

**STATE OF CALIFORNIA  
DEPARTMENT OF INSURANCE  
300 Capitol Mall, 17th Floor  
Sacramento, CA 95814**

**FINAL TEXT OF REGULATION**

**SPECIAL INVESTIGATIVE UNITS**

**June 19, 2020**

**REG-2018-00023**

Title 10. Investment  
Chapter 5. Insurance Commissioner  
Subchapter 9. Insurance Fraud  
Article 2. Special Investigative Units ~~Regulations~~

Amend 2698.30. Definitions.

As used in this article, the following definitions shall apply:

- (a) "Act" means any violation of California Code of Regulations, Title 10, Chapter 5, Section 2698.30-42, inclusive.
- (b) "Authorized governmental agency (agencies)" shall have the same meaning as used in the Insurance Frauds Prevention Act (IFPA).
- (c) "Claims handler" means every employee and agent of an insurer whose principal responsibilities include the investigation, adjustment, settlement, and resolution of claims.
- (d) "Commissioner" means the Insurance Commissioner of the State of California.
- (e) "Communication" includes the referral of suspected insurance fraud to the Department of Insurance and providing information and documents requested by the Fraud Division.
- (f) "Contracted entity" means any entity with which an insurer contracts to perform SIU or integral anti-fraud personnel duties or functions on behalf of the insurer. "Contracted entity" includes subcontractors and sub-subcontractors contracted to perform SIU or integral anti-fraud personnel duties or functions on behalf of the insurer. The term "contracted entity" does not include the insurer's affiliates, or subsidiaries, with which the insurer contracts to perform SIU or integral anti-fraud personnel duties or functions on behalf of the insurer. "Contracted entity" does not include entities with whom an insurer, or another of the insurer's contracted entities, contracts to provide an expert opinion on a medical, technical, or scientific topic, or perform a discreet, specific investigative task such as surveillance, accident reconstruction, background checks, scene inspections, social media checks, interviews, witness canvassing, Arising Out of Employment/Course of Employment (AOE/COE) investigations, activity checks, or database vendor services including, but not limited to, ISO ClaimSearch, LexisNexis, and Accurant, on

behalf of the insurer in connection with the insurer's performance of its SIU or integral anti-fraud personnel duties or functions. However, the immediately preceding sentence notwithstanding, entities that (1) participate in the claims handling function of the insurer, (2) make decisions on behalf of the insurer with respect to the insurer's SIU or integral anti-fraud functions, or (3) contract with other entities to perform SIU or integral anti-fraud duties or functions on behalf of the insurer, are included within the meaning of the term "contracted entity."

(~~g~~) "Department" means the California Department of Insurance.

(~~h~~) "Fraud Division" means the California Department of Insurance Fraud Division formerly known as the Bureau of Fraudulent Claims.

(~~i~~) "Hearing" means an adjudicative proceeding initiated by the Insurance Commissioner pursuant to the provisions of California Insurance Code ~~S~~section 1875.24(d).

(~~j~~) "Inadvertent" means unintentional.

(~~k~~) "Insurer" means every insurer admitted to do business in this state except the following:

- (1) Reinsurers.
- (2) Title insurers.
- (3) Fraternal fire insurers.
- (4) Fraternal benefit societies.
- (5) Firemen, policemen, or peace officer benefit and relief associations.
- (6) Grant and annuity societies.
- (7) Home protection.

(~~l~~) "Integral anti-fraud personnel" includes insurer personnel who the insurer has not identified as being directly assigned to its SIU but whose duties may include the processing, investigating, or litigation pertaining to payment or denial of a claim or application for adjudication ~~of~~ claim or application for insurance. These personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties.

(~~m~~) "Reasonable belief" is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences therefrom.

~~(nm)~~ "Red flag" or "red flag event" means facts, circumstances, or events which, singly or in combination, support(s) an inference that insurance fraud may have been committed, and includes patterns or trends that may indicate fraud, facts or circumstances present on a claim, and behavior or history of person(s) submitting a claim or application.

~~(on)~~ "Regulations" means these regulations, California Code of Regulations, Title 10, Chapter 5, Subchapter 9, Article 2.

~~(pe)~~ "Special Investigative Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.

~~(qp)~~ "Suspected insurance fraud" includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium, and application fraud. These facts may include evidence of doctoring, altering or destroying forms; prior history of the claimant, policy holder, applicant, or provider; receipts; estimates; explanations of benefits (EOBs), medical evaluations or billings; medical provider notes (commonly known as SOAPE notes; Subjective complaint, Objective findings, Assessment, Plan and Evaluation); Health Care Financing Administration (HCFA) forms; police and/or investigative reports; relevant discrepancies in written or oral statements and examinations under oath (EUO); unusual policy activity; and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

~~(rq)~~ "The Insurance Frauds Prevention Act" or "(IFPA)" shall refer to California Insurance Code sections 1871-through 1879.8.

~~(sf)~~ "Willful" means a purpose or willingness to commit the act or make the omission referred to in the California Insurance Code or in these regulations. The Commissioner shall use the factors set forth at California Code of Regulations, Title 10, Section 2591.3(d)(1)(A-E) to determine whether or not an act is willful.

NOTE: Authority cited: Sections 1872.4, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 9080, 10970, 11400, 11520, 11760, 11880, 12400.1, 12743, 12921(a) and 12926, Insurance Code.

Amend Section 2698.33. SIU and Integral Anti-Fraud Personnel Contracted Responsibilities.

(a) Any contract entered into by an insurer, or an entity under contract with an insurer for the performance of SIU or integral anti-fraud personnel duties or functions as provided under these regulations, shall not relieve the insurer of any obligation under these regulations or the IFPA.

(b) Notwithstanding any other provisions of these regulations, a complete and executed copy of any such agreement, including all attachments, exhibits and amendments thereto, shall be provided to the Fraud Division upon request by the Fraud Division on execution.

(c) Any contract entered into by an insurer with a contracted entity under this section shall:

(1) Specify all SIU or integral anti-fraud personnel duties and functions to be performed by the parties to the contract and how the insurer monitors performance of the contract responsibilities;

(2) Not include provisions that could provide disincentives to the referral and/or investigation of suspected insurance fraud;

(3) Not include provisions that purport to relieve an insurer of any obligation to comply with the requirements of these regulations and the IFPA; ~~and~~

(4) Expressly ~~include a provision to~~ require the contracted entity to comply with all applicable provisions of the IFPA and this article ~~these regulations;~~ and

(5) Expressly require the contracted entity to include the following provisions in any agreement the contracted entity may enter into with any subcontractor to perform SIU or integral anti-fraud personnel duties or functions for the contracted entity on behalf of the insurer:

(A) Subcontractor to provide entire agreement to the Fraud Division upon request: An express provision requiring that the contractor provide to the Fraud Division a complete and executed copy of any such agreement between the contractor and its subcontractor, including all attachments, exhibits and amendments thereto, upon request by the Fraud Division,

(B) Subcontractor to be bound by same requirements as contractor: An express provision that any such agreement between the contractor and its subcontractor shall conform to the requirements set forth in subdivisions (c)(1), (c)(2), (c)(3), and (c)(4) of this Section 2698.33, and

(C) Limitations on subcontractor contracting with other entities: An express provision that, in the event any subcontractor to the contracted entity contracts with any other entity or entities to perform SIU or integral anti-fraud personnel duties or functions on behalf of the insurer, the agreement between the subcontractor and the entity so contracted (hereinafter a “sub-subcontractor”) shall contain the following provisions:

1. Sub-subcontractor to be bound by same requirements as contractor and subcontractor: The express provision described in subdivision (c)(5)(B) of this section,

2. Sub-subcontractor to provide entire agreement to the Fraud Division upon request: An express provision identical in substance to the provision described in subdivision (c)(5)(A) of this section, binding the subcontractor to provide, upon request by the Fraud Division, the documents specified in that subdivision (c)(5)(A) but with respect to the agreement between the subcontractor and its sub-subcontractor, and

3. No further subcontracting: An express provision prohibiting the sub-subcontractor from permitting, or contracting with, any other entity to perform the SIU or integral anti-fraud personnel duties or functions which the sub-subcontractor has contracted with the subcontractor to perform on behalf of the insurer.

(d) An insurer shall no later than April 1, 2021 ensure that the provisions described in subdivisions (c)(5)(A) through (c)(5)(C) of this section are included in any and all of its contracts with contracted entities for the performance of SIU or integral anti-fraud personnel duties or functions.

NOTE: Authority cited: Sections 1875.23, 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.34. Communication with the Fraud Division and Authorized Governmental Agencies.

(a) The insurer and any entity performing the SIU function(s) shall comply with specific sections of the IFPA regarding communication with the Fraud Division and authorized governmental agencies.

(b) On written request by the Fraud Division or an authorized governmental agency, an insurer or its agents, shall release in a timely and complete manner any or all relevant information deemed important that the insurer may possess relating to any specific incident of insurance fraud. ~~Such~~The information released pursuant to this subdivision (b) shall include:

- (1) Insurance policy information;
- (2) Applications;
- (3) Policy premium payment records;
- (4) History of claims;
- (5) Information relating to the carrier's investigation, including statements, proof and notice of loss;

- (6) Claim file documents;
- (7) Claim notes;
- (8) Investigation files;
- (9) Investigator notes; and
- (10) Other information which the Fraud Division or an ~~A~~authorized ~~G~~governmental ~~A~~agency may deem relevant and important.

(c) For the purpose of this section, timely release of information means immediate, but no more than thirty (30) calendar days after the request or, in the event of a request relating to workers' compensation insurance fraud, sixty (60) calendar days after the request, unless otherwise agreed to by the Fraud Division or by the other authorized governmental agency making the request.

(d) Information released pursuant to this Section 2698.34 shall be transmitted only as follows, unless otherwise agreed to by the Fraud Division:

- (1) Via the Fraud Division's electronic portal provided for this purpose;
- (2) As hardcopy; or
- (3) In an electronic file.

For purposes of this subdivision (d)(3):

(A) If the file is password-protected, the password must be provided to the Fraud Division and must not expire.

(B) If the file is encrypted, the insurer shall provide Fraud Division with any materials necessary in order for the encrypted information to be accessed by the Fraud Division.

(~~ee~~) A single written request shall be considered sufficient to compel production of all information deemed relevant by the requesting governmental agency relating to any specific insurance fraud investigation. The single request is applicable throughout the duration of the investigation and is applicable to the requested records of the insurer named in the request and the records of all persons, agents, and brokers employed by and conducting business on behalf of the insurer.

NOTE: Authority cited: Sections 1872.4, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.

Reference: Sections 1872.3, 1873, 1874.2, 1874.4, 1875.4, 1875.20, 1875.21, 1875.24, 1877.1, 1877.2, 1877.3, 1877.4, 1877.5, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.35. Detecting Suspected Insurance Fraud.

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute, and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document, and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer. The red flags listed pursuant to the immediately preceding sentence shall be specific to each line of insurance, or each insurance product, transacted in or issued by the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against red flags and other criteria that may indicate possible fraud.:

~~(1) Patterns or trends of possible fraud;~~

~~(2) Red flags;~~

~~(3) Events or circumstances present on a claim;~~

~~(4) Behavior or history of person(s) submitting a claim or application; and~~

~~(5) Other criteria that may indicate possible fraud.~~

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.36. Investigating Suspected Insurance Fraud.

(a) The SIU shall establish, maintain, distribute, and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction, that includes consideration of factors indicating insurance fraud.

(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.

(3) Utilizing one or more industry-recognized databases identified by the SIU as appropriate for use in fraud investigations involving the particular line of insurance in question.

(4) Preservation of documents and other evidence obtained during an investigation.

(5) Writing a concise and complete summary of the entire investigation, which is specific to the investigation at hand, is separate from any other document prepared in connection with the investigation, and includes the investigators's findings regarding the suspected insurance-fraud and the basis for their findings. The summary shall answer the following questions:

(A) What facts caused the reporting party to believe insurance fraud occurred or may have occurred?

(B) What are the suspected misrepresentations and who allegedly made them?

(C) How are the alleged misrepresentations material and how do they affect the claim or insurance transaction?

(D) Who are the pertinent witnesses to the alleged misrepresentation, if there are pertinent witnesses?

(E) What documentation is there of the alleged misrepresentation, if documented?

(F) In addition, the summary prepared pursuant to this subdivision (a)(5) shall include a statement as to whether or not the investigation is complete.

(b) Each investigation of suspected insurance fraud shall include performing at least the procedures specified pursuant to subdivision (a) of this Section 2698.36, to the extent they are applicable.

(c) The SIU shall investigate each credible referral of suspected insurance fraud that it receives from integral anti-fraud personnel, including automated or system-generated referrals. A credible referral of suspected insurance fraud is one that includes a red flag or red flags. However, the first sentence of this subdivision (c) notwithstanding, in the event that upon a preliminary review the SIU determines that it is reasonably clear that the red flag or red flags contained in the referral is not or are not the result of suspected insurance fraud, the SIU need not open an investigation. In the event that the SIU refrains from opening an investigation pursuant to the immediately preceding sentence, the SIU shall document in the claim file or SIU investigation file the reasons supporting its conclusion that the red flag or red flags contained in the referral is not or are not the result of suspected insurance fraud.



NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.37. Referral of Suspected Insurance Fraud.

- (a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and, as required, district attorneys.
- (b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

(d) The SIU shall complete as much of its investigation as is reasonable prior to the time the referral is made to the Fraud Division. Each referral of suspected insurance fraud shall indicate whether the investigation is complete or further investigation is needed.

~~(e)~~ The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act.

~~(f)~~ The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation.

NOTE: Authority cited: Section 1708, Civil Code; Sections 1872.4, 1874.6, 1875.24, 1875.4, 1877.3, 1877.5, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1872.5, 1873.2, 1874.2, 1874.4, 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.38. Referral Content.

A referral of an act of suspected insurance fraud to the Fraud Division shall be legible and on a form as directed by the Department and contain the information and data to the extent applicable, as provided in the following:

- (a) Fraud and referral type
  - (1) Fraud type

(2) New referral/amended referral indicator

(b) Reporting party information

(1) Two-digit Reporting party code type, as follows:

- (A) Carrier/licensed insurer: .....01
- (B) Private sector self-insured: .....02
- (C) Public sector self-insured: .....03
- (D) Third party administrator: .....04
- (E) State Compensation Insurance Fund (SCIF): ....05

(2) Reporting party name

(3) Reporting party California Certificate of Authority ~~Company~~ number

(4) Reporting party self-insured/ or contracted third party license number, as appropriate

(5) Reporting party address, city, state, and zip code

(6) Reporting party email address (generally, contact address)

(7) Reporting party Federal Employer Identification Number

(c) Alleged victim information, as appropriate

(1) Alleged victim company name

(2) Alleged victim California Certificate of Authority ~~Company~~ number

(3) Alleged victim self-insured or contracted third party license number, as appropriate

(4) Alleged victim address, city, state, and zip code

(d) Insurance policy or claim information, as appropriate

(1) Claim number associated with referral

(2) Insurance policy number associated with referral

(3) Date of loss or injury

(4) Geographic location where loss or injury occurred

(5) Insurance premium dollar loss

- (6) Total potential loss on claim prior to the identification of fraud
- (7) Total claim loss paid to date
- (8) Actual suspected fraudulent loss amount paid to date
- (9) The A complete summary synopsis of all the facts on which the reasonable belief of the insurance fraud is based, that has been prepared pursuant subdivision (a)(5) of Section 2698.36.

(A) The summary shall include the following information, if known:

- 1. The facts that caused the reporting party to believe insurance fraud occurred or may have occurred.
- 2. The suspected misrepresentations and who it was that allegedly made them.
- 3. How the alleged misrepresentations are material and how they affect the claim or insurance transaction.
- 4. Identification of pertinent witnesses to the alleged misrepresentation.
- 5. What documentation there is of the alleged misrepresentation.

(B) In addition, the summary prepared pursuant to this subdivision (d)(9) shall include a statement as to whether or not the investigation is complete.

- (10) Disaster claim indicator
- (e) Other agency referral information, as appropriate
  - (1) Names of other authorized governmental agencies receiving this referral
  - (2) Names of any District Attorney's Office receiving this referral
  - (3) National Insurance Crime Bureau (NICB) referral indicator
  - (4) The names of any other agencies receiving this referral
- (f) Referral contact information, as appropriate
  - (1) Referral contact name, title, and phone number
  - (2) Claim or case file handler and phone number

- (3) Name and phone number of person who completed referral
- (4) Date referral was completed (not required if submitted electronically)

(g) Information for each party associated with the referral

- (1) Name of party and identification of the role of the party to the loss
- (2) Phone number
- (3) Address, city, state, and zip code
- (4) Date of birth or age
- (5) Social security number
- (6) Tax identification number
- (7) Driver's license number
- (8) State of party's driver's license
- (9) Vehicle license plate number
- (10) Vehicle license plate state
- (11) Vehicle identification number
- (12) Other names or identifiers used by the party
- (13) Claim of injury indicator

NOTE: Authority cited: Sections 1872.4, 1874.2, 1875.24, 1877.3, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.39. Anti-Fraud Training.

Requirements for training provided by and for the SIU shall include:

- (a) The insurer shall establish and maintain an ongoing anti-fraud training program, planned and conducted to develop and improve the anti-fraud awareness skills of the integral anti-fraud personnel.

(b) The insurer shall designate an SIU staff person to be responsible for coordinating the ongoing anti-fraud training program.

(c) The anti-fraud training program shall consist of three (3) levels:

(1) All newly-hired employees shall receive an anti-fraud orientation within ninety (90) days of commencing assigned duties. The orientation shall provide information regarding:

- (A) the function and purpose of the SIU;
- (B) an overview of fraud detection and referral of suspected insurance fraud to the SIU for investigation;
- (C) a review of the Fraud Division's insurance fraud reporting requirements;
- (D) an organization chart depicting the insurer's SIU; and
- (E) SIU contact telephone numbers and email addresses.

(2) Integral anti-fraud personnel shall receive annual anti-fraud in-service training, which shall include:

- (A) review of the function and purpose of the SIU;
- (B) introduction/review of the written procedures established by the SIU regarding the identification, documentation, and referral of incidents of suspected fraud to the SIU;
- (C) identification and recognition of red flags or red flag events;
- (D) any changes to current procedures for identifying, documenting, and referring incidents of suspected insurance fraud to the SIU;
- (E) the Fraud Division's insurance fraud reporting requirements; and
- (F) introduction/review of existing and new, emerging insurance fraud trends.

(3) The SIU personnel shall receive at least five (5) hours of continuing anti-fraud training per calendar year. The training shall that includes; instruction in one or more of the following topics:

- (A) investigative techniques;
- (B) communication with the Fraud Division and authorized governmental agencies;

- (C) fraud indicators;
- (D) emerging fraud trends; ~~or~~
- (E) legal and related issues.

(d) The training requirements stated in subdivision (c) of this Section 2698.39 shall not apply to persons retained to provide an expert opinion on a medical, technical, or scientific topic on behalf of the insurer and who do not participate in the claims handling or decision making function of the insurer.

(e) Training, instruction, or courses that may be used in order to satisfy the requirement stated in subdivision (c)(3) of this section shall include, without limitation: anti-fraud conferences; SIU roundtables hosted by the Fraud Division; anti-fraud association meetings and trainings; and insurer in-house trainings.

~~(f)~~ Records of the anti-fraud training ~~provided to all staff~~ shall be prepared at the time training is provided and be maintained and available for inspection by the Department on request. The training records shall include:

- (1) the title and date of the anti-fraud training, instruction, or course;
- (2) the name, ~~and~~ title, and contact information of the instructor(s), to the extent applicable;
- (3) copies of the training, instruction, or course materials or, if the materials are unavailable, a description of the training, instruction, or course content;
- (4) the length of the training, instruction, or course; and
- (5) the name and job title(s) of participating personnel.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.40. SIU Annual Report.

(a) Each insurer shall file a report as prescribed herein, at the time its initial Certificate of Authority is issued, and annually thereafter. After the filing of the report at the time of the initial issuance of its Certificate of Authority, an insurer may satisfy the requirement stated in the preceding sentence by ensuring that each year the information required to be reported pursuant to this Section 2698.40 with respect to the performance of the insurer's SIU functions is reported

truthfully, accurately, and completely by another insurer in the insurer's holding company group (hereinafter a "primary reporting insurer"), which conducts the insurer's SIU operations on behalf of the insurer. The annual report shall be due no later than ninety (90) days after the date of mailing of the notification by the Department. The Department shall issue the notification in June of each year.

(b) A complete, accurate, and truthful annual report shall be submitted on a form as prescribed by the Department and shall include the following information.

(1) The insurer's California Certificate of Authority Number, the lines of insurance the insurer is currently writing in California, the insurer's contact information and, in the case of a primary reporting insurer, the names and California Certificate of Authority Numbers of the insurers serviced by the primary reporting insurer's SIU.~~The name(s), title(s) and contact information of the insurer's SIU personnel; or~~

(2) The name(s), title(s), and contact information of the insurer's SIU personnel working on California fraud investigations; or ~~the name of the organization and organizational contacts with whom the insurer has contracted for the maintenance of the SIU that~~ investigates suspected insurance fraud occurring in California, or for any function of that SIU thereof; and

(3) The names of personnel whose duties include communication with the Fraud Division on matters related to the reporting, investigation, and prosecution of suspected fraudulent claims or other suspected insurance fraud.

(4) A description of the insurer's methods and copies of written procedures used by the insurer or its contracted entities for detecting, investigating, and reporting suspected insurance fraud. The material that is required to be included pursuant to this subdivision (b)(4) shall include at least the following:

(A) A description of any written procedures or other methodologies used to identify claims, applications, or other transactions as following patterns or trends that may indicate possible insurance fraud;

(B) A description, by line of business, of insurance fraud patterns or trends and the procedures put in place to deter, and detect instances of, the identified patterns or trends; and

(C) A description of the insurer's processes and activities to ensure that all integral anti-fraud personnel are identifying instances of suspected insurance fraud and referring those instances to the SIU.

(5) A description of, and copies of, the insurer's plan, and the plans of any contracted entities, for initial and ~~ongoing~~ fraud education and training for integral anti-fraud personnel pursuant to this article, including identification of the topics covered, a

description of the process used in order to ensure the training is received, and proof that the training occurred~~these regulations.~~

(6) A written description or chart outlining the organizational arrangement of the insurer's SIU and integral anti-fraud personnel, including personnel of any contracted entities, who are responsible for the detection, investigation, and reporting of suspected insurance fraud that occurred in California.

(7) A description of how the SIU is adequately staffed to meet the requirements herein and the expertise of the staff. The description shall include:

(A) The total number of SIU staff employed by the insurer to investigate suspected insurance fraud occurring in California;

(B) An indication of whether (1) all of the staff members included in the number reported pursuant to subdivision (b)(7)(A) of this Section 2698.39 investigate only suspected insurance fraud occurring in California, or (2) some or all of those staff members also investigate suspected insurance fraud investigate suspected insurance fraud occurring in other states;

(C) Total hours of insurer employee time spent working on fraud investigations of suspected insurance fraud that occurred in California;

(D) In the event it is impracticable to report the total hours of insurer employee time spent working on fraud investigations of suspected insurance fraud that occurred in California pursuant to subdivision (b)(7)(C) of this section, the product resulting from the mathematical operation described in subdivision (b)(7)(D)3. of this section may instead be reported, together with a notation to the effect that the alternate method described, below, in this subdivision (b)(7)(D) was used in lieu of reporting the hours count called for in subdivision (b)(7)(C):

1. Divide the number of California claims or other transactions resulting in the SIU's opening an investigation, reported pursuant to subdivision (b)(8)(C) of this section, by the number of investigations opened nationwide by the insurer's SIU during the last calendar year;

2. Multiply the number of SIU staff employed by the insurer nationwide to investigate suspected insurance fraud by the quotient resulting from the operation described in subdivision (b)(7)(D)1. of this section;

3. Multiply the product resulting from the operation described in subdivision (b)(7)(D)2. of this section by 2080 hours.



(E) Total hours of contracted SIU personnel time spent working on fraud investigations related to the insurer's claims and, if applicable, other transactions, occurring in California; and

(F) A description of how the insurer measures the effectiveness of its SIU.

(8) For each reported company:

(A) The number of California claims processed by the insurer during the last calendar year; and

(B) ~~¶~~The number of claims or other transactions referred to the SIU during the last calendar year that involved suspected insurance fraud occurring in California; and

(C) The number of those referred claims or other transactions reported pursuant to subdivision (b)(8)(B), above, that resulted in the SIU's opening an investigation for each reported company, for the past calendar year.

(9) For each reported company, ~~¶~~the number of incidents of suspected insurance fraud reported to the Department and to district attorney offices in California, for each reported company, for the past during the last calendar year.

(10) A description of any significant, changes, and any significant anticipated changes, to the insurer's structure and operations that have impacted or will impact the insurer's SIU operation, as well as a description of the impact of any such significant changes or significant anticipated changes on the insurer's SIU operation.

(11) A listing of all lines of insurance the insurer issues in California, the number of active policies for each line of insurance, and a description of each product or program offered for each line of insurance.

(12) Insurers who enter into contracts for the purpose of compliance with these regulations shall for each such contract provide a complete copy of the fully executed, existing contract, including all attachments and addenda~~um~~, to the Department and shall specify the manner in which the contract is monitored. The material included pursuant to this subdivision (b)(12) shall include a listing of all entities so contracted with, a description of the services provided by each such entity, and a description of each entity's SIU.

(13) The number and type of civil actions initiated in California by each reported company alleging acts of insurance fraud during the preceding calendar year, the case name of each such action, the county in which it was filed, the court name and case number, and the Department of Insurance case number indicated on the letter sent to the insurer from the Fraud Division acknowledging receipt of the fraud referral.

(c) A statement signed under penalty of perjury pursuant to the laws of the state of California, must accompany all reports mentioned herein. This statement must be signed by an officer of the holder of or applicant for the Certificate of Authority who attests to the accuracy of the reported information and the signor's personal knowledge of the existence and proper maintenance of an SIU described in this report and these regulations.

(d) The insurer is to maintain a copy of the annual report that will be available for review during examinations as conducted pursuant to section 2698.41 of these regulations or as otherwise requested by the Department.

(e) For the purpose of these regulations, the name(s) of the insurer's personnel who will communicate with the Fraud Division shall not be made part of the public record and shall be released only pursuant to the provisions of Insurance Code ~~CIC~~ ~~§~~section 1873.1 applicable to information acquired pursuant to Article 3 of the Insurance Frauds Prevention Act.

NOTE: Authority cited: Sections 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.

Amend Section 2698.41. Examinations.

(a) The commissioner may conduct examinations of an insurer's SIU and related operations, including operations undertaken by entities under contract with the insurer, as deemed necessary to determine compliance with the requirements of this article.

(b) If the insurer is found to be in compliance, a final written report of examination will be provided to the insurer on completion of the examination. If an insurer is found to be in noncompliance, a draft written report of examination, including identification of violations of these applicable provisions of statute and regulation, and required corrective action, if any, will be provided to the insurer on completion of the examination.

(c) Corrective action and compliance plan.

(1) Notwithstanding any penalty imposed pursuant to the regulations, within thirty (30) days of receipt of a draft written report of examination identifying any violation(s) of these regulations or underlying statute, an insurer shall submit to the Department a plan demonstrating how the insurer will correct such violation(s) and achieve compliance. Such plan shall be subject to examination by the Department. If accepted by the Department, the plan shall be submitted as a supplement to any existing annual report and shall be accompanied by a statement of an officer of the insurer as otherwise required for annual reports. Failure to submit a corrective action and compliance plan pursuant to this subdivision (c)(1) or to comply with such plan when accepted by the Department shall be considered a violation of these regulations.

(2) Any insurer ~~that, submitting a written report pursuant to Subsection 2698.41 subdivision (c)(1) of this Section 2698.41, setting forth a~~ submits a corrective action and compliance plan may also submit ~~any of the following information to the Commissioner in conjunction with the plan report required by Subsection 2698.41(c)(1):~~

~~(A) any written materials~~ that may rebut any matters contained in the draft examination report.

(d) A final written report of examination will be provided to the insurer after review by the Department of the insurer's corrective action and compliance plan and any other written materials submitted in conjunction with the plan.

NOTE: Authority cited: Sections 730 et. seq., 1875.24, 1879.5 and 1879.6, Insurance Code; *Calfarm Ins. Co. v. Deukmejian* (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; and *Garris v. Carpenter* (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688. Reference: Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926, Insurance Code.