

# EMERGING TRENDS IN THE INVESTIGATION OF INSURANCE CLAIMS

*“A GUIDE FOR CLAIMS  
AND LITIGATION PRACTICES  
IN THE SECOND DECADE OF THE NEW  
MILLENNIUM”*

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# Emerging Trends in the Investigation of Insurance Claims

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## **I. Introduction**

It is a trite and overused adage to say more change has taken place in recent times than ever before. No doubt more than a century ago, the same may have been said regarding the advent of the automobile replacing the horse and buggy. Reality is, however, we are currently in an era unlike any before in the history of our society or the world. It is axiomatic, therefore, since the insurance industry is an outgrowth of service to society, we too are facing more change than ever known before.

The explosion of technology with ever faster electronic communication, the economic roller coaster from boom to bust and the reality of a changing American demographic as “baby boomers” grow older, are but a few of the sociological changes affecting the insurance industry. In addition to these external factors, there have also been a number of internal changes within our own industry.

The past decade has evidenced the largest swing ever in the centralization of insurance claims, with litigation management and insurance fraud investigation being handled remotely rather than through local offices. Use of virtual offices and increased travel now mean SIU investigators and claim handlers may physically be located hundreds, if not thousands of miles away from the insured and the loss location. The desire to decrease expenses has adversely affected the ability to investigate insurance claims to the same extent and depth which was done for decades before. Whether these changes within our industry are permanent, or a passing trend, will be written by the next generation to come. Whatever the future may hold, these changes are the reality we are dealing with in today’s environment in the investigation of insurance claims.

## **II. Aggressive Targeting of Bad Faith Claims**

Do not think for a moment, though, the work we are doing is in a vacuum. Every step the insurance industry is taking with regard to the investigation of claims, cutting cost, using internal investigators and counsel, handling claims from hundreds or thousands of miles away and increasing workloads on staff, is being watched not only by consumer advocates, but by plaintiff-oriented attorneys throughout the United States. Various schools of thought will argue this is being done to protect consumers, but as with many other things in society, a bottom line monetary interest is frequently not very far away.

Insurance carriers should be more concerned than ever before about the risk of bad faith litigation and high-dollar bad faith verdicts. As we enter the second decade of the new millennium, there are more law firms, attorneys and websites promoting and advocating insurance bad faith claims than ever before. Websites routinely and aggressively target bad faith claims, promoting themselves as the “protector” of consumer interest. Websites such as [www.policyholdersofamerica.org](http://www.policyholdersofamerica.org) and [www.badfaithinsurance.org](http://www.badfaithinsurance.org) specifically promote themselves as “watchdogs” over the insurance industry and encourage people to bring litigation against insurers.

Even ten years ago, the concept of bad faith was rarely known by most policyholders. The vast majority of bad faith claims were generated from a disgruntled policyholder seeking advice from an attorney. In the new era of the technology communication explosion, we have seen a dramatic increase in cases where individuals seek out legal advice for the sole purpose of filing a bad faith claim either for monetary

gain, or truly because the insurer has not acted properly. Websites such as these very aggressively point to insurers utilizing in-house origin and cause investigators, in-house legal counsel and hiring attorneys who are not qualified or are the “low bidder” to represent an insured all as evidence of insurers not acting in the best interest of their insureds.

In addition to these websites, a growing number of law firms across the United States are targeting insurers for bad faith, and promoting their services via the Internet to potential plaintiffs. Insurance consumers in the midwest can now easily retain the services of legal counsel to represent them from the east or west coasts, or anywhere in between. Law firms with Internet advertising promote themselves with slogans such as “your insurance against insurance” or “we help people when insurance companies don’t keep their promises” and invite disgruntled policyholders and claimants to proceed with bad faith litigation.

The obvious question should be: are these new and aggressive techniques working? The answer is, astoundingly, yes. Across the United States, bad faith verdict amounts are increasing dramatically with recent reported awards including verdicts for sixteen million, thirty-five million and in excess of fifty million dollars. This should be of concern to you, because all of us are only “one claim away” from the same result. Frequently, it is not the major loss claim which leads to the substantial bad faith verdict, but instead a relatively minor or mid-level claim which does not get the attention or review it deserves. Of grave concern in this era of cost control in the investigation of insurance fraud claims is whether the cost savings by trying to go a “cheaper” route are

truly savings in the long run when the insurance company gets “hit” with a multi-million dollar bad faith verdict.

Most importantly, we in the insurance industry are often times responsible for bad faith verdicts simply because we engage in activities or practices which, when commonly viewed by members of the jury, incite distrust and anger. The simple test we should be using internally is whether our actions in handling a claim reflect the standard which a jury would reasonably expect us to engage in regarding a first or third party claim.

If, for example, your company utilizes a house counsel program and does so entirely properly for defense of your insureds when they are sued by third parties, your “rationale” for this program is there is no conflict of interest by house counsel since staff attorneys are defending the interest of insureds. This has long been the hallmark of establishing an in-house counsel program, and one which is completely proper. When you hold a “mirror” up to this argument, and use your same house counsel to investigate an insured of the company for potential fraud, you have now put your house counsel into the untenable position where you are admitting their true “client” is the insurance company and they not acting in the “best interest” or defense of the policyholder who paid the premium to your company.

This caution applies not only to house counsel programs. If you are going to retain outside legal counsel to assist your company in the investigation of a fire loss or a questionable theft claim, do you really want a situation when your attorney is cross-examined in the bad faith trial, they admit they have never before handled a fire investigation or an insurance fraud investigation nor have any training whatsoever in

how to investigate property or personal injury fraud claims? These types of things routinely anger jurors, and are the “seeds” which grow into the multi-million dollar bad faith verdicts. The time to address these problems and not allow the “seeds” to “germinate” is not when the suit papers arrive for the bad faith lawsuit. The time to act is now by making certain you have the proper team in place to handle the investigation and ultimate litigation, if necessary, of insurance fraud claims.

The sad reality is, in the economy of the new millennium, many insurers are lagging behind in addressing these issues. We have entered an era where cost-cutting and control is superseding our ability to properly and effectively handle these most sensitive of all insurance claims where fraud is being investigated. We are not only failing to keep up, but are falling behind and ultimately will pay the cost through millions of dollars of bad faith verdicts.

It should never be enough for us to simply “keep up.” Our job as a claims professional, SIU investigator, attorney or expert should at all times be to “stay ahead of the curve,” so we provide the highest quality of service not only to the company, but also to the insureds who place their trust and confidence in the insurer to whom they have paid a premium. To secure a better understanding of how we achieve this goal we must look at what trends are emerging in our society today which are directly impacting upon the investigation and litigation of insurance claims.

### **III. The Effect of the “Great Recession” on Claims and Litigation:**

The biggest factor affecting insurance claims today is what has been deemed “the great recession.” Since the fall of 2008, the landscape of the world economy, and

the American economy, have changed dramatically. This economic “shift” has had a dramatic effect on all aspects of our society, and we would be foolish to think there has not been an impact on the insurance claims process as well. The question for us to consider is whether the effect is “good” or “bad.”

The answer to this question is a mixture of both. In the real estate boom times of the last twenty years, one of the best arguments against an arson defense was the insured had no motive to burn the home due to the rapid appreciation of values in the real estate market. Those days are now gone.

Reality is, it is much easier for a juror to now understand the concept of financial motive for insurance gain. This is applicable in an arson fire as much as in a bodily injury claim arising from a questionable impact accident. Economic reality has made it much easier to convince a court or juror a person does, in fact, have a financial motive to create or advance an insurance claim.

If this is the advantage, however, we must also be cautious regarding the disadvantage. As an attorney who has jury-tried cases for a quarter century, I have learned it is often the “little things,” or “hidden issues” which drive a jury verdict. We will be blind to the concept of economic reality if we do not equally understand jurors may find themselves in a much more sympathetic or empathetic position when looking at a claimant who they truly feel committed an intentional act or inflated a claim for monetary gain. Jurors may find themselves, even subconsciously, understanding and relating to the person presenting the claim, and feel they may have done the same given a similar circumstance. This places a heavier burden upon the insurance industry, and we as insurance attorneys, to educate jurors regarding such key factors as the cost of

insurance fraud and the impact of fraudulent and related claims on policy premiums, the number of claims which have to be processed and investigated and the overall impropriety of allowing in our society such claims to proceed.

Another factor we must now contend with in virtually every bad faith or insurance claim trial is the “AIG Syndrome.” Although it had little or nothing to do with its property and casualty business, the virtual collapse of AIG several years ago became one of the hallmark financial bailouts of the “great recession.” Since that time, in every insurance jury trial I have done, I have had to address on *voir dire* the effect of the AIG collapse and economic bailout. On some very real level, jurors often have a tendency to “broad brush” the entire industry with the animosity many of them feel toward the economy in general and the AIG bailout in specific. When this is combined with the clear fact juries for decades have not held a positive impression of insurance carriers, it creates a major impact which we must address at trial. This is as a major impact but not an impossible hurdle. In our firm, we have successfully won cases both before and after the 2007 economic collapse. The key to success is understanding the new issues which our economy has wrought and having an action plan in place to address those in the courtroom. If we do this, we are staying ahead of the curve, and are on the path to victory.

Although it has always been true, in these economic times we also must be more attuned to the geographic and socio-economic environment in which the claim we are handling, or litigating, is taking place. While it is true all parts of our country have been impacted by these recessionary times, not every part of the country has been impacted equally. There is a vast differential between what is happening in the economy of

Detroit, Michigan versus Atlanta, Georgia, which has a more diverse and less industrial-based economy.

In this era of increasing claims and investigation centralization, we must be attuned to the marketplace in which the claim we are handling is occurring for a number of reasons. These include knowing what the local economy issues are, whether one or more of these factors may be a motivating factor for the fraud which may have been committed, and also having a full and complete understanding of how we should best present our claim, or case, to a court or jury in the local jurisdiction. These should be the type of issues which legal counsel is prepared to investigate, understand and advise a client of as part of the claim investigation and potential denial and litigation process. Remarkably, this does not require a person to be living in the area as much of this data can be derived from relatively simple research.

Reality is, we simply have to look beyond the obvious and be willing to work harder and investigate more fully to do our jobs properly in this new era. Here are some specific examples of where policies and procedures utilized for decades in the investigation of claims may need to be rethought and updated for our current times:

**a. Anticipatory Financial Motive**

Historically, we have looked backwards in time to determine whether at the time of a loss, a person had a financial motive to cause a loss to occur. While this still may be relevant in many claims, we are “missing the boat” if we are not looking forward to address the newly-emerging concept of “anticipatory financial motive.” For example, on a fire loss claim are you researching to determine whether the local business employing the insured has announced plans for major job cutbacks, total closing of the office or

plant or relocation of jobs out of the country? On an increasing basis, insureds are committing insurance fraud realizing the “end is in sight,” and they are willing to take some type of action to remain financially secure before their finances are dwindled.

#### **b. Denial of Refinancing or Credit Realignment**

In like manner, it is no longer sufficient to only look at an individual’s bank accounts to determine whether they were overdrawn or delinquent in making payments at the time of the loss. Each of these factors is still relevant, but in addition we must be look to factors such as:

- Were loan applications submitted and denied in the months or years prior to the loss?
- Are balloon payments on mortgages coming due in the future with no ability to pay the mortgage?
- Are adjustable rate mortgages readjusting to higher levels?
- Have the insureds been “flipping” credit card balances to avoid paying high interest rates, but can no longer secure introductory financing rates causing a substantial increase in their monthly debt expense?

#### **c. Analysis of Neighborhood or Community Decline**

With the increasing centralization of claims and SIU functions, I have seen a number of fire loss claims where no physical inspection of the loss location was done by the insurance carrier. In virtually every part of the country, you will find neighborhoods where a very nice home exists, but is surrounded by homes which are in severe decay, or have been vacated due to foreclosure. If you are simply looking at a static photo of the loss location, you may not have an appreciation for the surrounding environment.

This may be relevant in investigating the claim to determine what impact the surrounding homes and neighborhood have on the value of the home, and whether the insureds had a motive to commit arson due to the declining value of their home based upon the condition of the surrounding properties. Although nothing surpasses an actual scene view, programs such as “Google Earth” can be a tremendous asset in viewing the pre-loss condition of the property as well as securing a much better understanding of the surrounding neighborhood property conditions.

#### **d. Other Financial Conditions**

Other factors are also now relevant to a thorough and complete investigation of insurance claims. When considering financial motive, are you looking at the age of children (or perhaps grandchildren) the insureds are responsible for? A fire or theft loss or other insurance claim may be motivated by upcoming college education needs. Not long ago, we had a claim involving insurance fraud where the father committed the fraud to pay for his son’s law school education!

In addition to searching bank account records, you should also be looking at retirement plans, 401(k) plans and reductions in defined benefit retirement programs for certain insureds. Although an insured may have positive balances in their personal bank accounts, if you learn their employer is eliminating or drastically cutting back on retirement benefits, or you analyze severe drops in the value of 401(k) plans with an impending retirement in the next several years, you may find new avenues of financial motivation to commit insurance fraud which have been overlooked in more healthy economic times.

#### **IV. Changes in the Type of Arson Fires**

In the same manner, arsonists are also becoming more creative and the spectrum of arson fires is broadening. Arson has been, and will always remain, a crime for monetary gain, however, we must be ahead of the spectrum in investigating and analyzing whether a fire truly is unintentional, or has a more ominous root cause.

Kitchen fires remain one of the most difficult claims to prove an intentional act. Not surprisingly, recent trends have shown a dramatic increase in kitchen fires. Equally, however, improved investigation techniques now allow these fires to be investigated more fully. Studies have also shown electronic cook tops and sophisticated cooking systems with built-in sensors may not even reach sufficient temperatures to permit a grease fire or non-metallic object to ignite. You also should be investigating these “accidental” fires to make certain there is not an underlying motivation of an upcoming house sale or retirement where it is “convenient” for the insurance company to pay for a new kitchen being installed in the home.

Although these fires will remain difficult to investigate well into the future, as with any other claim or law suit, often these matters come down to conducting a thorough and complete investigation and deciding whether a jury will reasonably believe the fire was accidental or intentionally set.

Fires associated with meth labs are also on the rise. In contrast to other types of fires, meth lab fires are generally easy to establish regarding the source of the fire. What is frequently overlooked, however, is most insurance policies do not have a criminal act exclusion and do not automatically void coverage for a meth lab fire, especially when it is a rental property owned by an “innocent” landlord. These types of

fires require additional and extensive investigation as well as a careful review of the policy language. Although most policies may not provide a criminal act exclusion, virtually every policy contains an exclusion for increased hazard. The key components of meth include highly flammable components and, often times, components from fireworks. Our firm has successfully investigated and sustained denials of coverage based upon the increased hazard exclusion contained in most policies.

Also, do not automatically assume a landlord is truly an “innocent” third party. Background checks, court docket checks and examination under oath testimony of the landlord should all be considered in the appropriate claim to determine whether the landlord was involved in the illegal activities, or was substantially aware illegal activities and increased risk were occurring at the rental property.

Another factor which is frequently overlooked in insurance fire investigations are the increasing number of outbuilding fires. Detached garages, party barns, sheds and even boat docks can become a quick source of cash to pay down credit card debt or other financial obligations without dramatically affecting a person’s lifestyle or living conditions and while keeping intact family mementos and treasures. Our firm was involved several years ago in the investigation of a mid-day fire of a large historic barn where the elderly insured was overheard by a local police officer making the comment at the fire scene, “I just created two new building lots to sell.”

This claim is significant for two reasons. First, there are an increasing number of outbuilding fires involving not only the structure itself, but normally an extensive amount of contents being claimed as well. In these types of losses, fraudulent insureds benefit from an infusion of money from the insurance carrier without really sustaining any

“tangible” loss of value or possessions. However, the financial gain to use the insurance proceeds for other needs or purposes may be tremendous. Possible motivation for these types of claims may include:

- Payment of credit card debt
- Paying off of first or second mortgages
- Payment for college tuition for children (or grandchildren)
- Increasing the amount of available resources for retirement

The second significant point regarding this claim, but which is also indicative of claims across the United States, is the aging demographic of America. Far too frequently, we look at claims and simply “assume” an older person would not commit insurance fraud or the crime of arson. As America becomes an increasingly older population with aging “baby boomers,” the same morals, social values and motivations of yesterday’s 30-50-year-olds are now firmly implanted in today’s senior citizens. While it has never been good to “profile” or “stereotype” any claimant, we also should not equally adhere to twenty years of stereotypical assumptions that older people are less likely to commit insurance fraud. In today’s changing economy and aging demographic, retirees, executives, widows/widowers and others are equally capable of committing arson or fraud as any other age group or demographic.

Older couples who planned to retire from northern climates to warmer weather in the south may find their retirement plans dashed due to the inability to sell a home, decreased market value of their home or other economic factors including job loss or less retirement income than planned. The burning of an existing home may be just the

“ticket” needed to purchase the retirement home or condominium in another state which otherwise was not an economic possibility.

You also should not automatically dismiss what appears to be a person of sound financial condition as not having a financial motive to commit insurance fraud. What may appear to be wealthy individuals with extremely nice homes, cars and even positive balances in their bank account may actually be persons facing financial crisis under the surface with excessive credit card debt, second or third home payments and cost for boats or recreational vehicles which they can no longer afford.

The “bottom line” in any of these issues is still the financial motivation to commit insurance fraud and the associated financial gain of profiting from an insurance loss. It is these factors over which we must remain vigilant at all times.

## **V. Securing Information from Mortgagees and Realtors**

Another area in which we are failing to even “keep up with the curve” is securing important information and documentation from sources such as realtors and mortgage companies. Many questionable property claims arise within the first 6-18 months of a person purchasing a property. This may occur for a myriad of reasons including buyer’s remorse, lack of funds to update and remodel the home as planned or hoped for, or due to other financial difficulties which have impacted the insureds since the purchase of the home. Frequently on these claims, we will see assertions made regarding either the outstanding condition of the home when it was purchased or claims being made of extensive improvements or remodeling to the home without accompanying sales receipts or other independent verifiable proof.

It is the rare claim, however, where the extra effort is applied to go back and research what information and documentation may exist to verify or establish the condition of the home at the time of original purchase. In today's era virtually every real estate listing agent takes extensive photographs, and often video, of each listed property for sale. Frequently, real estate broker websites or multiple listing services post virtual tours of listed properties. From our experience, most realtors retain this information and using an authorization form, we have been able to secure extensive photographic and video evidence concerning the condition of the property sometimes only weeks before a loss occurred. Obviously, as the period of time increases from the date of purchase of the home to the date of loss this may render this type of investigation less relevant. The point, we need to consider securing this information on the appropriate claim.

In addition to realtors retaining information, another fruitful source of information may be securing records directly from the mortgagee which loaned the money for purchase of the home. This is extremely important since we often overlook the fact a mortgagee is an insured under the insurance contract and equally has the duty to cooperate in the investigation even before a final decision is made regarding coverage to the named insured.

Within the past decade, mortgage companies have become more keenly aware of the risk associated with taking a security interest in properties. For this reason, many mortgage companies now require a pre-closing inspection of the real estate which is going to be the subject of the mortgage. This will often involve a professional inspector who tours the property and issues to the mortgage lender a written report complete with

photographs identifying the overall condition of the property and any structural or mechanical defects including issues associated with any electrical problem, utility service or the roof structure and condition. Especially on claims involving wind loss and where the remaining usable life of a roof system is at question, this type of engineering or inspection report may be crucial to your investigation, but is often overlooked.

You will find each mortgage lender may have different standards, with some not having any type of inspection report and others having an extensive file of highly relevant information. The key point is, you will never know unless we remain vigilant and seek out and review these types of records, so we are making a correct and fully informed decision regarding a submitted claim.

Financial motive is also an issue we often overlook in seeking appropriate documentation. For decades, virtually every closing on a real estate purchase involves issuance of a HUD-1 statement. This statement details all financial transactions involving the property purchaser and seller. This document is often overlooked as being crucial to establish what financial interest the insured may actually have in the property. Often it is extremely relevant to know whether the insured invested any of their own personal money as a down payment of the property. The HUD-1 form is also the best way to verify information regarding the actual purchase price, loan information and other important financial documentation regarding the real estate transaction.

Until several years ago, we would frequently only look at whether the property was actually in foreclosure at the time the loss occurred. If your company is still doing this, you are significantly behind the times. With the explosion of foreclosures across the United States, it is crucial we not only determine whether the property was actually

in foreclosure at the time of the loss, but request the mortgage company to provide all communications to the insured in the months leading up to the loss to determine whether any notices of foreclosure were sent. In almost every jurisdiction, mortgage companies will send multiple notices of intended foreclosure prior to actually instituting a legal proceeding.

Frequently, when you request documentation from the mortgage company, you will also learn the company, in addition to planning to institute foreclosure, will serve notices to vacate the property prior to filing suit. These notices frequently provide the insured a period of thirty days to vacate the property. Routinely, insurance carriers and insurance attorneys are overlooking these important documents. If you simply ask the insured at the examination under oath whether the property was in foreclosure at the time of the loss, the insured may truthfully answer “no,” even though the insured received multiple letters of intent to file foreclosure and even had been instructed by the lien holder to vacate the property due to non-payment of the mortgage.

**a. Duties and responsibilities of mortgagees and lien holders.**

Along this same line, we also overlook the duties and responsibilities of a mortgagee or lien holder under the insurance contract once a foreclosure has actually occurred. For example, a mortgagee of a foreclosed property is still subject to all of the duties and responsibilities of any other insured under the insurance contract. This may include many duties which are often overlooked during the course of the claim process or investigation.

Most insurance contracts contain a requirement to notify the insurer if there is a substantial change in the use, occupancy or risk associated with the property.

Depending upon the jurisdiction you are in, many courts have construed a foreclosure action and vacating of the property to constitute a substantial change in risk, and have held mortgagees liable for the duty to notify the insurer once they take possession of the property due to foreclosure proceedings.

In like manner, virtually every policy contains a vacancy exclusion. Once the mortgage company becomes aware the property is vacant, this too should trigger a responsibility under your policy for the lien holder to notify the insurer of the vacancy of the property. Failure of the lien holder to timely do so may result in the insurance carrier properly invoking the vacancy exclusion or, as cited above, invoking the substantial change in risk provision of the property based upon the previously occupied residence or building now being vacated. Differing jurisdictions have interpreted policy language concerning vandalism and whether or not the act of arson constitutes vandalism under the policy. It is imperative to check with your legal counsel to determine whether the vacancy/vandalism exclusion applies to arson in your particular state. Our firm has taken an aggressive approach on this issue, often successfully arguing the crime of arson is a criminal act which by its very nature requires vandalism of the property to enter upon the premises and cause physical harm.

Mortgage companies in possession of a property also have the duty to mitigate damage. Each year we receive calls during the winter months regarding claims made by banks or other lien holders on vacant property where pipes freeze during the winter. Frequently, our investigation of these claims discloses the property was vacant with no activated utilities. If the jurisdictional law so permits, we will deny these claims based upon the failure of the mortgage company or lien holder to mitigate their damages by

maintaining the utility service to the property so pipes would not freeze or sump pumps would continue to operate.

Especially on commercial losses, there may also be a duty on the part of the insurer to secure the property. This may include even providing security services, protective measures such as boarding up large areas of glass to avoid vandalism by breakage or other similar and appropriate measures to protect the property.

## **VI. Getting the Best Return from your Expert Witness Investment**

In today's era of cost-consciousness, it is more important than ever to secure value from expert witness services. The money we expend on expert witness services should be spent wisely and be focused on protecting the interest of the company, or our insureds, as specific situations may warrant. Too often, I see situations where the lack of proper expert witness testimony is fatal to what may have been an otherwise successful claim. These costly errors, like most others, can be avoided rather simply.

The first key to selection of an expert is not to be seeking your expert after the loss occurs. Although in some situations a truly unique category of expert witness services may be required, most of the claims we encounter involve selection of origin and cause, accident reconstruction, independent medical or forensic accounting experts. There is simply no excuse for not having a team of experts identified, vetted and ready to assist your company in any geographic area as need arises. In my opinion, if we wait until after the fact to select an expert, we are already "behind the eight ball."

Selection of the wrong expert can literally cost your company millions of dollars. Our firm was involved in a major fire loss of a commercial structure in suburban Cleveland where due to claim centralization, the SIU investigator flew in from New York and simply asked one of the local fire fighters to recommend an origin and cause investigator. The subsequently prepared report overlooked key information and failed to comply with the provisions of NFPA 921. In a claim valued at more than two million dollars, and in what appeared to be a clearly incendiary fire, the insurance carrier's own expert witness report became fatal to its investigation.

Like so many other aspects of the claim investigation process, the procedure to identify and screen proper experts is not complicated or involved. Following these simple steps will lead you on the path to selection of competent and trustworthy experts:

- Identification of Experts
  - Contact other carriers
  - Contact your own defense counsel
  - Check with professional licensure associations
  - Check with recognized professional trade associations such as IAAI, NSPII, IASIU or other similar organizations
- Check background information
  - Request references
  - Speak to adjusters, SIU personnel and attorneys who have used the expert previously

- Request transcripts of actual depositions and courtroom testimony and read through those to determine whether the expert can withstand cross-examination and effectively convey opinions
- Conduct background checks and civil and criminal docket checks regarding your experts
- Specifically identify whether your expert has ever been the subject of any *Daubert* challenge, and the results
- Periodically update your listing
  - Do not become complacent or continue to use an expert simply because the company simply “has always done so”
  - Although you should remain loyal to experts who remain loyal to your company, this does not mean you should not consider adding new, up and coming experts to the portfolio of experts available to assist your company in investigation and litigation matters

As a trial attorney, the most important thing to me is an expert witness who is not only competent, but who can convey his or her opinions to the jury. An expert may write a wonderful report, attach beautiful digital photographs and be cheaper than any other expert your company can hire; this expert, however, will be worthless to you and me if they cannot withstand cross-examination in deposition or at trial. Even more importantly, these experts must be able to communicate their qualifications, scientific knowledge and analysis to the jury effectively and with high impact. Too often, I see insurance carriers overlooking these factors even though you are staking millions of

dollars of your company's resources upon the ability of your expert to convey their opinion in the courtroom.

One of the emerging trends in origin and cause investigation is the marked contrast between "old school" and "new school" fire investigators. When I began in practice nearly a quarter-century ago, virtually all origin and cause investigators came from a background of having worked for a local fire department. These experts were imminently qualified based upon literally years of experience of "digging out" fires and conducting investigations. Possessing little or no college-level experience, they brought to the courtroom the respect and dignity of public service and unquestionable practical experience.

More than a decade ago, a new trend began to emerge. Younger origin and cause investigators, who possessed extensive college-level training including Master and Doctorate level degrees in fire science investigation, began appearing upon the scene. These new experts brought tools such as computer modeling to the courtroom and stressed their training and experience as scientists since many of them never worked for a fire department.

I have frequently been asked which of these experts is "better?" My answer has consistently been the same and is resoundingly: "the one who can most effectively communicate to the jury." The simple reality is, whether we are talking fire investigation, forensic accounting, bad faith issues or any other aspect of expert witness testimony, there are many excellent and skilled experts available who bring a myriad of varying backgrounds. The key is identifying the appropriate expert on each file while making

certain the expert has the ability to “go the distance” including effectively meeting our needs to testify at a jury trial if the claim, and case, so warrant.

We too, however, play an important role in making certain our expert is prepared to conduct a complete and thorough investigation and give impactful trial testimony. One of the most effective ways I have found to cross-examine an expert is to attack their opinions based upon their not being provided all relevant data upon which an opinion should be based.

For example, in personal injury litigation, I frequently cross-examine the treating physician in the video deposition by getting the doctor to admit they are fully aware they have just testified under oath giving opinions in a lawsuit to a jury. I then have the doctor testify they agree before giving opinion testimony it is wise to have as much relevant information to review as possible. I then ask if the plaintiff’s attorney ever “bothered” to provide a transcript of the plaintiff’s deposition testimony in the case in which the doctor is currently testifying. I have never once had a doctor answer they have read the deposition of the patient/plaintiff. This allows me to then attack the doctor’s credibility while also implying the plaintiff’s attorney may have been withholding relevant information from the doctor by not wanting the doctor to even see the client/patient’s sworn testimony regarding their injuries, prior medical history and claims they are making as a result of the accident or injury for which the physician is treating the patient. It amazes me how easy this is to do, and how unprepared most opposing counsel and experts are when confronted with the failure to provide what jurors may well believe is relevant information.

If appropriate, make certain you, or your legal counsel, are providing your expert with all relevant information he or she may require to conduct a thorough investigation. The “filter” you should use is not based upon your years of experience in handling of insurance claims, or even what the expert tells you they need, but what reasonably a jury would expect this expert to review or been provided as part of preparing their opinion and report in their field of expertise.

Relevant information may include items such as:

- Accident, police or fire reports
- Photographs, videos, inventories or repair estimates
- Recorded or written statements, EUO transcripts or depositions
- Reports or findings of other experts on the claim/case whether on your side or the opposition
- Any other relevant data or information

The key to successful use of expert witnesses is to partner with your expert and be fully engaged in the process. Respect the expertise of the expert you have hired (or get a different one), but equally do not be afraid to question or challenge opinions or explore fully the underlying foundations of your expert’s opinion to determine how solid they truly may be.

Remember too, even if someone is an expert, we all bring different backgrounds, insight and experiences to each claim or lawsuit we handle. The jurors who will decide the case are not experts either. They will have questions they want answered regarding the expert’s findings. Consider your expert’s opinions and value the skills they bring to the case, but at all times be willing to have open and honest discussions. This will do

nothing other than improve the ultimate quality of the services provided by that expert, and lead to the best possible report or testimony concerning the claim investigation process.

Before we leave the area of expert witnesses, we also need to address wording in reports and test results, as this may have a dramatic impact upon the future of the claim and resulting litigation. Collectively, we must take a more aggressive role in making certain expert witness reports are authored correctly, and in accordance with professional guidelines such as NFPA 921 and ASTM. Equally, however, these reports must be written in a manner allowing us to continue a claim investigation until the point all relevant information has been collected. We should not have an expert witness or lab report at the onset of a claim which is later utilized against us at a trial solely because the report was not worded correctly.

Although insurers are collectively improving upon this issue, for many years I observed a number of claims being paid solely because the origin and cause report read: “...*the cause of this fire is undetermined.*”

There are a number of fires which must, for many reasons, be classified as undetermined. We should never attempt to skew or change the scientific findings in any investigation. However, there is absolutely nothing wrong with a report containing the following alternative language:

*...at this time, and in accordance with NFPA 921, this fire must be categorized as “undetermined.” However, as the investigation of this fire is ongoing, we reserve the right to change or supplement this finding based on new or additional information which may subsequently be*

*determined. An undetermined fire classification does not mean this fire was not caused by an intentional human act, and further investigation of this loss may be warranted.*

This language keeps open the opportunity to investigate the fire loss further while more accurately reflecting the role of the origin and cause investigator by strictly focusing upon whether the origin and/or cause of the fire is capable of being identified.

A recent experience on a claim demonstrates the need to better communicate with the professionals we rely upon, such as laboratory technicians. On a large fire loss, we received a lab report containing the following language:

*No ignitable liquid residues were detected in the exhibit. Negative findings do not exclude the possibility that an ignitable liquid may have been used.*

This was brought to my attention by the SIU investigator and origin and cause expert because they were extremely troubled. In a phone conversation, the lab technician told them the sample appeared for all practical purposes to be gasoline. When the written report was received, it appeared to directly contradict the prior oral report statement.

I was asked to meet with the laboratory technician. One of the first things he told me was his father started the lab, and he had run the lab for twenty years since. In the forty years the lab had been in operation, I was the first attorney who took the time to visit the lab and speak with anyone regarding how their reports impacted a jury trial.

What I learned was surprising. The lab technician advised his report was in keeping with what he believed he was mandated to provide to the insurance company, which was simply a report citing the ASTM standard. He had been taught this in college

decades before, and simply “assumed” this was all anyone was interested in. When I explained to him ASTM is highly important, but the test in the courtroom is whether to a reasonable degree of scientific certainty his opinion is supported by a preponderance of the evidence, I learned no one ever explained this standard to him and he did not realize the difference between ASTM classifications and the burden of proof required in civil litigation.

The net result of our meeting was his re-drafted report which the expert agreed was not only 100% accurate, but contained much more relevant information reflecting his findings:

*In accordance with ASTM 1618-06, the above exhibits were negative of ignitable liquid residue. However, based on a reasonable degree of scientific certainty, Exhibit 1 contained many similar components of gasoline. Even though the minimum criteria utilizing ASTM 1618-06 classification was not met, in all scientific probability it was gasoline. Furthermore, negative findings do not exclude the possibility that an ignitable liquid was used.*

As with most other issues, the problem was simply a failure to communicate. We must make certain our experts understand the need for fully accurate information which meets the standard of admissibility for the courtroom. This allows us the opportunity to present relevant information to fully and completely inform the jury of all pertinent facts concerning a claim investigation.

One of the best ways to share information and make certain everyone has full and complete knowledge of all relevant information is to conduct a conference call to

discuss a claim before any final decision is made. Frequently in our firm, we will convene the conference call to protect its contents under the doctrine of attorney-client privilege and attorney work product. At the start of the call, we involve our outside experts as appropriate, and request them to provide any additional insight or information which they believe the insurance carrier needs to possess before making a final decision regarding the claim. Once we have the opportunity to discuss the claim fully and candidly with our experts, we then excuse them from the call and proceed with a detailed review and discussion of the claim involving the claims personnel, special investigations unit, underwriting (if warranted) and any other appropriate persons who will be involved in the ultimate decision to pay or deny the claim.

We have found this process to be extremely beneficial in making certain complete and accurate information is shared throughout the spectrum of the claim investigation process. When done effectively, this is something we should be very proud to share with the jury, demonstrating the collective expertise and consideration which was given in the final claim decision process.

Frequently at trial I will prepare a demonstrative exhibit to use on closing argument showing the jury the actual names, job titles and collective years of experience of the individuals involved in the claim decision process. Often times, plaintiffs' attorneys will try to mislead the jury by claiming a single "rogue" adjuster or manager denied a claim for improper reasons. When the jury is shown the number of personnel involved, their years of insurance experience and the detail required in the claim denial process, they frequently tell me after the trial concludes they were

impressed by the time and effort the insurance carrier spent in making certain a correct decision was made.

## **VII. Identifying Connections between Parties in Bodily Injury Claims**

An ever-present problem for the insurance industry remains bodily injury fraud. With the downturn in the economy we are once again seeing a dramatic rise in bodily injury claims involving fraudulent practices. Insurers must remain diligent to identify these claims early on, as many medical providers engage in these types of practices for months or years before the pattern of fraudulent activity is identified.

The best way to identify bodily injury fraud early on is to look for connections which may not appear initially on the surface. These connections often include:

- Claims where repeatedly the same personal injury attorneys and medical providers are appearing on a recurring basis.
- Although it is harder to do so in the era of insurers using centralized mail centers, identify on envelopes and correspondence addresses between attorneys and medical providers which are close in location, or even in the same building. In the past year alone, our firm has identified several instances where chiropractic providers and plaintiff's attorneys are in adjacent suites, and even have shared office arrangements.
- Although it requires more effort to do so, be diligent in identifying telemarketing and questionable medical/legal connections. Recently, we identified a "company" placing brochures in hospital emergency rooms claiming to "assist" accident victims. This was a thinly-veiled system of

marketing a network of medical providers with a connection to a particular law firm. Looking at the brochure itself, no one would suspect it involved a medical/legal connection, but in reality the goal of the “company” was to steer reportedly injured parties first to specific medical providers who would then make an immediate referral to the law firm.

- In recorded statements, EUOs and depositions, insurers should be much more aggressive in identifying medical and lawyer solicitation activities. Rarely do we see a file where the claimant is asked in a recorded statement whether they have been solicited by any medical provider or lawyer. These type of solicitation calls or letters are not subject to physician-patient or attorney-client privilege. Neither of these privileges attach until the person actually becomes a patient treating with the physician, or a client of the law firm. Accordingly, you should be able to garner all information regarding solicitations made by medical providers or lawyers before the actual retention date of services is entered into.

In addition to identifying common patterns and practices you should always be evaluating both current and new medical providers to be on the “lookout” for questionable medical services. As relates to clinics and other medical providers, important information to consider in this process includes the following:

- a. Is the medical provider a “solo” facility, or part of a regional or national chain?**

There are a growing number of regional and national medical providers, many of whom are legitimate, but others who are engaging in highly questionable practices.

Often these particular clinics will try to hide their regional or national affiliations, and appear to be a local service provider. With one chain of clinics, we have been able to identify common ownership through a national owner by simply going to the Secretary of State's website and running a search on the incorporation documents for the local clinics. Doing so has clearly established the actual incorporators and owners of the clinics are not local, but are with the company's national headquarters.

These same type of national providers often change the names of clinics every several years. The physical location of the clinic generally does not move, but the name of the clinic will change. This is apparently done to make it appear the clinic is locally owned and has changed ownership. In truth, these are name changes only and are often done to avoid the insurance carrier collecting "too much" history on the practices of the clinic. By changing the name and tax identification number, it is the goal of the medical provider to avoid leaving an identifiable trail of questionable medical billing or treatment practices which can be traced by insurers.

**b. Look for indicators on mailings and faxes to show whether the clinic is actually local, or part of a regional or national chain.**

Many national medical providers use standard forms for patient charting, reports and billing. Often these will be able to be identified by simply looking at the documents and realizing various clinics are using the exact same wording and reporting systems. While this can be due to purchased computer software, often it is indicative of what appears to be a local clinic having regional or national ties.

Look at return mailing addresses and facsimile transmission numbers to determine where information, including medical reports and billing statements, are

actually emanating from. If a clinic is truly local, there would be no reason for patient reports or billing statements to be sent from an out-of-state location. Remarkably, this can also be true for attorneys and law firms. Our firm has encountered situations where one medical provider was actually writing demand letters on behalf of a law firm and mailing them from their corporate offices hundreds of miles away. Recently, we have also learned of various “services” which are marketing themselves to plaintiffs’ attorneys where the “service” will take the information and prepare a settlement demand package on behalf of the attorney and mail it from their offices using the attorney’s return address and letterhead.

**c. Identify treatment patterns.**

Especially when you are investigating potential chiropractic fraud, it is important to note many clinics will not engage in excessive treatment, as they do not want to draw attention to their treatment and billing practices. The intent of these clinics is to provide approximately 6-8 weeks of treatment with most, if not all, conditions fully resolving. The treatment appears “reasonable,” and the claim is capable of a prompt settlement. Clinics engaging in these types of practices will often utilize computer-generated or “cookie cutter” style of reports. Reports are normally extremely brief and contain little actual information.

One of the key identifiers we look for is when multiple persons from the same vehicle are claiming injury from an accident. We have literally seen situations where 3-5 persons from the same vehicle are treated, ranging in age from 17-85 years. Interestingly, they all end up at the same medical provider, are treated on the same exact dates, for identical injuries, for the same duration of treatment and each person’s

treatment regimen ends at the same time with no residual treatment required. These are the type of “red flags” which are often right under our noses, but which insurers fail to consider, simply overlook or choose to ignore in exchange for making a “quick settlement.”

Doing so may bring you a quick settlement on a claim while simultaneously opening the flood gate for a torrent of these types of claims to occur in the weeks, months and years ahead until you are willing to change your practices. These types of treatment “mills” began approximately fifteen years ago. Although certain insurance carriers have taken an aggressive role toward this type of treatment, sadly many refuse to do so or simply ignore the problem. Not only are the original medical providers continuing to operate in this manner, but there are now a number of “copycat” medical providers who seeing the insurance industry’s willingness to pay these providers are now duplicating their tactics across the country.

Experience has shown these medical providers will cease targeting insurance carriers when your company is willing to take them on aggressively and demonstrate you are not simply willing to pay claims for questionable treatment. This may require additional expense for a limited time period and more aggressive claim handling on your part, but the long term financial results have proven successful for many carriers.

Keep in mind these clinics operate on a very simple program which, when you identify it, becomes obvious in how claims are being presented to your company. Specifically, these clinics use the following model:

**Step 1.** A clinic is established in a market. Either ties are made immediately to a local law firm, or in some situations the clinic owner will

seek out an attorney and advance the cost to open a law office to “service” the clinic patients. We have uncovered leases and rental agreements documenting these practices.

**Step 2.** Runners or personnel from the law firm secure police reports from accidents. These reports are screened to identify the non-at-fault driver, and in states where the information is provided, are also screened to determine the identification of the insurance carrier. In some markets, the clinic providers have even been known to sue local police departments when they cannot secure the police reports quickly enough for their solicitation purposes.

**Step 3.** Telemarketing is used to call the non-at-fault parties listed on the police report. These telemarketing tactics are often fraudulent by either stating or implying the insurance carrier for the at-fault driver wants to make certain the person is not injured, and is offering a free chiropractic consultation. Once the person agrees, the call is then transferred to a “confirmer” to make certain the person will appear for the appointment, normally to occur the next day.

**Step 4.** When the “patient” arrives for the “free” visit, conveniently a representative from the law firm also happens to be at the clinic at the same time and is available to sign the person up as a new client to assist them with their injury claim. The “free” chiropractic visit normally has no purpose or value (in fact, under oath one chiropractor we deposed who had been doing these exams for many years could not even describe or

tell us what the “free” examination consisted of). The goal of this visit is simply to sign the person up with a law firm and thereafter begin a treatment program for which fees are charged.

**Step 5.** The goal then changes to making certain the person stays with the treatment regimen for approximately 6-8 weeks, normally generating less than five thousand dollars of chiropractic billing. In some situations, promotional items are gifted to the patient to reward them for continuing the treatment regimen.

**Step 6.** At the end of the treatment process, the patient is released and the law firm submits a demand package for a relatively reasonable settlement with no residual injury or future treatment required. Once payment is made by the carrier, fee sharing agreements then kick-in between the national chain owners of the chiropractic clinic and the law firms, resulting in substantially higher payments going to the chiropractor normally than to the reportedly injured person.

Each company must make the decision regarding how you respond to these type of questionable medical and legal practices. Yes, there is value in securing quick and reasonable settlements in the short-term. Carriers, however, who take a longer-term view of claims practices and indemnity payments will normally find aggressively investigating and countering these type of activities pays a high financial and claim volume decrease return for many years to come.

### **a. Auto Body Shop Practices**

Another important area to note is many of the same schemes and billing practices used by medical providers have been adopted in more recent years by highly questionable body shop and auto collision centers. Our firm has received an increasing number of referrals involving highly inflated storage charges or questionable forms authorizing high charges or repairs to be undertaken before the insurance company even inspects the vehicle. It is important insurance companies remain vigilant concerning body shop fraud as well.

In this era of digital photography, there is simply no reason not to have multiple photographs of vehicle damage from all angles including the undercarriage. In certain situations, it may even be advisable for the insurance carrier to retain physical possession of evidence such as bumpers and internal bumper shock absorbers as these may be relevant not only to the extent of physical damage done to the vehicle, but also for subsequent biomechanical analysis regarding the severity of impact and whether any injury may have ensued.

## **VIII. Using the Electronic Era to your Strategic Advantage**

The electronic era has brought an entirely new dimension to claim investigation. Today, we have more information available at our fingertips than any point in the history of the world. The question becomes: “how are we effectively using this data?”

To the dismay of many private investigators, it is now easier than ever to secure personal information regarding individuals making insurance claims. Social networking sites such as “Facebook,” “MySpace” and “LinkedIn” profiles provide a wealth of

information and insight not only into a person's background, but also increasingly into their daily activities.

On one recent claim, a woman gave tearful testimony regarding the extreme emotional distress from the loss of her husband in a wrongful death case and testified about how her entire life had been "destroyed." Interestingly, her Facebook page (which, like those of many older people, did not have privacy protections in place and was fully accessible) displayed a number of pictures taken at various exotic locations since the accident with her girlfriends, bearing captions describing what a wonderful time of life she was enjoying on her many trips! While she did no doubt grieve the loss of her husband, there was certainly a disconnect between her testimony and what was posted on her social media site.

Insurance companies must also be careful, especially in first party claims, in how far they go in investigating even what may be deemed "public" information. Since passage of the Federal Privacy Act, insurance carriers and other businesses are required to send to their customers a written privacy policy statement. As relates to insurance carriers, these privacy policy statements are normally drafted by corporate lawyers who have no knowledge of what we do in insurance fraud investigations.

It is imperative you review your company's privacy policy statement to ensure it does afford the opportunity to investigate fully any claim of insurance fraud without violating the privacy policy statement. I am always amazed as I travel around the country lecturing on this issue how few claims professionals and SIU personnel have ever read their own company's privacy policy. Aggressive plaintiffs' attorneys are now utilizing these privacy policy statements to inflame juries by trying to show the Claims

Department and SIU violate their own company privacy policy statements which were sent to insureds (and which the insureds can then ostensibly rely upon) in the claims investigation process. This is certainly never what was intended under the Federal Privacy Act, but is a consequence of insurance carriers issuing privacy policy statements without considering their impact upon the claims investigation process.

When accessing social media sites, it is also important to remember in this new era of communication, some old rules still apply. In the past two decades, we have heard very little about “pretext” interviews. Many years ago these were banned by insurance carriers and others as being an improper way to secure information by misrepresenting your identity to secure information. An entire new generation of claims professionals is now handling claims and may not realize trying to access social media sites by creating a “fake” identify (so the person will not know you are with the insurance company) is not only a “pretext” interview, but is illegal in many states. Quite simply, we do not need to do this as in today’s era, much of the information we need to investigate a claim fully is available in the public domain.

Search engines as common as “Google” and “Bing” provide a wealth of information. Prior lawsuits, articles authored by experts, newspaper articles and other information is simply a “click” away if we avail ourselves to these modern search engines. By using Internet tools such as “Google Earth,” we can secure aerial and even street-level views of homes or business in their pre-fire loss condition or view accident scenes for purposes of accident reconstruction.

While there are many advantages to utilizing the Internet to assist in claim investigation, it has also opened up an entirely new avenue for insurance fraud.

Internet fraud schemes range from fraudulent jewelry appraisal services to elaborate websites which allow you to create false documents and even secure witnesses who will lie about your whereabouts for a fee. These websites are rampant and are fertile ground for insurance fraud. One jewelry appraisal service operating out of Australia will issue appraisals without seeing the item. This site boasts it is illegal to engage in the very actions they are marketing, but if the “customer” inputs all of the data and prints the form, the insurance company will never know. This same company promotes what it brazenly calls the “12 month ahead rule” as justifying a very high value for appraised items since the item might dramatically increase in value during the one-year period before the insurance policy again renews.

Other websites such as [www.redoreceipt.com](http://www.redoreceipt.com) and [www.salesreceiptstore.com](http://www.salesreceiptstore.com) claim they are simply for “fun,” but blatantly promote providing of false and fake receipts in exchange for a monetary payment. These receipts often cannot be discerned from original receipts unless the insurance carrier is willing to put the extra effort into contacting the retailer, or the store security department, to verify the authenticity of the receipts submitted. In recent years we have seen a dramatic increase in the use of fraudulent receipts for not only theft and property damage claims, but especially when replacement cost coverage is being sought and the insured can secure a cash profit without actually replacing the items which were originally reportedly damaged or destroyed.

One website you must visit if you have not already done so is [www.alibinetwork.com](http://www.alibinetwork.com). This service promotes itself as creating a complete package of information including fake airline tickets, hotel receipts and even witnesses who will

establish an alibi to cover where someone actually may have been at the time an event, such as a fire, occurred. The elaborate extent to which services such as this will go to provide false and fraudulent information is limited only by how much a person is willing to pay. Sadly, this is only the “tip” of the virtual iceberg which exists on the Internet today, and which is costing insurance carriers literally millions of dollars each year.

There are ways, however, in which we can effectively and efficiently fight back. Use of reverse telephone number searches, checking for postings on sites such as “Craigslist” to see if items reportedly stolen have been posted for sale, either before or after the loss, and seeking retrieval of computer hard drive information are tools we often overlook.

If your company is not already doing so, consider requiring your insured to allow access to their computer hard drive on appropriate claims. This is not something you want to routinely do on every claim, but it should be addressed in your authorization form, especially on fire losses. Modern computer technology allows the retrieval of important data from computer hard drives even if the computer has sustained what may appear on the outside to be extensive damage.

An example is a fire, arson and misrepresentation denial and subsequent jury trial we handled for a major insurer. In the examination under oath, the insured denied having any intention to sell the home, but a search of his computer hard drive revealed a request made shortly prior to fire to the website [www.housevalues.com](http://www.housevalues.com). This website is not a mainframe computer giving an appraisal, but instead is a real estate sales service where local realtors buy zip codes. When a person requests an appraisal the service notifies the local realtor who then makes contact and does a very old fashioned

style appraisal. By securing the records from this website, we were able to locate the local realtor who actually spoke to the insured about listing his home only several days before the fire. The realtor's testimony at the jury trial was extremely impactful and proved the insured had not been truthful in his examination under oath testimony.

Other important data you may want to consider analyzing on computer hard drives include searches for insurance or arson investigation information, inquiries made for refinancing (including online applications) and assistance in filing bankruptcy. Computer searches have also disclosed "recipes" for incendiary mixtures and detailed room-by-room personal property contents lists prepared several days prior to the fire. Also be mindful of looking for information such as emails to agents to confirm coverage and persons making searches of real estate sites for out-of-state property for a planned move after receipt of the insurance proceeds.

One of the other valuable tools just beginning to be utilized by insurers is link analysis. Either using internal insurance company-provided link data services, or even common websites which provide net mapping or link data analysis services, it is now possible to "view" connections which may indicate questionable claims or potential insurance fraud.

In its simplest form, link analysis allows you to input identifying information regarding a number of individuals or companies and then the computer will identify any "links" between the parties you have entered into the system. Once a link analysis is completed, it is often times amazing to see the connections which appear but were not evident on the surface. Link analysis is most effective when a company is aggressively willing to take this concept and enter data from the largest number of claims in the data

“pool” as possible. The more information you input into the link data system, the more you will identify connections between various claims, which when looking on a singular basis are simply not evident.

An example of an effective link analysis investigation dealt with a large number of property fires occurring in a Midwestern state. When the insurance carrier aggressively began a link analysis process, the company entered into the system the following identifiers:

- Named insured(s) on the policy
- Realtor involved in the sale of the home
- Title company or real estate attorney handling the closing
- Mortgage broker involved in securing of the residential loan
- Bank or financial institution issuing the mortgage including, where available, the identification of the individual loan officer
- Insurance agent issuing the policy
- Board up contractor who arrived after the fire
- Public adjuster handling the claim
- Repair contractor selected to do the repairs
- Attorney for the claimant

By inputting this data, the insurance carrier was able to then map an overall picture of the claims being presented. What became evident very quickly was a scheme occurring between an area realtor a particular mortgage broker with ties to a loan officer at a large bank and one of the company’s own agents. The pattern which developed demonstrated individuals were being selected to buy homes through the

realtor, with the promise of a quick payoff in exchange for taking out the mortgage, insuring the home with the selected agent and then a fire occurring normally within 3-6 months of purchase. Although this insurer knew there had been a dramatic increase in fire losses, it was not until the link analysis was completed the pieces of the puzzle fell into place and could then be dealt with appropriately.

In addition to the rising use of computers, there has also been a dramatic increase in the availability of video and still photography information which we are not using to our strategic advantage in claim investigations. Often, you may have available extremely relevant video for an injury or property claim which you are simply overlooking.

In today's more security-conscious environment, and with lower technology costs, many homes and businesses now have video security. Even if the insured property does not have security, often adjacent residential or commercial properties may have video surveillance which contains relevant data to the claim you are investigating. Sometimes simply standing at the scene where the event took place and looking around will alert you to video cameras which may contain information you would not have previously thought to even ask about. Video surveillance may show persons arriving and leaving scenes, vehicles being parked or taken from locations or even accelerants being purchased by an arsonist shortly before the fire.

Another source of evidence we often overlook includes either video or still pictures taken by ATM machines. This is a good example of where a fully-integrated claim investigation can lead to good results. If you are looking at securing of bank records from an insured only for the purpose of determining financial information, you

are behind the times. On a recent claim, we requested the claimant to provide complete copies of their bank statements. The insured testified to being several hundred miles away at the time the fire occurred. The bank statement showed an ATM withdrawal made at a nearby ATM on the same day as the fire. The insured testified in the examination under oath to having stopped by the ATM on his way out of town. The bank statement only showed the ATM location, amount and date of the transaction. By contacting the bank, however, we were able to secure an actual copy of the receipt printout showing the exact time the ATM withdrawal was made, and we were additionally able to secure a still photograph with a clear picture of the claimant making the withdrawal ten minutes after the fire occurred. This was the same period in time in which the insured testified under oath he was several hundred miles away.

In like manner, we have actually been able to secure video showing the occurrence of an accident. Many major metropolitan areas now have video surveillance on major highways such as the ARTIMIS systems. Although various jurisdictions retain this information for differing periods of time, if an insurance company moves quickly, often times you will be able to secure actual video which may show the positioning of the vehicles, their respective movements and the actual impact of the accident.

In addition to major highways, many cities now have intersection cameras which contain video information which may include the actual video of the accident taking place. Consider too, video cameras at intersections can record and identify specific vehicles travelling through the intersection. On a recent fire loss in Michigan, an insured was questioned regarding whether an intersection camera would show her vehicle

travelling through the intersection near the fire scene in the time leading up to the fire. This led to a complete confession, even though the video had not yet been secured.

Even if you are not able to secure video of the accident itself, many police and fire vehicles now are video camera-equipped. Too often we overlook the fact a camera at an accident scene may show the debilitated plaintiff moving around freely with no restrictions whatsoever and looking under the vehicle for damage. Similarly, on a fire scene we may be able to track the pattern of fire movement from a truck-mounted camera. This may later be relevant to reconstructing a fire model to show the fire spread rapidly due to an accelerant being applied.

We do not always need to rely on elaborate video systems. Rarely in recorded statements taken of first or third parties do I ever see the question even asked of an insured whether any pictures were taken at the scene of the accident or event using cell phone photo or video cameras. When we know virtually everyone now carries a cell phone capable of photographic or video recording of events, it would certainly be prudent for us to include this type of questioning in our routine statements for a claim investigation.

In the years ahead, another emerging trend which will yield a great amount of data is the use of black box technology in motor vehicles. At the current time, there are still disputes regarding who owns this data, and who has access to retrieve the information from the black box. Technology is also rapidly improving, allowing these boxes to store an increasing amount of data regarding the use and operation of the vehicle.

In a recent case in Kentucky, the insured driver claimed in a fatality accident the plaintiff pulled out on a highway into his lane, and although he tried to “slam” on the brakes, he could not avoid striking the decedent’s vehicle. Although the insurance carrier could not access the black box, the state police did and they shared the data which showed the insured was travelling ninety-six miles per hour with no braking at the time of impact.

In the future, insurance companies will increasingly rely on black box technology data. In fact, many companies are talking about basing insurance premiums in the future on the agreement from the insured to allow the insurance carrier to download the data to determine driving practices. We are not yet at this juncture, but will be in the very near future. Insurance companies that are looking toward this future are already starting to include language regarding retrieval of black box data in their claims investigation authorizations.

## **IX. Conclusion**

A decade into the new millennium, we stand at an important crossroad. We have more tools available to battle insurance fraud than at any point in history, yet insurance fraud remains rampant. Most statistics show insurance fraud in America today costs each individual insured more than five hundred dollars per year in increased insurance premiums. Insurance fraud in America has been estimated to have a financial impact equivalent to the earnings of a Fortune 50 corporation.

Although we know the reality is we cannot eradicate insurance fraud, we can certainly do our part to seize upon emerging trends and new technologies in the battle

against insurance fraud to effectively curtail its rise. The duty rests upon us to investigate claims appropriately, ethically and aggressively. As an attorney who tries insurance fraud cases around the country, I am routinely told by jurors they rule in favor of the insurance carrier because the insurance company conducted a thorough and complete investigation, resulting in overwhelming evidence to support the finding of denial of coverage for insurance fraud.

The resources are available to us. The question is how willing are we to adapt our claim investigations, our team of experts and our attorneys to utilize these new technologies and trends to the most strategic advantage possible? Quite simply, if we are willing to, stay “ahead of the curve” and think “outside the box,” we will not only investigate claims more thoroughly and professionally, but leave our professions on a solid foundation for the future as even more new technologies and trends lay ahead.

***For more information on this and other programs and materials to assist in the investigation and handling of insurance fraud investigations, and related litigation, please contact us at anytime.***



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