Zalma's Insurance Fraud Letter

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"History Teaches Us That Men And Nations Behave Wisely Once They Have Exhausted All Other Alternatives."
Abba Eban

New Charges and Rewards Announced for the Capture and/or Conviction of Senior Leaders of Notorious Mexican Cartel

More than $100 Million Offered for Information Leading to the Arrests and/or Convictions of Eight CJNG Fugitives

Reward some photos below were taken from wanted posters of the eight CJNG fugitives that can be found here.

The Department of Justice, in coordination with the Drug Enforcement Administration (DEA), Federal Bureau of Investigation (FBI), U.S. Immigration and Customs Enforcement Homeland Security Investigations (HSI), Internal Revenue Service Criminal Investigation (IRS-CI), U.S. Customs and Border Protection (CBP), and National Coordination Center (NCC) announced new charges of the most-wanted leaders of Cártel de Jalisco Nueva Gene ración (CJNG), one of the most prolific and dangerous drug cartels in Mexico. Alongside the indictments, the Department of State's Bureau of International Narcotics and Law Enforcement Affairs (INL) announced more than $100 million in reward offers for information leading to the arrests and/or convictions of **Juan Carlos Valencia** González also known as "Pelen," 41; **Audias Flores Silva** also known as "Jardine," 45; **Julio César Montero Pinzón** also known as "Target's," 44; **Carlos Andrés Rivera Varela** also known as "La Farma," 40; **Hugo Gonzalo Mendoza Gaytán** also known as "Sapo," 37**; Ricardo Ruiz Velasco** also known as "RR" / "Tripa," 42; **Julio Alberto Castillo Rodríguez** also known as "Chorro," 49; and **Griselda Margarita Arredondo Pinzón**, 36. These new enforcement actions are part of the NCC Homeland Security Task Force initiative to counter the narco-terrorist cartels that endanger the American people.

Last year, prosecutors in our Office's Business and Securities Fraud Section and International Narcotics and Money Laundering Section obtained a superseding indictment against two senior leaders and a criminal associate of CJNG in connection with a fraud scheme targeting Americans who owned timeshare properties in Mexico," said U.S. Attorney Joseph Nocella Jr. for the Eastern District of New York.

"CJNG's criminal enterprise has exploited financial systems and defrauded thousands of Americans, fueling violence and narcoterrorism across borders," said Deputy Chief Gary Shapley of IRS-CI. "IRS-CI is committed to dismantling these networks — tracking illicit proceeds, exposing fraud, and holding cartel leaders accountable. Today's coordinated action demonstrates the power of U.S. law enforcement partnerships and our resolve to protect the American public from the devastating impact of transnational crime. We will continue to pursue those who threaten our communities, wherever they operate."

"CJNG produces and traffics multi-tonnage quantities of drugs, including cocaine and methamphetamine, into the United States, and uses extreme violence to further its operations. On Feb. 20, 2025, the State Department designated CJNG as a foreign terrorist organization. About a year later, in February 2026, CJNG's notorious top leader, Nemesio Oseguera Cervantes, also known as "El Mencho," was killed during a Mexican military operation. According to court filings, Valencia González assumed the role of CJNG's top leader following El Mencho's death.

Increased Rewards Announced

The Department of Justice previously unsealed a federal indictment charging Valencia González with conspiracy to manufacture and distribute cocaine and methamphetamine for unlawful importation into the United States, as well as use of firearms, one of which was a machinegun, during and in relation to the charged drug trafficking crime. Valencia González is El Mencho's stepson, who reportedly organized numerous crimes of violence as a CJNG leader, in addition to manufacturing, transporting, and distributing tonnage quantities of narcotics. The State Department announced today the newly increased reward of up to $25 million for information leading to Valencia González's arrest and/or conviction.

The superseding indictment against Flores Silva was originally unsealed in May 2026, charging him with conspiracy to manufacture and distribute cocaine, heroin, and methamphetamine destined for the United States, use of firearms, one of which was a destructive device, in furtherance of the drug trafficking crime, and money laundering conspiracy. Flores Silva, a high-ranking member of the CJNG, was arrested in Mexico in April 2026. The State Department announced today the newly increased reward of up to $15 million for information leading to Flores Silva's conviction.

If convicted of these charges, which were filed in the District of Columbia, Valencia González and Flores Silva face up to two consecutive life prison terms.

New Charges and Rewards Announced

The Department of Justice also announced the recent unsealing of criminal charges against five additional senior CJNG leaders.

The filings allege that Mendoza Gaytán, El Mencho's godson, procured the majority of the CJNG's weapons, trained sicarios at CJNG's training camps, and oversaw operations, including forced recruitment and violent enforcement, across multiple strategic CJNG locations.

The court documents further allege that Ruiz Velasco, another close associate of El Mencho and a Grupo Elite leader, oversaw all CJNG operations in several Mexican territories, including drug trafficking, bribery, procurement of weapons, and enforcement**. Ruiz Velasco** is also allegedly involved in the transportation, importation, and distribution of drugs, including the distribution of methamphetamine, fentanyl, and heroin within the United States and the collection of narcotics proceeds.

The court filings allege that **Castillo Rodríguez**, El Mencho's former son-in-law, was responsible for various aspects of the CJNG's operations, including overseeing CJNG operations in Colima, Mexico, collecting drug proceeds, paying for precursor chemicals used by the CJNG to manufacture methamphetamine, purchasing tonnage quantities of methamphetamine from CJNG suppliers, and overseeing the transportation of cocaine and methamphetamine shipments for importation into the United States.

The unsealed indictments allege that these five defendants participated in conspiracies to manufacture and distribute cocaine, methamphetamine, heroin, and fentanyl destined for the United States for over a decade. The indictments further allege that these defendants used, carried, brandished, or discharged firearms, some of which were semi-automatic weapons, machineguns, and destructive devices, during and in relation to the charged drug trafficking crimes. If convicted of these charges, which were filed in the District of Columbia, all five defendants face up to two consecutive life prison terms.

The State Department also announced today a reward of up to $15 million for information leading to Mendoza Gaytán's arrest and/or conviction; a reward of up to $15 million for information leading to Castillo Rodríguez's arrest and/or conviction; a reward of up to $10 million for information leading to Montero Pinzón's arrest and/or conviction; a reward of up to $10 million for information leading to Rivera Varela's arrest and/or conviction; and a reward of up to $10 million for information leading to Ruiz Velasco's arrest and/or conviction.

Relatedly, the State Department also announced a reward of up to $2 million for information leading to the arrest and/or conviction of Arredondo Pinzón, Montero Pinzón's half-sister. In coordination with Montero Pinzón and Rivera Varela, the three allegedly ran an international fraud scheme organized and controlled by the CJNG, which targeted Americans who own timeshare properties in Mexico. As announced in September 2025, Arredondo Pinzón is charged in the Eastern District of New York with conspiracy to commit wire fraud and money laundering. A superseding indictment returned in October 2025, also charges Montero Pinzón and Rivera Varela with conspiracy to commit money laundering, conspiracy to provide and providing material support to a foreign terrorist organization, and charges Montero Pinzón with conspiracy to commit wire fraud. If convicted, Arredondo Pinzón, Montero Pinzón, and Rivera Varela face up to 20 years in prison on each count related to the fraud scheme.

The Money Laundering, Narcotics and Forfeiture Section's (MNF) mission is to take the profit out of crime, eliminate drug cartels, and protect the U.S. financial system. MNF pursues criminal prosecutions and criminal and civil asset recovery actions involving financial facilitators who launder profits for criminals; financial institutions and their officers and employees whose actions threaten the U.S. financial system and financial institutions; international money launderers who support transnational organized crime; and the top command and control of international drug trafficking organizations.

MNF's Narcotic and Dangerous Drug Unit investigates and prosecutes the top command and control elements of international drug cartels, drug trafficking organizations, and related transnational criminal organizations.

The Health and Safety Unit of the Fraud Section works with law enforcement partners to investigate and prosecute violations of federal laws designed to protect public health and safety. The unit focuses on corporations and individuals who make and sell dangerous drugs, food, and other consumer products that could cause significant harm to Americans.

The Transnational Criminal Organizations Strike Force investigates and prosecutes cartels and transnational criminal organizations by bringing charges that include terrorism, racketeering, and operating a continuing criminal enterprise. DEA's Bilateral Investigations Unit is an elite group of experienced DEA special agents that are entrusted with handling the most sensitive, expansive, and difficult investigations that target the world's most violent drug traffickers and terrorists.

Civil Rights Division Secures Settlement with OpenAI for Discriminating Against U.S. Workers

The Justice Department's Civil Rights Division announced today that it has secured a combined $3,200,000 settlement with **OpenAI OpCo LLC**, a San Francisco, California-based artificial intelligence company, and its subsidiary, Statsig Inc., a Bellevue, Washington-based software development company (together, OpenAI). The settlement addresses allegations that both companies violated the Immigration and Nationality Act (INA) by discriminating against U.S. workers and instead preferred workers with temporary employment visas, when the companies hired and recruited during the Permanent Labor Certification (PERM) process.

"It is illegal to discriminate against U.S. workers by preferring temporary visa holders for jobs," said Assistant Attorney General Harmeet K. Dhillon of the Justice Department's Civil Rights Division. "This substantial settlement ensures that OpenAI redresses harm and changes its recruitment practices so that U.S. workers receive a fair opportunity for highly sought-after technology positions."

The Department's investigation found that OpenAI did not advertise positions it sought to fill through the PERM program on its external job website, even though its standard practice was to do so with other jobs. OpenAI also required applicants to mail paper applications for positions advertised as part of PERM recruitment, even though the company permitted electronic applications for other positions. In addition, OpenAI took other steps to discourage U.S. workers from applying, such as advertising positions on the radio late at night. While there were fewer than ten PERM positions at issue, the resolution amount reflects the harm to U.S. workers when they are shut out of applying for lucrative technology jobs.

Under the terms of the settlement, OpenAI will pay $1,200,000 in civil penalties to the United States and establish a back-pay fund of $2,000,000 to compensate victims of the companies' discriminatory practices. In addition, OpenAI will give U.S. workers fair opportunities to apply for jobs as part of PERM recruitment by posting the positions on its public career website and accepting electronic applications. The agreement also requires OpenAI to train its personnel on the INA's anti-discrimination requirements, revise its employment policies, and be subject to departmental monitoring and reporting requirements, to prevent future discrimination.

The PERM program allows employers to sponsor workers for permanent resident status if the companies perform good-faith recruitment but cannot find qualified U.S. workers. However, during this process, companies cannot illegally discriminate against U.S. workers based on their citizenship status.

Wisdom

MR. ENGLERT: "… *Chiarella* says fraud in a statute is very broad, but it's broad enough to cover the common law and no more. If Congress wants to go broader than the common law –" JUSTICE BREYER: "Well, fine. But what is – I'm talking the common law. All I know about contracts came from Blackjack Dawson, my contracts teacher –" *Universal Health Services, Inc. v. United States ex rel. Escobar* (2016)

"Poetry is adjectives expressed in nouns. **— Leo Stein**

"It is not that we have a soul, but that we are a soul." **– Rachel Naomi Remen**

"Guard with jealous attention the public liberty. Suspect everyone who approaches that jewel. Unfortunately, nothing will preserve it but downright force. Whenever you give up that force, you are inevitably ruined." **—Patrick Henry**

"Many social ills are less the consequence of oppressive control than of oppressive lack of control." — **Alvin Toffler**

"Newspapers ... serve as chimnies to carry off noxious vapors and smoke." **—Thomas Jefferson**

"The greatest good you can do for another is not just share your riches, but to reveal to him his own." **— Benjamin Disraeli**

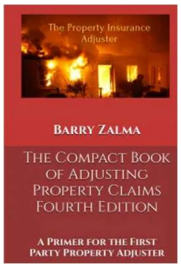
"People don't resist change; they resist BEING changed**."** — **Peter Bregman**

"Arbitrary power is most easily established on the ruins of liberty abused to licentiousness." — George Washington

"No matter how much deception, camouflage, or brainwashing is employed, statism, socialism, and communism can never sustain public support. Throughout history, the Left has therefore begun by changing the rules and altering the demography — if not initially through changes to election rules, bureaucratic fiat, and biased court orders, then eventually through sheer violence." – **Victor Davis Hanson**

Compact Book of Adjusting Property Claims Fourth Edition

In Kindle, paperback and hardback formats, *The Compact Book of Adjusting Property Claims, Fourth Edition is now available for purchase here* and here.



The Fourth Edition contains updates and clarifications from the first three editions plus additional material for the working adjuster and the insurance coverage lawyer. Primer for the First Party Property Adjuster The insurance adjuster is seldom, if ever, mentioned in a policy of insurance. The strict wording of the first party property policy sets the obligation to investigate and prove a claim on the insured.

Standard first party property insurance policies, based upon the more than a century old New York Standard Fire Insurance policy, contain conditions that require the insured to, within sixty days of the loss, submit a sworn proof of loss to prove to the insurer the facts and amount of loss.

In general, failure to file the proof within the time limited by the policy is fatal to an action upon it (*White v. Home Mutual Ins. Co*., 128 Cal. 131, 60 P. 666 (1900); *Beasley v. Pacific Indem. Co.,* 200 Cal.App.2d 207, 19 Cal.Rptr. 299 (Cal. App. 1962).

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

Health Insurance Fraud Convictions

New Mexico Woman Pleads Guilty to $4M Medicaid Fraud

Dorothea Irving, 47, of Farmington, New Mexico, woman pleaded guilty to working with a non-emergency medical transport (NEMT) company to submit millions of dollars in false and fraudulent claims to New Mexico Medicaid for ineligible and non-existent trips to medical appointments.

According to court documents, Irving worked as a driver between 2020 and 2026 for a company that provided non-emergency medical transportation. The New Mexico Medicaid program covers the cost of transportation for non-emergency medical services, such as routine doctors' appointments, for Medicaid recipients who lack access to transportation by personal vehicle or public transportation. Instead of driving Medicaid beneficiaries who lacked transportation to their medical appointments, Irving and the company engaged in a multi-year scheme to submit fraudulent claims for purported transportation provided to Irving and her children.

Together with the company, its owner, and other employees and drivers, Irving submitted false trip records claiming that she or her children were the Medicaid beneficiaries without transportation, claiming trips that had not occurred, and claiming to have been an attendant for her children on their own trips. Irving and other drivers also signed trip forms falsely representing to have driven each other to appointments to disguise the fact that they were driving themselves. In many instances, the fraudulent trips involved Irving, another driver, or minor children purportedly traveling to Alcoholics Anonymous meetings across New Mexico at great distances.

The NEMT company used the false trip records to submit millions of dollars in fraudulent claims to New Mexico Medicaid, including false claims that each passenger in the vehicle had taken a separate trip. For the trips taken by Irving and her children as the supposed Medicaid recipient without transportation, the company submitted fraudulent claims of approximately $3,957,788 and received approximately $4,142,942 from Medicaid. Irving herself received approximately $980,901 from the company over four years of the scheme.

Irving pleaded guilty to conspiracy to commit health care fraud. A sentencing date has not been set and she faces a maximum penalty of 10 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Adult Day Care Owner Pleads Guilty to $500,000 Medicare Fraud Scheme

Yolanda Matthews, 58, of Farmington Hills, admitted to continually billing and submitting false and fraudulent claims to Medicare for psychotherapy services that were never provided. A Michigan woman pleaded guilty today to billing Medicare for psychotherapy services that were never provided to residents of her adult day care center.

According to court documents, Matthews admitted to fraudulently billing for providing services at her adult day care center during periods in which the Medicare beneficiary was actually admitted to a hospital, forging claims in the names of social workers who were no longer employed at the adult day care center, and even billing Medicare for providing psychotherapy services to beneficiaries after they had died. All told, Matthews submitted over $539,000 in false and fraudulent claims to Medicare.

Matthews was charged as part of the 2026 National Health Care Fraud Takedown. Matthews pleaded guilty to conspiracy to commit health care fraud. She is scheduled to be sentenced on Nov. 18, 2026, and faces a maximum penalty of 10 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

The Fraud Division Announces Charges Against 19 Defendants for Medicaid Home Health Aid Schemes

Division Expands Northeast Strike Force to Philadelphia to Target Health Care Fraud Schemes, Provide Full-Spectrum Accountability

The Justice Department's National Fraud Enforcement Division (Fraud Division) announced a major investment in combatting Medicaid fraud through a significant expansion of the Division's Northeast Health Care Fraud Strike Force to Philadelphia, Pennsylvania, an enforcement initiative uniting the Division's Health Care Fraud Section with the U.S. Attorney's Office for the Eastern District of Pennsylvania. The Health Care Strike Force model has proven to be one of the most powerful tools in the federal enforcement arsenal, responsible nationally for the prosecution of over 6,200 defendants who collectively billed federal health care programs and private insurers more than $45 billion.

In connection with the announcement, the Fraud Division, U.S. Attorney's Office, and Pennsylvania Attorney General today announced criminal charges against 19 defendants, including owners and employees of home care companies, for their alleged participation in various fraud schemes involving over four million dollars in claims to Medicare and Medicaid. The Pennsylvania Attorney General also announced a plea agreement involving the final defendant in a previously-charged 21 defendant case involving over $1.7 million in claims.

The Fraud Division's expansion into the Eastern District of Pennsylvania brings enhanced federal resources to a district with an established tradition of strong health care fraud enforcement. The partnership between the Fraud Division and the Eastern District of Pennsylvania will uniquely enable law enforcement to combat criminals who hide behind corporations to commit fraud. Philadelphia and its surrounding areas have vibrant and cutting-edge health care technology and insurance industries, and the Eastern District of Pennsylvania has long been a prime venue for private lawsuits that bring unlawful corporate conduct in the health care industry to the attention of law enforcement. The Unit's corporate enforcement efforts align closely with the U.S. Attorney's Office in the Eastern District of Pennsylvania and its history of successful criminal and civil actions against corporate bad actors operating in the health care industry. In particular, the Health Care Fraud Unit has significantly expanded its focus on corporate accountability, resolving cases against companies engaged in systemic illegal conduct, including recent corporate resolutions with AP of South Florida LLC, Atlantic Biologicals Corp., ExThera, and Troy Health Inc. Just last week, the Fraud Division announced the first declination of a health care company under the new Department-wide Corporate Enforcement Policy, which resulted from a voluntary self-disclosure by eye care group Campus Eye.

"Home care funding exists to assist America's elderly and most vulnerable — not to fund schemes in which aides claim be providing care while incarcerated or vacationing in Miami and Saudi Arabia," said Assistant Attorney General Colin M. McDonald of the Justice Department's National Fraud Enforcement Division. "Today's charges and the expansion of our Northeast Strike Force into the Eastern District of Pennsylvania send a clear message to fraudsters in the region: the Department of Justice will relentlessly pursue you and use all available tools to protect Medicaid and the programs everyday Americans rely on."

"Home care fraud is everywhere, and the victim is all of us taxpayers. Medicaid claims data and the experience of veteran prosecutors all point to the systematic exploitation of reimbursable home care programs," said U.S. Attorney David Metcalf for the Eastern District of Pennsylvania. "Today, we sound the alarm on the scale of this fraud by announcing some truly egregious cases, in which numerous people are charged with filing fraudulent claims for caregivers who were not actually providing home care services, but in fact were dead, in prison, or trafficking drugs. This racket ends today."

"Health care fraud is not a victimless crime – it undermines public trust and diverts critical resources from patients who need them," said Special Agent in Charge Wayne A. Jacobs of the FBI Philadelphia Field Office. "No single agency can tackle complex health care fraud schemes alone. Let today's announcement be a warning to those engaging in similar activity: if you seek to exploit our health care systems for personal profit, you should expect the FBI and our partners to uncover your scheme and bring it to an end. Every dollar stolen through fraud is a dollar diverted from patient care, and the FBI will continue its work to safeguard the public's trust and hold accountable those who abuse these vital programs."

Today's announcement, which charges company owners, home health aides, and Medicaid recipients, including individuals with significant criminal records, shows the diversity of the Fraud Division's work and its emphasis on full-spectrum accountability. The Strike Force's expansion makes clear that the Fraud Division will use every available legal tool to identify, investigate, and prosecute offenses against the American people. The Fraud Division and its partners in the Eastern District of Pennsylvania and the Pennsylvania Office of the Attorney General will pursue anybody who seeks to profit at the expense of American taxpayers, regardless of whether the wrongdoing is in the boardroom or in the sickroom. With the newly expanded Northeast Strike Force, the District will have the resources to pursue these allegations and ensure that corporate criminal actors are brought to justice.

Home Care Fraud

Recently, the Eastern District of Pennsylvania has become the target of fraudsters seeking to take advantage of Medicaid's home care funds, which should be devoted to assisting elderly and ill Pennsylvanians to age in place with dignity. Today's announcement is a result of coordinated and dedicated investigations and prosecutions at the federal and state levels.

Today's cases demonstrate that even the boldest fraudsters will be caught and stopped. In one case announced today, four defendants, two purported aides and two Medicaid recipients, were charged in connection with a conspiracy to submit claims for home health services that never occurred. One purported aide claimed to be providing services while she was incarcerated; another purportedly provided services while hospitalized. These four defendants caused over $440,000 in claims to Medicaid. In another of today's cases,

two defendants, father and son, were charged after the son, a purported aide, claimed to be providing services while driving for a ride-share and food delivery service. On one occasion, the defendants claimed services while the son was in the midst of a traffic stop in which he was cited for possession of marijuana; on another, the defendants claimed services while the father was in court participating in a sentencing hearing for another individual. Medicaid paid over $200,000 for care purportedly provided to the father. In a third case being announced today, a purported aide and a Medicaid recipient were charged after the recipient claimed to be so debilitated that he needed dozens of hours of home health assistance, resulting in over $160,000 in claims to Medicaid. In reality, the recipient had a day job as a carpenter working in the construction industry.

Social media posts depicting defendant's vacation to Miami, Florida, while he billed for providing home care services to a Medicaid recipient in the Eastern District of Pennsylvania.

The defendants' conduct was characterized by extraordinary greed. In one case, the Pennsylvania Attorney General charged a purported home health aide who claimed to have provided services to up to seven Medicaid recipients at once. On over 1,100 occasions, the defendant allegedly claimed to have provided care for more than 24 hours in a single day, totaling over 64,000 hours that could not have been worked. As alleged, Medicaid paid over $1.2 million as a result of the scheme. Another defendant who was charged in today's announcement, a purported aide, claimed to have worked over 8,700 overlapping hours. As alleged, there were nearly 400 days on which the defendant claimed to be working for more than 24 hours in a day. The defendant allegedly caused over $180,000 in loss to Medicaid. In another case, a defendant was charged who claimed to have provided over 1,300 hours of home care services for a Medicaid recipient who was himself incarcerated on state drug charges. A defendant in one case was captured on a recorded conversation stating that "this home health care is the best kept secret . . . I made a buck plus [each of] the last five years, that's, that's a half a million dollars . . . I ain't checking on nobody."

The defendants in today's announcement were not deterred by the physical impossibility of their claims, as several defendants were charged with claiming to have provided services while they were out of the country. For example, one defendant pleaded guilty to charges brought by the Pennsylvania Attorney General for his claims to be providing home care services while he was, among other places, in Saudia Arabia. Nineteen other defendants previously pleaded guilty in connection with this case. Another defendant, charged by the U.S. Attorney's Office for the Eastern District of Pennsylvania, allegedly claimed to provide services while traveling overseas on multiple occasions. The defendant caused nearly $600,000 in claims to Medicaid, most of which were fraudulent.

Today's announcement also includes a home care agency, which was charged alongside its two owners. As alleged, the agency and its owners billed Medicaid for hundreds of false and fraudulent clock-ins and clock-outs for home care shifts, falsely representing that two agency employees were providing home care services to clients. In total, the defendants caused Medicaid to pay approximately $224,000 for the affected employees' purported work.

Expanding the Northeast Strike Force to the Eastern District of Pennsylvania

As part of the expansion, the Northeast Strike Force, led by Acting Assistant Chiefs Miriam Glaser Dauermann and Patrick J. Campbell, will coordinate closely with the Eastern District of Pennsylvania's Health Care Fraud Section, led by Assistant U.S. Attorneys Tony Scicchitano and Paul Shapiro, to establish the new office of the Strike Force. The Strike Force will work in partnership with the HHS Office of Inspector General, the Federal Bureau of Investigation, the Drug Enforcement Administration, and other law enforcement partners, reflecting the Department's determination that the need for coordinated, aggressive action in this region is urgent and undeniable.

CEO of Skincare Company Pleads Guilty to FDCA Charges and Mail Fraud

Bryce Cleveland, the President and CEO of **Scalpa, Inc**., pleaded guilty today to three charges related to Scalp's selling of skincare products that had not been approved by the U.S. Food and Drug Administration (FDA).

Cleveland, 42, of Scottsdale, Arizona, pleaded guilty to mail fraud, introduction of an adulterated device into interstate commerce, and introduction of an unapproved new drug into interstate commerce. Cleveland was apprehended late last year in Colombia and removed back to the United States where he was arrested on an outstanding federal warrant by the U.S. Marshals Service after an indictment against him was returned in July 2024.

In 2015, Scalpa was a for-profit corporation incorporated in Arizona that marketed and sold medical devices and drug products intended to affect the structure and function of the human body. Between March 2018 and December 2020, Cleveland devised a fraudulent scheme to unlawfully enrich himself by marketing and delivering others to market and deliver, unapproved devices to consumers, including the **ScalpaJECT Hyaluronic Acid,** and **Hyaluronans Pen**, while making false representations that the devices were not subject to FDA regulation. Similarly, Cleveland introduced and delivered, and caused others to introduce and deliver, the unapproved new drug "Scalpatox" into commerce.

The **ScalpaJECT Hyaluronic Pen, Hylaron Pen**, and similar unapproved and misbranded devices and drugs are especially concerning from a public health perspective because injectable drug products can pose risks of serious harm to users. Injectable products are delivered directly into the body, sometimes directly into the bloodstream, and therefore, bypass some of the body's key defenses against toxins and microorganisms that can lead to serious and life-threatening conditions.

Scalpatox was an unapproved and misbranded botulinum toxin product. On Nov. 5, 2025, the FDA issued a warning to owners of websites illegally marketing unapproved and misbranded botulinum toxin products, commonly called Botox. The agency is aware of adverse events associated with unapproved and misbranded botulinum toxin products, including botulism symptoms.

Cleveland has agreed to be sentenced to a prison term of between four and eight years. He has also agreed to pay restitution for the entire scope of his criminal conduct, and to forfeit $800,000.

Two Additional Ophthalmology Practices Agree to Pay $2.3M to Resolve Allegations of Fraudulent Claims to Medicare and Medicaid for Cranial Ultrasounds

New York ophthalmology practices **Mark D. Fromer, P.C.** doing business as **Fromer Eye Centers** and **Floral Park Ophthalmology P.C**. have agreed to pay a total of $2.3 million to resolve alleged violations of the False Claims Act arising from their billing for trans-cranial doppler ultrasounds (TCDs) through a kickback arrangement with a third-party testing company. The Estate of Mark Fromer, the former owner of Fromer Eye Centers, also joined in the settlement with the practice. Both practices have agreed to cooperate with the Justice Department's ongoing investigations of other participants in the alleged scheme.

The settlements announced today resolve allegations that the settling practices knowingly submitted, and caused the submission of, false claims to Medicare (and, with respect to Fromer Eye, Medicaid) for medically unnecessary TCDs. The United States alleges that the settling practices performed TCDs on thousands of patients and billed Medicare and Medicaid hundreds of dollars per test. Before the patients received the results of the test, the practices and the third-party testing company allegedly identified the patients as having received a serious diagnosis that could qualify the patient for reimbursement of a TCD. However, the United States alleged that nearly all patients who received TCDs never had that diagnosis, and it was not reflected in the patient's medical history or in the TCD results. In addition, Floral Park Ophthalmology allegedly received remuneration paid by the third-party testing company to induce the practice to refer its Medicare and Medicaid patients to the testing provider for TCDs.

Fromer Eye Centers and the Estate of Mark Fromer will pay $1,800,000 and Floral Park Ophthalmology will pay $500,000. Of the total settlement amounts, $384,000 will be paid to the State of New York for its share of Medicaid, which is a jointly funded federal and state program.

The civil settlements resolved claims in a lawsuit filed under the *qui tam* or whistleblower provision of the False Claims Act, which permits private parties to file suit on behalf of the United States for false claims and share in a portion of the Government's recovery. The *qui tam* was filed by a whistleblower who will receive approximately $132,000 in connection with the settlement with Fromer Eye Centers.

CEO and VA Employee Plead Guilty to Paying and Receiving Illegal Health Care Kickbacks and Bribes

Two Florida men pleaded guilty this week to conspiracy to pay and receive illegal health care kickbacks and bribes.

According to court documents, **Laurent Cassagnol**, 43, and **Heriberto Rivera**, 43, both of Orlando, Florida, conspired to refer patients of the VA Community Care Program (VACCP) to **Family Integrative Medicine of Orlando, LLC** (FIMO) for acupuncture, chiropractic adjustments, and other holistic medical services. Rivera, the CEO of FIMO, admitted to paying kickbacks and bribes to Cassagnol, an **Advanced Medical Support Assistant** for VACCP, in exchange for Cassagnol steering VA patients to FIMO for medical services. Cassagnol admitted to accepting Rivera's payments. As a result of the conspiracy, the VA and VACCP was billed for over $14 million in claims that were procured through the payment of kickbacks and bribes, of which over $11 million was paid. The investigation was the result of a complaint made to the VA Office of the Inspector General (VA-OIG) fraud hotline.

Cassagnol and Rivera both pleaded guilty to conspiracy to pay and receive kickbacks and bribes. Cassagnol and Rivera are scheduled to be sentenced on Nov. 5. Each defendant faces a maximum penalty of five years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Medicare Advantage Provider Complete Health to Pay $14,100,000 to Settle False Claims Act Suit

Complete Health Partners Holdings, headquartered in Jacksonville, Florida, agreed to pay $14,100,000 to resolve allegations that they violated the False Claims Act by causing the submission of false diagnosis codes in order to increase payments that they received from the Medicare Advantage program.

Under the Medicare Advantage (MA) Program, also known as Medicare Part C, Medicare beneficiaries may opt out of traditional Medicare and enroll in private health plans offered by insurance companies known as Medicare Advantage Organizations, or MAOs. The Centers for Medicare & Medicaid Services (CMS) pays the MAOs a fixed monthly amount for each Medicare beneficiary enrolled in their plans. CMS adjusts these monthly payments to account for various "risk" factors that affect expected health expenditures for the beneficiary. In general, CMS pays MAOs more for sicker beneficiaries expected to incur higher healthcare costs and less for healthier beneficiaries expected to incur lower costs. To calculate the payment amounts, CMS uses a health-based risk adjustment model — the Hierarchical Conditions Category (HCC) model — that takes into account diagnoses reported by healthcare providers. In general, the more severe the diagnosis or costly the associated treatment, the higher the risk score and the higher the corresponding payments to the MAO.

Complete Health Partners Holdings (Complete Health) is a management services organization that manages, owns or otherwise operates affiliated provider groups operating out of Florida, Alabama and Colorado. Under the contracts, the MAOs agreed to pay Complete Health a percentage of the payments they received from CMS. This "risk sharing" compensation arrangement gave Complete Health a financial incentive to submit additional diagnosis codes to increase its patients' risk scores and the corresponding payments made by CMS.

The settlement resolves allegations, from 2020 to 2023, Complete Health submitted diagnosis codes within Hierarchical Condition Code (HCC) 55 (Drug and Alcohol Dependence) and HCC 59 (Major Depressive, Bipolar, and Paranoid Disorders) that were not clinically

valid, not properly supported by the beneficiary's medical records, and/or not considered in the care, management, or treatment of the beneficiary.

The United States contends that Complete Health disseminated incorrect coding guidance to its coders and physicians regarding diagnosis codes within HCC 55 and HCC 59. The United States further contends that Complete Health coders reviewed its beneficiaries' medical records and identified additional diagnosis codes for chronic conditions, including diagnoses within HCC 55 and HCC 59. Complete Health then prompted doctors to add those diagnosis codes, even when the diagnosis codes were unsubstantiated or not clinically justified. As a result, the doctors added those diagnosis codes, which were not accurate. These diagnoses resulted in an increase in payment from CMS to the MA Plans in which the beneficiaries were enrolled, and the MA Plan then passed along a portion of the increased payment to Complete Health.

The civil settlement resolves claims brought under the *qui tam* or whistleblower provisions of the False Claims Act by Karen Bowers, former Associate Director of Risk Adjustment at VIVA Health. Under those provisions, a private party can file an action on behalf of the United States and receive a portion of any recovery. The *qui tam* case is captioned *United States ex rel. Karen Bowers vs. Complete Health Partners, Inc., Pharos Capital Group, LLC, Viva Health Inc., and Blue Cross and Blue Shield of Alabama,* Civil Action No. 3:22-cv-463 (M.D. Fla.). Karen Bowers will receive approximately $2,467,500 as her share of the federal recovery.

Texas Laboratory, Former CEO, and Florida Businessman Pay a Total of $36.4M to Settle Allegations of Kickbacks and Unnecessary Genetic Testing

Access DX Laboratory, located in Houston, Texas, its former CEO **Michael Stewart**, and Florida businessman **Harold Shatz,** have each entered into settlements and will pay a combined total of $36.4 million to the United States to resolve allegations that they violated the False Claims Act (FCA) by paying kickbacks and billing Medicare and Medicaid for medically unnecessary genetic testing.

The United States alleged that, from January 2018 through January 2020, Access DX, Stewart, and Shatz paid kickbacks to marketers in return for referrals of patients for genetic testing, unbundled billing codes for genetic testing, paid telemedicine providers for false and fraudulent doctors' orders, and submitted and caused the submission of false claims for genetic testing.

In connection with its settlement, **Access DX** 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). The CIA requires Access DX to implement auditing and accountability provisions, including implementation of a robust compliance program, training and education requirements, and a review of arrangements with referral sources.

On June 24, Stewart agreed to plead guilty to conspiracy to defraud the United States and to pay and receive health care kickbacks in violation of 18 U.S.C. § 371. *United States v. Stewart*, Case No. 4:22-cr-328 (S.D. Tex.). On Oct. 15, 2025, Shatz agreed to plead guilty to conspiracy to defraud the United States and to pay and receive health care kickbacks in violation of 18 U.S.C. § 371. *United States v. Shatz*, No. 4:24-cr-330 (S.D. Tex.). Both men entered into civil FCA settlements at the time of their pleas.

Prominent Attorney Sentenced to Prison for Tax Evasion and Mortgage Fraud

SCOTUSblog Founder Hid Millions in Gambling Income and Debts

Thomas C. Goldstein, a prominent appellate attorney who argued more than 40 cases before the U.S. Supreme Court and co-founded the widely read legal website SCOTUSblog, was sentenced to 72 months in prison today for tax crimes and mortgage fraud. The Court additionally revoked Goldstein's bond and remanded him into custody.

The sentence held Goldstein accountable for cheating the tax system and lying to mortgage lenders. Mr. Goldstein concealed millions of dollars in income, disguised income with foreign bank accounts, and manipulated his law firm's books — all to fund his gambling and lifestyle. He then repeatedly chose not to pay taxes owed. There is no tax case too big, no scheme too complex, and no hiding place too remote for the Fraud Division.

According to court documents and evidence presented at trial, Goldstein, of Chevy Chase, Maryland, was the sole owner of **Goldstein & Russell, P.C**., a boutique law firm specializing in appellate litigation, including litigation before the U.S. Supreme Court. Goldstein was also a high-stakes poker player, frequently playing in games involving tens of millions of dollars.

Between 2016 and 2024, Goldstein repeatedly chose not to pay taxes on time, as required by law. He also assisted in the preparation of false tax returns for himself and his law firm, and he engaged in a scheme to evade taxes for 2016. Goldstein carried out the scheme by hiding millions of dollars in poker winning from the government and his accountants, diverting legal fees to his personal bank account to satisfy poker-related debts, directing people to pay his creditors instead of sending payments directly to him, channeling gambling winnings through foreign bank accounts and causing personal payments for poker debts to be falsely classified as "legal-fee" expenses on the firm's books and records. As a result, Goldstein underreported his income and did not pay much of the taxes that he owed, while spending millions on personal expenses such as poker, travel, and luxury goods.

In 2021, Goldstein submitted false mortgage applications to two separate mortgage lending companies, seeking financing to purchase a $2.6 million dollar home in Washington, D.C. On those mortgage applications – which required Goldstein to list all his liabilities and debts – Goldstein omitted millions of dollars of liabilities, including more than $14 million he owed for poker-related debts, as well as taxes he owed the IRS. Goldstein's false statements to one of the mortgage lenders enabled him to obtain a $1.98 million loan.

On Feb. 25, a federal jury convicted Goldstein of tax evasion, assisting in the preparation of false tax returns, willful failure to timely pay taxes and making false statements to mortgage lenders. In addition to the term of imprisonment, U.S. District Judge Lydia Kay

Griggsby for the District of Maryland ordered Goldstein to serve five years of supervised release, pay $3,103, 427 in restitution, and ordered forfeiture but at an indeterminate amount.

Brooklyn Adult Daycare Owner Sentenced to 57 Months for Medicaid Fraud Scheme

Eric Zhu, 29, of Brooklyn, New York, owned **Prime Life Adult Day Care LLC** (Prime Life). From approximately 2020 through 2025, Medicaid recipients were paid illegal cash kickbacks and bribes in exchange for enrolling with Prime Life. Between 2020 and 2025, Prime Life fraudulently billed Medicaid approximately $3.2 million for SADC services that these Medicaid recipients never received. Medicaid paid approximately $3.2 million based on these false and fraudulent claims. Zhu used multiple business entities to launder the fraud proceeds and generate the cash used to pay kickbacks and bribes to the Medicaid recipients, some of which was recovered during a search of Prime Life, as shown below.

A Brooklyn man surrendered to the U.S. Bureau of Prisons today to begin serving 57 months in prison in connection with his leadership of a $3.2 million Medicaid fraud and illegal kickback scheme at his social adult daycare (SADC) center. The defendant was also ordered to pay almost $3.2 million in restitution and to forfeit $1.5 million in fraud proceeds.

According to court documents, Zhu exploited vulnerable Medicaid recipients by paying them illegal cash bribes to enroll in his adult day care program, then fraudulently billed Medicaid $3.2 million for services that were never actually provided. This scheme stole millions from American taxpayers and undermined a program meant to help those in need. Today's surrender to federal authorities shows we are holding Zhu and other fraudsters like him accountable.

Texas Physician Sentenced to 12 Years in Prison for Operating a Houston-Area Pill Mill

Maryam Qayum, M.D., 68, of Montgomery County, Texas, owned, operated, and was the sole prescriber at Recare Health Clinic (Recare). Qayum operated **Recare** as a cash-only pill-mill, selling controlled substance prescriptions to street-level drug dealers who were referred to at Recare as "providers." "Providers" purchased prescriptions for high strength, highly addictive opioids oxycodone and hydrocodone. Qayum issued these prescriptions without a legitimate medical purpose, and often without ever interacting with the patient. According to court documents, Qayum issued prescriptions for more than 3 million opioid pills between 2022 and 2025, when her clinic was shut down by law enforcement.

Qayum, was sentenced yesterday to 12.5 years in prison for operating her Kingwood medical clinic as an illegal pill mill that issued prescriptions for over 3 million opioid pills.

According to court documents: Court documents detail how Recare, like many pill-mill clinics, operated well outside the course of a normal medical practice, including charging more for prescriptions for drugs with higher street value. A prescription for oxycodone 30mg cost as much as $500, while hydrocodone prescriptions were often $300, and Recare's staff frequently took "tips" from drug dealers to fast track their patients and prescriptions. The following note listing the cash price for each prescription was seized when law enforcement executed a search warrant at Recare.In March 2026, Qayum pleaded guilty to conspiracy to unlawfully distribute controlled substances.

In addition to Qayum, four other defendants were previously sentenced in this case:

Melvin Sampson, 56, of Houston, Texas, was sentenced to 210 months in prison in June 2026. In March 2026, Sampson pleaded guilty to conspiracy to unlawfully distribute controlled substances. Sampson was a street-level drug dealer who brought patients to Recare, filled prescriptions at Surge Rx and elsewhere, and resold the drugs he obtained on the black market.

Tomi-Ko Bowers, APRN, 71, of Cleveland, Texas, was sentenced to 96 months in prison in June 2026. In March 2026, Bowers pleaded guilty to conspiracy to unlawfully distribute controlled substances and was a nurse practitioner at Recare.

Lester Stokes, 38, of Houston, Texas, was sentenced to 63 months in prison in June 2026. In March 2026, Stokes pleaded guilty to conspiracy to unlawfully distribute controlled substances and was Recare's security guard.

Jared Williams, RPh, 49, of Pearland, Texas, was sentenced to 42 months in prison in July 2026. In March 2026, Williams pleaded guilty to unlawfully distributing a controlled substance and was the owner and pharmacist in charge at Surge Rx, which filled illegitimate prescriptions issued by Qayum. DEA and the Conroe Police Department investigated the case.

Justice Department's Fraud Division Announces Unprecedented Fraud Enforcement Actions in Southeast Resulting from Federal–State Partnerships

The Justice Department's National Fraud Enforcement Division on July 30, 2026 announced a series of significant fraud enforcement actions across the Southeastern United States, the product of robust federal-state partnerships with Alabama, Florida, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina. The charges announced encompass 17 cases spanning the seven states. These recent cases involve over $350 million in intended losses and include cases involving SNAP benefits, Small Business Administration loans, housing benefits, and tax fraud. From July 4 alone, federal prosecutors charged cases reaching over $90 million loss and implicating 12

named defendants. The Division separately announced the formation of federal-state anti-fraud task forces in North Carolina, Mississippi, and Florida.

The Division additionally announced new federal-state cooperation agreements with this group of states to strengthen ongoing fraud enforcement efforts, following a recent roundtable that brought together 18 U.S. Attorneys Offices, seven State Attorneys General Offices, five federal law enforcement partners, and over 50 state officials.

Building a National Model of Federal-State Cooperation

In connection with these fraud enforcement actions, the Fraud Division, U.S. Attorneys' Offices, federal law enforcement officials, and state partners announced the following innovative steps to enhance federal–state cooperation to detect, investigate, and prosecute fraud:

The Fraud Division and Secretaries of State from Alabama, Florida, Georgia, Louisiana, Mississippi, and South Carolina as well as State Treasurers from Florida, Mississippi, and South Carolina announced data sharing agreements that provide the Fraud Division access to publicly available corporate registration and public benefits payment data held by these state agencies. This data will help the Fraud Division proactively identify connections and patterns across both business entities and public benefits payment activity — cutting through the shell companies, layered structures, and complex financial trails that fraudsters rely on to conceal control and carry out largescale schemes.

Federal and State Partners Represented at the 2026 Southeast Fraud Enforcement Partnership Event

Alabama: Secretary of State Wes Allen and Chief Examiner Rachel Riddle.

Florida: Attorney General James Uthmeier, Secretary of State Cord Byrd, and Chief Financial Officer Blaise Ingoglia.

Georgia: Attorney General Chris Carr and Secretary of State Brad Raffensperger.

Louisiana: Attorney General Liz Murrill, Secretary of State Nancy Landry, Auditor Michael Waguespack, and Inspector General Angele Davis.

Mississippi: Attorney General Lynn Fitch, Secretary of State Michael Watson, Auditor Shad White, and Treasurer David McRae.

North Carolina: Attorney General Jeff Jackson and Auditor Dave Boliek.

South Carolina: Governor Henry McMaster, Attorney General Alan Wilson, Secretary of State Mark Hammond, Treasurer Curtis Loftis, Inspector General Sean Fay, and Director for South Carolina Department of Social Services Tony Catone.

U.S. Attorneys Offices:

Northern District of Alabama, Middle District of Alabama, Southern District of Alabama, Northern District of Florida, Middle District of Florida, Southern District of Florida, Northern District of Georgia, Middle District of Georgia, Southern District of Georgia, Eastern District of Louisiana, Middle District of Louisiana, Western District of Louisiana, Northern District of Mississippi, Southern District of Mississippi, Eastern District of North Carolina, Middle District of North Carolina, Western District of North Carolina, and District of South Carolina.

Federal Agencies:

U.S. Department of Agriculture (USDA) Deputy Secretary Stephen Vaden, FBI Assistant Director Heith Janke, Homeland Security Investigations (HSI) Assistant Director James Harris, Small Business Administration Office of Inspector General William Kirk, and USDA Inspector General John Walk.

These partnerships and actions demonstrate how state and federal partners can work together to strengthen fraud detection, share information, and accelerate enforcement efforts nationwide. The Department encourages every state across the country to partner with the Fraud Division on similar efforts.

Federal and State Partners Represented at the 2026 Southeast Fraud Enforcement Partnership Event

CASES

Alabama

Northern District of Alabama led by U.S. Attorney Phillip Williams, *United States vs. Michael Shine*. Michael Shine is a tax preparer based in the Birmingham area who owns and operates Shine's Professional Services. He has filed and caused to be filed literally thousands of tax returns falsely claiming energy tax credits that were baseless and fraudulent, causing almost $70 million in loss as charged in a complaint.

Example of "Self-Prepared" Attestation Seized During Search Warrant From United States vs. Michael Shine.

Middle District of Alabama led by U.S. Attorney Thomas Govan, *United States v Kevin Padgett et al*. Kevin Padgett and co-defendants were charged in a mail fraud, wire fraud, and money laundering conspiracy in connection with their scheme to sell approximately $7 million counterfeit U.S. Postage Stamps.

Southern District of Alabama led by U.S. Attorney Sean Costello, *United States v. Nia Bradley, et al*. Five defendants, Nia Bradley, Randy Burden, Steve Jones, Larry Knight, and Dejuan Lamar, board members and employees of the Prichard, Alabama Water and Sewer Works, created false invoices for work that was never performed and created fictitious construction companies for the purpose of defrauding the utility for a total loss amount of roughly $2.5 million.

Northern District of Florida led by U.S. Attorney John Heekin, *United States v. Lekishaan Huggins*. The former manager of the Tallahassee Housing Authority used former tenants' Personally Identifiable Information (PII) to fraudulently obtain U.S. Department of Housing and Urban Development (HUD) rent subsidies for a total case loss of just over $500,000. As charged, Huggins used fraudulently obtained funds to sustain her luxurious lifestyle, including vacations, buying luxury apparel and jewelry, and having a celebrity chef cater her private Christmas party.

Middle District of Florida led by U.S. Attorney Greg Kehoe, *United States vs. Daniel Liburdi*. Daniel Liburdi pled guilty in the Middle District of Florida to filing a false tax return and agreed to restitution of nearly $35 million and forfeiture including multiple properties in Miami Beach and the U.S. Virgin Islands and three luxury vehicles (Land Rover Range Rover, a Ferrari 812 and a Ferrari F8).

Southern District of Florida led by U.S. Attorney Jason A. Reding Quiñones, *United States vs. Rajaie Ali et al*. Defendants Rajaie Ahmad Ali, Sami Jamhour, Cristian Amaro, and Adel Amro concocted a scheme to use willing food stamp recipients to sell their EBT stamp benefits at a discounted rate for cash. The scheme, launched in 2019, caused nearly $20 million in fraudulent EBT transactions at a Kwik Stop convenience store in Miami. Two of the indicted co-conspirators are foreign nationals. Defendant Ali is even subject to a final order of removal from the United States.

Georgia

Northern District of Georgia led by U.S. Attorney Theodore Hertzberg, *United States v. Ian Patrick Jackson*. Defendant Ian Patrick Jackson pled guilty for running a fraud and money laundering scheme that stole more than $3 million in CARES Act funds administered by the SBA in the form of PPP and EIDL loans. Jackson has twice been convicted of previous fraud felonies, recruited at least nine business owners into his scheme to submit fraudulent applications, and spent the proceeds on personal expenses, including restaurant dining, spa services, phone and credit card bills, and travel to California, Texas, and Aruba.

Southern District of Georgia led by U.S. Attorney Meg Heap, *United States v Melanie Charise Thompson and Toriono Laselle Byrd*. Defendant Thompson was indicted for orchestrating a scheme to defraud the Hinesville Housing Authority (HHA) of millions of dollars by using HHA funds to pay her former boyfriend for work that he never completed or paid him far in excess of what he should have been paid for work that was completed, sometimes in return for kickbacks. Purchases from fraud proceeds included custom jewelry worth over $100,000, a gold bracelet, a diamond ring, a Porsche Panamera, a Cadillac Escalade, a Bently Flying Spur, real estate, a hot tub, and tickets to a Janet Jackson concert, reaching nearly $3 million in loss.

Louisiana

Eastern District of Louisiana led by U.S. Attorney David Courcelle, *United States vs. Spivey*. Spivey was sentenced for his role in a conspiracy to commit health care fraud. Spivey conspired with his codefendant, Jamie McNamara, to fraudulently submit $174 million in fraudulent claims to Medicare for medically unnecessary cancer genetic testing and cardiovascular genetic testing. The genetic tests Medicare patients were lured into did not provide them with any answers on their predisposition to life threatening illnesses and cost taxpayers millions of dollars.

Western District of Louisiana led by U.S. Attorney Zach Keller, *United States v Patel et. al. Defendants*, including former law enforcement officials, spent nearly 10 years manufacturing false crime reports as part of a visa-fraud scheme. The operation netted the officers $5,000 per "victim" and helped hundreds of foreign nationals secure U visas for false crimes.

Middle District of Louisiana led by U.S. Attorney Kurt Wall, *United States v Chakesha Scott et al*., Chakesha Scott was the CEO of Impact Charter School in Baker Louisiana, which received state and federal funds. Instead of using those funds to benefit the students, Scott and her indicted co-conspirators diverted nearly $1.5 million in federal funds to pay off family members for overinflated contracting invoices, buying herself luxury vehicles, and even paying for her personal travel expenses.

Mississippi

Northern District of Mississippi led by U.S. Attorney Scott Leary, *United States v. Lakieth Faulkner et al*. Lakeith Faulkner was an attorney and an employee of the Small Business Administration (SBA) who, as a part of his actual job, worked with borrowers and was uniquely positioned to understand the Economic Injury Disaster Loan (EIDL) approval process. Faulkner devised a kickback scheme with co-conspirators including Tierra Scott, a former IRS employee, to generate more than $11.5 million in fraudulent loan payments by the SBA.

Southern District of Mississippi led by U.S. Attorney Baxter Kruger, *United States v. Qadir Shabazz, et al*. As alleged, federal inmates housed at the Yazoo Federal Correctional Complex conspired to steal unemployment insurance benefits and EIDL funds using falsified identities, generating approximately $4.3 million in losses. Trial is set for February 2027.

North Carolina

Western District of North Carolina led by U.S. Attorney Russ Ferguson, *United States v. Dumitru*. Two Romanian brothers illegally in the United States pled guilty to wire fraud charging them with orchestrating a fraud scheme involving SNAP benefits affecting victims across multiple states, causing nearly $766,000 in loss. A victim reported that she was shopping with her family on their monthly grocery run for approximately $700 of SNAP-eligible items. Because the defendants had used her SNAP benefits, the transaction was denied, and the victim was unable to purchase food or school supplies for her family.

Middle District of North Carolina led by U.S. Attorney Dan Bishop, *United States v. Adedayo Afolabi Fateru*. Fateru pled guilty as a member of a money laundering ring involving proceeds of various fraud schemes including false applications for Economic Injury Disaster Loans (EIDL) and false applications for unemployment benefits. He caused nearly $1.7 million in loss.

Eastern District of North Carolina led by U.S. Attorney Ellis Boyle, *United States v. Mitchell et al*. A Robeson County woman (along with seven co-conspirators) who was the owner of a North Carolina tax return preparation business pled guilty to conspiring to prepare false returns claiming fraudulent refunds based on COVID-19 tax credits, causing nearly $25 million in loss.

South Carolina

District of South Carolina led by U.S. Attorney Bryan Stirling, *United States v. Misty Dawn Woody*. Misty Dawn Woody was charged by indictment for making false statements relating to healthcare matters. In her role as an employee for Vital Care, a medical patient transport service, Woody allegedly copied and forged a physician's signature on over one hundred certification forms for patients that were no longer under that physician's care. She submitted those forms to Medicare causing over $1.8 million in false and fraudulent billing.

On April 7, the Department of Justice announced the creation of the National Fraud Enforcement Division (Fraud Division). The Fraud Division is laser-focused on investigating and prosecuting those who commit fraud against the American people. The Department's work to combat fraud supports President Trump's Task Force to Eliminate Fraud, a whole-of-government effort chaired by Vice President J.D. Vance to eliminate fraud, waste, and abuse within Federal benefit programs.

Nevada Doctor Charged with $95M Wound Care Fraud on Medicare

National Fraud Enforcement Division's first announced charges in Nevada since the formation of the West Coast Health Care Fraud Strike Force

Stephen Dubin, M.D., 74, of Henderson, Nevada, charged with a $95 million scheme to defraud Medicare by billing for medically unnecessary amniotic wound allografts that he and others applied to elderly Medicare patients.

A federal grand jury in the District of Nevada returned an indictment yesterday charging "This indictment exposes a scheme driven by greed, not medicine. As alleged, this provider exploited elderly patients by pushing costly and unnecessary medical procedures, then lied to Medicare to pocket millions of taxpayer dollars," said Assistant Attorney General Colin M. McDonald of the Justice Department's National Fraud Enforcement Division. "Schemes like this drain Medicare of resources and impose substantial burdens on the taxpayers who fund it. Let this serve as a warning: any healthcare professional who tries to get rich at the expense of patient care can expect to face the same scrutiny — and the same consequences."

"Healthcare fraud is not a victimless crime; it steals vital resources from elderly and vulnerable citizens who truly need life-saving treatments," said First Assistant U.S. Attorney Sigal Chattah for the District of Nevada. "These defendants prioritized personal greed over patient care by weaponizing complex billing codes for advanced wound care products. As part of the West Coast Health Care Strike Force, our office, alongside our federal law enforcement partners, will continue to aggressively dismantle predatory schemes that target public healthcare programs."

According to court documents, Dubin, a medical doctor and sole owner of **Dubin Medical Consultants, Inc**. (also known as **Wound MD**) caused Medicare to be billed over $95 million for expensive amniotic allografts that he procured through illegal kickbacks and bribes. Dubin allegedly applied these allografts to elderly patients — including vulnerable patients in hospice care — without medical necessity. Medicare paid over $54 million based on Dubin's false and fraudulent claims.

As alleged in the indictment, Dubin received illegal kickbacks, bribes, and rebates from two different allograft distributors. Some of these illegal payments were falsely structured to appear as legitimate "Rebate Agreements" while concealing their true nature and illegal payments. These purported rebates substantially reduced Dubin's true net cost of acquiring the allografts. Dubin allegedly submitted claims to Medicare seeking reimbursement for the price listed on sham full-price invoices, instead of the actual price he paid for the allografts. Dubin and others allegedly kept as profit the difference between Medicare's reimbursement and the price paid for the allografts.

The indictment also alleges that Dubin received illegal kickbacks from one allograft distributor through payments from a pass-through bank account held in the name of a shell company in exchange for purchasing allografts from the distributor.

Induced by these illegal kickbacks, bribes, and rebates, Dubin and his co-conspirators applied allografts without regard to medical necessity, including by applying allografts to infected wounds; to wounds that were not responding to allograft treatment; without first attempting, completing, or confirming conservative wound care treatment as required by Medicare; and in quantities that far exceeded

the size of wounds. Dubin allegedly selected allografts that would maximize his profit, not based on the patient's need. To conceal the lack of medical necessity, Dubin falsified patient medical records to make it appear as though the application of allografts was medically reasonable and met Medicare requirements.

Dubin used the proceeds of his alleged offenses to fund a lavish lifestyle, including having multi-million-dollar yachts built for him.

Dubin is charged with conspiracy to commit health care fraud and five counts of health care fraud. If convicted, he faces a maximum penalty of 10 years in prison.

15 Million Medi-Cal Settlement Against the Skilled Nursing Facility Chain

Sweetwater Care Resource, LLC and affiliates (Sweetwater), a licensed skilled nursing facility (SNF) chain that violated state staffing requirement laws entered into a settlement with California Attorney General Rob Bonta who secured a $15 million settlement with The settlement includes $12.5 million in penalties and costs and $2.5 million in funds toward improving staffing and securing a compliance monitor. The settlement also includes injunctive terms imposing an Independent Compliance Monitor for all 17 Sweetwater SNFs for the next three years. The case was filed under California's Unfair Competition and False Advertising Laws.

Skilled nursing facilities cater to some of the state's most frail, elderly, and vulnerable residents. The California Legislature established minimum staffing regulations for SNFs that choose to operate in California. These laws require SNFs to provide a minimum of 3.5 direct care service hours per resident day from nurses and aides, 2.4 hours of which must come from certified nurse assistants.

However, from 2021 to 2024, while Sweetwater accepted tens of millions of dollars to care for Medi-Cal patients in its SNFs, an investigation conducted by the Division of Medi-Cal Fraud and Elder Abuse (DMFEA) revealed systemic understaffing of Sweetwater nursing homes, in violation of California law. Staffing data indicates that in over 14,126 instances, Sweetwater SNFs were staffed below California mandatory minimum staffing levels for nursing homes.

Four Men Plead Guilty to $2M Minnesota Medicaid Fraud

Defendants Operating Out of the Griggs-Midway Building Used Artificial Intelligence to Fabricate Records

Four Minnesota men pleaded guilty to defrauding Minnesota's Housing Stabilization Services (HSS) program out of approximately $2.2 million and concealing the scheme by using artificial intelligence to create fake records when questioned by insurance companies.

This case is part of the ongoing collaboration between the U.S. Attorney's Office for the District of Minnesota and the Health Care Fraud Strike Force to combat prolific fraud on government programs in Minnesota. It also highlights a burgeoning trend of fraudsters using artificial intelligence to further a fraud scheme targeting health care programs in Minnesota and around the country.

According to court documents, **Moktar Hassan Aden**, 31, **Mustafa Dayib Ali**, 29, **Khalid Ahmed Dayib**, 26, and **Abdifitah Mohamud Mohamed**, 27, all of the Twin Cities area, set up **Brilliant Minds Services LLC** in the notorious Griggs-Midway Building in St. Paul, Minnesota, and enrolled the business as a Medicaid program provider. They promised to help people with disabilities – including seniors and people with mental illnesses and substance use disorders – find and maintain housing through the State's now-defunct HSS program. Instead, they submitted thousands of HSS claims to Medicaid for services that were never provided or significantly inflated the claims for higher reimbursements.

Image

The defendants, together, signed up approximately 350 people for HSS and then billed the program despite doing nothing to assist these Medicaid recipients. When asked to provide supporting documentation for their claims, the defendants fabricated records using ChatGPT in an attempt to conceal their theft. In total, from April 2022 through April 2025, the defendants stole approximately $2.2 million from Minnesota Medicaid for services they fraudulently claimed to have provided to these 350 Medicaid recipients.

In separate hearings held between July 7 and July 23, 2026, the defendants each pleaded guilty to one count of wire fraud. They each face a maximum penalty of 20 years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors. Sentencing dates have not yet been set by the Court.

Velox's Pharmaceuticals Agrees to Pay Over $46M to Resolve Criminal and Civil Liability for Kickback Schemes

Velox is Has Entered Into a Deferred Prosecution Agreement and Will Pay the Largest Sunshine Act Recovery in History

Veloxis Pharmaceuticals Inc. (Veloxis), a drug manufacturer based in Cary, North Carolina, agreed to pay over $46 million to resolve criminal and civil allegations that it paid kickbacks to induce prescriptions and purchases of Envarsus XR (Envarsus), a kidney transplant immunosuppression drug.

As part of the government's resolution with Veloxis, the company entered into a deferred prosecution agreement (DPA) in connection with a criminal information filed today in the District of Massachusetts charging Veloxis with conspiracy to commit violations of the federal Anti-Kickback Statute by paying for, among other things, lavish meals, alcohol, and luxury resort stays, to induce healthcare providers to recommend or prescribe Envarsus. As part of the DPA, Veloxis has agreed to pay a criminal penalty of more than $10 million.

Today's resolution should serve as a warning to any healthcare company that tries to improperly influence the decisions of healthcare providers. Kickbacks can erode medical decision-making, result in unnecessary prescriptions of branded drugs, and waste federal healthcare funds.

Attempting to improperly influence medical decision-making for financial gain is dangerous, yet it is exactly what Veloxis was doing. Instead of prioritizing patient safety, they were prioritizing profits. Treatment decisions need to be based on what's best for the patient, not what's best for the drug manufacturer's bottom line, or what lavish meal or resort stay they can offer.

The settlement resolves allegations that Veloxis operated with a principal focus on sales, providing kickbacks in the form of luxury resort stays, lavish meals, and payments to induce health care professionals to recommend and prescribe its kidney transplant immunosuppression drug. The DOJ concludes that it is harmful when pharmaceutical companies prioritize profits over patients and the FBI and DOJ's partners are committed to fighting health care offenses, one case at a time, and seeing perpetrators held accountable.

Kickbacks that distort medical decision making put patients at risk and undermine trust in our health care system.

Veloxis used lavish perks and concealed payments to push its drug, and today's resolution is intended by the DOJ to make clear that this conduct will not be tolerated. HHS OIG will continue working with our law enforcement partners to protect patients, uphold the integrity of federal health care programs, and hold companies accountable when they violate the law.

The resolution also includes a civil settlement of allegations that Veloxis caused the submission of false claims to federal healthcare programs by paying kickbacks to hospital personnel and specialty pharmacies, in violation of the False Claims Act. Veloxis has agreed to pay $34.45 million to the United States and certain states to resolve those civil allegations. In addition, Veloxis agreed to pay a $1.55 million civil penalty to the Centers for Medicare & Medicaid Services (CMS) to resolve allegations that Veloxis knowingly failed to report to CMS certain payments to physicians under the Open Payments Program (also known as the "Sunshine Act"). This is the largest Sunshine Act recovery since the law was passed in 2010.

Veloxis' Criminal Liability for Conspiring to Pay Kickbacks

According to admissions and court documents filed in the District of Massachusetts, from October 2016 and continuing through in or around June 2023, Veloxis and its employees engaged in a scheme to pay kickbacks to transplant health care providers (HCPs) to induce them to prescribe, order, or recommend or arrange for prescribing or ordering Envarsus for kidney transplant recipients. During the relevant time, Veloxis manufactured and sold a single drug, Envarsus, for use as an immunosuppressant in adult kidney transplant recipients. Envarsus, a drug taken once a day for the life of the kidney transplant recipient, competed against the generic form of the same drug, which was taken only once a day. To gain market share for Envarsus against a cheaper generic drug, Veloxis engaged in an aggressive marketing strategy pursuant to which it promoted Envarsus to HCPs at and tied to transplant centers and hospitals who could influence the placement of Envarsus on the formulary and/or protocol of their respective facilities.

These marketing efforts included various tactics that violated the federal Anti-Kickback Statute, including but not limited to taking HCPs and at times, their spouses or guests, to lavish dinners and on expensive trips and retreats under the guise of "advisory boards," providing gifts and expensive alcohol to HCPs, and making purported consulting payments to HCPs for work that was not actually performed. In many of these instances, Veloxis employees submitted falsified company expense reports to conceal their illegal marketing efforts, including by falsely adding names to the list of attendees at dinners and events (to decrease the apparent cost per attendee of the meals) and omitting the names of physicians who attended the meals (to avoid Sunshine Act reporting requirements). This false reporting resulted in Veloxis' failure to properly report the sums it paid to physicians, which further obscured its illegal activities.

Veloxis admitted that it intended the improper remuneration it provided to HCPs to result in increased Envarsus prescriptions, as demonstrated, in part, by communications between Veloxis employees and certain HCPs. For example, in connection with a surgeon's request to attend a speaker program, a Veloxis employee told the surgeon that the Veloxis employee "need[ed] scripts. Lots of them." Several months earlier, the Veloxis employee had told the surgeon that he was "over Sales" and needed the surgeon "more than ever," and instructed the surgeon that it was "[t]ime to open your Rolodex and make things happen." The statement of facts filed with the DPA details additional examples of Veloxis' kickbacks and related efforts to disguise and conceal its unlawful conduct.

Veloxis' Civil Liability for False Claims to Federal Healthcare Programs

The resolution also resolves allegations that Veloxis violated the False Claims Act by knowingly causing the submission of claims to Medicare, Medicaid, and TRICARE for Envarsus prescriptions written by HCPs or filled by pharmacies to which Veloxis had knowingly and willfully paid kickbacks in violation of the Anti-Kickback Statute. In connection with the civil settlement agreement, Veloxis admitted that from 2016 to 2023, it paid kickbacks to HCPs in the form of lavish meals, alcoholic beverages, expensive trips, resort stays, gifts, and purported consulting fees to induce prescriptions of Envarsus. Veloxis admitted that it concealed those kickbacks by falsifying company expense reports and business records as to the recipients, amounts, and purpose of the payments; and creating consulting agreements for purported consulting work that was not actually performed.

With respect to Veloxis' obligation to report physician payments under CMS's Open Payments Program, Veloxis admitted that because its reports to CMS were based on falsified expense reports, Veloxis underreported, or failed to report, the true amounts of its payments or transfers of value to those physicians.

In addition, Veloxis admitted that from 2017 to 2023, it paid kickbacks to specialty pharmacies in the form of per-patient and per-month payments to induce those pharmacies to begin or continue purchasing Envarsus instead of competitor drugs, including a cheaper generic drug. Veloxis admitted that it disguised the unlawful purpose of the kickback payments to the pharmacies by falsely describing the payments in written contracts as being for "enhanced services" such as data collection or adherence services. In fact, Veloxis admitted

that it paid the pharmacies regardless of whether they provided any data, provided the specified data fields, or provided the data in the specified format, and without confirming whether any adherence services were provided.

Under the civil settlement agreement, Veloxis will pay **$21,211,251** to the United States to resolve the False Claims Act allegations and an additional **$13,238,749** to certain States for claims settled by certain State Medicaid programs. Veloxis also agreed to pay a civil penalty of **$1.55** million to resolve allegations that it knowingly failed to report the amounts of its payments to physicians under the CMS's Open Payments Program. In connection with the civil settlement, Veloxis entered into a five-year Corporate Integrity Agreement (CIA) with the HHS-OIG.

The CIA requires, among other compliance provisions, that Veloxis implement a compliance program to identify and address the Anti-Kickback Statute risks associated with other financial arrangements and retain an independent compliance expert to perform a review of the effectiveness of the compliance program.

Attorney General Hanaway Obtains Medicaid Fraud Guilty Plea For Over $37,000 In Services Not Provided

Missouri Attorney General Catherine Hanaway announced that her Medicaid Fraud Control Unit (MFCU) obtained a Medicaid Fraud conviction against personal care attendant (PCA) **Darrell Carr**, who submitted false statements and time records in order to receive payments from Missouri Medicaid. Carr was a PCA for his father-in-law, the Medicaid recipient, where he clocked in and out on 509 occasions from March 10, 2021, to February 22, 2023.

Carr was originally hired to care for his father-in-law in 2017 through Medicaid vendor **Deer Valley Home Health Services, LLC**. In 2021, the recipient's grandson moved him to a senior living facility. Both the recipient and his grandson said that Carr did not provide services after the recipient moved to the facility. However, Carr continued to clock in and out on 509 occasions from 2021 to 2023 as if he were still providing services to his father-in-law.

Additionally, employment timesheet records show that, of the 509 false records, there were 344 instances in which Carr simultaneously logged time as a PCA while he was actually working as a security guard at a grocery store. By making false statements and time records, Carr stole $37,819.39 from Medicaid for services not provided.

On August 3, 2026, Carr pled guilty to healthcare fraud, a class D felony, and was sentenced to pay full restitution of $37,819.39 and a civil penalty of $10,000.00, for a total of $47,819.39. He was also ordered five years supervised probation.

Bad Faith Suit Fails After Insurer Declares Policy Void

State Farm Must Try Breach of Contract Claim Only

Breach of Condition is Ground to Deny Claim and Void Policy

In *Arutyun Darakchyan v. State Fann General Insurance Company et al*., No. 2:25-cv-03880-CAS-AJRx, United States District Court, C.D. California (August 11, 2026) Plaintiff Arutyun Darakchyan sued State Farm General Insurance Company after State Farm denied his homeowners burglary claim for losses allegedly sustained at his Tarzana residence.

Plaintiff reported that burglars entered through a kitchen window while he and his family were away, claimed stolen property totaling more than $83,000, and submitted proof-of-loss materials, inventory lists, photos, alarm records, phone records, and later appeared for an examination under oath.

State Farm assigned the claim to its special investigative unit, questioned the timing and duration of the reported burglary, requested additional documents and records, identified discrepancies between the police report, inventory, receipts, and plaintiff's testimony, and ultimately denied the claim based on alleged breaches of post-loss duties and alleged concealment or misrepresentation.

On February 20, 2024, State Farm took a recorded statement from plaintiff. Plaintiff reported that on the night of the burglary, his oldest son, Gregor, immediately left the party they were at and arrived at the Property a couple of minutes before plaintiff.

THE POLICY

The State Farm policy provided: "This policy is void as to [the insured] … if [the insured] … has intentionally concealed or misrepresented any material fact or circumstance relating to this insurance, whether before or after a loss."

LAW:

Summary judgment is proper only when there is no genuine dispute of material fact and the moving party is entitled to judgment as a matter of law. Under California law, breach of contract requires a contract, plaintiff's performance or excuse for nonperformance, defendant's breach, and damages. California recognizes substantial compliance where the insured performs enough of the required obligations and does not completely fail to comply.

Breach of the Implied Covenant of Good Faith

State Farm argued that plaintiff s second claim for breach of the implied covenant of good faith and fair dealing fails because State Farm did not wrongfully withhold benefits due under the Policy. State Farm's denial of benefits was reasonable because State Fann's reasonably concluded that plaintiff breached the Policy. State Farm denial of the Claim was objectively reasonable.

DISCUSSION:

State Farm argued that pl7aintiff could not recover because he failed to satisfy policy conditions, including prompt notice, production of supporting records, preservation or exhibition of damaged property, production of his son's phone records, and production of household members for examinations under oath.

ANALYSIS:

The Court held that factual disputes precluded summary judgment on the breach of contract claim, including disputes over substantial compliance, materiality of requested documents, timing of notice, and whether plaintiff could compel family members to appear for examinations. The same genuine dispute and the claim discrepancies gave State Farm an objectively reasonable basis to deny the claim, defeating the bad faith and negligent misrepresentation claims.

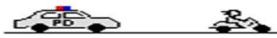
CONCLUSIONS:

State Farm's motion for summary judgment was denied as to plaintiff's breach of contract claim but granted as to breach of the implied covenant of good faith and fair dealing, negligent misrepresentation, and punitive damages.

the Court DENIED State Farm's motion for summary judgment on plaintiff s breach of contract claim, GRANTSED State Farm's motion for summary judgment on plaintiffs claim for breach of the implied covenant of good faith and fair dealing, GRANTED State Farm's motion for summary judgment on plaintiffs claim for negligent misrepresentation and GRANTED State Farm's motion for summary judgment on plaintiff s claim for punitive damages.

ZIFL OPINION

State Farm with a factual basis for concluding that its insured had committed fraud and denied the claim for breach of material conditions and for fraud was relieved of most of the lawsuit except breach of contract because the court applied the doctrine of "substantial compliance" although the reasons for its conclusion of fraud were obvious.



Property Investigation Checklists: Uncovering Insurance Fraud, 16th Edition Now Available

Property Investigation Checklists: Uncovering Insurance Fraud, 16th Edition by Barry Zalma, Esq., CFE, is now available. The 16th Edition provides detailed guidance and practical information on the four primary areas of any investigation of suspicious claims is now available.

The book also examines recent developments in areas such as arson investigation procedures, bad faith, extracontractual damages, The fake burglary, and Lawyers Deceiving Insurers, Courts & Their Clients During, Catastrophes — A New Type Of Fraud and the appendices includes the NAIC Insurance Information and Privacy Protection Model Act and usable forms for everyone involved in claims and will provide necessary information to the claims adjuster, SIU fraud investigator, claims manager, or coverage lawyer so he or she can be capable of excellence. The 16th Edition's 971 pages also include new subjects or subjects that are substantially revised, including:

1. Hard fraud vs. soft fraud;
2. The statement process.
3. The Innocent Co0Insured Doctrine
4. Declaring a policy void for breach of condition.
5. Proof of Loss
6. The mutual covenant – It's a two-way street.
7. Reproduction or replacement cost
8. The costs of investigation
9. Recent rescission cases.

Available as a paperback or an ebook at https://store.legal.thomsonreuters.com/en-us/products/property-investigation-checklists-43526329 The newest book joins other insurance, insurance claims, insurance fraud, and insurance law books by Barry Zalma all available at the Insurance Claims Library – https://zalma.com/blog/insurance-claims-library/

Guilty of Misprison of a Felony Admitted by Owner of Insurers

Second Trial of Coram Nobis Relief Fails

Coram Nobis is an Extraordinary Remedy

In *United States Of America v. David Judd Disiere*, Criminal Action No. 99-151-SDD-SDJ, United States District Court, M.D. Louisiana (August 10, 2026 David Judd Disiere was convicted in 2000 after pleading guilty to misprision of a felony under 18 U.S.C. § 4 in connection with allegations involving a scheme to influence the resolution of an investigation into insurance companies he owned.

He was sentenced to probation and a fine, did not directly appeal, and completed probation in 2003. After an earlier unsuccessful postconviction challenge, Disiere filed a second petition for writ of error *coram nobis* in 2024, claiming his plea was coerced by prosecutors' threats relating to an employee allegation, that those threats were concealed from the court, that his counsel was ineffective, and that the factual basis did not establish the elements of misprision.

This is Disiere's second attempt at obtaining *coram nobis* relief. His first *Writ of Error Coram Nobis* was filed on April 9, 2001, and challenged his conviction on the ground that "the factual basis he helped draft was insufficient to support the misprision charge." Because he was still serving a term of probation in April 2001, and thus "in custody" for purposes of habeas relief, the Court converted his appeal *coram nobis* into a challenge under 28 U.S.C. § 2255.

LAW:

Coram nobis is an extraordinary remedy available only to correct fundamental errors resulting in a complete miscarriage of justice when the petitioner is no longer in custody and no other remedy is available. A petitioner must show continuing civil disabilities, an error of sufficient magnitude, and sound reasons for failing to seek relief earlier. The writ is not a substitute for direct appeal or a means to relitigate claims that were or reasonably could have been raised in a prior § 2255 proceeding.

DISCUSSION:

The government argued that the petition was untimely because Disiere knew, or should have known, the facts underlying his claims at the time of his plea or shortly thereafter. The court agreed. It found that the alleged threats, concealment, and ineffective assistance were all based on facts available to Disiere in 2000, yet he did not raise them on direct appeal, in his earlier postconviction petition, or during probation.

Later-discovered evidence concerning counsel's alleged concealment, the prosecutor's later professional misconduct, FOIA delays, and affidavits from former FBI agents did not supply a sound reason for the long delay.

ANALYSIS:

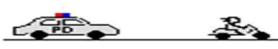
The court focused on timeliness rather than reaching the merits of whether the conviction involved fundamental error. It reasoned that Disiere's present claims depended on information known to him when he entered the plea, including the alleged prosecutorial pressure and the absence of those alleged promises or threats from the plea proceeding. His fear-of-reprisal argument was undermined by the fact that he previously attacked the plea on other grounds. His actual-innocence theory largely repeated arguments rejected in the prior § 2255 proceeding, and the FBI affidavits were not treated as newly discovered because he did not show they could not have been obtained earlier through diligence.

CONCLUSION:

The court denied Disiere's petition for writ of error *coram nobis*. Because he failed to provide sound and justifiable reasons for waiting nearly two decades to seek relief on claims available much earlier, the petition was untimely and the court did not need to decide whether the alleged errors were fundamental.

ZIFL OPINION

Disiere's failure to present sound and justifiable reason for his nearly twenty year delay in seeking *coram nobis* relief, or any other form of post-conviction remedy, was fatal to the to his second try. Insurance criminals do as much as possible to avoid jail. He plead guilty to a crime where he failed to report a crime, that gave him only probation. Then, even after he completed the probation he tried a second *coram nobis* attempt only to be properly rejected by the court.



Other Than Health Insurance Fraud Cases

Canadian Man Pleads Guilty to Hacking U.S. Cloud Storage Provider and Extorting Its Customers for Millions

Connor Riley Moucka, 26, of Kitchener, Ontario, pleaded guilty to a widespread computer hacking conspiracy that resulted in the compromise of over 165 victim organizations, the theft of billions of sensitive customer records and the extortion of numerous victims.

Connor Moucka hacked over 150 companies and organizations, obtained extremely sensitive information, and extorted the victims for millions of dollars. Moucka was arrested just six months after these breaches began, demonstrating this Department's firm commitment to investigating and prosecuting sophisticated cybercriminals who cause extensive harm to American businesses and consumers. Today's guilty plea serves as a reminder to all cybercriminals, regardless of where they live, that they cannot hide behind a wall of anonymity. You will be found and brought to justice.

Hiding behind a screen is no shield from justice. Connor Moucka learned that when he was arrested just months after he began targeting U.S. companies, stealing sensitive information, and extorting victims for millions of dollars. His guilty plea highlights the FBI's commitment to protecting American businesses and consumers from cybercrime and reflects our strong partnership with the Royal Canadian Mounted Police and other international law enforcement agencies. The FBI will continue to identify, locate, and hold cybercriminals accountable, wherever they operate.

According to court documents, between February and October 2024, Moucka and his co-conspirators used stolen login credentials to compromise cloud-hosted data belonging to at least 165 customers of a U.S.-based software-as-a-service company. Moucka and others used their unauthorized access to these customers' computer systems to steal billions of sensitive customer records and download terabytes of information, including individuals' non-content call and text history records, banking and other financial information, payroll records, Drug Enforcement Administration (DEA) registration numbers, driver's license numbers, passport numbers, social security numbers and other personally identifiable information. They then extorted victims by threatening to publish data online.

In addition to extorting victims, Moucka and his co-conspirators advertised the victims' data for sale online, including on the cybercrime forums *BreachForums*, Exploit.in *and XSS.is, as well as on Telegram. Through these actions, Moucka personally obtained at least $495,000. The harm to the* conspirators' victims was much greater, with victim companies suffering over $9.5 million in actual losses — a number that does not include losses suffered by the companies' customers, totaling at least 100 million individuals.

Moucka pleaded guilty to four counts of the indictment, including computer fraud, wire fraud, aggravated identity theft, and a related conspiracy. He is scheduled to be sentenced on Oct. 27 and faces a mandatory minimum penalty of two years in prison on the aggravated identity theft count and a maximum penalty of 30 years in prison on the remaining counts. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Two TD Bank Insiders Sentenced to Prison for Facilitating Money Laundering, Fraud

A New York-based former employee of TD Bank, N.A. was sentenced today to 46 months in prison for facilitating a money laundering network's movement of millions of dollars through TD Bank accounts. A second New York-based former employee of TD Bank, N.A. and another financial institution was sentenced yesterday to 24 months in prison for conspiring to commit wire fraud affecting a financial institution and making false bank entries or reports as a bank employee.

According to court documents, **Wilfredo Aquino**, 47, of Manhattan, New York, leveraged his position as a TD Bank assistant store manager to facilitate a money laundering network's movement of hundreds of millions of dollars through TD Bank accounts from 2019 to February 2021. During that time, the leader of the network, **Da Ying Sze,** also known as David, and his co-conspirators moved approximately $474 million through TD Bank accounts by depositing cash at TD Bank stores in New York, New Jersey, and elsewhere. In February 2022, David pleaded guilty to coordinating a $653 million money laundering conspiracy, operating an unlicensed money transmitting business, and bribing bank employees in connection with financial transactions.

During David's money laundering scheme, Aquino processed approximately 1,680 official bank checks at TD Bank for David and his co-conspirators, totaling more than approximately $92 million. Nearly all of these bank checks were funded with a corresponding cash deposit exceeding $10,000, which triggered TD Bank's legal requirement to file a currency transaction report (CTR). Although Aquino knew that David was conducting these cash deposits, Aquino never identified David as the "conductor" on the CTR. Aquino also knew that TD Bank had closed other accounts linked to David for suspicious activity; one colleague even warned Aquino that David's activity "looks like money laundering." In February 2021, Aquino facilitated three of David's money laundering transactions, totaling almost $2 million in cash, in a third party's account. He failed to report David as the conductor of the transactions, thus concealing David's role in the money laundering scheme.

Aquino accepted numerous retail gift cards from David totaling over $11,000 in return for his facilitation of this scheme, including for the three transactions in February 2021.

In January 2026, Aquino pleaded guilty to conspiring to launder monetary instruments.

According to court documents, from January 2021 through May 2021, Edward Low, also known as "a Mang Wah Low" and "Eddie Low," 31 of Flushing, New York, accepted bribes and leveraged his position as a TD Bank, N.A. retail employee to fraudulently obtain confidential customer information that he passed to outside co-conspirators, who used it to take over accounts and steal money from customers. Low also processed some of their illicit transactions. In total, Low received at least $26,700 in bribes and facilitated $484,572.16 in fraud at TD Bank.

Then, from May 2022 through August 2022, while employed at another financial institution, Low accepted a bribe to falsify bank records to open an account in the name of a shell company. Low's co-conspirators then used that account to commit at least $47,195 of fraud.

In February 2026, Low pleaded guilty to conspiring to commit wire fraud affecting a financial institution and making false bank entries or reports as a bank employee.

Assistant Attorney General A. Tysen Duva of the Justice Department's Criminal Division; U.S. Attorney Robert Frazer for the District of New Jersey; Special Agent in Charge Jenifer L. Piovesan of IRS Criminal Investigation (IRS-CI) Newark Field Office; and Special Agent in Charge Patricia Tarasca of the Federal Deposit Insurance Corporation Office of Inspector General (FDIC OIG) New York Region made the announcement.

The IRS-CI Newark Field Office and the FDIC OIG New York Region investigated the cases. The Department also thanks the Morristown Police Department for its assistance with the investigation.

Trial Attorneys D. Zachary Adams and Chelsea R. Rooney of the Criminal Division's Money Laundering, Narcotics and Forfeiture Section and Assistant U.S. Attorney Mark J. Pesce, Deputy Chief of the Criminal Division for the District of New Jersey, prosecuted the case.

The Money Laundering, Narcotics and Forfeiture Section's (MNF) mission is to take the profit out of crime, eliminate drug cartels, and protect the U.S. financial system. MNF pursues criminal prosecutions and criminal and civil asset recovery actions involving financial facilitators who launder profits for criminals; financial institutions and their officers and employees whose actions threaten the U.S. financial system and financial institutions; international money launderers who support transnational organized crime; and the top command and control of international drug trafficking organizations.

MNF's Bank Integrity Unit investigates and prosecutes banks and other financial institutions, including their officers, managers and employees whose actions threaten the integrity of the individual institution or the wider financial system.

Former Brooklyn Bank Manager Sentenced to Prison for Laundering Proceeds of Medicare Fraud for Transnational Criminal Organization

A Brooklyn man was sentenced yesterday to 18 months in prison for conspiring to launder more than $8 million in health care fraud proceeds through a U.S. bank on behalf of a transnational criminal organization (TCO).

Renat Abramov, 37, of Brooklyn, New York, a former relationship manager at a U.S. bank branch in the Sheepshead Bay section of Brooklyn, used his position to aid a foreign-based TCO that spearheaded the largest health care fraud case ever prosecuted by the Department of Justice, as uncovered by Operation Gold Rush.

The TCO, based in Russia and elsewhere, orchestrated a multi-billion-dollar health care fraud and money laundering scheme to steal from Medicare and private health insurance companies by submitting fraudulent claims for durable medical equipment through dozens of medical equipment companies. These medical equipment companies were owned on paper by nominee owners, many of whom were not lawfully present in the United States, in a manner that disguised the true beneficial ownership and control of the companies by the foreign-based TCO.

Abramov acted as a concierge banker for participants in the health care fraud and money laundering scheme. Among other things, Abramov opened bank accounts for the nominee owners of several medical equipment companies, which were then used to deposit more than $8 million in health care fraud proceeds. Once deposited, the nominee owners and their handlers transferred the money into offshore accounts. Abramov also assisted nominee owners with wire transactions and provided information about the status of accounts.

In February 2026, Abramov pleaded guilty to conspiracy to commit money laundering.

Kansas Woman Sentenced to Probation for Insurance Fraud

Jinky Alcantara, aged 39, pleaded guilty on May 26, 2026, in Johnson County District Court to one felony count of insurance fraud. Alcantara produced false invoices to her insurance company as part of a burglary claim with the intent to financially gain from the submission of the false writings. She was sentenced on July 16, 2026, to 24 months of supervised probation and assessed $500 in fines, with additional court costs and fees.

Kansas Insurance Commissioner Vicki Schmidt announced a Johnson County woman has been sentenced to 24 months of probation for insurance fraud.

Las Vegas Woman Sentenced to Prison in $5M Refund Fraud Scheme

Iris Hondermann owned and operated **Silver State Tax & Multiservices LLC**, a tax preparation business in Las Vegas. A Las Vegas woman was sentenced August 5, 2026 to 30 months in prison for conspiring to defraud the United States by filing false tax returns with the IRS and diverting portions of the resulting tax refunds to herself and her codefendant.

According to court documents and statements made in court, An individual close to Hondermann worked for the business and was charged in the same scheme. From approximately 2017 through 2021, Hondermann and her codefendant prepared tax returns for clients that included one or more false items, including business profits and losses, COVID-19 sick and family leave credits, and residential energy credits.

Between 2017 and 2021, Hondermann and her codefendant prepared false tax returns with the IRS seeking more than $5 million in refunds that their clients were not entitled to receive. At times, Hondermann and her codefendant also diverted portions of client tax refunds to themselves. From 2017 through 2021, they diverted more than $1.1 million in fraudulent tax refunds to bank accounts one or both of them controlled.

Hondermann pleaded guilty to one count of conspiring to defraud the United States. Honderman's codefendant, who admitted to filing false tax returns for clients as part of the same scheme, still awaits sentencing.

Tax Shelter Promoter Pleads Guilty to Conspiring to Defraud the IRS

Promoter, Along with His Conspirators, Caused a Tax Loss of Approximately $43 Million

Larry C. Conner, 69, of Frisco, Texas conspired with others to defraud the IRS by promoting to taxpayers nationwide an abusive trust tax shelter in which taxpayers diverted nearly all of their income through a series of three purported "non-grantor" trusts and a so-called "private family foundation" for purposes of evading the assessment of taxes owed on that income. Conner pleaded guilty to conspiring to defraud the IRS by promoting and selling a fraudulent tax shelter.

Court documents, from at least February 2018 until September 2023, Conner promoted the abusive trust tax shelter at in-person seminars to clients in the name of The Business Solutions Group (TBSG). Conner sold the trusts and foundations used in the abusive trust tax shelter for a fee typically ranging from $25,000 to $50,000. Conner admitted that he knew the tax shelters he promoted were fraudulent based on repeated warnings he received from attorneys and accountants that the tax shelter was fraudulent and illegal and his knowledge and receipt of materials that the IRS publishes to educate the public about the illegal nature of abusive trust tax shelters.

Conner further admitted to personally using the abusive trust tax shelter from 2016 through 2021, to evade income taxes on about $5.2 million of his income.

Conner admitted to promoting the abusive trust tax shelter in concert with the following individuals, among others: a Colorado couple, **Timothy McPhee** and **Marcia Predmore**; a Nevada Certified Public Accountant, **Weldon Wulstein**; a Wyoming-based bookkeeper, **Suzanne Thompson**; a Mesquite, Nevada man, **Roderick Prescott**; and an Arizona-based tax preparer, **Kent Ellsworth**. Conner and his co-conspirators' caused the filing of false tax returns fraudulently sheltering approximately $156 million in income, which resulted in an approximate tax loss to the IRS of $43 million.

McPhee previously pleaded guilty to conspiracy to defraud the United States, tax evasion, and, in a separate case, wire fraud. He is currently serving a 151-month prison sentence.

In a separate five-week trial taking place throughout May-June 2026, a jury found Predmore, Wulstein, Thompson, and Prescott guilty of conspiracy to defraud the United States and other tax-related felonies. All four are scheduled to be sentenced in January 2027.

Kent Ellsworth pleaded guilty to two counts of aiding and assisting in the preparation of a materially false and fraudulent tax return and is pending sentencing in the District of Arizona on Dec. 7.

Conner pleaded guilty to conspiracy to defraud the United States. He is scheduled to be sentenced on Jan. 26, 2027, and faces a maximum penalty of five years in prison. A federal district court judge will determine any sentence after considering the U.S. Sentencing Guidelines and other statutory factors.

Rentfrow Inc. Agrees to $2.25M Civil Penalty and Injunction for Alleged Violations of Fair Credit Reporting Act and FTC Act

RentGrow Inc. was ordered to pay a $2.25 million civil penalty judgment and injunction against RentGrow to resolve allegations that it violated the Fair Credit Reporting Act (FCRA) and the FTC Act in connection with background reports it furnishes to assist landlords and property managers in screening tenants for rental housing.

Tenant screening reports can significantly affect the outcome of a housing application. Consumers deserve to know that the information contained in those reports is accurate, that the reporting is transparent, and that they have a meaningful opportunity to address information that may affect them.

In a complaint filed in the U.S. District Court for the District of Columbia, the government alleged that RentGrow failed to maintain reasonable procedures to ensure maximum possible accuracy of the information in its tenant screening reports, failed to disclose to consumers upon request the information contained in those consumers' reports and the sources of that information, and failed to comply with required procedures when a consumer disputed the accuracy of a report, in violation of FCRA. The government further alleged that RentGrow violated the FTC Act's prohibition on deceptive business practices by misrepresenting to tenant applicants that upon successful dispute of their report, corrections to or removals of inaccurate information were reported to landlords and property managers.

The stipulated order resolving those allegations requires RentGrow to pay a $2.25 million civil penalty and imposes an injunction against it prohibiting the alleged misconduct and requiring related compliance reporting, monitoring, and recordkeeping.

Chinese-Owned Company to Pay More Than $11M to Resolve False Claims Act Allegations Relating to Paycheck Protection Program Loan

Continental Aerospace Technologies Inc. agreed to pay $11,772,680.14 to resolve allegations that it violated the False Claims Act by submitting false claims to obtain a Paycheck Protection Program (PPP) loan for which it was not eligible.

PPP loans were intended to help small businesses in the United States.

PPP loans were meant to help small American businesses survive the economic turmoil caused by the pandemic. Continental, however, was part of a large Chinese-owned corporation and allegedly provided false information to the SBA to obtain taxpayer funds to which it was not entitled. This matter is just one of many cases in which our office continues to hold corporations, particularly those owned by a foreign government, accountable when they submit false claims to obtain American taxpayer money.

Congress created the PPP in March 2020 to provide emergency financial assistance to Americans suffering from the economic effects of the COVID-19 pandemic. Under the PPP, eligible businesses could receive forgivable loans guaranteed by the Small Business Administration (SBA). Regulations provide various eligibility requirements for the PPP, including limitations on the number of

individuals the borrower and its affiliated entities employed. In their loan applications, borrowers were required to certify that they were eligible for the PPP and that the information they provided was accurate.

Continental designs and manufactures aircraft engines and parts. At the time it applied for its PPP loan, it was part of a large multinational corporation partially owned by Aviation Industry Corporation of China (AVIC). AVIC is wholly owned by the State-Owned Assets Supervision and Administration Commission of the State Council (SASAC), an arm of the People's Republic of China.

In applying for its PPP loan, Continental certified that it was eligible for the PPP. The United States alleges that Continental was not eligible because it was affiliated with other companies in the United States and China, and together with its affiliates across the globe, Continental employed more individuals than permitted by SBA's size standard for its industry. The United States also contends that Continental was not eligible because it was ultimately owned by a government entity in violation of SBA rules.

The civil settlement includes the resolution of claims brought under the *qui tam* or whistleblower provisions of the False Claims Act, which permit private parties to file an action on behalf of the United States and receive a portion of any recovery. The lawsuits were filed by GNGH2 Inc. in the Eastern District of Wisconsin and Andrew McCarley in the Southern District of Alabama. In connection with the settlement, GNGH2 Inc. will receive $1,765,902.02.

Judd Wire Inc. Agrees to Pay $1.014 Million to Settle False Claims Act Allegations for Failing to Test Wire and Cable Used By the United States

Judd Wire Inc., of Turners Falls, Massachusetts, agreed to pay **$1,014,000** to resolve allegations that it violated the False Claims Act by failing to perform tests required by specifications for certain wire and cable products used by the U.S. Navy. In connection with the settlement, the United States acknowledged that Judd Wire took significant steps entitling it to credit for cooperating with the government.

"The performance of safety tests of military equipment is a critically important part of taking care of our Sailors and Marines and the gear their lives and missions depend on," said General Counsel of the Department of the Navy David W. Denton Jr. "When contractors fail to do so they need to be held accountable. The Navy Acquisition Integrity Office will continue to expand our partnership with the Task Force to Eliminate Fraud on procurement fraud matters and take administrative action when appropriate."

The settlement resolves allegations that from September 2011 to August 2021, Judd Wire produced wire and cable products that were used by the United States but failed to perform all tests required by each of the 29 wire and cable specifications covered by the settlement. Judd Wire voluntarily disclosed the testing lapses to the United States, cooperated with the U.S. investigation, and implemented remedial measures.

Lindberg's Right-Hand Man Sentenced to Two Years After Cooperating With Prosecutors

Almost four years after he pleaded guilty, the top associate to convicted briber, insurance entrepreneur and fraudster Greg Lindberg has been sentenced to two years in prison.

Christopher Herwig, who was chief investment officer for Lindberg's Eli Global and other companies, also must forfeit $842,000, the federal judge in the Western District of North Carolina ordered on Wednesday.

Lindberg, convicted of attempting to bribe North Carolina Insurance Commissioner Mike Causey in 2018, was also convicted of skimming more than $2 billion in reserves from his life insurance and reinsurance companies and using the proceeds to fund other projects and to pay for jets, mansions and a 214-foot yacht.

Prosecutors have called it one of the largest insurance fraud schemes in U.S. history. Lindberg is now serving a 12-year sentence in federal prison.

Herwig, a chartered financial analyst who worked closely with Lindberg for years, has been remorseful and cooperative with prosecutors since his indictment, court filings suggest. He was convicted in December 2022, but prosecutors held off on sentencing recommendations until after Lindberg's prosecution was final.

Herwig (photo included in federal court filing)

Herwig's sentencing memorandum, filed by his attorney, said the years since his indictment gave him more time with his family and community. The memo also gave Herwig's account of Lindberg's illicit actions through the years.

For years, Herwig said, all seemed well with Lindberg's far-flung business enterprises.

"It was not until 2016, when Lindberg began to stray from the company's original path and changed its investment models, that things went sideways," the memo reads. Lindberg "was the controlling party with ultimate financial control and interest over multiple insurance companies, dozens of operating companies, and more than a hundred holding and pass-through entities."

Herwig was "swept into the vortex" of Lindberg's schemes and began to turn a blind eye.

"Chris caused numerous wire transfers that took funds away from insurance companies, represented to the North Carolina Department of Insurance that the FINCO investment structures were 'unaffiliated' with Global Growth (formerly known as Eli Global), falsely represented to ULICO that the investments held as cash in the ULICO 2017 Trust were properly classified under the affiliated definition, and signed off on Lindberg's $3.1 mortgage purchased by the ULICO 2017 Trust," the memo notes.

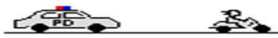
Lindberg was the mastermind, and he "manipulated individuals, insurance companies, the Insurance Commission, trusts, and others to bend to his will."

Herwig's sentencing came two days after the federal judge overseeing much of the prosecution and litigation that resulted from Lindberg's actions chastised Lindberg for trying to escape further restitution.

Lindberg's attorneys have said that Lindberg had refunded $1 billion to the victims of his financial schemes before he was ordered to do so by the courts, But a court-appointed special master who examined the books has found that Lindberg still owes more than $1.6 billion. Lindberg now disputes that, saying he owes nothing more.

This week, U.S. District Judge Max Cogburn questioned Lindberg's motives.

Lindberg was left without counsel for part of the proceedings, after his attorneys had withdrawn from the case and other attorneys had filed court papers without signatures, the newspaper reported.



It Doesn't Pay to Lie in an Application for Insurance

Rescission for Material Misrepresentation

An Insurer May Rescind An Insurance Policy Where The Applicant Made A Material Misrepresentation In The Application.

In *Union Mutual Fire Insurance Company v. 844 Knickerbocker, LLC, et al.* No. 2024-10359, Index No. 602824/22, 2026 NY Slip Op 04789, Supreme Court of New York, Second Department (July 29, 2026) Union Mutual Fire Insurance Company issued commercial insurance policies to 844 Knickerbocker, LLC, and Sanjaya Mallick based on applications stating that the insured property contained two apartment units. After an underlying personal injury action was filed, Union Mutual determined that the property actually contained three apartment units and rescinded the policies on the ground that the defendants had made a material misrepresentation in the applications.

LAW:

A misrepresentation is material if the insurer would not have issued the same policy, or would have issued it only on different terms, had the true facts been disclosed. To establish materiality as a matter of law, the insurer must submit documentation of its underwriting practices, such as manuals, guidelines, bulletins, or rules addressing similar risks.

DISCUSSION/ANALYSIS:

The Appellate Division held that Union Mutual made a prima facie showing of entitlement to summary judgment by submitting an underwriter affidavit and underwriting guidelines demonstrating that the correct information regarding the number of apartment units would have affected the premium charged.

The defendants failed to raise a triable issue of fact in opposition. As a result, the Supreme Court erred in denying Union Mutual's motion for summary judgment and in granting the defendants' cross-motion dismissing the complaint.

CONCLUSION:

The order was reversed. Union Mutual was entitled to summary judgment declaring that the policies were void *ab initio* and that it had no duty to defend or indemnify the defendants in the underlying personal injury action. The matter was remitted for entry of an appropriate declaratory judgment.

An insurance company has a right to rescind an insurance policy if the applicant makes a material misrepresentation on the insurance application

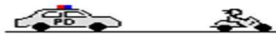
To establish materiality as a matter of law, the insurer must present documentation concerning its underwriting practices, such as underwriting manuals, bulletins, or rules pertaining to similar risks, which show that it would not have issued the same policy if the correct information had been disclosed in the application.

Here, the plaintiff demonstrated its prima facie entitlement to judgment as a matter of law on the complaint. The plaintiff established that the defendants made a misrepresentation in the applications for the subject insurance policies that was material by submitting an affidavit of its underwriter, as well as certain guidelines showing that a higher premium would have been charged if the correct information had been disclosed. Accordingly, the trial court (Supreme Court) should have granted the plaintiff's motion for summary judgment on the complaint and denied the defendants' cross-motion for summary judgment dismissing the complaint.

Since this is a declaratory judgment action, the appellate court remitted the matter to the Supreme Court, Nassau County, for the entry of a judgment, among other things, declaring that the subject insurance policies are void ab initio and that the plaintiff is not obligated to defend or indemnify the defendants in the underlying.

ZIFL OPINION

Insurance is a contract of good faith and fair dealing. An insurance application is a statement of facts presented to an insurance company as a request for insurance and must be presented fairly, completely and in good faith. When the insurer failed to tell the truth by telling the insurer it was insuring a two unit apartment when it was really three. That was a material misrepresentation and grounds for rescission.



Barry Zalma

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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.

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Barry Zalma founded Barry Zalma, Inc. in 1979 to address every type of insurance claim and coverage challenge.

After serving as a Special Agent in U.S. Army Intelligence (1964–1967), he began his insurance career in 1967 as a claims trainee with Fireman’s Fund, gaining deep knowledge of the industry while attending law school at night. Admitted to the California Bar in 1972, he specialized in insurance coverage, claims defense, and bad faith litigation for over 45 years before shifting to full-time consulting and expert witness work in 2017 (license now inactive).

Today, Mr. Zalma is an internationally recognized authority on:

- Insurance claims handling
- Coverage interpretation
- Bad faith litigation
- Insurance fraud detection and investigation

He has testified as an expert in state and federal courts across the U.S., from California to the British Virgin Islands, often helping cases settle after his reports or depositions demonstrate clear industry standards. His work emphasizes ethics: he will not tailor opinions to favor a retaining party if facts indicate otherwise—in such cases, he withdraws and refunds retainers.

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