Swiss Re

General Public Release

Contestable Claims: Just say "Know"

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February 20, 2018

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Impact of Insurance

Impact of Insurance

Benefit payments represent one of the largest components of an insurers expenditures.

In 2015[1] the life industry paid in America:

- $74 billion to life beneficiaries
- $78 billion in annuity benefits
- $18 billion in disability income benefits
- $10 billion in long term care coverage
- $15 billion in dividend
- $115 billion in health insurance

Insurance makes a difference in peoples' lives – we make a difference

[1] Source: ACLI- https://www.acli.com/Posting/RP16-009 ACLI - http://www.acli.com/Tools/Industry%20Facts/Benefits%20Paid/Pages/Default.aspx

The Claim Examiner

Much like underwriting, investigating claims is an art, not science.

Just like investigative journalists, we answer the who, what, when, where, why, and how.

who is the insured?
what did the insured tell us?
when did the insured apply?
where did the application take place?
why did he/she want the insurance?
how did it come about?

What is the job of a Claim Examiner

"The job I'm talking about takes brains and integrity. It takes more guts than there is in 50 salespeople. It is the hardest job in the business.

To me, a claim person is a surgeon, their desk is an operating table and those pencils are scalpels and bone chisels. Those papers are not just forms and statistics and claims for compensation. They're alive, they're packed with drama, with twisted hopes and crooked dreams.

A claim person, Walter, is a doctor and a bloodhound and a cop and a judge and a jury and a father confessor, all in one."

From: Edward G. Robinson as Claims Manager Keyes,

in the 1944 movie "Double Indemnity".

Primary functions of the Claim Examiner

Getting it right – The Examiner's role includes:

- Assess eligibility for payment
- Pay eligible claims accurately and promptly
- Treat claimants fairly and consistently
- Comply with the various state and federal regulations
- Identify and resist ineligible claims

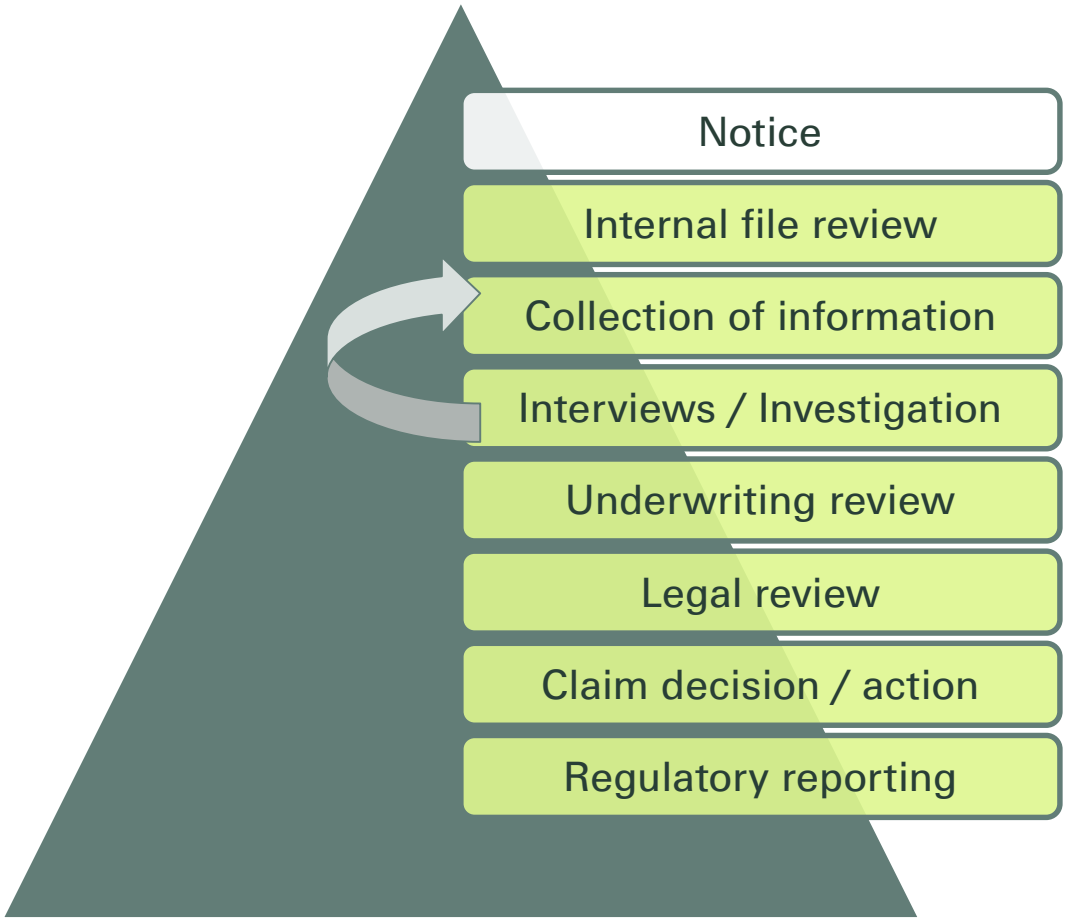
Public policy and many state regulations require fraud detection and prevention procedures:

Example – SAR (Suspicious Activity Report) or STR (Suspicious Transaction Report)

Financial Crimes Enforcement Network (FinCEN), an agency of the United States Department of the Treasury

Claims Process

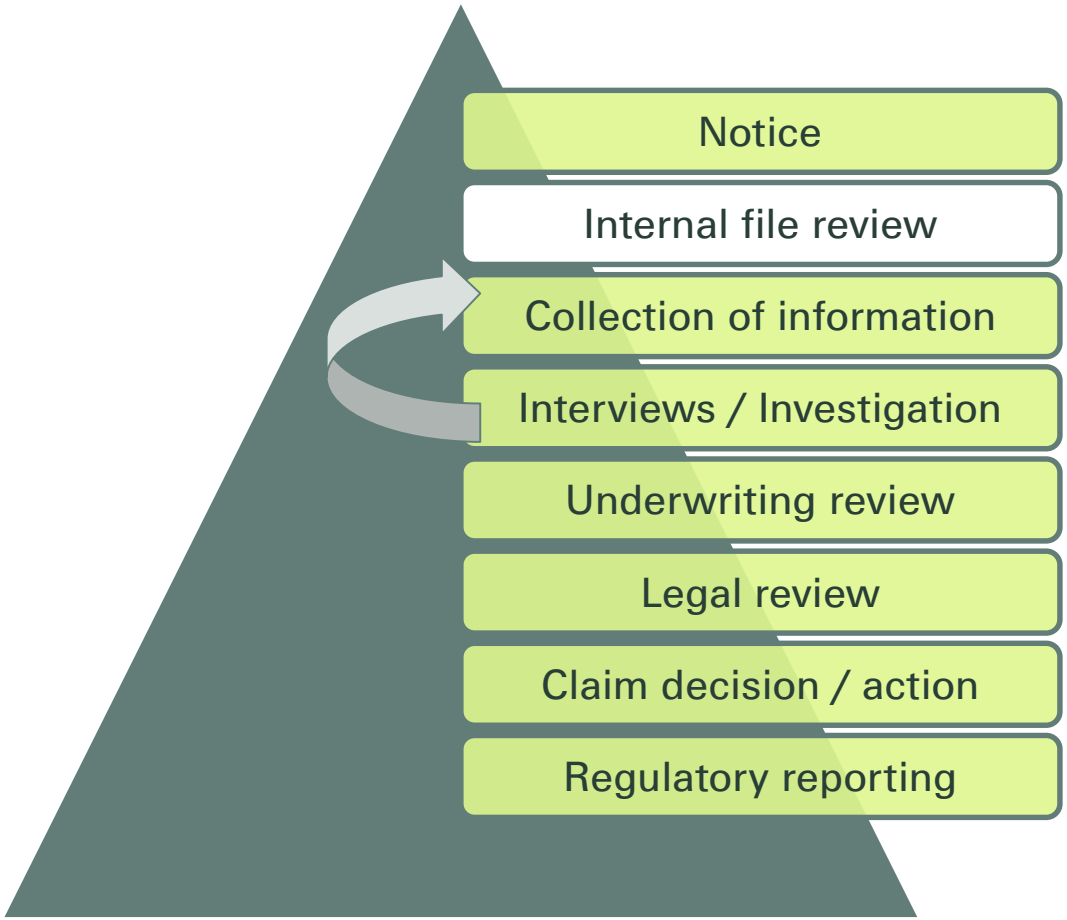
Claims Process



Start of the claim process and point of initial data collection: Who, What, When, Where, and How

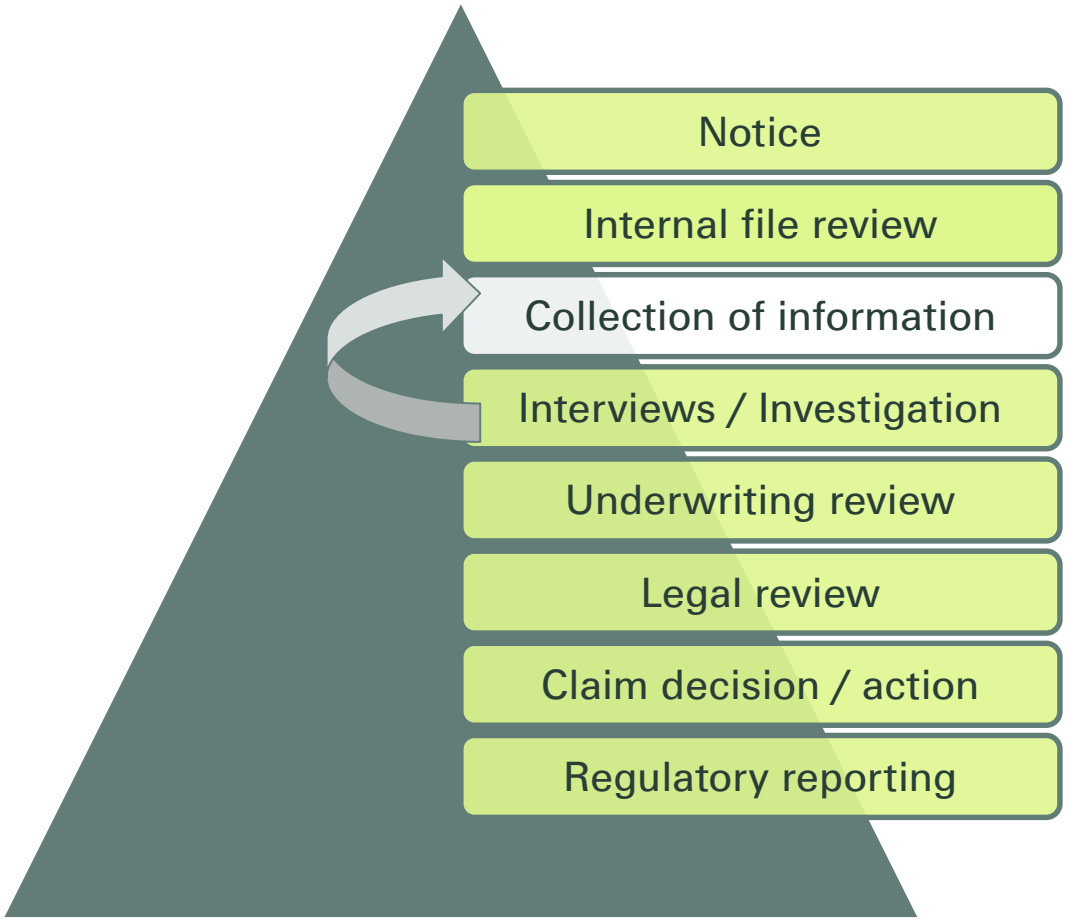
- names and contact information of parties involved
- anticipated beneficiary
- name of executor or personal representative
- manner and cause of death
- location of death (domestic or foreign)
- note anything unusual

Claims Process



- Who are the parties to the policies?
- Were policy changes appropriate?
- Is this a high-risk claim (eg. early claim, foreign death, missing person, etc.?
- Were procedures followed?
- Send forms / information per state regulations
- Determine policy amounts
- Is an investigation or interview appropriate?

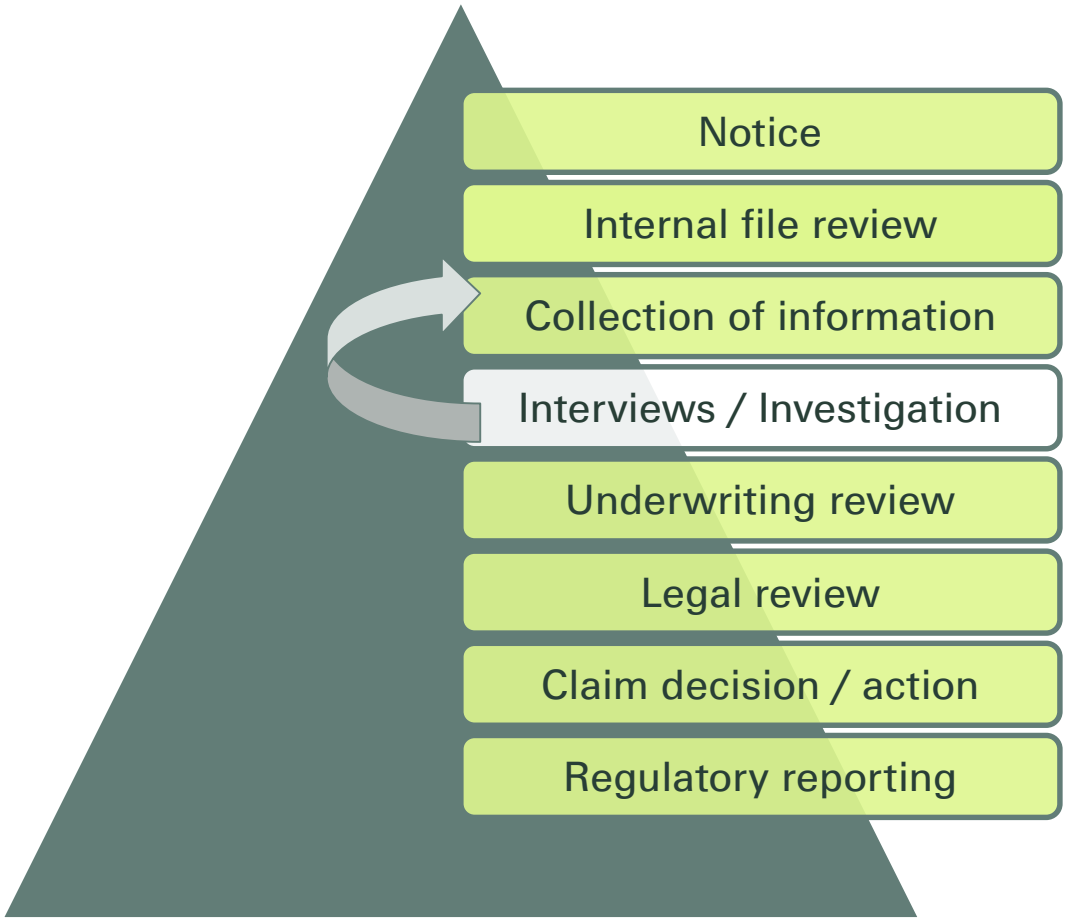
Claims Process



Information required may be minimal to extensive. For most claims, a claimant statement and death certificate are sufficient.

Collection of information may require a more thorough investigation of the circumstances of death.

Claims Process



If appropriate, interviews allow a dialogue with the parties which can uncover critical facts such as:

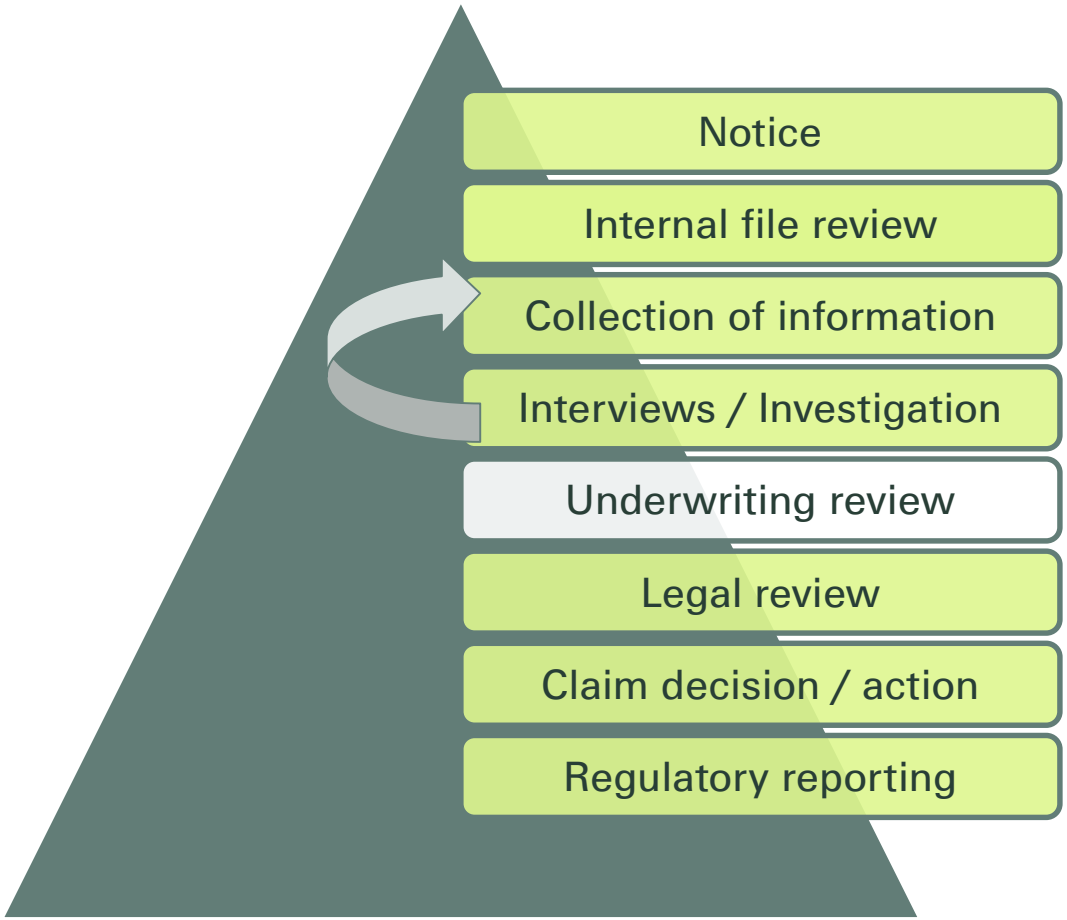
- Purpose of insurance
- Medical history
- Avocation history
- Smoking history
- Circumstances of death

Parties may include:

- Beneficiary
- Agent
- Coroner
- Police
- Etc.

In person interviews can yield information that cannot be ascertained from forms

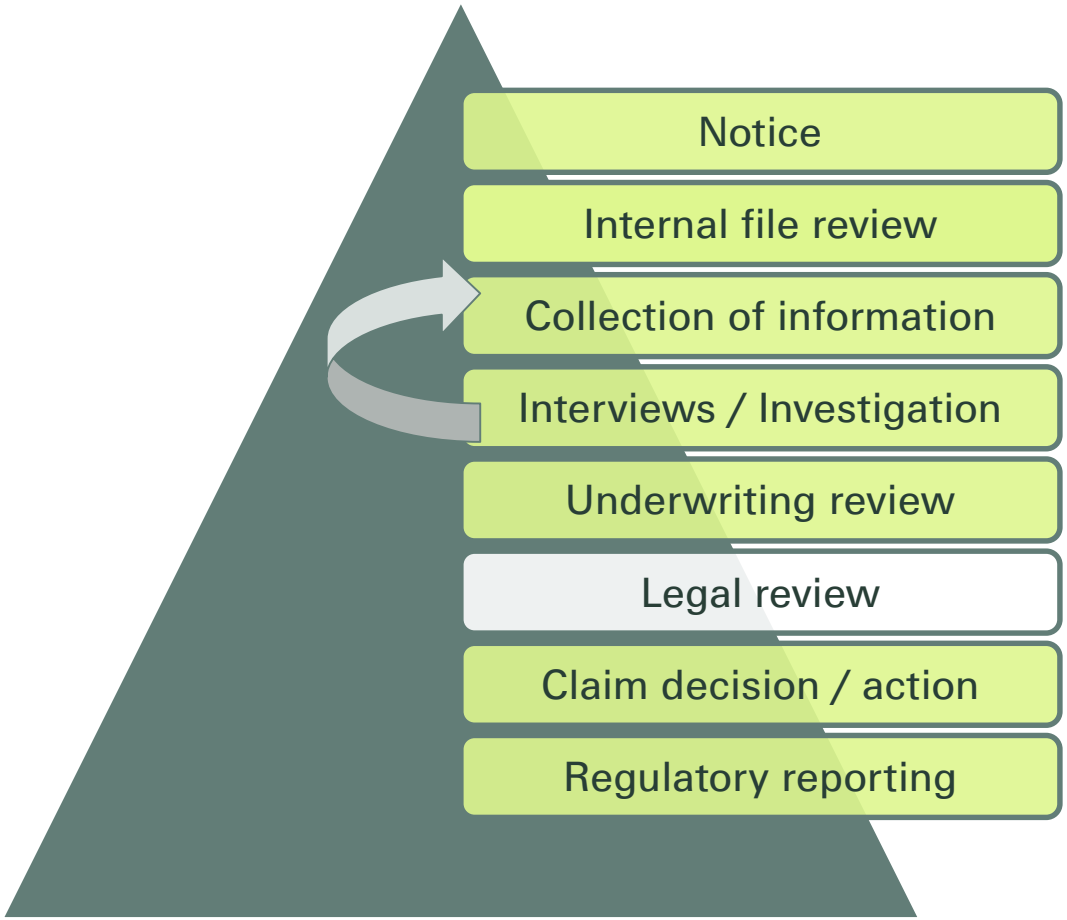
Claims Process



Underwriting reviews are critical for claims where the benefits may be contested.

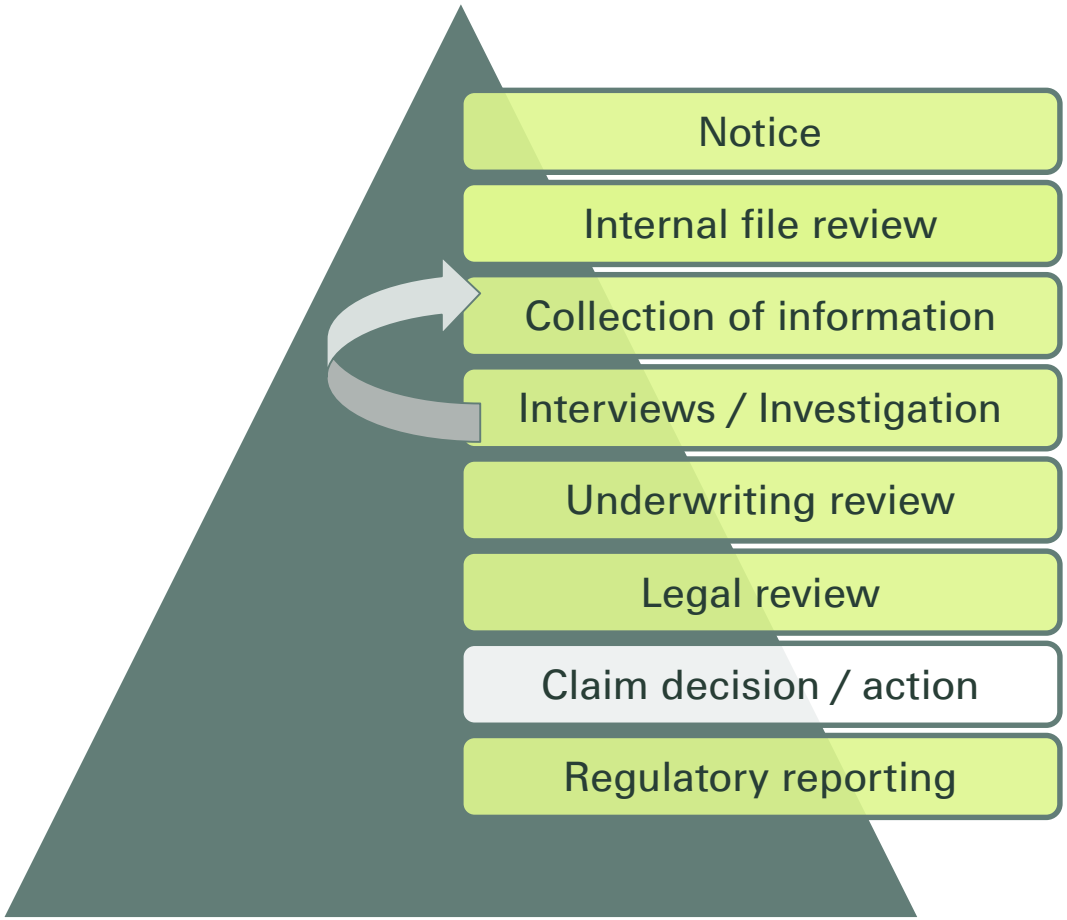
- Was there non-disclosed information contained in the underwriting material
- Was any non-disclosure material
- Were procedures followed or were exceptions made
- Were all application questions answered
- How well is the agent's block performing

Claims Process



For cases where the benefits may be contested or the policy voided, a legal review is important to insure regulations and case law are consistent with ultimate decision.

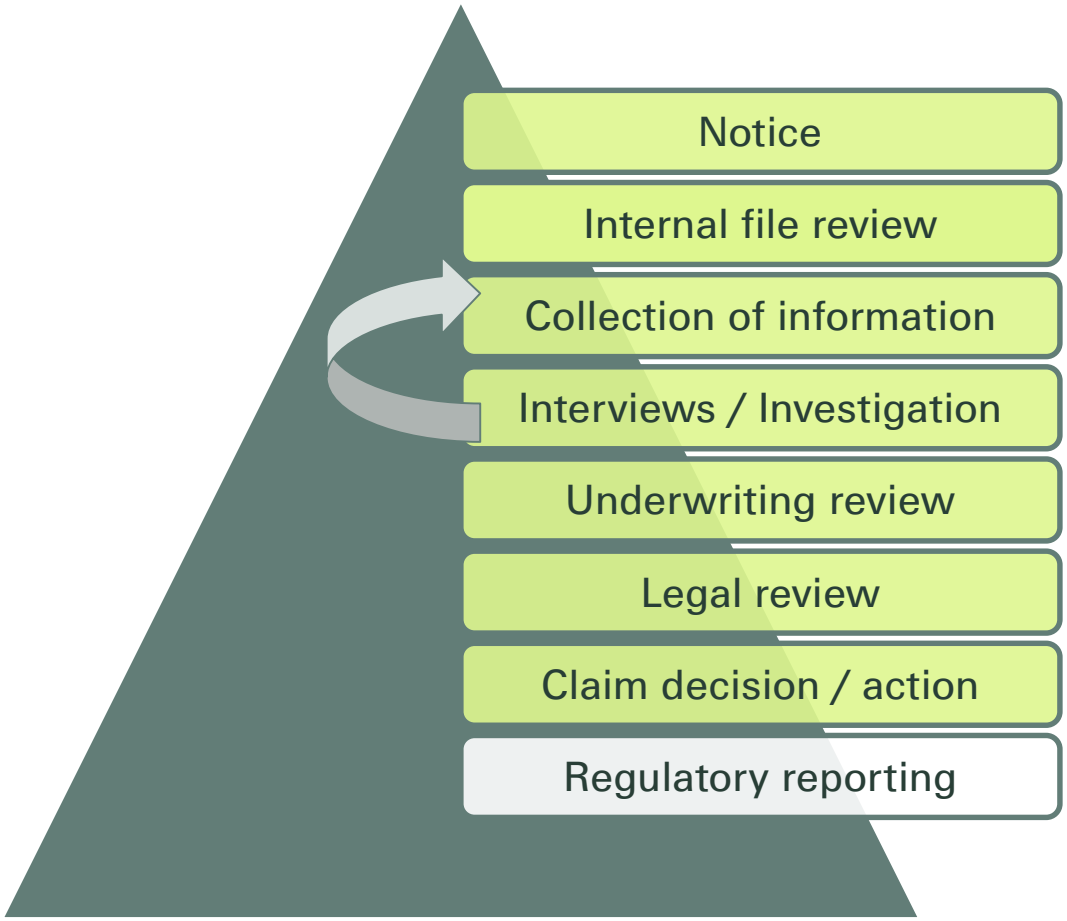
Claims Process



Once all facts are obtained, a claim decision can be reached and action taken.

If Reinsurance is involved, it is critical to get the reinsurers input prior to communicating a decision, particularly on high-risk claims

Claims Process



Many states have specific claim reporting requirements including the reporting of payments and the reporting of suspected fraud

The Initial Review

The Application Process

- On an application for individual life insurance, insured must answer a number of questions regarding their health, lifestyle and finances.
- The applicant may had to have undergone an exam and lab tests.
- Additionally, an APS, personal interview, scripts or MVR may have been obtained.

The Underwriting File

- Are the questions completed in their entirety? If not, why not?
- Is the Paramed/Med Exam, lab work, any APS, financial report, personal interview or other personal and medical information completed in full or obtained according to normal practice?

For the Claims Examiner, it's all designed to get a clear picture of what the underwriter was seeing. Does the applicant give any hints or leads to make one think it doesn't make sense or that it does make sense?

THE CLAIM PROOFS

Review the claim forms to see if they are completed in their entirety. Is the death certificate certified or a certified copy? Have you received all company required forms? Why or why not?

---FOR THE CLAIM EXAMINER, THE CLAIM PROOFS AND THEIR EYEBALL ARE TWO OF THE GREATEST TOOLS AT THEIR DISPOSAL---

Claim Investigation

Claim Investigation

... the claim examiner's primary tool

Keys to the successful investigation

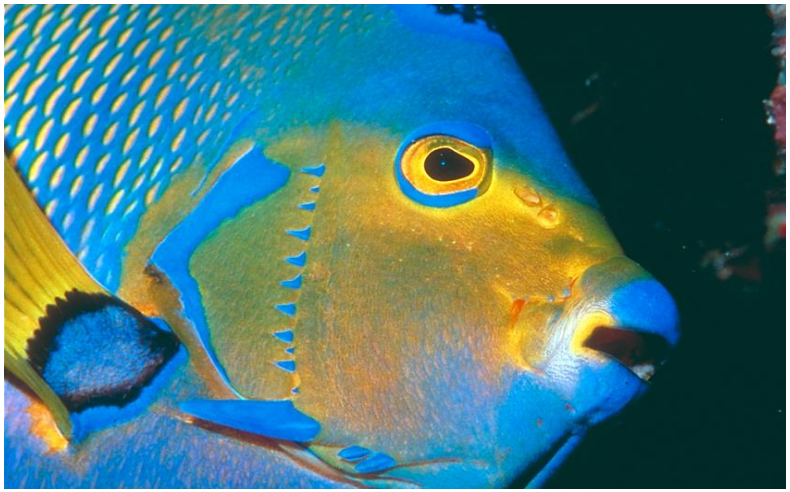
- Initiate the investigation promptly
- Manage the investigation closely

but remember the number one rule.....

Be objective!

Treat each claim as valid and legitimate until the facts of the case prove otherwise

Don’t just go on a fishing trip



Contestable Claims

- If the claim is contestable, at a minimum clinical notes will be obtained from the attending physician.
- Information in this file will be compared against what was disclosed on the application.
- Depending upon cause of death, additional information may be requested.
- Examples: coroner's report, motor vehicle accident report, driver's abstract, police report, criminal history

Why the Contestable Period?

Antiselection

- The tendency of individuals who believe they have a greater than average likelihood of loss to seek insurance protection to a greater extent than do those who believe they have an average or a less than average likelihood of loss

Why investigate so thoroughly?

- Unfair to other stakeholders if non-meritorious claims are paid
- Prevent company from becoming a target for fraud
- Overinsurance may result in temptation to stage the insured's death, commit suicide, or homicide

Investigation Process

- Obtain objective facts to confirm eligibility for coverage
- Should be done fairly and consistently, not arbitrarily
- Claims typically investigated include:
  - Early claims
  - Foreign deaths (regardless of age of policy)
  - Questionable documents or circumstances
  - Missing persons
  - Cases where fraud is reasonably suspected
- The claim examiner becomes an investigator of facts

Investigation Process

- The claim begins with the solicitation for coverage !

  Every action taken by the company or its representatives can become relevant to the final claim decision

- The claim process begins at the notice of claim
- Internal file reviews
- Review of documents from the claimant eg. death certificate, claimant statements, etc.
- Data collect information is generally accomplished through vendors
- Underwriting must determine if any misrepresentations are material
- Legal should review for soundness of decision if benefits are to be denied

Investigation Components

Medical information

- **Hospital records**
- **Physician records**
- Dental records
- Autopsy report
- **Pharmacy records**
- Pharmacy database search

Interviews

- Soliciting agent
- Spouse or other relatives
- Medical providers
- Co-workers
- Authorities

Official reports / other sources

- Accident reports
- Fire department reports
- Aviation accident reports
- **Internet queries**
- **Proofs of death**
- Report of the death of an American citizen abroad
- Police reports
- Emergency medical services
- Motor vehicle reports
- Coast Guard reports

Investigation Components

Non-medical factors to be considered

- Occupation
- Finances
- Trust documents (if applicable)
- Other insurance (issued and applied for)
- Avocations, hobbies
- Purpose of insurance makes sense relative to information obtained in investigation
- Insurable interest

Suicide Investigations

- Could the death be accidental or homicide?
  - Don't always rely on the death certificate – if in doubt, investigate
  - Insured may stage death to appear accidental
- Conduct a personal background check
- Develop physical description of the scene
- Obtain official reports
- Confirm activities prior to death
- Motive...a key factor
- Engage forensic experts if needed
- Investigate any misrepresentation in the application (if contestable)

Review of the Underwriting File

- Document name of attending physician and date of last visit
- Make note of all disclosures on the application
- Review lab results, APS and any medical records received
- Compare claim proofs against information on the underwriting file

Medical Records Obtained at Claim Time

- Review and compare against what was known at time of underwriting

Nondisclosure ?

- Identify the question(s) on the application that appears to have been answered incorrectly
- Refer to underwriting to determine if misrepresentation is material and to confirm that there are np issues with the underwriting file

Medical Records Obtained at Claim Time

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Nondisclosure ?

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Contestable Claims

- Usual parameters for a contestable claim for a life insurance policy:

- The death happens within 2 years of the policy issue date...or within 2 years of a policy change date such as reinstatement or increase in face amount requiring new evidence of insurability

- Additions for riders and benefits: Often the entire face amount may not be contestable when added to in force policies, only the “add on” portion.

- Our focus will be on base policy and original issue date.

Contestable Claims

If a claim is contestable, at minimum clinical notes will be obtained from the attending physician

Information from the APS will be compared against what was disclosed on the application

Depending on cause of death , additional information may be requested.

Examples: Coroner’s report, motor vehicle report, police report, criminal history

Complex investigation may be warranted

- A private investigator may be hired
- In-house special claims investigation units may be used
- May conduct interviews with the beneficiary, and other parties such as the insured's employer, the police or the coroner, if applicable
- Written statement may be obtained
- If death was in a foreign country, an on-site investigation may be conducted

The role of the underwriter at claim time

- An underwriter reviewing a contestable claim must determine if the information disclosed and obtained during the initial risk assessment was complete and accurate when compared to the information that is obtained during the claim investigation.
- If the investigation information is different or reveals previously nondisclosed information, then a determination has to be made whether the information, had it been known or disclosed as the time of initial underwriting, would be “material” to the risk assessment.
- In other words, had the information been known at the time of initial underwriting would the decision to issue been different.
- Including a different (less favorable) rate.
- Or even a postpone of decline.

The role of the underwriter at claim time

- However, if there was undisclosed information, it may not be clear cut "material misrepresentation".
- It must also be determined if the disclosed information on the application and other evidence completed in their entirety? If not, why not?
- Were the exam, labs, APS, financial reports, PHI, MIB etc...obtained in accordance within the usual company guidelines?
- Was the information reviewed in accordance with normal company practice and established underwriting manual guidelines?
- What if a requirement is waived and at claim time it is determined that material information would have been revealed?
- Can a claim then still be denied?

The role of the underwriter at claim time

- The discretionary APS

- Did the underwriting procedures and guides require an APS based on disclosed information?

- If the answer is “yes” the underwriter may need to involve their legal department to determine if there is a legally defensible position to deny the claim

Legal Review

- The attorney will review all the facts such as if the waiver of an APS or an underwriting decision made “outside the box” of established company practice negates a “material misrepresentation” argument
- A government regulation or statue may also prohibit the company from acting on a claim denial: i.e. “Causal” States, they require that denial of a claim for material misrepresentation must be directly related to the cause of death.
- Example: Non-smoker assertions when the insured died of lung cancer from smoking.
- Often factors such as face amount vs potential legal fees are also factored in to a decision to contest a claim
- Jurisdiction often matters as some venues are difficult to defend a claim denial and jury awards for “punitive” damages are prohibitive

Case studies

Case #1 – AKA "Just passing through"
The Underwriting -

- Requested $1 million on a 73 year old female who was born in India and resided in the U.S. for 8 months
- Client initially declined based on their residency rules of minimum 12 months in the U.S.
- Same agent resubmitted an application on the proposed insured but changed the time resided in the U.S. to 16 months

Case #1 – The Underwriting

- Personal information listed no "Green Card" number, no driver's license but did list a Visa number.
- Financial information listed employment as "retired" with no income but $3 million in assets, all in India.
- Her son was owner/beneficiary and his address and phone were identical to the proposed insured.
- No significant health history was given and no doctor had been seen in the U.S. so no medical records were obtained.
- Age/amount exam, labs and ECG were favorable.
- The client issued at Standard (not preferred).

Case #1 – The Claim

- The insured died in India just outside the contestable period.
- Son was interviewed and advised that insured was only in the U.S. for 11 months total.
- Admitted that she had diabetes and heart problems.
- Medical records obtained from India showed diabetes treated for 10 years and died of a sudden MI.

Case #1 – The Claim

- The son contacted the primary care doctor in India and he revised his information and sent a letter stating the diabetes diagnosis was 10 months prior to death not 10 years
- Client paid the claim and the reinsurance treaty stipulated we follow the client's claim decision

Case #1 – Lesson learned?

- Client was on notice (or should have been) when second application was submitted. Red flags on finances and (lack of) medical information
- A "Visa" can be valid but does not mean you are a "permanent resident". Tourist Visa = 12 months
- Foreign death investigations are often worth the extra time and expense.
- Be weary all the same, bribery and fraud are common and available for a (relatively small) price.

Case #1 – The outcome

- Swiss Re Claims initiated an internal discussion memo and suggested a clarification and redefining of eligible lives regarding U.S. "residents".
- Our suggestions were adopted and they are now part of the treaty template defining eligible lives as U.S. (or Canadian) citizens, or permanent residents with a "Green Card".

Case #2 – AKA "Z" mom is dead and "Z" agent is rich

- 77 year old female applied for $7 million. A newly created Trust was the owner/beneficiary. Several trustees listed, including her son.
- Two agents of record for uneven splits in commission.
- Financial information provided by the primary agent listed assets of $20 million. Mostly real estate including the multi-story apartment building where she lived in Brooklyn.
- $1 million yearly income from rentals and investments No other life insurance in force.

Case #2 – The Underwriting

- All age and amount requirements received. Including an inspection report that mirrored the financial information originally provided by the agent.

- The insured was in relatively good health and the policy was approved at standard rates for $7 million.

Case #2 – The Claim

- The insured died within the contestable period of a bowel obstruction and sepsis.
- We received the initial death notice for the $7 million and soon after received a notice from a different client for a $5 million policy on the same insured.
- The $5 million policy was signed and issued just after the issue date of the $7 million policy. Both written by the same agent with the same financial information including "no" answer to "other life insurance in force or pending". The answers, however, were on the application and made part of the contract for the $5 million policy.
- The investigation eventually uncovered 2 additional policies with other carriers issued soon after the original $7 million. Total line ended up at $20 million spread across 4 policies from 4 different carriers but all written by the same agent.

Case #2 – The Claim

- Claims investigation included an interview with the son. His answers were "shaky" regarding his mother's finances and the relationship of the other Trustees.
- An interview with the second agent caught him "cold" on the front porch of his home. At first he denied his own identity. He also gave vague answers as to details regarding the insured, and his witnessing the application at her "house" in Brooklyn.

Case #2 – The Claim

- Interview with the building manager (15 story structure) revealed the insured had lived for past 20 years in a 1 room, rent controlled, studio apartment. She not only had no ownership in the building, but no real assets and was dependent was on SSDI.
- The "Trustees" other than the son, were (no surprise) third party investors that had never met and had no insurable interest in the insured.
- The whole series of applications were STOLI and initiated by the agent(s) who were partners and cut each other in on the commissions.

Case #2 – The Claim

- What are the issues?
- Any recourse regarding overinsurance?
- Opinion from Underwriting: not their practice to routinely confirm whether or not concurrent apps are settled or closed. Take client's statement on the app to be truthful. Will sometimes request an amendment.
- Legal opinion: insured's statement on the application is too weak to use as a defense.

Case #2 – The Claim

- What was the outcome of the $7 million claim?

- What was the outcome of the 3 subsequent claims for a total of $13 million?

Case #2 – The Outcome

- The $7 million was paid and we reimbursed our client 100% of Swiss Re's proportionate share.
- Why?
- The other three claims were settled out of court for return of premium.
- Why?

Case #2 – The Outcome

- There was no material misrepresentation on the $7 million application since all financial information was on the agent's statement and not part of the legal contract.
- For the other 3, the applications were signed subsequent to the $7 million application and all had the financial questions as part of the contract.
- The client with the $7 million claim has since (or sense?) revised their part 1 forms to include all financial questions as part of the contract.

Case #3 –AKA "Where's your Mama" The Underwriting:

- 65 year old female applied for $350,000, all papers were signed and witnessed in San Diego, CA in May, 2007.
- Occupation listed as running a day care. Her son and daughter in law were owners and beneficiaries.
- No MD or no significant medical history given. Age/amount exam, labs and ECG were completed and favorable.
- Policy was issued as applied for in June, 2007

Case #3 – The Claim

- The insured died in Mexico just over 2 years after the issue date of June, 2007.
- Due to the foreign death an investigation was conducted in Mexico and the U.S.
- It was quickly determined that the insured did indeed die suddenly of a cerebral hemmorhage. Family members (5 of her 6 children lived in the same small village) were very cooperative and showed the investigators the grave and helped secure and verify all proofs of death and burial documents

Case #– The Claim

- The only child of the insured that did not live in Mexico was the son who was the owner/beneficiary (of course) who lived in San Diego, CA.
- It was verified that the insured did in fact visit that son in California and lived with him for a total of 3 months, returning to Mexico in December, 2006 and never travelled there again (or anywhere else for that matter).
- What's wrong with this picture?

Case #3 – The Outcome

- The application, paramed exam, etc... were all done in San Diego in 2007 several months after the insured had returned to her village in Mexico.
- It was eventually discovered that the daughter in law was a former insurance agent and colluded with the writing agent and the paramed examiner to get a stand in for the application, exam etc...
- Lesson learned? Cut your siblings in on the scam? They had no idea of the policy or the fraud so had no reason not to be forthright with the investigators.
- Fraudsters were all convicted and did jail time.

Case #4 – AKA "Wile E. Coyote" The Underwriting-

- Two polices totalling $20 million were issued on a 50 year old male who admitted to having insulin dependent diabetes.
- He was owner/founder and ran the day to day operations of a large company. The financials were closely reviewed and amount of insurance was justified.
- He was issued $15 million and $5 million term policies at substandard rates due to his health condition.

Case #4 – The Claim

- He died within the contestable period (by less than a month). His body was reportedly found by his handyman behind a barn of his large country estate with a gun shot wound directly through his heart.
- A police investigation was conducted including interviews of the wife who initially said the insured complained of stress and insomnia and was going to go for a walk at 4:30 AM (not part his usual routine) to clear his head. When he did not return she and the handyman started a search that led to his body being found a few hours later.

Case #4 – The Claim

- The police and coroner quickly ruled death a suicide by self inflicted gun shot wound.

- Before any proofs were provided or claim forms sent out, the lawyer representing the wife/beneficiary contacted the client company and requested out of respect not to take any action or send any forms yet and that he would contact them at a later date when things settled down. The client held off as requested.

Case #4 – The Claim

- After 3 months the lawyer did contact the client and presented a 100 plus page document disputing the cause as suicide. It included a forensic psychiatrist's report stating that the insured was not suicidal. It also has gun "experts" that provided an explanation on how the shot directly through his heart was an unfortunate "accident".
- The spouse changed her story and said the insured was going after a coyote that has recently killed their daughter's cat. He must have slipped due to the early morning dew and fell on the gun.

Case #4 – The Claim

- The writing agent was interviewed and he advised that he had just met with the insured the week before his death and did a overview of his policies and reiterated what the contestability and suicide provisions meant and that the polices were still contestable. So…the insured would never have committed suicide since he was so recently reminded of the consequences to his life insurance coverage
- Incidentally (or Coincidentally ?), no suicide note was ever found.

Case #4 – The Outcome

- Still unclear.
- Client has hired a team of experts to rebut point by point the spouse's team's findings, including an experienced independent coroner who is also an avid hunter and basically states the other gun "expert" explanation defies the laws of physics.
- The case is dragging in the courts and has not been scheduled for a trial date yet.

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