

24-A §2186. INSURANCE FRAUD PREVENTION

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1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud:

(1) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

- (a) An application for the issuance or renewal of an insurance policy;
- (b) The rating of an insurance policy;
- (c) A claim for payment or benefit pursuant to an insurance policy;
- (d) Payments made in accordance with an insurance policy; or
- (e) Premiums paid on an insurance policy;

(2) Presenting, or causing to be presented, or preparing any information containing false representations as to a material fact with knowledge or belief that the information will be presented to or by an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

- (a) A document filed with the superintendent or the insurance regulatory official or agency of another jurisdiction;
- (b) The financial condition of an insurer;
- (c) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance in all or part of this State by an insurer;
- (d) The issuance of written evidence of insurance; or
- (e) The reinstatement of an insurance policy;

(3) Soliciting or accepting new or renewal insurance risks on behalf of an insurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(4) Removing, concealing, altering or destroying the assets or records of an insurer or other person engaged in the business of insurance;

(5) Embezzling, abstracting, purloining or converting money, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

(6) Transacting the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance; or

(7) Attempting to commit, aiding or abetting in the commission of, or conspiring to commit the acts or omissions described in this subsection. [1997, c. 675, §2 (NEW).]

B. "Insurer" means an authorized insurance company, fraternal benefit society, reinsurer, surplus lines insurer, unauthorized insurer, nonprofit hospital and medical service organization, health maintenance organization, risk retention group or multiple employer welfare organization. "Insurer" also includes an insurance producer or other person acting on the behalf of an insurer. For the purposes of this section, "insurer" also means the state Medicaid program. [2009, c. 13, §2 (AMD).]

[2009, c. 13, §2 (AMD) .]

2. Fraudulent insurance acts prohibited. A person may not commit a fraudulent insurance act.

[1997, c. 675, §2 (NEW) .]

3. Fraud warning required. Fraud warnings are required in accordance with the following.

A. All applications and claim forms for insurance used by insurers in this State, regardless of the form of transmission, must contain the following statement or a substantially similar statement permanently affixed to the application or claim form: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits." [1997, c. 675, §2 (NEW) .]

B. The lack or omission of the statement required in paragraph A does not constitute a defense in any criminal prosecution or civil action for a fraudulent insurance act. [1997, c. 675, §2 (NEW) .]

C. This subsection applies to all insurers except reinsurers. The statement required in paragraph A must be included in all applications and claim forms filed and approved for use by the superintendent on or after January 1, 1999. [1997, c. 675, §2 (NEW) .]

[1997, c. 675, §2 (NEW) .]

4. Reporting of fraudulent insurance acts. Fraudulent insurance acts must be reported in accordance with this subsection.

A. An insurer shall, annually on or before March 1st or within any reasonable extension of time granted by the superintendent, file with the superintendent a report relating to fraudulent insurance acts that the insurer knew or reasonably believed had been committed during the previous calendar year. The report must contain information required by the superintendent in the manner prescribed by the superintendent. The information must be reported on an aggregate basis and may not contain any information identifying any individuals or entities. The superintendent shall adopt by January 1, 1999 rules necessary to define the information that must be reported. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A. [1997, c. 675, §2 (NEW) .]

B. On the July 1st following the filing of the initial reports required by paragraph A, and annually thereafter, the superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters. The report must include aggregate information detailing the fraudulent insurance activity experienced by insurers in this State. [1997, c. 675, §2 (NEW) .]

[1997, c. 675, §2 (NEW) .]

5. Insurer antifraud plans. Within 6 months of the effective date of this Act, every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud; [1997, c. 675, §2 (NEW) .]

B. Educate appropriate employees on the antifraud plan and fraud detection; [1997, c. 675, §2 (NEW) .]

C. Provide for the hiring of or contracting for fraud investigators; and [1997, c. 675, §2 (NEW) .]

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud. [1997, c. 675, §2 (NEW) .]

[1997, c. 675, §2 (NEW) .]

6. Civil penalties. Any violation of this section is subject to civil penalties and other remedies as provided in section 12-A. Notwithstanding section 2165-A, subsection 1, the superintendent may issue emergency cease and desist orders on the basis of conduct involving fraudulent insurance acts.

[1997, c. 675, §2 (NEW) .]

7. Recovery costs. In a civil action in which it is proven that a person committed a fraudulent insurance act, the court may award reasonable attorney's fees and costs to the insurer. In a civil action in which the insurer alleges that a party committed a fraudulent insurance act that is not established at trial, the court may award reasonable attorney's fees and costs to the party if the allegation is not supported by any reasonable basis of law or fact.

[1997, c. 675, §2 (NEW) .]

SECTION HISTORY

1997, c. 675, §2 (NEW). 1999, c. 5, §1 (AMD). 1999, c. 5, §2 (AFF).
2009, c. 13, §2 (AMD).

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