptions. The PBMs processed and approved claims for prescription drugs on behalf of insurance companies. Bolos and his co-conspirators defrauded the PBMs into authorizing millions of dollars' worth of claims that private insurers such as Blue Cross Blue Shield of Tennessee, and public insurers such as Medicaid and TRICARE, paid to pharmacies controlled by the co-conspirators.

Peter Bolos was convicted by a federal jury in December 2021. Roix, Assad, Palso, Smith, Maikel Bolos, and various associated business entities pleaded guilty to their roles in the conspiracy. Taneja, Kapoor, and Sterling Knight pleaded guilty to felony misbranding in a conspiracy with Bolos. U.S. District Judge J. Ronnie Greer imposed sentences this week for all of the defendants except Roix, whose sentencing hearing was rescheduled for June 15, 2022.

On May 16, the court sentenced Bolos to 14 years in prison and $2.5 million in forfeiture. On the same date, the court also sentenced Palso, 48, of Lutz, Florida, to 33 months in prison. Bolos and Palso also were each ordered to pay nearly $25 million in restitution.

On May 17, the court sentenced Smith, 52, of Tampa, to 42 months of imprisonment. The now-defunct corporate entities that Smith created, **Alpha Omega Pharmacy, Germaine Pharmacy, Zoetic Pharmacy, ULD Wholesale LLC**, and **Tanith Enterprises**, all were sentenced to pay nearly $25 million in restitution. The court also sentenced Taneja, 47, of Tampa, to 10 months of imprisonment and a $10,000 fine.

On May 18, the court sentenced Kapoor, 48, of Temple Terrace, Florida, to three years' probation and a $10,000 fine. Sterling Knight, a now-defunct corporate entity that Kapoor and Taneja created, was sentenced to pay $21 million in restitution. The court also sentenced Maikel Bolos, 36, of Tampa, to 15 months of imprisonment and a $25,000 fine.

On May 19, the court sentenced Assad, 37, of Tampa, to 24 months of imprisonment and to pay nearly $25 million in restitution. HealthRight was sentenced to pay $4.25 million in restitution.

Court documents and evidence at trial established that Bolos, Assad, and Palso owned and operated **Synergy Pharmacy** in Palm Harbor, Florida. Under their direction, Synergy employed Roix, a Florida telemarketer operating under the name HealthRight, to generate prescriptions for Synergy and the other pharmacies involved in the scheme. The prescriptions were typically for drugs such as pain creams, scar creams and vitamins. Evidence showed that to obtain the prescriptions, Roix used HealthRight's telemarketing platform as a telemedicine service, cold-calling consumers and deceiving them into agreeing to accept the drugs and to provide their personal insurance information. HealthRight then paid doctors to authorize the prescriptions through its telemedicine platform, even though the doctors never communicated directly with the patients and relied solely on the telemarketers' screening process as the basis for their authorizations. Because this faulty and fraudulent process made the prescriptions invalid, the drugs were misbranded under the Food, Drug and Cosmetic Act. Evidence showed that Synergy and the other pharmacies nonetheless dispensed the drugs to consumers as part of the scheme so that Bolos could submit fraudulent reimbursement claims.

Court documents and evidence at trial further established that during the conspiracy, which lasted from May 2015 through April 2018, Bolos and Palso, along with Assad, paid Roix millions of dollars to buy at least 60,000 invalid prescriptions generated by HealthRight. Evidence showed that Bolos selected specific medications for the prescriptions that he could submit for profitable reimbursements at inflated prices, and that Bolos, Palso, and Assad used illegal means to hide this activity from the PBMs so it could remain undetected.

Miami-Based Virtuox, Inc. Agrees to Pay $3.15 Million To Resolve Claims It Defrauded Medicare

VirtuOx, Inc. ("VirtuOx"), based in Coral Springs, Florida and operating Medicare approved Independent Diagnostic Testing Facilities ("IDTF"), has agreed to pay $3,150,000.00 to resolve allegations that it submitted or caused to be submitted false claims to Medicare for reimbursement.

The United States alleged that, from January 2016 to December 2020, VirtuOx violated the False Claims Act by falsely identifying the place of service for certain services it performed to obtain a higher rate of reimbursement from Medicare. In particular, the United States alleged that, in connection with its billing for overnight pulse oximetry claims, VirtuOx knowingly submitted false claims to Medicare identifying its IDTF located in San Francisco, California as the location of service for overnight pulse oximetry tests when, in fact, no services were performed at that location in relation to the overnight oximetry claims.

The United States further alleged that, from January 2016 to December 2020, VirtuOx administered overnight pulse oximetry tests and, at times, also billed Medicare for single determination pulse oximetry tests (commonly referred to as an oxygen "spot check") for the same patient when in fact the only test performed was the overnight test. In particular, the United States alleged that, because an awake reading is necessarily taken as part of an overnight pulse oximetry test, the separate billing of a "spot check" is redundant and generally not necessary. Accordingly, the United States alleged that VirtuOx knowingly submitted false claims by separately billing for both an oxygen "spot check" and an overnight pulse oximetry test when only an overnight pulse oximetry test was performed.

Contemporaneous with the civil settlement, VirtuOx entered into a Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG). The five-year CIA requires, among other things, that VirtuOx retain an outside expert to perform annual claims reviews that address the place of service identified on the claim.

This matter arose from a lawsuit filed by Amber Watt in federal court in Miami, Florida. The lawsuit was filed under the *qui tam*, or whistleblower, provisions of the False Claims Act, which permit private individuals to sue on behalf of the government for false claims and to share in any recovery. The whistleblower share to be awarded in connection with the settlement is $630,000.00.

Owner Of Drug Testing Lab Sentenced in Medicare Kickback Scheme

Rakesh Reddy Kothuru, 49, pled guilty in January 2022 to one count of knowingly and willfully making false representations of material facts for payments under federal health care programs. The conviction means Kothuru is subject to mandatory exclusion from future participation in federal health care benefit programs, including Medicare and Medicaid. Pursuant to his plea agreement, Kothuru was required to pay $500,000 prior to his sentencing to be credited toward the court-ordered forfeiture and restitution.

Kothuru, a Las Vegas, Nevada-based laboratory owner, who paid another lab owner to direct urine samples to his lab for testing and then billed the federal government for that testing, was sentenced last week to four months of house arrest and ordered to pay a total of $510,000 in forfeiture, restitution, and fines.

According to court documents, Kothuru was the majority owner of **Laboratory Services of America, LLC** (LSA), a Las Vegas-based lab that provided drug testing on urine samples. After performing that testing, ATL routinely sent tested samples to other laboratories for "confirmation" testing.

One of those other labs included **American Toxicology Labs** (ATL), formerly owned by **Michael Norman Dube**, who also owned a chain of clinics in Tennessee and Virginia that purported to treat opioid addiction with buprenorphine. Providers at those clinics frequently ordered urine drug screens for their patients in order to assess current drug use and to gather medically necessary information that would be pertinent to treatment.

In January 2015, Kothuru and Dube entered into an arrangement in which Dube would refer all of ATL's tested urine samples to LSA for confirmation testing in exchange for cash kickback payments to Dube's personal checking account.

Between March 23, 2015, and September 20, 2016, Kothuru's lab received more than $750,000 from Medicare, Virginia Medicaid, Kentucky Medicaid, and TennCare in compensation for confirmation testing performed on samples directly related to services illegally billed and collected in accordance with the kickback scheme between Kothuru and Dube.

As part of a previous guilty plea in 2011 to intentionally omitting information from reports as required under the Controlled Substances Act, Dube had been prohibited by the Department of Health and Human Services from ever participating in any federal health care program again. As part of his involvement in the kickback scheme with Kothuru, Dube pleaded guilty in March 2021 to two counts of health care fraud, sentenced to 36 months in federal prison, and ordered to pay over $9,000,000 in fines, forfeitures, and restitution costs.

Orthotic Brace Suppliers Convicted In $6.5 Million Health Care Fraud Scheme

Bruce Stroud, 40, **Bobbi Stroud**, 39, husband and wife and residents of Prosper, Texas, and **Kenric Griffin**, 52, of Frisco, Texas, jointly owned and operated four orthotic brace suppliers: **New Horizons Durable Medical Equipment, Striffin Medical Supply, 4B Ortho Supply**, and **Grace Professional DME** were convicted by a federal jury in Dallas, Texas and Arkansas May 16, 2022 for a $6.5 million illegal kickback scheme, including violations of the federal Anti-Kickback Statute.

According to court documents and evidence presented at trial, evidence showed that between January 2017 and April 2019, the Strouds and Griffin, through their companies, caused approximately $12.5 million to be billed in claims to Medicare for unnecessary braces based on brace orders received in exchange for illegal kickbacks. Medicare paid the defendants approximately $6.5 million for those claims. The defendants concealed the scheme by entering into numerous sham agreements with purported marketing companies that characterized the illegal payments for doctors' orders as "marketing" expenses.

The Strouds and Griffin were convicted of conspiracy to defraud the United States and to offer and pay illegal health care kickbacks, and seven violations of the Anti-Kickback Statute. The defendants are all scheduled to be sentenced on Sept. 7. Each defendant faces a total of up to 55 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Oklahoma City Hospital Pays Over $1.1 Million To Settle Claims of Making False Claims to Medicare

Oklahoma Heart Hospital South, LLC ("OHHS"), has paid $1,151,770.50 to settle civil claims stemming from allegations it violated the False Claims Act by submitting false claims to Medicare.

OHHS is an Oklahoma limited liability company that owns and operates the Oklahoma Heart Hospital South, which is an acute care hospital located in Oklahoma City. Following an internal review and audit, OHHS discovered irregularities regarding its billing of certain services, and proactively contacted the United States to self-disclose the issues. Thereafter, the United States investigated the disclosures and issues raised by OHHS. Throughout the investigation, and to its credit, OHHS cooperated with the United States Attorney's Office and the U.S. Department of Health and Human Services Office of Inspector General in the investigation.

The voluntary disclosure and investigation revealed that from June 1, 2013, through May 31, 2019, OHHS submitted claims to Medicare for Intensive Cardiac Rehabilitation ("ICR") services provided to Medicare beneficiaries. Before billing Medicare for these services, OHHS was required to have a physician complete and sign an individualized treatment plan ("ITP") for the patient. If the patient was going to receive ICR for longer than 30 days, a physician must complete and sign updates to the ITP every 30 days thereafter. The United States alleges that claims for ICR services submitted by OHHS to Medicare for payment violated the False Claims Act because a physician did not complete and/or sign ITPs and/or ITP updates for certain Medicare beneficiaries.

To resolve the claims, OHHS agreed to pay $1,151,770.50 to the United States. In reaching this settlement, OHHS did not admit liability, and the government did not make any concessions about the legitimacy of the claims. The agreement allows the parties to avoid the delay, expense, inconvenience, and uncertainty involved in litigating the case.

Woman Convicted of Laundering Over $750,000 From Health Care Fraud Scheme

Jesmina Ramirez, 50, of Miami Gardens, laundered hundreds of thousands of dollars in fraud proceeds by cashing checks written from five fraudulent medical supply companies and returning that cash, minus a fee, to her co-conspirators. The five fraudulent medical supply companies for whom she laundered money – **BF Distributors Corp.; Timely Medical Services Corp.; Ortho-Med Solution Inc.; Expedited Medical Supplies Corp.;** and **Prime Orthopedic Solutions Corp**. – billed Medicare, Medicaid, and private insurers more than $48 million for medical equipment the companies never actually purchased and never provided to any patients. Ramirez laundered the stolen money by cashing more than 120 checks from the fraudulent companies over more than two years.

A federal jury convicted Ramirez, a Florida woman, May 13, 2022 for laundering approximately $786,000 in money stolen from Medicare, Medicaid, and private health insurers as part of a sprawling health care fraud scheme in Miami.

Ramirez was convicted of one count of conspiracy to commit money laundering and one count of money laundering. She faces up to 20 years in prison on each count. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors. Sentencing is scheduled for July 13.

Boulder Health System, Physician Assistant, And Nurse Practitioner Agree to Resolve Investigation into Improper Prescribing of Opioids

Boulder Community Health, a not-for-profit health system in Boulder, Colorado, **Christopher Kreider** (a Physician Assistant), and **Bonnie Wilensky** (a Nurse Practitioner), have agreed to resolve allegations relating to improper opioid prescribing at the Mapleton Pain Clinic in Boulder. The allegations are that Kreider and Wilensky wrote prescriptions for opioids in dosages, at frequencies, and in combinations with other substances that were outside the course of their professional practice. As a result, these prescriptions were not valid under State law and not covered by the Medicare Part D program. BCH will pay $350,000. Kreider has agreed to have his practice supervised for the next two years and to complete 60 hours of continuing education regarding the prescribing of controlled substances, addiction, and alternatives to opioids for pain management. Wilensky has agreed not to prescribe any controlled substances for a period of two years.

Boulder Community Health owned the Mapleton Pain Clinic, a multi-disciplinary clinic treating patients with chronic pain that operated in Boulder. Boulder Community Health closed the Mapleton Pain Clinic in March 2017. The United States alleges that, while employed at the Mapleton Pain Clinic, Kreider and Wilensky regularly wrote prescriptions for opioids at high dosages and in dangerous combinations with other controlled substances (such as benzodiazepines and muscle relaxants), ignoring indications of patient substance use disorder, misuse and abuse of prescriptions, and mental health issues. The United States also contends that Boulder Community Health, by its ownership of the Mapleton Pain Clinic, failed to properly supervise its employees' prescribing practices and implement appropriate controls to prevent the improper prescribing of addictive opioid medications and other controlled substances.

Physician Partners of America to Pay $24.5 Million To Settle Allegations of Unnecessary Testing, Improper Remuneration to Physicians and A False Statement in Connection with Covid-19 Relief Funds

Physician Partners of America LLC (PPOA), headquartered in Tampa, Florida, its founder, **Rodolfo Gari**, and its former chief medical officer, **Dr. Abraham Rivera**, have agreed to pay $24.5 million to resolve allegations that they violated the False Claims Act by billing federal healthcare programs for unnecessary medical testing and services, paying unlawful remuneration to its physician employees and making a false statement in connection with a loan obtained through the Small Business Administration's (SBA) Paycheck Protection Program (PPP). Certain PPOA affiliated entities are jointly and severally liable for the settlement amount, including the **Florida Pain Relief Group, the Texas Pain Relief Group, Physician Partners of America CRNA Holdings LLC, Medical Tox Labs LLC** and **Medical DNA Labs LLC**.

The United States alleged that PPOA caused the submission of claims for medically unnecessary urine drug testing (UDT), by requiring its physician employees to order multiple tests at the same time without determining whether any testing was reasonable and necessary,

or even reviewing the results of initial testing (presumptive UDT) to determine whether additional testing (definitive UDT) was warranted. PPOA's affiliated toxicology lab then billed federal healthcare programs for the highest-level UDT. In addition, PPOA incentivized its physician employees to order presumptive UDT by paying them 40% of the profits from such testing in violation of the Stark Law, which prohibits physicians from referring patients to receive "designated health services" payable to Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship, unless an exception applies.

The United States further alleged that PPOA required patients to submit to genetic and psychological testing before the patients were seen by physicians, without making any determination as to whether the testing was reasonable and necessary, and then billed federal healthcare programs for the tests.

The United States further alleged that when Florida suspended all non-emergency medical procedures to reduce transmission of COVID-19 in March 2020, PPOA sought to compensate for lost revenue by requiring its physician employees to schedule unnecessary evaluation and management (E/M) appointments with patients every 14 days, instead of every month as had been PPOA's prior practice. PPOA then instructed its physicians to bill these E/M visits using inappropriate high-level procedure codes. Moreover, the United States alleged that at the same time PPOA was engaged in this unlawful overbilling, PPOA falsely represented to the SBA that it was not engaged in unlawful activity in order to obtain a $5.9 million loan through the PPP. The settlement announced today resolves liability under the False Claims Act and the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA) arising from the false claims submitted to federal healthcare programs for the E/M visits as well for PPOA's false statement in connection with its PPP loan.

In connection with the settlement, PPOA also entered into a five-year Corporate Integrity Agreement (CIA) with the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG). Under the CIA, PPOA agreed to undertake significant compliance efforts, including: maintain a compliance department, medical director and oversight board; retain a compliance expert; provide management certifications; maintain written standards, training and education; obtain multiple annual claims reviews by an Independent Review Organization; establish a risk assessment and internal review process; and implement monitoring of testing referrals.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Donald Haight, Dawn Baker, Dr. Harold Cho, Dr. Venus Dookwah-Roberts and Dr. Michael Lupi, who are current or former employees of PPOA or its affiliated entities. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery.

On May 17, 2021, the Attorney General established the COVID-19 Fraud Enforcement Task Force to marshal the resources of the Department of Justice in partnership with agencies across government to enhance efforts to combat and prevent pandemic-related fraud. The task force bolsters efforts to prevent fraud by, among other methods, augmenting and incorporating existing coordination mechanisms, identifying resources and techniques to uncover fraudulent actors and their schemes, and sharing and harnessing information and insights gained from prior enforcement efforts. For more information on the department's response to the pandemic, please visit https://www.justice.gov/coronavirus.

Southwest Nu-Stop Philadelphia & Dr. Reid Guilty

Southwest Nu-Stop Philadelphia Inc. (Southwest), a Philadelphia-based drug and alcohol treatment facility, and its owner **Dr. Lloyd Reid** pleaded guilty to Medicaid fraud for paying illegal kickbacks to recovery homes in Philadelphia. As a result of this investigation, Southwest closed both of its locations and has ceased operations.

The investigation conducted jointly by the Office of Attorney General Medicaid Fraud Control Section and the United States Department of Health and Human Services (HHS) showed that Reid and Southwest profited by receiving millions of dollars from Medicaid in exchange for providing poor quality treatment to recovery home residents who were forced to attend treatment at their facilities. The recovery homes would threaten the residents with life on the streets if they choose to attend treatment at a different facility. More than 75 percent of all of Southwest's patients resided at a recovery home.

The facility was repeatedly reprimanded by Philadelphia's Community Behavioral Health (CBH) for providing substandard care to its patients. Southwest continued to provide insufficient treatment to its patients, and in January 2020, a client fatally overdosed while at Southwest's treatment facility.

The investigation revealed between December 2016 and June 2019, Southwest received more than $12,662,864 in Medicaid funds for allegedly providing drug and alcohol treatment. During this time, Reid paid recovery homes over $1,178,453 in kickbacks.

Southwest and Reid both entered a guilty plea to the charge of Medicaid Fraud. Sentencing will be scheduled for a later date. The case was investigated by Supervisory Special Agent James Conn, and is being prosecuted by Senior Deputy Attorney General Eric Stryd.

Attorney General Bonta Announces Settlement Resolving Medi-Cal Fraud Allegations Against Prism Enterprises

Prism Enterprises, Inc. (Prism) settled with the state of California for submitting false claims for payment to the Medi-Cal Program in relation to services for children and young adults with autism spectrum disorders. Prism contracted with several Medi-Cal managed care organizations to provide treatment services to children and young adults diagnosed with autism spectrum disorders, as well as to provide training sessions to the children's parents and caregivers. Under the settlement, Prism will pay a total of $650,000 to the state and federal governments, with California receiving a gross share of $390,000. The settlement is based on Prism's ability to pay.

The resolution stems from a 2019 lawsuit filed in the U.S. District Court for the Southern District of California under the qui tam or whistleblower provisions of the California and federal False Claims Acts. The acts permit private parties to file suit on behalf of both

the State of California and the United States for false claims and to share in a portion of the governments' recoveries. The case, United States and the State of California, ex rel. Diana Mason v. Prism Autism Foundation, was filed by Mason, a licensed board-certified behavioral analyst, who was employed by Prism from March 2018 to June 2018 when she observed Prism's alleged fraudulent activities. Mason, who did not participate in the misconduct, quit working for Prism because the alleged fraudulent activities continued to occur even after she reported the problems to Prism's owner. She will receive $78,000 as her share from the California settlement.

After the whistleblower lawsuit was filed in 2019, a collaborative investigation by the California Department of Justice's Division of Medi-Cal Fraud and Elder Abuse (DMFEA) and the U.S. Attorney's Office for the Southern District of California identified 2,363 fraudulent claims that Prism submitted for canceled appointments, no-shows, and rescheduled appointments from September 2016 to December 2019. For example, Prism submitted claims for caregiver training sessions while the comment section in the patient's medical record noted that the autistic child's caregiver was out of the country on the dates the services were supposedly rendered. Training sessions are provided by a therapist to teach the parents and caregivers how to interact with their autistic children to promote social interaction skills, manage problem behaviors, and teach daily living skills and communication.

Through the DMFEA, the California Department of Justice works to protect Californians by investigating and prosecuting those who perpetrate fraud on the Medi-Cal program. DMFEA also investigates and prosecutes those responsible for abuse, neglect, and fraud committed against elderly and dependent adults in the state. The Division regularly works with whistleblowers and law enforcement agencies to investigate and prosecute crime, and urges the public to report Medical fraud and abuse at oag.ca.gov/dmfea/reporting.

Podiatrist Guilty of Fraud

Renae Louise Witt, 42, a Tustin podiatrist was found guilty in February of billing insurance companies for medical services that were never actually done.

Witt, 42, was sentenced to 364 days in jail followed by two years of probation, Orange County District Attorney's officials said in a news release. The podiatrist was also ordered to pay restitution to two insurance companies she billed for care she didn't actually perform.

Witt worked at **Tustin Place Medical Group** and submitted claims totaling $174,395 for services she claimed to have completed for six different patients between Aug. 28, 2015 and April 3, 2017, OCDA officials said. The insurance companies wound up paying out just over $75,861. When Anthem Blue Cross began an investigation into the suspicious billing, she fabricated medical records.

Witt also faces a 10-year suspension of her medical license, OCDA officials said.

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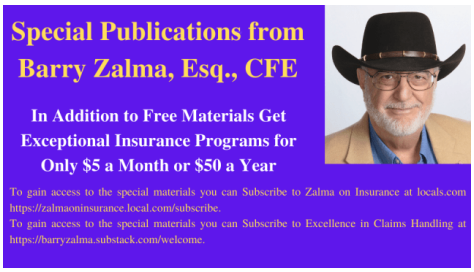

Barry Zalma has created at Locals.com and substack.com a series of insurance educational materials most of which are free to anyone. The free materials include more than 441 videos and more than 4200 digests of recent appellate court opinions and more than 81 videos dealing with true crime stories of insurance fraud.

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A source for the insurance claims person to become an insurance claims professional who can provide excellence in claims handling to the insurance buying public.

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In search of profit, insurers have decimated their professional claims staff. They laid off experienced personnel and replaced them with young, untrained, unprepared people. A virtual clerk replaced the old professional claims handler. Process and computers replaced hands-on human skill, empathy and judgment. Money was saved by paying lower salaries. Within three months of firing the experienced claims people gross profit increased.

The promises made by an insurance policy are kept by the professional claims person. Keeping a professional claims staff dedicated to excellence in claims handling is cost-effective over long periods of time. A professional and experienced adjuster will save the insurer millions by resolving disputes, paying claims owed promptly and fairly, and by so doing avoid litigation.

The professional claims person is an important part of the insurer's defense against litigation by insureds against insurers for breach of contract and the tort of bad faith. Claims professionals resolve more claims for less money without the need for either party to involve counsel. A happy insured or claimant satisfied with the results of his or her claim will never sue the insurer.

Incompetent or inadequate claims personnel force insureds and claimants to public insurance adjusters and lawyers. Every study performed on claims establishes that claims with an insured or claimant represented by counsel cost more to resolve than those where counsel is not involved. Prompt, effective, professional claims handling saves money for both the insured and the insurer and fulfills the promises made when the insurer sold the policy.

Insurers who believe they can handle first or third party claims with young, inexpensive, inexperienced and untrained claims handlers should be accosted by angry stockholders whose dividends have plummeted or will plummet as a result. When an insurer compromises on staff, profits, thin as they may have been previously, will move rapidly into negative territory. Tort and punitive damages will deplete reserves. Insurers will quickly question why they are writing insurance. Those who stay in the business of insurance will either adopt a program requiring excellence in claims handling from every member of their claims staff, or they will fail.

Insurance is a business. It must change—this time for the better—if it is to survive. It must rethink the firing of experienced claims staff and reductions in training to save "expense." Insurers should, if they wish to succeed, adopt a program to promote excellence in claims handling that can help insurers keep the promises made by the insurance policy and avoid charges of breach of contract and the tort bad faith in both first and third party claims.

Insurers must understand that they cannot adequately fulfill the promises they make to their insureds and their obligations under fair claims practices acts without a professional, well trained and experienced claims staff. An insurer must work vigorously and intelligently to create a professional claims department or recognize it will lose its market and any hope of profit.

An insurer whose claims staff is made up of people who are less than professional will find itself the subject of multiple instances of expensive, counterproductive litigation.

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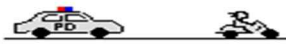


NICB Reports That Fraudulent Disaster Claims Cost P&C Insurers Extra $4.6bn to $9.2bn

The National Insurance Crime Bureau (NICB) has done some analytical work to quantify the impact of one of the most topical inflationary factors for catastrophe and severe weather claims, so particularly relevant to the ILS and reinsurance market, fraudulent claims.

The NICB said that property and casualty (P&C) insurers in the United States paid between $4.6 billion and $9.2 billion extra in disaster claims because of insurance fraud in 2021. They say this is "a cost policyholders bear through their insurance premiums."

The fraud is also paid by reinsurance capital providers. Fraudulent claims are, for P&C insurers, resulting in them passing on more losses through quota shares and more readily tapping their excess-of-loss reinsurance arrangements as well.

The NICB estimates that disaster fraud adds between 5-to-10 percent to the total insurance claims paid bill following a disaster event.

They also noted that the Federal Bureau of Investigation found that of the $80 billion in government funding for reconstruction following Hurricane Katrina, insurance fraud may have accounted for $6 billion or about 7.5%.

In Florida, where litigation and fraud costs have caused much of the property insurance crisis situation existing today. Litigated claims continue to rise in the state of Florida, inflating premiums for consumers, and reinsurance recoveries for carriers.

The insurance buyers in Florida hope the upcoming legislative special session, with its main focus being on stemming the litigation and fraud tide, might reduce this inflationary burden on the insurance and reinsurance system in Florida.

Fraudulent claims impose on insurers and reinsurers a hidden tax imposed upon the insurance consumer, whether P&C insurers, reinsurers and retrocessionaires.

The inflationary burden to insurance claims costs from fraud and litigation is an added expense the insurance and reinsurance industry does not need to bear, especially at a time when financial market and commodity inflation is running significantly higher.

At up to 10% of US natural catastrophe and severe weather insured losses over the course of a year, fraudulent claims can definitely be the difference between a reinsurance arrangement attaching, or not, over that period. Pricing for fraudulent factors is challenging, but becoming much more embedded into insurance and reinsurance pricing processes, meaning carriers should expect to pay more for their reinsurance while this additional inflationary tax on claims persists at such levels.

One method to help reduce insurance fraud is through consumer awareness. Consumers and contractors following disasters are inextricably linked. Armed with the understanding of the claims process and contractor hiring, consumers will be able to identify potential fraud, and, in the process, protect themselves and their wallet.

Deceitful contractors – or those passing themselves off as contractors – will try to take advantage of disaster victims. To avoid falling for these practiced schemes, the NICB encourages disaster victims to contact their insurer, law enforcement or NICB investigators should they experience the following:

- A contractor that approaches you offering unsolicited services.
- The contractor states they are approved by FEMA or other government agencies.
- A contractor offers advice on how to interpret insurance policies.
- A contractor requires you to pay upfront to do the job or "get you on the schedule faster."
- A contractor that will not provide you with their state and local business licenses, physical business address and telephone numbers, and references.

NICB created Contractor Fraud Awareness Week in 2021 to highlight the growing problem of contractors and vendors that take advantage of disaster victims in the aftermath of catastrophes.
For more information on avoiding contractor fraud or to become a partner of NICB's second annual Contractor Fraud Awareness Week, visit www.nicb.org.

The NICB recommends reviewing these tips before you act on a contractor's offer for services:

- Be suspicious of any contractor who tries to rush you, especially on non-emergency or temporary repairs. If possible, shop around for a contractor by getting recommendations from friends and neighbors. Be wary of anyone knocking on your door offering unsolicited repairs to your home.
- Never pay for work up front. Always inspect the work and make sure you're satisfied before you pay. Most contractors will require a reasonable down payment on work, but don't pay anything until you have a written contract.
- Get three written estimates for the work and compare bids. Check credentials with the Better Business Bureau or state attorney general's office to see if the firm has any outstanding complaints.
- Always have a written, detailed contract that clearly states everything the contractor will do, including prices for labor and materials, clean-up procedures, and estimated start and finish dates. Never sign a contract with blank spaces, which a crooked contractor can alter after they have gotten your signature.
- Don't believe a contractor who says they are supported by the government. The Federal Emergency Management Agency (FEMA) does not endorse individual contractors or loan companies; call FEMA toll-free at 800.621.FEMA for more information.
- Avoid paying with cash; use a check or credit card instead. This creates a record of your payments to the contractor.

Every property insurer should explain to their catastrophe claims staff of the red flags of fraud and the need to conduct as thorough investigation as possible to reduce catastrophe fraud. In that regard every catastrophe team should include one or more SIU investigators to assist the claims handlers.

To report fraud, call us at 800.TEL.NICB or fill out our online form.

Other Insurance Fraud Convictions

Guilty of Faking Auto Theft

John Michael Fletcher, 61, was convicted of False Reports and Filing a False Insurance Claim. Fletcher, a Knoxville man was convicted of falsely telling police his car had been stolen before attempting to receive an insurance payment for more than the vehicle's worth.

On December 7, 2018, Fletcher asked an employee to move his H3 Hummer motor vehicle. He then told Knoxville Police and his insurance company that the Hummer had been stolen. Bright and Roberts explained that Fletcher claimed he had purchased the vehicle for nearly double what he actually paid for it.

Nearby surveillance video showed the vehicle being moved, and once the vehicle was found, there were no signs of forced entry or damage to the ignition showing it had been stolen. At sentencing, prosecutors expect to seek an enhanced sentence because Fletcher reportedly threatened the insurance agent when they did not pay the claim. Fletcher also has a prior conviction for Second Degree Murder out of Washington County, Tennessee.

False Reports and Filing a False Insurance Claim are both Class D felonies carrying a punishment between two and four years. Sentencing for this case will take place on July 16.

Jacksonville Contractor Pleads Guilty to Felony Home Repair Fraud

Clint A. Stevens, the owner of a Jacksonville construction company pleaded guilty to home repair fraud May 24, 2022 in Morgan County Court. Stevens, a 45-year-old owner of C&A Construction, pleaded guilty to home repair fraud, a Class 4 felony. The single charge stems from an arrest by Jacksonville Police on April 12th, 2021 after an investigation.

According to the charges Stevens misrepresented material facts relating to terms of a contract or promised performance, saying September 28, 2020 that he would start repairs on a home on Pintail Court by October 2020 and then didn't initiate the work.

Stevens has settled tort damages, small claims, and breach of contract cases on 9 separate occasions dating back to 2013. The settlements include restitution totaling nearly $100,000. One small claims case remains open dating from February of last year.

According to the Better Business Bureau, Stevens' construction business has received 7 complaints over the last 3 years.

Morgan County Assistant State's Attorney Chad Turner says that the felony charges don't preclude a potential lawsuit down the line: "When this case was initiated, when we first got the police reports in and the investigation was concluded at least to a point where the Jacksonville Police felt comfortable making an arrest, Mr. Stevens came forward with the full restitution to the victim that was the subject of this case. I doubt it resulted in civil litigation, but certainly the paying of restitution would not preclude some sort of civil litigation. Literally, on the day of his arrest and when he bonded out of the Morgan County Jail, somehow Mr. Stevens came up with the money to pay the full amount of restitution in the charged case."

Stevens was sentenced to 1 year of probation, a $500 county fine plus probation fees and court costs. Turner says that Stevens must all pay restitution to a local business in a separate investigation initiated by the Jacksonville Police: "Mr. Stevens was required to make full restitution to a local business that he had defrauded that was a subsequent investigation that was initiated by the Jacksonville Police Department after this particular case was charged. He did plead guilty to a felony, and while obviously he was trying to negotiate to avoid that, we thought that it was important in order to, not that it is hugely and readily accessible to the home repair/construction consumer, we thought it was important that he get a felony so that people would know if they chose to look him up before hiring him for any future contracting jobs."

C & A Construction is not listed as a licensed roofing contractor in the State of Illinois. Currently, general contracting businesses do not have to be licensed by the state. However, local governments can require contractors to possess a surety bond and insurance to operate in their locality.

Dayton Businessman Sentenced To Prison

Brian Higgins a Dayton businessman was taken into custody after being sentenced on May 25, 2022 by U.S. District Judge Thomas M. Rose on five federal charges related to insurance fraud.

Higgins, 51, was sentenced to 36 months in prison on witness retaliation convictions and 24 months on mail fraud convictions. The terms are to be served concurrently.

He also was ordered to pay restitution of $84,113.04, according to court documents. Higgins was found guilty in January of three counts of mail fraud and two counts of tampering with a witness with intent to retaliate. The jury found Higgins not guilty of two counts of tampering with a witness.

Higgins was accused of defrauding insurance company Assurant of money the company paid him for repairs that were to be made to a home he co-owned in Dayton.

According to court documents and trial testimony, in 2014 and 2015, Higgins filed a fraudulent insurance claim in connection with water damage to a Residence, an 8,000 square-foot house in Dayton.

Higgins used the money for personal expenses, including travel, hotels, dining out, funding a new restaurant, paying telephone bills and at a casino, according to the news release.

The witness tampering charges were related to a civil lawsuit he filed against Mike Marshall, Scott Waters and their now-defunct company United Demolition Excavation and Site Management of Dayton. Both Marshall and Waters testified for the prosecution.

Higgins was the final defendant of those indicted as part of a federal public corruption investigation in the Dayton region announced in 2019. His was the only case that did not involve public contracting allegations. Higgins is also the only defendant who did not reach a pretrial guilty plea agreement with prosecutors.

That investigation led to the convictions of:

- Former Dayton city commissioner Joey D. Williams, 56, of Dayton, on one count of corruptly soliciting a bribe.
- Former state representative Clayton Luckie, 58, of Dayton on one count of mail fraud.
- Former Dayton city employee RoShawn Winburn, 48, of Huber Heights on one count of corruptly soliciting a bribe.
- Green Star Trucking, owned by former Trotwood Mayor Joyce Sutton Cameron, 73, on one count of conspiracy to engage in mail fraud.
- Steve Rauch Inc., owned by Steve Rauch, 66, of Germantown, on one count of conspiracy to engage in mail fraud.

The two companies were fined, Luckie served his term and Williams was released from prison early due to the COVID-19 pandemic. Winburn is scheduled to begin serving his term on August 10.

United Demolition was the company Williams took a bribe from to help the company get a city contract, and it ultimately did such poor work that the city withheld payment on those contracts, a 2020 Dayton Daily News investigation found.

Higgins is the former owner of the now-defunct Sidebar 410 restaurant in the Oregon District. Another business of his, GSSP Enterprise, had a contract to haul bodies for the Montgomery County Coroner's office. That contract was terminated after a 2012 Dayton Daily News investigation found GSSP was delinquent on hundreds of thousands of dollars in federal and state taxes, and that Higgins had an undisclosed business relationship with Ken Betz, who was then the director of the coroner's office.

Singapore Based Insurance Agent Convicted of Fraud and Sentenced to Two Weeks

Patricia Quek Puay Yi, 40, a woman who was an insurance agent when she worked with a financial services manager to try and cheat insurance firm Manulife of $1,128.57 was sentenced to two weeks' jail on May 17, 2022.

The court heard that the money was not disbursed after Manulife conducted a check. Quek pleaded guilty to a cheating charge, committed the offence with **Silver Huang Hsin Tian**, 27, in 2020.

At the time of the offence, Quek was working with AIA Singapore while Huang was employed at Pias, a broker firm that deals in insurance.

Huang was sentenced to one week's jail on May 10, 2022 after she pleaded guilty last month to her role in the ruse.

Separately, Quek was fined $7,000 on Tuesday over an unrelated drink driving charge. She was also disqualified from driving all classes of vehicles for three years from her date of release.

For her cheating offence, Deputy Public Prosecutor Chong Yong said that Quek was at a hotel on June 29, 2020, when she tripped over a barricade rope, fell and injured her right foot. Three days later, she sent Huang a message via messaging platform WhatsApp, stating that she wished to get an "accidental plan".

Huang then told Quek that she dealt with insurance policies under Manulife and the older woman expressed her interest in them.

Quek signed the documents for a Manulife insurance policy on July 3 that year and Huang submitted them to the firm.

Both women knew that Quek's injuries pre-dated her application for the Manulife policy. Despite this, Huang told Quek in a WhatsApp conversation that she could "just try" to claim under the policy and "see what happens".

The Manulife policy came into effect on July 15, 2020, and Quek had surgery on her right foot five days later. She was hospitalized until July 24 that year. Huang then filled up and submitted an accident and health claim form, falsely stating that the date of the accident was July 18, 2020, to try to induce Manulife to disburse $1,128.57 to Quek.

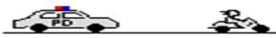
On Sept 3, 2020, Manulife sent Quek a letter stating that it could not admit her claim. The letter stated that Manulife had confirmed with United Specialist Centre that her right foot was treated on July 6 that year, before the policy inception date.

The DPP reported that Manulife's level of rigor in verifying the integrity of the claim.

Zalma on Insurance Blog Posting

- The Law of Unintended Consequences & Insurance May 27, 2022
- No Good Deed Goes Unpunished: Insurance Coverage Cannot be Created by Estoppel May 27, 2022
- True Crime of Insurance Fraud Video Number 81 May 26, 2022
- Health Insurance Fraud Convict Appeals Again May 26, 2022

- True Crime of Insurance Fraud Video Number 80 May 25, 2022
- Estoppel Cannot Create Insurance Coverage May 25, 2022
- California Fair Claims Settlement Practices Regulations 2022 Now Available May 24, 2022
- True Crime of Insurance Fraud Video Number 79 May 24, 2022
- Lawyer Appointed by Insurer had a Duty of Zealous Representation May 24, 2022
- True Crime of Insurance Fraud Video Number 78 May 23, 2022
- Judgment Debtor Can Sue Indigent Defendant's Insurer May 23, 2022
- True Crime of Insurance Fraud Video Number 77 May 20, 2022
- Named Peril Policy Only Covers What it Agrees to Cover May 20, 2022
- True Crime of Insurance Fraud Video Number 76 May 19, 2022
- Statute of Limitations Defeats Equal Protection Claim May 19, 2022
- True Crime of Insurance Fraud Video Number 75 May 18, 2022
- Coverage Cannot Be Created by Arguing Waiver or Estoppel May 18, 2022
- True Crime of Insurance Fraud Video Number 74 May 17, 2022
- Lack of Covered Concurrent Cause Defeats Concurrent Cause Argument May 17, 2022



New Book: Ethics For the Insurance Professional Third Edition

How The Covenant of Good Faith and Fair Dealing Requires Insurance Professionals to Act Ethically and With Utmost Good Faith and Fair Dealing

by Barry Zalma

Ethics is Essential to the Insurance Professional

Insurance is, by definition, a business of the utmost good faith. This means that both parties to the contract of insurance must act fairly and in good faith to each other and do nothing that will deprive the other of the benefits the contract of insurance promised.

In essence the covenant requires that each party to the contract of insurance treat the other ethically, fairly and in good faith.

Without the covenant of good faith and fair dealing and without the people who work in the insurance industry applying and fulfilling the covenant ethically, insurance is impossible. One cannot act fairly and in good faith without being a person with a well-formed ethical compass.

In *Carter v. Boehm* S.C. 1 Bl. Burr 1906, 11th May 1766. 593, 3 Lord Mansfield in the British House of Lords stated: "Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of that fact, and his believing the contrary."

Insurers, when making a decision to insure or not insure a risk, rely on the information provided to them by the insured. As Lord Mansfield instructed, the insured must provide the information requested honestly and in good faith. Failure to do so is unethical and breaches the covenant of good faith.

The implied covenant explains that no party to a contract of insurance should do anything to deprive the other of the benefits of the contract. By so doing an insurer must keep all the promises made by the policy fairly, promptly and in total accord with the promises made by the policy. Similarly, a person insured must treat the insurer ethically, fairly and in good faith when seeking the insurance.

The implied covenant of good faith and fair dealing imposes obligations not only as to claims by a third party but also as to those claims made by the insured. When the insurer unreasonably, and in bad faith, withholds payment of the claim of its insured, it is subject to liability in tort. For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement, it again must give at least as much consideration to the latter=s interests as it does to its own. Therefore, since, at the very least 1766, the business of insurance is a business of the utmost good faith. Each party to a contract of insurance must deal with each other ethically. The general duty of good faith and fair dealing incorporated by reference into every policy of insurance requires a complete understanding of ethics and ethical behavior.

In every insurance contract there is an implied covenant of good faith and fair dealing that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. It was the decision of the California Supreme Court in *Gruenberg v. Aetna Insurance Co.,* 9 Cal.3d. 566, 108 Cal. Rptr. 480 (1973) that first stated that the tort of bad faith will apply to first party insurance in the state of California. Gruenberg was adopted in a majority of the states of the United States making the breach of an insurance contract unethically and in bad faith became a tort.

The covenant is mutual and the principles of good faith and fair dealing impose an affirmative obligation on the insured to cooperate as much as it requires the insurer to treat the insured fairly with regard to every claim presented.

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Available as a Kindle blook. Available as a paperback. Available as a hardcover.

True Crime Stories of Insurance Fraud

There are now available at https://rumble.com/zalma more than more than 81Video True Crime Stories of insurance fraud.

Barry Zalma, Esq., CFE presents videos so you can learn how insurance fraud is perpetrated and what is necessary to deter or defeat insurance fraud. This Video Blog of True Crime Stories of Insurance Fraud with the names and places changed to protect the guilty are all based upon investigations conducted by me and fictionalized to create a learning environment for claims personnel, SIU investigators, insurers, police, and lawyers better understand insurance fraud and weapons that can be used to deter or defeat a fraudulent insurance claim. You can see all the True Crime Stories of Insurance Fraud and insurance law with a total of more than 420 videos at https://rumble.com/zalma.

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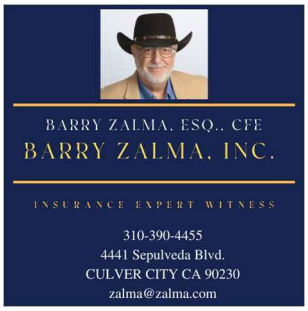
Barry Zalma has created a special locals.com community called https://zalmaoninsurance.local.com/subscribe. For only $5.00 a month you can view insurance law materials and webinars on insurance claims handling sufficient to train your claims personnel as perpetrators of excellence in claims handling.

Barry Zalma, Esq., CFE

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 54 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.



Over the last 54 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

Barry Zalma, Inc., 4441 Sepulveda Boulevard, CULVER CITY CA 90230-4847, 310-390-4455; Subscribe to Zalma on Insurance at locals.com https://zalmaoninsurance.local.com/subscribe. Subscribe to Excellence in Claims Handling at https://barryzalma.substack.com/welcome. Write to Mr. Zalma at zalma@zalma.com; http://www.zalma.com; http://zalma.com/blog; I publish daily articles at https://zalma.substack.com, Go to the podcast Zalma On Insurance at https://anchor.fm/barry-zalma; Follow Mr. Zalma on Twitter at https://twitter.com/bzalma; Go to Barry Zalma videos at Rumble.com at https://rumble.com/c/c-262921; **Go to Barry Zalma on YouTube- https://www.youtube.com/channel/UCysiZklEtxZsSF9DfCoExpg; Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/** Read posts from Barry Zalma at **Go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/**

New Book now Available at Amazon.com:

Insurance Fraudsters Deserve No Quarter

New Book That Explains How to Defeat or Deter Insurance Fraud

What every insurer should know about how it can be proactive in the efforts against insurance fraud by refusing to pay every fraudulent claim.

How Giving No Quarter Worked

Many years ago, a client I represented was offended that an insured tried to defraud him and the people who were names in the syndicate he represented at Lloyd's, London. I walked the Underwriter through the debris of the house that was burned, showed him some of the remains of the allegedly highly valuable fine arts, and then explained how he was deceived into issuing the policy. I was the attorney for Lloyd's underwriters for the fine arts and Imperial Casualty for the homeowners policy. Once it became clear to the Underwriter, I was given the following instruction: "Take No Prisoners!" The military instruction to give no mercy to the enemy.

Typically, if you give or grant no quarter, you treat someone—usually an opponent or foe of some kind—harshly. You don't take pity on them or give them any leeway or concession. That is what I did. The claim was denied, the policy was rescinded, and the bad faith suit that resulted was litigated without quarter or concession. It took more than five years, a motion for summary judgment, an appeal, and eventually a judgment in favor of the insurers that resulted in payment to the insurers of every dollar advanced and every dollar expended in investigation and defense of the bad faith suit. That was followed by suits against the claims adjuster, death threats and a bomb threat that took 15 years of my professional life. The appellate decision can be read at *Imperial Casualty & Indemnity Co. v. Sogomonian,* 243 Cal.Rptr. 639, 198 Cal.App.3d 169 (Cal. App. 1988).

After Mr. Sogomonian and his co-defendants were compelled to pay fraudulent claims against Imperial and the Lloyd's underwriters dropped precipitously. Giving no quarter to a fraud perpetrator not only defeated a fraudulent claim but deterred others from attempting fraud.

The *Imperial v. Sogomonian* case and many similar cases is why I am convinced that giving no quarter to a fraud perpetrator is the best way to deter and defeat insurance fraud and why I wrote this book to convince more insurance professionals to emulate the insurers that defeated the Sogomonian attempt at fraud.

Available as a paperback here. Available as a hardcover here. Available as a Kindle Book here.

New Book:

California Fair Claims Settlement Practices Regulations 2022

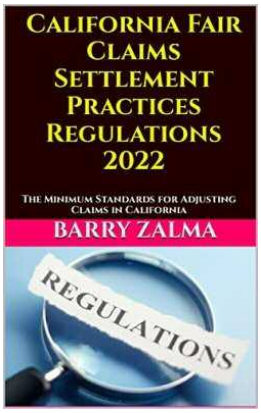
Now Available at Amazon.com

Minimum Standards for Adjusting Claims in California

Every Claims Person in California Must Read, Understand, or be Trained About the California Fair Claims Settlement Practices Regulations by September 1 of Each Year

This book was designed to assist insurance personnel who do business in the state of California.

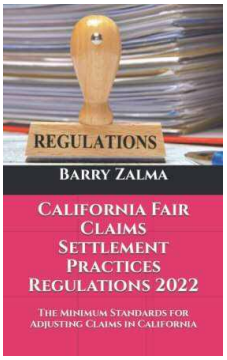
It will provide advice to:



- all insurance claims personnel,
- claims professionals,
- independent insurance adjusters,
- special fraud investigators,
- private investigators who work for the insurance industry,
- the management in the industry,
- the attorneys who serve the industry,
- public insurance adjusters,
- policyholders and
- counsel for policyholders working with insurers doing business in California

The information needed to properly, efficiently, and fairly resolve insurance claims in full compliance with the requirements of the Regulations so they can understand that the Regulations are merely minimum standards and every insurer requires that the service provided exceeds the requirements of the Regulations.

Since the California Regulations appear to be detailed, Draconian, and as or more extensive than similar regulations in other states, understanding and working under the Regulations should suffice in every state.



The insurer's lawyer will need to know, and establish, that the insurer fulfilled the requirements of the Regulations since it will show to a trier of fact that the insurer fulfilled the minimum standards required and required its claims personnel to comply with the Regulations. A knowledge of the Regulations can assist the lawyer in evaluating the exposure faced by an insurer and help the lawyer present an effective defense to an insurer sued for breach of the covenant of good faith and fair dealing.

Similarly, the lawyer representing a policyholder client needs complete knowledge of the Regulations to use them to prove that the insurer failed to fulfill the minimum standards set by the Regulations. Although not evidence of bad faith failure to fulfill the requirements of the Regulations can go a long way to convince a trier of fact (judge or jury) that the insurer did not act fairly and in good faith. Compliance with the Regulations is important to the evaluation of a claim for breach of the covenant of good faith and fair dealing and evaluation of a claim of damages resulting from the tort of bad faith.

Knowledge of the requirements of the Regulations is important to everyone involved in the business of insurance whether as an insurance adjuster, insurance claims management, public insurance adjuster, policyholder, defense lawyer, insurance coverage lawyer, and policyholder's lawyer.

For detail about this book and many more by Barry Zalma go to the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/

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