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Policyholder Obligations (Occurrence versus Claims Made)

by Charles H. Morgan, J.D., CPCU, CLU, CSP, ARM, and Samuel M. Kinney, ARM

- **Charles H. Morgan, J.D., CPCU, CLU, CSP, ARM,** is vice president, risk management for Fleet Insurance Services, LLC.
- **Samuel M. Kinney, ARM,** Fleet Insurance Services, LLC.

Editor's note: While the following piece may seem more applicable to the *Claims Quarterly* than to this publication, it is a fundamental aspect of loss control to anticipate claims and to take all reasonable steps to avoid them where possible. This is particularly true with respect to claim-related problems, such as coverage disputes. Nowhere is this potential problem more acute than in the numerous pitfalls resulting from flawed applications for claims-made coverage, particularly with respect to employment-related claims. This brief article will trace the roots of this problem, and, hopefully, offer some insight as to how problems may be avoided.

Introduction

Until the 1970s, almost all liability insurance policies were written on an "occurrence" form. This meant that the policy that paid the claim was the policy that was actually "in force" at the time the claim occurred, hence the name "occurrence" form. The event *triggering* coverage was referred to as the coverage "trigger." Therefore, this policy was said to have an "occurrence" trigger. An example of this trigger could be a situation wherein a pharmaceutical company produces and markets a certain drug to young women. If these women began to give birth to children with birth defects some years later and they could establish that the drug taken a few years before was the cause of the birth defect, then the women would have a potential claim against the drug company. In an "occurrence" form of insurance, the policy that the pharmaceutical company had at the time it sold the drug would be the policy that would pay the losses from the birth defects occurring several years later. This is because the damage "occurred" when the women took the drug, not when they had the baby several years later. This loss exposure could not have been anticipated by insurance companies. The premiums they charged were often not adequate to pay claims for losses occurring years before.

In order to address this problem, a new coverage "trigger" was developed. The purpose of this new trigger was to limit the insurance company's exposure to claim situations where the actual claim in the form of demands for monetary damages do not manifest themselves as actual claims for some time in the future following when the damaging event actually occurs. This new "trigger" is the "claims-made" trigger. The policy that responds to this trigger is the policy that is "in force" at the time the actual claim is made and reported *not* when the situation giving rise to the claims occurs, as is the case of the "occurrence" trigger. Underwriters then further defined their liability by then requiring that the claim be *made* and *reported* during the policy period. Thus the current "claims made and reported" form that is most commonly used today. In the example given above, this means that the policy that is in force for the pharmaceutical company at the time the claim for the birth defect is made and reported would be the policy that would pay the claim, not the policy that was in force at the time the women took the drug. The problem that this creates for the insured is that it requires him to be extremely aware of when claims are made and very quick to report them to the carrier in order to avoid the risk of losing coverage for failure to report. While this may seem simple, what actually constitutes a reportable claim is often unclear.

Insurers further limited their exposure under this new trigger by establishing the retroactive date. Under a "Claims Made and Reported" policy, the situation giving rise to the claim must occur *after the*

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retroactive date and the *claim* must be *made and reported* to the insurance company *during the policy period*. If there is no retroactive date, the policy is said to have *full prior acts*. This means that the policy will respond to any covered claim that is made and reported during the policy period. But the company *must* still report the claim during the policy period in order to preserve coverage. New policies are often written with a retroactive date that is the same as the first day the policy was in force. In this situation the policy would only respond to situations that occurred after the inception date of the policy that resulted in a claim that was made and reported during the policy period. Policies that are written with full prior acts cost more than those with a recent retroactive date because with full prior acts the policy must respond to claims arising out of situations occurring for the complete history of the company. A policy written with a retroactive date that is the inception date of the policy will only respond to claims arising out of situations occurring from the retro date onward, which in the event of a new policy may only be a few days long. In spite of the advantages of having full prior acts, it is still critical to report any claim of which the insured has knowledge during the policy period when he or she first has knowledge of the claim.

Changing Insurance Companies

When an insured seeks to switch from one claims-made carrier to another, care must be taken to make sure that the retroactive date from the old policy is carried over to the new policy. If the new policy does not have the same retroactive date as the proceeding policy, there will be an uninsured gap in coverage. If the carrier change is for competitive reasons, insurers are generally willing to provide the old retroactive date as long as there was continuous coverage in force back to the original retroactive date. The other issue to consider when making a change of carrier is that most full-form applications contain a warrantee that confirms that the applicant is not aware of anything that could give rise to a claim under the policy. It is critically important to understand that the application forms a part of the ultimate policy and a materially incorrect answer on the application could provide the insurance company with legal grounds to void the policy and not pay a claim. If you are aware of a situation that could give rise to a claim, then report it to your current carrier in order to preserve your rights of recovery under your old policy and then report under the new application. The new insurer will then exclude it from future coverage, but you will have coverage for the reported situation under the policy you are leaving so it should not be an issue.

Claims Made and Reported

The claims made and reported policy requires that any situation that falls within the definition of a claim that is contained in the policy be reported during the policy period. The definition of what may constitute a claim differs widely from insurance company to company. The following are two common definitions of "claim" that are different.

AIG Public Officials and Employment Practices Liability Policy

"'Claim' means a judicial proceeding alleging a Wrongful Act that is filed against an Insured in a court of law or equity and which seeks Damages or other relief. Claim shall also mean an administrative proceeding alleging a Wrongful Act, provided an enforceable award of Damages can be made against an Insured at the administrative proceeding."

Diamond State Public Officials policy

a. a demand for damages or services or notice of legal process (including service of suit papers) alleging liability of the insured arising from alleged public officials wrongful acts or employment practices wrongful acts; or

b. written or oral notice of a party's intention to hold an insured responsible for any alleged public officials wrongful acts or employment practices wrongful acts; or

c. an awareness of a proceeding, event or development which has resulted in or could in the future result in the assertion of a claim against the inured.

All of the highlighted words are further defined in other parts of this policy.

Virtually any knowledge of a fact situation that may subsequently result in a formal claim should be reported in the application. The reason for this is that if you have a reportable situation, you should have already reported it under your current policy in order to preserve the coverage for which you have paid a premium. It is vital to have the strictest respect for full disclosure in this process. The application cannot be based on the knowledge of the individual applicant alone. It is common place in industry to poll the officers, senior managers and board of an organization in order to confirm that all reportable events have been addressed.

While securing the input from all affected senior staff regarding potential prior acts at a single location may seem straightforward, the problem can prove daunting where multiple locations are involved. In the case of a school system or municipality, for example, there will clearly be a wide number of semi-autonomous locations where such prior acts may have been experienced but not necessarily reported to the applicant. This can be particularly true for employment practices liability exposure. Prior to submitting the application, therefore, the business administrator or town supervisor will have to poll senior staff in the district to assure that the data is in fact correct to the letter lest a subsequent claim be denied for having falsified the information on the initial submission for coverage. It would be advantageous to meet with your broker who can assist in designing an incident and claims-reporting system that can reduce the likelihood of an unreported situation compromising your future coverage. ■

The Ripple Effect of Safety

by Chris Conti, CPCU, CSP

Chris Conti, CPCU, CSP, is the owner of RiskWise, a safety consulting company. Conti can be reached at (225) 413-7542 or chris@riskwise.biz or www.riskwise.biz.

The development and implementation of a workplace safety program or the lack of such a program has a ripple effect that flows to affect other aspects of the organization. When a company has established a safety program and has educated workers on what is expected in the performance of their jobs, positive benefits flow back to that organization. This is a return on the investment of the safety education. The positive benefits that enhance an organization include:

1. improved productivity as workers aren't missing work due to injuries
2. improved morale among employees as they aren't talking about that "missing finger"
3. lower experience modification factor as fewer injuries lowers the mod
4. lower workers compensation insurance cost
5. improved bid position to quote jobs more competitively
6. lack of negative press that comes when plants have serious injuries
7. lack of OSHA fines due to compliance
8. avoidance of the indirect or hidden cost from losses

This is a positive ripple effect. The reverse can be said of companies that do not have workplace safety programs. They may experience a negative ripple effect throughout the organization and beyond. Of the items listed above we can simply reverse the positive and state them in a negative light.

1. poor productivity as workers are missing work due to injuries
2. poor morale among employees as they are talking about that "missing finger"
3. higher experience modification factor as more injuries raises the mod
4. higher workers compensation insurance cost
5. poor bid position as to not quote jobs competitively
6. negative press that comes when plants have serious injuries
7. OSHA fines due to noncompliance
8. possible nonrenewal of insurance coverage

This is a negative ripple effect. We can surmise that an organization that continues to have injuries will experience the negative side of events. In addition to the above positive items being turned around into negative items, there are additional negative events.

In addition to the actual dollars paid out in claims and premiums to provide workers compensation insurance coverage, there are various indirect costs associated with injuries and injury management. It is estimated that indirect costs usually approach four times the cost of an injury. So, if a particular accident cost $10,000 to provide medical care and lost wages, the estimated indirect cost is $40,000 in "other" costs to the company.

Indirect cost defined—cost associated with injuries other than the claim dollars spent. Often these costs are "hidden" in the form of nonproductive activity.

Types of Indirect Cost

1. Managers' time dealing with the claim—filling out claim forms, doing accident investigations, dealing with adjusters, speaking with doctors, nurses, and the injured worker, etc.
2. Lost productivity of the injured worker—the injured worker was (usually) more productive than a new hire may be because he or she had been trained to do his or her particular job and has experience at that job.
3. Loss of product due to contamination of blood, hair, spillage, etc.
4. Loss of use of equipment due to the pending investigation.
5. Loss of time due to OSHA investigations.
6. Time needed to hire a replacement until the injured worker can return to work.

Indirect costs, while "hidden," drive up the "cost" of a claim, affect morale of the staff, and do not serve to increase revenue nor reduce expenses. So, while not readily visible, hidden costs do negatively affect the bottom line.

Therefore, the prevention of workplace injuries has a direct and positive impact on the bottom line, which is due to the nonexistence of the above issues.

Proaction always has a much improved outcome over reaction. We can plan, direct, control, and monitor performance when we are thinking ahead of what might occur to negatively impact the firm. However, when we react the horse is out of the barn and we have to work to mitigate losses, minimize negative impacts to the firm, and clean up the event.

Why is it that we rarely have time to proact and prevent but we always have to make the time to react and contain? Like most management decisions, the choice is yours. Are we going to spend some time preventing injuries or spend our time taking care of the injured worker/machine/product? ■

Designing a Fraud-Fighting System for Workers Compensation to Maximize Your Workers Compensation Investigation Funds

by Kevin Rainbolt, CPCU, ARM

■ **Kevin Rainbolt, CPCU, ARM,** is currently serving as the vice president of the CPCU Society's Mount Diablo Chapter. He is employed as a senior fraud investigator with a large multi-line insurance company, and in 2001 was named Fraud Investigator of the Year. He has been in his current position for seven years and has been working in special investigative units for more than 10 years. He is a licensed private investigator in the State of California, and holds the CPCU and ARM designations. Kevin obtained a B.S. in criminal justice from California State University in 1993.

Editor's note: This article originally appeared in the CPCU Society's July 2003 *CPCU eJournal*.

Abstract

This article will help you fight back against workers compensation fraud by implementing a proactive, cost-effective approach and help prevent you from wasting your investigative funds by utilizing surveillance as a cure-all. The Fraud-Fighting System will suggest methods to enable your claims service to consistently and successfully identify the type of claimant fraud, focus the suspicion, and design a strategy to uncover and use the evidence obtained.

How much did your company spend on field investigations last year? Do you think you got your money's worth? Many companies spend significant funds but do not get the expected results. In this article, I will introduce a useful guide for formulating strategies to combat workers compensation claimant fraud.

Like many others employed in special investigative units (SIU), when I began in the early 1990s, I had very little working knowledge about efficient workers compensation fraud-fighting strategies, much less an effective fraud-fighting system. Since then I have had the advantage of observing various SIU practices in multiple states throughout the northwestern portion of the country. I have noted the mixture of strategies used by multiple carriers and their varying effectiveness in both civil and criminal cases. The Fraud-Fighting System involves a combination of the successful concepts.

The predominant tactic in the industry is to focus on the type of workers compensation fraud most typically known as malingering. Malingering can be described as misrepresentations regarding physical abilities made by a person for the purpose of extending the period of disability. The general strategy for combating malingering is to conduct multiple days of surveillance in an effort to catch the injured worker physically active beyond the alleged abilities. I have noted that at SIU meetings, the conversation, and even the studies, almost always center on malingering cases. Also, the effort is typically only reactive to a successful surveillance investigation. Hence, the discussions center on what to do with the video after it is obtained. The common procedure is to simply try to obtain good surveillance footage and, if successful, introduce it to an evaluating physician and/or, in the occasional circumstance, to a law enforcement authority. All too often, the representations previously made by the claimant are not clear enough to compare to the video evidence. The inefficiency with this approach is that companies spend thousands of dollars on case after case with no pre- or post-surveillance plan. The end results are rarely worth the time and money spent.

Not only are there other important types of workers compensation fraud, but there are activities to be considered before surveillance. I have prepared a simple "Fraud-Fighting System" designed to systematically and efficiently combat what I have identified as the five general types of workers compensation fraud. The principle behind the system is simple—if there is no lie, there is no fraud.

Step #1—Identify the Type of WC Claimant Fraud

Keep in mind that although the types of fraud are almost never mutually exclusive, the idea is to identify the most obvious type and build an efficient fraud-fighting strategy around the suspicion.

What are the five general types of workers compensation claimant fraud?

I classify them as:

1. False Claim—The purported accident is staged. The claimant may have sustained an actual injury the day before while engaged in off-work activities or may have planned and faked the soft-tissue injury.
2. Malingering—As mentioned earlier, the alleged symptoms are exaggerated, or misrepresentations are continuously made for the purpose of extending the period of disability.
3. Concurrent Employment—The injured worker is gainfully employed elsewhere. Most state laws allow a reduction in workers compensation

benefits if the injured worker is earning an income. However, it is not typically fraud, per se, unless the claimant is asked and lies about the employment.

4. Prior Injury—The injured worker intentionally provides an inaccurate medical history for the purpose of avoiding apportionment of the current disability to a prior injury.
5. Check Fraud—Although it is the least typical type of workers compensation insurance fraud, the strategies for combating it are unique and deserve discussion.

Step #2—Analyze and Focus the Suspicion

Identifying the type of fraud is the first step in the right direction. Very often, there will be multiple types identified, but narrowing them down to the most evident will focus your strategy, minimize your costs, and increase your odds of success. For example, if the claim has been accepted but you suspect that it was a false claim and that the claimant is malingering, consider which type of fraud can be proven. If the injury occurred months or years before, chances are that you will not be able to gather the necessary evidence to prove it was falsely filed, but you can focus the effort on proving your suspicion of malingering.

Step #3—Establish and Implement an Investigative Strategy

The following discussion of strategies is not intended to be all-inclusive, but it should provide an understanding of the intent of the system.

False Claim—Proving that an injury did not occur is just as important as proving that it did. The strategy should attempt to gain facts to confirm that the purported incident did or did not happen. Surveillance, for example, is almost never effective in proving that an alleged incident and/or injury did not occur. Here are some guidelines for conducting effective compensability investigations:

- Before assigning an investigator, attempt to mentally recreate the alleged event. Think critically about the timeline, the mechanics of the incident, and the accident environment. Consider the weak points of the purported scenario and plan your investigation around the most vulnerable inconsistencies.
- A key success factor is the timeliness of the investigation. Statements obtained long after the injury are simply not as good as those obtained shortly after the event.
- Try to use only investigators that specialize in conducting compensability investigations. Trained investigators can make all the difference.
- Ensure that the investigators are obtaining at least two forms of identification from the injured workers and that they study the IDs for authenticity.
- Always run claims index reports using both the claimant name and the SSN independently. Look for other non-workers compensation claims, such as auto accident claims, that occurred near the date of the industrial incident.

Malingering—This type of fraud is thought to be the most common and costly type of workers compensation claimant fraud. The workers compensation industry continues to implement systems to manage the risk, but fraud and abuse evolve as well. Consider the following when designing a plan to combat a suspected malingerer:

- Time after time, I have reviewed cases where adjusters conducted surveillance as a panacea to all suspected fraud. The common result is that even if good film is obtained, it is not useful because there was no clear representation(s) made by the injured worker as to his or her capabilities either before the surveillance or very soon afterwards. Before beginning surveillance, ensure that the claimant has made specific statements about his or her abilities and inabilities. Ensure that you ask what sort of everyday things the claimant can and cannot do such as mowing the lawn, washing the car, walking the dog, etc. Also, be sure to ask the claimant if he or she has worked since the date of injury. Train your investigators to obtain specific answers, not subjective responses, such as "sort of," "maybe," or "sometimes."
- If the claimant is represented and a deposition was done months or years before, obtain a detailed report from the treating physician. One successful approach I have observed is to create a form letter with useful questions to be routinely sent to the medical providers.
- If the injured worker is not represented, consider obtaining an in-person recorded statement to document the claimant's represented abilities and inabilities. Try to keep the statements made, and the surveillance obtained, within a one-to-two month period. The closer the two pieces of the puzzle are, the better.
- Once the statements and the video evidence are gathered, make a list of the things the claimant said he or she could and could not do. Then, review the video footage and make a separate list of the activities the claimant

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performed. Be completely objective. Look for obvious signs of pain or discomfort displayed by the claimant while performing the activities. Compare the two lists and make note of the inconsistencies.

- Once the list of objective discrepancies is created and you are confident that the claimant is malingering and has misrepresented his or her abilities, consider sending it to the evaluating physician, along with the video footage. Request that the physician review the video and submit a written report to you that outlines his or her opinion regarding how the video impacts his or her decisions regarding the permanency and extent of the disability. (Obviously, you will want to seek legal counsel.)

Concurrent Employment—The injured worker is receiving loss time benefits and is gainfully employed with a company other than the one he or she was working for at the time of the injury. Most state laws allow the carrier to reduce the workers compensation benefit entitlement if the injured worker is earning an income. However, it is not typically fraud, per se, unless the claimant is asked and lies about the employment. Here are some useful techniques:

- Create a questionnaire to be sent to the claimant on a routine basis. One effective procedure is to time the sending of the questionnaires with the disability checks. The questionnaire should address both employment and income since the date of the injury. The form should require a date and signature from the claimant.
- If the claimant has not been asked, and you suspect he or she is working elsewhere, consider contacting him or her by telephone and obtain a recorded statement regarding his or her activities since the injury.
- If the injured worker has obtained counsel, and no recent statements about his or her ability have been obtained, there are two general options:
  - Conduct a claimant deposition. Your defense counsel may advise against it if the timing in the litigation cycle is off.
  - Conduct a pre-surveillance activities check. Most surveillance vendors are familiar with this strategy. An investigator will arrive in the claimant's neighborhood during the usual time people leave for work.

If the injured worker denies employment and/or income, and you are certain he or she is working, then you must obtain some form of proof of the employment. A simple call to the employer may be enough, or you may have to send an investigator to the location. In one case that I worked, the claimant was roofing the home of his physical therapist. Once I explained to the therapist that we knew what was taking place, he provided the cancelled checks that had been used to pay the claimant. If the case is litigated, you will have the power of subpoena to obtain the information.

Prior Injury—The injured worker intentionally provides an inaccurate medical history for the purpose of avoiding apportionment of the current disability to a prior injury. I routinely receive calls from enthusiastic adjusters saying they have an airtight fraud case. They've found records for a prior injury! I hate to be the one to burst the bubble, but there are some general considerations:

- Was there an actual injury, or just complaints of pain? I once heard a useful expression made by a physician during a criminal hearing. He said, "Pre-existing symptomology is not the same as pre-existing pathology." In other words, if the prior injury did not result in a permanent disability, the current injury cannot be apportioned to the prior injury. So, although the claimant lied about his prior back pain, it has no material relevance to his current back injury. Before spending your company's money on depositions and record-copying services, find out if the prior injury was more than just complaints of pain, or, in other words, that you can apportion the current injury to the prior.
- If you find that there was a permanent injury, the next question is whether or not the claimant has been asked if he or she had a prior injury. Again, no lie, no fraud. Use the same techniques to allow the claimant to tell the truth, or lie, as discussed in the Concurrent Employment section above.
- Is the prior injury similar to the current injury? In other words, are the injuries of the same body part? Consider if a physician may determine that the current injury is related to the prior injury.
- Finally, never rule out the possibility that the claimant sustained an aggravating injury after the injury related to the claim you are adjusting. One technique is to procedurally run the claims index reports using both the claimant name and the SSN independently every six months. I have had a number of such cases. One indicator is that there is a spike in the frequency in medical treatment.

Check Fraud—Yes, check fraud. As mentioned previously, workers compensation check fraud is the least typical type of workers compensation insurance fraud. However, I have had a number of cases where the claimant denied ever receiving the check. Amazingly, a person with a remarkably similar signature cashed it. Here are some general techniques for handling the situation:

- One pre-loss control technique I would suggest is that company personnel deliver all drafts of significant value. If your company has SIU staff, consider having them hand-deliver the checks that exceed an established limit.
- Obtain some form of documentation from the claimant that he or she did not receive the check. The best evidence is an affidavit, signed and notarized. The language of the affidavit can be simple and to the point, the

importance being that you are obtaining a written statement, under penalty of perjury, that the check was not received. The reason that the perjury is so important in this type of case is that law enforcement personnel may view this type of fraud as more closely related to theft than workers compensation fraud.

- Once the claimant makes the statement that he or she did not receive the check, you must then prove that he or she did, if that is your suspicion. Obtain the cancelled check and identify the bank that honored it. Request that the claimant sign a release of information written specifically for the bank that you identified. Once you have the release, the bank will at least verify if the check was deposited into the claimant's account.
- Some banks maintain their security video footage for months at a time. Be sure to ask to view the footage for the date and time the check was cashed.
- I had one case where there were three individuals with the same, but uncommon, name in the same city. Coincidentally, two of them had workers compensation claims and were represented by the same attorney. The adjuster contacted the attorney for the address of the claimant and the attorney gave the address of the wrong claimant. The check was sent and cashed. Two months later the mistake was realized. I asked the wrong claimant if he had received the check and he was certain that he had not. Once I went through the steps described above I learned that the check had been delivered to the wrong claimant's address, but it was intercepted and cashed by his son, who also had the same name. The learning point for me in this case was that there are numerous possibilities and no assumptions should be made.

Step #4—Organize Your Evidence

All too often, adjusters obtain bits and pieces of good evidence and they are not useable because they did not bring it all together in one concise package. In the state of California, a term used by law enforcement officials and SIUs is the "Prosecutable Package." The evidence is presented in a three-ring binder. What follows is a typical outline.

- Cover Page—Includes such things as the claim number, claimant name, and identifying information.
- Costs Incurred—Usually includes a breakdown of the total amounts paid in categories such as medical, indemnity, and legal. Law enforcement personnel might also appreciate a breakout of the benefits you believe were fraudulently obtained.
- Summary—A two-to-three paragraph description of the suspicion and the evidence obtained.
- List of Witnesses—Includes names, addresses, telephone numbers, and one or two sentences of what the witness can testify to.
- Summary of the Relationship among the Insured, the Carrier and the TPA—Law enforcement personnel will appreciate this as it is often difficult to determine which entity is the potential victim.
- Materiality Statement—A one-to-two paragraph statement made by the claims handler as to why the misrepresentation made by the claimant had an impact on the claim. For example, "Had the prior injury records not been uncovered, Mr. Claimant would have been entitled to full compensation for 100 percent of the disability. However, in light of the records, and the medical opinion of Dr. Smith regarding apportionment, Mr. Claimant is only entitled to 10 percent of the disability."
- Table of Contents—List the evidence you have provided.
- Evidence—Attach copies of the key supporting evidence in chronological order, with tabs that correspond to the Table of Contents.

Not every case will need to be assembled in such a detailed manner. Actually, some law enforcement agencies that I have worked with prefer that you do not assemble it. They simply want a copy of the entire file. You should check with the agency to which you will be referring the case for the preferred method. Of course, not every case will warrant a referral to law enforcement either. Consider the beyond a reasonable doubt burden of proof. Nevertheless, even if you plan to make a solid denial of the claim, or reduce the permanent disability entitlement, or take a credit for benefits overpaid as a result of concurrent employment, having your evidence clearly organized will be beneficial.

Step #5—Preserve the Evidence and Follow Up

Regardless of whether or not you submitted your case to law enforcement, be sure to preserve the original evidence. Create a simple but effective system that can be conveniently and consistently adhered to. For example, instead of maintaining audiocassette tapes in an evidence room, keep them in a sealed envelope with the claim file.

Follow up with the agency that you submitted your case to on a monthly basis. The saying "the squeaky wheel gets the grease" definitely applies and it lets them know that your company is interested in the outcome and will be completely cooperative.

Summary

The fraud-fighting system explained is not a cure-all but will assist in maximizing your organization's workers compensation fraud-fighting dollars. The general theme is that there must be a clear, documented statement from the claimant before you commit resources to proving your suspicion of fraud. Without the unequivocal statement, your suspicion does not have a foundation on which to build an argument even for fraud abuse much less a criminal fraud case. Workers compensation fraud-fighting techniques are constantly evolving as the rules change; nevertheless, it is not as complex as it is often made out to be. And never forget the most important credo . . . no lie, no fraud. ■

The Loss Control Section developed the seminar "Good to Great: Achieving the Transition in Workers Compensation" held at the CPCU Society's 59th Annual Meeting and Seminars in New Orleans, LA.

Mark Your Calendar!

2004 CPCU Society Educational Events

April 22-23	National Leadership Institute Tampa, FL
October 23-26	60th Annual Meeting and Seminars Los Angeles, CA

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Loss Control Quarterly Editor
Charles H. Morgan, J.D., CPCU, CLU, CSP, ARM
Fleet Insurance Services
(H) 6 Hickory Road
Summit, NJ 07901
Phone: (908) 653-3177
Fax: (908) 272-4878
E-mail: charles_morgan@fleet.com

Loss Control Quarterly Assistant Editor
Donald J. Jackson, CPCU
Zurich North America
27 Palm Lane
Westbury, NY 11590-6311
Phone: (516) 997-8859
Fax: (516) 997-2107
E-mail: don.jackson@zurichna.com

Loss Control Section Chairman
Eli E. Shupe Jr., CPCU
Cincinnati Insurance Company
(H) 7705 Chelsea Court
Hamilton, OH 45011
Phone: (513) 870-2447
Fax: (513) 881-8663
E-mail: eli_shupe@cinfin.com

Sections Manager
John Kelly, CPCU
CPCU Society

Managing Editor
Michele A. Leps, AIT
CPCU Society

Production Editor/Design
Joan Satchell
CPCU Society

CPCU Society
720 Providence Road
PO Box 3009
Malvern, PA 19355-0709
(800) 932-2728
www.cpcusociety.org

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CPCU Society
720 Providence Road
Malvern, PA 19355-0709
www.cpcusociety.org

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