NEW YORK STATE
DEPARTMENT*of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

March 15, 2013

Dear Governor Cuomo, Majority Leader and President Pro Tem Skelos, Majority Coalition Leader Klein, and Speaker Silver:

On behalf of the Department of Financial Services, I hereby submit a copy of the report required by § 409(b) of the Financial Services Law on the activities of the Financial Frauds and Consumer Protection Division (FFCPD).

As prescribed by the Financial Services Law, in 2011 DFS began the work of integrating the Banking and Insurance Departments. Article 4 of the Financial Services Law provided for the creation of the FFCPD "to more thoroughly uncover, investigate and eliminate the myriad financial frauds that may be perpetrated in, and may involve the people of, New York state" by, among other things, consolidating the responsibilities of the Insurance Frauds Bureau and the Criminal Investigations Bureau that were administered, respectively, by the former Department of Insurance and Banking Department

This Report outlines in greater detail these and other initiatives of the FFCPD during 2012.

I am proud of what the FFCPD has accomplished this year and am confident it will continue to reflect the vision and goals that the Governor had when he proposed its creation. To that end:

- We have improved and will continue to improve our responsiveness to consumers.
- We have accomplished and will continue to accomplish necessary reforms in the financial sector.
- We will continue to investigate and strive to prevent fraud, misconduct and criminal activity in those areas of the banking, finance and insurance industries, as authorized by the Financial Services Law.
- We will continue to improve the efficiency and effectiveness of our operations.
- We will continue to work on handling and resolving consumer complaints expeditiously.

In sum, we will continue to strive to make the Financial Frauds & Consumer Protection Division as effective as possible in investigating and battling financial fraud and misconduct and protecting the interests of New York consumers.

Respectfully submitted,

Benjamin M. Lawsky

New York State Department of Financial Services Financial Frauds and Consumer Protection Report

Annual Report as required by § 409(b) of the Financial Services Law

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March 15, 2013

Benjamin M. Lawsky
Superintendent
New York State Department of Financial Services

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INTRODUCTION

In his 2011 State of the State address, Governor Cuomo announced his plan to introduce legislation, the Financial Services Law, to merge the New York State Insurance Department and the Banking Department into a single financial services regulator, the Department of Financial Services. The merger was proposed as a way to establish a single regulatory agency with broad oversight of the entire range of financial services that could also achieve , as well as to capitalize on efficiencies through government restructuring. To that end, the charge of DFS is to consolidate regulatory and non-regulatory functions and identify ways to become a more efficient and effective regulator. The Financial Services Law was introduced and passed as part of Governor Cuomo's 2011 budget. The merger became effective on October 3, 2011.

This report, required under § 409(b) of the Financial Services Law, summarizes the activities of the DFS in combating frauds against entities regulated under the banking and insurance laws, as well as frauds against consumers; the Department's handling of consumer complaints; and the Department's examination activities in the areas of consumer compliance, fair lending and the Community Reinvestment Act.*

Creation of the Division

The Financial Services Law created a new Financial Frauds and Consumer Protection Division (FFCPD) within DFS, which the statute provided "shall be a qualified agency, as defined in section eight hundred thirty-five of the executive law, to enforce the provisions of this article and article four of the insurance law and article II-B of the banking law." Fin. Serv. L. § 403(b).

One of Governor Cuomo's goals in merging the former Insurance and Banking Departments was to create an efficient state agency that seeks to promote business growth and enhance customer service while fighting fraud and providing necessary consumer protections. This goal is reflected in the mission of the FFCPD, which consolidated the consumer complaints, civil investigations, criminal investigations, and outreach units of both the former Banking and Insurance Departments, and which was empowered with new investigative and enforcement authority.

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* Financial Services Law § 409(b) provides:

> No later than March fifteenth of each year, beginning in two thousand twelve, the superintendent shall furnish to the governor, the speaker of the assembly and the temporary president of the senate a report describing the activities of the financial frauds and consumer protection unit. Such report shall describe (1) the unit's efforts with respect to (A) frauds against entities regulated under the banking and insurance laws; and (B) frauds against consumers; (2) the unit's activities to address consumer complaints; and (3) any recommendations of the superintendent with respect to changes of law that are desirable to address gaps in protection. The report may address such other matters relating to the activities of the financial frauds and consumer protection unit as the superintendent believes will be useful to the governor or the legislature.

Organization and Oversight

The FFCPD encompasses a Civil Investigation Unit (including a staff of attorneys investigating civil financial fraud, consumer law, banking law and insurance law violations, a unit conducting investigations of licensed insurance producers, and a staff of attorneys who bring disciplinary proceedings against insurance producers for violations of the insurance law), a Criminal Investigation Unit (composed of the bureaus handling banking criminal investigations and insurance frauds), a Consumer Assistance Unit (CAU), a Consumer Examinations Unit (which conducts fair lending, consumer compliance and Community Reinvestment Act examinations, and is responsible for the Banking Development District Program), and the Consumer Education and Outreach Unit.

The powers of the FFCPD are set forth in § 404 of the Financial Services Law. Paragraph (a) clarifies that the Superintendent is authorized to investigate activities that may constitute violations subject to §408 of the Financial Services Law, or violations of the Insurance Law or Banking Law. Under paragraph (b), if the FFCPD has a reasonable suspicion that a person or entity has engaged or is engaging in fraud or misconduct under the Banking Law, the Insurance Law, the Financial Services Law, or other laws that give the Superintendent investigatory or enforcement powers, then the Superintendent, in the enforcement of the relevant laws or regulations, can investigate or assist another entity with the power to do so.

A Note on DFS Storm Sandy Response and Regulatory Authority

On October 29, 2012, Storm Sandy made landfall in New York, bringing significant destruction to downstate New York. In the aftermath of the storm, DFS was called to marshal its resources to assist homeowners and business owners in getting timely and fair results on their insurance claims. FFCPD staff trained Department employees in insurance issues, and then deployed staff, seven days a week, to assist consumers across affected areas. FFCPD managed staff at permanent Disaster Assistance Centers, a mobile command center for daily events in affected areas, and an Insurance Response Unit consisting of teams deployed to homes and businesses to assist with complex insurance problems. Staff also assisted consumers at town hall and community events.

DFS processed a multitude of complaints and inquiries filed with the Department and received via the Department's emergency storm hotline. In the immediate aftermath of the storm, FFCPD staff from the Civil Investigations Unit and the Consumer Assistance Unit developed forms for gathering Sandy-specific information from consumers and used this to both resolve complaints quickly and keep real-time data of emerging consumer issues in the aftermath of the storm. This information was also used by the Department to develop emergency insurance regulations. On November 29, 2012 the Department issued an emergency regulation to speed up the claims process by requiring insurers to start claims investigation, including inspections, within six business days after receiving the report of a loss from a homeowner. This action was taken to speed the response of insurers to homeowners' storm losses. Also, because many claims remained unresolved for weeks and months, on November 26, 2013, insurers were limited in the time they could ask for extensions of deciding on a claim from 90 to 30 days, and were required to report to the Department on the number of, and reasons for, these extensions.

Throughout this report is additional information on DFS' comprehensive response to Storm Sandy, which will continue as New Yorkers recover and rebuild.

Civil Investigative and Enforcement Activities

The FFCPD Civil Investigation Unit includes a team of attorneys who, utilizing the investigative and enforcement powers granted by the Financial Services Law, investigate civil financial fraud, consumer law, banking law and insurance law violations. Some of the Unit's investigations, activities and initiatives in 2012 are discussed below.

Force-Placed Insurance

The Department launched an investigation of the force-placed insurance industry in the fall of 2011 after uncovering evidence of potentially problematic practices occurring at the expense of homeowners and investors in mortgage-backed securities. Specifically, the investigation is looking into whether homeowners and investors are harmed by high premium charges when banks and servicers "force-place" insurance on the properties they service. In a number of cases, the coverage is force-placed erroneously. Force-placed insurance is typically far more expensive than homeowners' coverage purchased by a homeowner, yet often provides less protection for the homeowner while protecting the lender's or investor's interest in the property. In 2011, the FFCPD issued document requests and subpoenas to mortgage servicers, insurers, and insurance producers as part of an ongoing investigation into force-placed insurance.

In May of 2012, the Department conducted public hearings concerning force-placed insurance and reviewed extensive evidence in the course of this investigation. Fifteen financial services companies were directed to provide written and oral testimony at the hearings and answer the Department's questions. The focus of the hearings was to probe the inner workings of the force-placed insurance industry and examine its impact on homeowners and investors.

In June 2012, the Department requested that all insurers currently writing force-placed insurance in New York propose, with justification, amended rates for force-placed insurance. Proposals have been received and are currently under review by the Department. The investigation is continuing.

No-Fault Insurance Fraud

DFS began a wide-ranging program to reduce consumer insurance costs by stopping deceptive doctors and shutting down medical mills that plague New York's no-fault insurance payment system. DFS issued Regulation 68-E, which enables DFS to de-authorize from the no-fault system those doctors who engage in fraudulent and deceptive practices. As part of an ongoing investigation, the Insurance Frauds Bureau sent letters to 135 medical providers suspected of possible fraud, requesting basic information that explained their no-fault billing practices. After following the procedures laid out in Insurance Law § 5109 and Regulation 68-E, the Superintendent scheduled hearings, conducted by the FFCPD, to determine whether the providers should be banned from the no-fault system. Hearings were held in October 2012 and more will be held as the investigation continues.

Mortgage Servicing Practices

In September 2011, Ocwen Financial Corporation was the first mortgage servicer to agree to the Department's landmark Mortgage Servicing Practices designed to correct robo-signing and other troubling foreclosure and servicing practices that were depriving homeowners of the opportunity to

avoid foreclosure. In December 2012, the Department required Ocwen to hire a monitor to ensure that the company complies with the agreement after an examination found indications of Ocwen violating the agreement. The examination revealed that that, in some instances, Ocwen failed to demonstrate that it had sent out required 90-day notices before commencing foreclosure proceedings or even that it had standing to bring the foreclosure actions. The exam also revealed gaps in Ocwen's servicing practices, including indications that in some instances it failed to provide the required single point of contact for borrowers; pursued foreclosure against borrowers seeking a loan modification; failed to conduct an independent review of denials of loan modifications; and failed to ensure that borrower and loan information was accurate and up-to-date.

Sandy-Related Investigations

DFS tracked and analyzed the myriad consumer complaints filed following Storm Sandy. In response to emerging trends, the Department opened investigations, including issuing subpoenas, into insurance companies to determine the companies' compliance with New York insurance claims practices laws and regulations. The investigations are ongoing.

Disciplinary Unit

In addition to the newly formed civil investigation team of attorneys, the Civil Investigations Unit also consists of disciplinary attorneys and examiners who oversee the activities of licensed individuals and entities who conduct insurance business in New York State. The goals of the Unit are to protect the public and ensure that licensees act in accordance with applicable insurance laws and Department regulations. There are currently more than 265,000 licensees in New York. Licensees include producers (agents and brokers), independent and public adjusters, reinsurance intermediaries, bail bond agents, viatical settlement brokers, and limited lines producers.

The Civil Investigations Unit monitors the insurance marketplace to determine if unlicensed activity is occurring and, if necessary, take steps to ensure that individuals or entities either achieve compliance or cease activities. The Unit reviews original and renewal licensing applications when irregularities are identified.

The Omnibus Crime Bill of 1994 disqualifies from employment in the insurance industry anyone convicted of a criminal felony involving dishonesty or a breach of trust. This ban, however, may be removed if approval for written consent to engage in the business of insurance pursuant to 18 U.S.C. §§1033 and 1034 is given by the Superintendent. The Civil Investigations Unit also reviews all such applications for written consent.

When a violation of the Insurance Law is proven, an administrative sanction may be imposed resulting in license revocation or suspension, the denial of pending applications, or monetary penalties imposed with corrective actions to address violations.

In 2012, the Department entered into approximately 222 stipulations imposing penalties on insurance companies or producers (i.e., agents or brokers). In addition, the Department held approximately 31 administrative hearings.

Stipulations in 2012

Type of Action	Total Requested	Total Completed	Fine Amount
Agent/ Broker	185	160	$836,537
Company	61	60	$13,374,500
Service Contact provider	2	2	$14,938
Total	248	222	$14,225,975

Hearings in 2012

	Total Requested	Total Hearings Held	Pending	Revocation	Monetary Penalty	Awaiting Final Order
Agent/Broker/ Applicant	44	31	13	8	1	11

THE CRIMINAL INVESTIGATIONS UNIT AND ENFORCEMENT ACTIVITIES

Under the merger creating DFS the Criminal Investigations Bureau of the Banking Department and the Insurance Frauds Bureau of the Insurance Department combined to form the Criminal Investigations Unit of FFCPD, although it retains some of the former organizational structure, as set forth below.

The Banking Criminal Investigations Bureau (CIB)

Highlights of 2012

- CIB conducted 63 investigations, which resulted in 12 convictions.
- 24 new cases were opened for investigation.
- The Mortgage Fraud Unit's investigations resulted in 21 arrests involving more than $27.5 million in losses to victimized homeowners and financial institutions.

Background

The Criminal Investigation Bureau of the former Banking Department was formed in 1992 with the passage of Chapter 321 of the Laws of 1992. The Financial Frauds Prevention Act of 1992 established a criminal investigations bureau within the Banking Department. The Act granted powers to the

Superintendent of Banks and, in turn, to CIB to investigate all possible violations of the New York Banking Law and certain enumerated misdemeanors and/or felonies of the New York Penal Code and to take appropriate action after such investigation.

CIB's areas of responsibility have grown in recent years. Since 2001, when the Superintendent of Banks began to issue anti-money laundering regulations to ensure compliance by licensees with applicable federal anti-money laundering laws and related regulations promulgated by the United States Department of the Treasury and the Office of Foreign Asset Control (OFAC), CIB has investigated violations of these laws and regulations. Similarly, as a result of the financial crisis, the New York Penal Code was amended in 2008 to address new crimes relating to residential mortgage fraud and CIB was granted authority to investigate possible violations relating to residential mortgage fraud activities. A Mortgage Fraud Unit (MFU) was created within CIB to provide investigative expertise to various federal, state, county and local investigative agencies. In 2009, the State legislature passed various measures relating to the licensure of mortgage loan originators who originate mortgage loans on residential real property and conformed state law to the federal law provisions of Title V of The Housing and Economic Recovery Act of 2008 (SAFE Act) and related regulations. CIB was delegated the responsibility to review applicants' criminal histories to assist the Mortgage Banking and Legal Divisions in their determinations of whether applicants meet the statutory requirements to be licensed or registered by DFS.

Operations and Activities

CIB conducts specialized investigations into criminal conduct involving the financial services industry and works cooperatively with law enforcement and regulatory agencies at the federal, state, county, and local levels. Among CIB's major focuses are the following areas:

Bank Secrecy Act and Anti-Money Laundering Investigations

CIB conducts criminal investigations into possible violations of the federal Bank Secrecy Act, federal and state anti-money laundering laws and related regulations, and possible violations of the federal OFAC laws and related regulations. Members of CIB have assisted federal, state and county prosecutors in numerous investigations relating to violations of both federal and state laws.

Investigations of Money Services Businesses

CIB works closely with numerous federal, state, county and local regulatory and law enforcement agencies to ensure compliance with federal and state statutes and related regulations pertaining to money services businesses, including licensed check cashers and money transmitters. CIB works closely with the New York/New Jersey High Intensity Crime Area and with the federal Financial Crimes Enforcement Network on matters designed to detect and eliminate the illegal transmission of money within New York State as well as to eliminate illegal money laundering. CIB also works closely with both federal and state tax officials to identify and prosecute individuals and companies for tax avoidance activities.

Mortgage Fraud Investigations Under CIB's Mortgage Frauds Unit (MFU)

CIB participates in numerous federal, state, county, and local mortgage fraud investigations. The Mortgage Frauds Unit (MFU) within CIB was created to combat mortgage fraud by providing investigative expertise and support to regulatory and law enforcement agencies. The MFU's three-fold mission is to investigate mortgage fraud cases throughout the State; to assist local, State and federal regulatory and law enforcement agencies in the investigation and prosecution of such cases; and to educate law enforcement and the financial sector in identifying, investigating and prosecuting mortgage fraud. The MFU is a member of several federal mortgage fraud task forces and its staff has provided expert testimony at trial and in grand jury proceedings. Since its inception in April 2007, the MFU has participated in investigations that have culminated in charges against more than 181 individuals and involved in excess of $396.5 million in losses to victimized homeowners and financial institutions. In 2012, mortgage fraud investigations resulted in 21 arrests in cases involving more than $27.5 million in losses to victimized homeowners and financial institutions. In 2012, cases that went to trial resulted in 12 convictions.

In furtherance of its mission, the MFU hosts a monthly Mortgage Fraud Working Group, created a Mortgage Fraud Training Course to train individuals in the investigation and prosecution of cases, and developed the Mortgage Fraud Forum to provide a platform for prosecutors across the state to explore trends and exchange ideas on methods to combat the epidemic of mortgage fraud.

Major Mortgage Fraud Investigations and Prosecutions During 2012

- **Takedown of Largest Fraud and Identity Theft Scheme in Nassau County History; 16 Guilty Pleas; Remaining Defendant Convicted:** After a two year multi-agency investigation in which the Criminal Investigations Unit provided substantial investigative assistance, the Nassau County District Attorney announced on March 17, 2011 that her office had filed four indictments charging seventeen individuals with more than 108 crimes for their roles in mortgage fraud and identity theft schemes that stole more than $20 million from homeowners, banks and the Nassau County government. The indictments represented the largest takedown of mortgage fraud in Nassau County history. Fourteen of the seventeen defendants were charged with Enterprise Corruption under the New York Organized Crime Control Act and related crimes, including grand larceny, scheme to defraud, and falsification of business records. Sixteen defendants entered guilty pleas. The remaining defendant was convicted on March 30, 2012 after trial and sentenced on June 19, 2012.
- **Guilty Plea of Former Schenectady Builder in $500,000 Mortgage Fraud-Related Theft:** Evidence developed during a joint-investigation conducted by CIB and the New York Attorney General's Office revealed that the builder already had several creditors at the time he sought to build two homes in Schenectady. Unable to obtain another line of credit, he enlisted the assistance of others to appear as borrowers on loan applications to Countrywide Home Loans. The loan applications indicated that the houses were to be the straw buyers' primary residences, however, the borrowers intended only to secure funding for the builder in exchange for payoffs of $5,000 each, not to reside in the houses. Though the builder used some of the loan money to build the houses, he also misappropriated some of the loan proceeds for personal purposes, such as paying the mortgage on his own home and repaying other debts he had incurred. The builder failed to complete construction of the homes and did not pay some of the subcontractors who had worked on the projects. The "straw buyers"

then defaulted on the loans and the lender sold the houses in short sales. The builder was charged with misappropriation of loan proceeds of $368,000 from Countrywide Home Loans. He was also charged with stealing from two private lenders who had agreed to loan him $75,000 and $60,000, respectively, during the same period he had engaged in the scheme to obtain the loan funds from Countrywide. As part of the plea bargain, he agreed to enter confessions of judgment in favor of the two lenders. The Criminal Investigations Bureau referred the matter to the Office of the Attorney General and assisted OAG in its investigation and prosecution of the case.

- **Owner of Tax Preparation Agency Arrested On 35-Count Indictment Charging Securities Fraud, Grand Larceny, Scheme to Defraud And Money Laundering:** On May 14, 2012, the arrest and unsealing of a 35-count indictment of Robert Van Zandt was announced. For decades, Robert Van Zandt was the owner and operator of the Van Zandt Agency, a well-known tax-preparation business in the Bronx. Starting in 2007, Van Zandt allegedly began accepting investments from tax preparation clients, who trusted him to manage their retirement funds and savings. In many cases, these investors handed over their entire life savings or retirement accounts to Van Zandt, only to see their money disappear. From at least February 2008 through January 2011, Van Zandt solicited money from unsuspecting clients, promising guaranteed rates of returns. Van Zandt's purported investment opportunities turned into a purely Ponzi-style scheme in approximately 2008. Van Zandt guaranteed high rates of return to new investors, promising to invest their money in lucrative securities and real estate projects. His clients' funds were not invested as promised, but rather were used to pay previous investors or diverted for personal expenditures. The scheme reaped over $4.6 million from February 2008 through January 2011 alone. The arrest of Van Zandt followed a joint investigation conducted by DFS and the New York State Office of the Attorney General. The Criminal Investigations Bureau provided substantial investigative support by analyzing the financial records that traced the proceeds of the fraud.
- **Arrests in Multi-Million Dollar Elder Abuse Scam:** On May 2, 2012, a lawyer based in Brooklyn and a woman who worked for him were arrested in an alleged scheme to steal an elderly woman's real property using false documents and fraudulent representations. The indictment alleged that the two defendants cultivated a relationship with the woman, who owned a residential apartment building in Harlem worth millions of dollars. The two defendants earned the woman's trust and persuaded her to sell the property to them for $3.1 million. Despite agreeing to buy the property for that amount, at the closing they presented the victim with multiple fake and fraudulent checks to make it appear as if they had paid the agreed upon price. They induced the victim to return all of the checks to them by representing that they would safeguard her money and give her a "private mortgage" on the property, however, they never recorded the private mortgage and subsequently submitted a fraudulent mortgage application to Washington Mutual Bank. They falsely represented to the bank that they had purchased the property and owned it "free and clear." Based on those and other fraudulent representations, the two defendants obtained a $1.8 million mortgage loan from the bank, which they failed to repay. This case was a joint investigation conducted with the New York Attorney General Office's Crime Proceeds Task Force and the United States Attorney's Office for the Southern District of New York. The Department funds the

OAG's Crime Proceeds Task Force and the Criminal Investigations Bureau provided substantial investigative resources to the investigation and subsequent prosecution.

- **Loan Officers Sentenced in Federal Court in Manhattan for Participating in a $9 Million Mortgage Fraud Scheme:** In August 2012, two loan officers were sentenced in federal court in Manhattan for their roles in a $9 million mortgage fraud scheme. The two loan officers and ten others defrauded various lending institutions by using fictitious and fraudulent "straw identities" to apply for mortgage loans. The two officers prepared and processed the fraudulent mortgage applications. Most of the loans quickly went into default. One was sentenced to two years of supervised release and ordered to forfeit $1,993,000. The other was sentenced to two years of supervised release and ordered to forfeit $2,554,000. The case was a joint investigation conducted with the New York Attorney General's Crime Proceeds Task Force and the United States Attorney's Office for the Southern District of New York. The Criminal Investigations Bureau provided substantial investigative resources to the investigation and subsequent prosecution.

- **Lawyer Sentenced in Manhattan Federal Court for Role in $9 Million Mortgage Fraud Scheme :** In October 2012, a real estate attorney was sentenced in federal court and ordered to forfeit $7.2 million. The lawyer and his co-conspirators defrauded various lending institutions by using fictitious and fraudulent "straw identities" to apply for mortgage loans. The lawyer acted as the lender's counsel on many of the fraudulent transactions, disbursed fraudulently obtained mortgage proceeds to co-conspirators, and lied to his clients about the fraudulent nature of the transactions. Most of the loans quickly went into default. The Criminal Investigations Bureau provided substantial investigative resources to the investigation, which was conducted jointly with the New York Attorney General's Crime Proceeds Task Force and the United States Attorney's Office for the Southern District of New York, and to the subsequent prosecution.

- **Defendants Charged with Conspiring to Violate Currency Reporting Laws:** In August 2012, after a joint investigation conducted by the United States Attorney's Office for the Southern District of New York, the Federal Bureau of Investigation and the CIB, the defendants were charged with conspiracy to defraud the United States and to evade currency reporting requirements through two check cashing establishments in Brooklyn. CIB provided investigative resources and industry expertise during the investigation.

- **Defendants Charged with Laundering Proceeds from Unlawful Activities:** After a joint investigation by the United States Attorney's Office for the Southern District of New York, the Federal Bureau of Investigation, the Drug Enforcement Agency, and the CIB, in which CIB provided investigative resources and industry expertise, defendants were charged in August with conspiracy to launder proceeds derived from narcotics trafficking.

- **Three Defendants Charged in 13-Count Indictment with Fraudulent Insurance Schemes Involving Over $100 Million *:*** A three year investigation stemming from the illegal activities by the former president of Park Avenue Bank lead to the indictment of three individuals. The October 2012 indictment alleges that (1) a Kentuch businessman, and co-consipator of the former bank president, engaged in a $53 million fraud on his clients and the IRS; (2) the businessman bribed two senior Park Avenue Bank officials to provide him and his businesses with illegal favors; (3) the businessman and a bank official engaged in a fraud on regulators and a publicly traded company; and (4) and the three men engaged in a $30

million fraud on the Oklahoma insurance regulator. The case is pending in federal court in the Southern District of New York. The CIB had referred an earlier case involving Park Avenue Bank to the U.S. Attorney's Office, which led to the discovery of the additional financial frauds contained in this indictment, for which CIB has also provided substantial investigative and analytical support to the prosecution.

CIB Support Activities for DFS Banking Regulatory Programs

ATM Program

The New York Banking Law authorizes DFS to enforce provisions of the ATM Safety Act (the "Act) as well as the security requirements set forth in New York City Local Law 70, which predated the Act. The primary purpose of the Act is to ensure the safety and convenience of ATM users by establishing minimum security measures at ATM locations. The ATM Inspection Unit within CIB ensures compliance with the Act by conducting inspections of bank-owned ATM facilities throughout the State and monitoring compliance submissions provided to DFS as required under the Act. The Superintendent has authority to assess fines for violations of the Act and to approve variances or exemptions of required security measures. The Act applies to all federal and state-chartered banking institutions, whether headquartered in or outside New York State, provided that the institution operates one or more ATMs within the State. As of year-end 2012, there were 5,065 ATMs under the ownership of a banking institution and, thus, subject to the security provisions of the Act.

On January 11, 2011, DFS adopted amendments to the Superintendent's Regulations relating to security measures that must be employed at ATM facilities. The amendments require that a banking institution file an annual report of compliance with the Superintendent certifying that the institution is in compliance with the Act. The amendments clarify the filing deadlines and require that the report be made under penalties of perjury. The amendments also require banking institutions found to be in violation of the required security measures to file with DFS a report attesting that corrective action has been taken to remediate the violation(s). This new reporting requirement facilitates the enforcement of the New York Banking Law, which provides that the Superintendent may, after due notice and a hearing, impose a civil penalty on a banking institution that fails to correct a violation of the Banking Law.

During 2012, the ATM Inspection Unit of CIB conducted 7,279 inspections. Of the 7,279 inspections, 1,418 resulted in the issuance of notices of violations.

Mortgage Loan Originator Licensing Support

CIB provides critical support to the Mortgage Banking Division's efforts to comply with the provisions of New York Banking Law Article 12-E. Article 12-E, which became effective July 11, 2009, establishes provisions to facilitate New York State's compliance with the federal SAFE Act. Under the SAFE Act, states were encouraged to increase uniformity, enhance consumer protection and reduce mortgage fraud through establishment of a national mortgage licensing system (NMLS). The NMLS, as established, is designed to provide minimum licensing standards and uniform applications for state-licensed mortgage loan originators, to provide a comprehensive licensing and supervisory database covering all 50 states, to enhance consumer protections and support anti-fraud measures, and to facilitate responsible individual behavior in the sub-prime mortgage marketplace.

One of the key tools in the SAFE Act is the requirement of a criminal background check of each mortgage loan originator applicant. During 2012, investigators within CIB reviewed 438 criminal history reports related to mortgage loan originator applications filed with the State.

Task Force/Working Group Participation

CIB is an active participant in numerous task forces and working groups designed to foster collaboration and cooperation among the many agencies involved in fighting financial fraud. Among the task force groups of which CIB is a member are the following:

- Crime Proceeds Strike Force
- FBI C-3 Mortgage Task Force
- FBI Bank Fraud Task Force
- HIFCA- El Dorado Task Force
- New York Identity Theft Task Force
- MAGLOGLEN
- New York State Mortgage Fraud Working Group
- National White Collar Crime Center
- New York External Fraud Committee
- Long Island External Fraud Committee

The Insurance Frauds Bureau (IFB)

Highlights of 2012

- Investigations conducted by Insurance Frauds Bureau staff resulted in 595 arrests during 2012.
- A total of 841 new cases were opened for investigation.
- By year-end 2012, prosecutors had obtained 382 convictions in cases involving the Insurance Frauds Bureau.
- Court-ordered restitution totaled $18 million as a result of Insurance Frauds Bureau criminal investigations.
- There were 195 arrests for health care fraud in 2012.
- The Bureau received 24,038 reports of suspected fraud during 2012, an increase of about 3% from 2011.
- The number of reports of suspected no-fault fraud totaled 13,944 at year-end 2012, accounting for 58% of all fraud reports received, versus 51 percent in 2011.

Background

Article 4 of the New York Insurance Law created the Insurance Frauds Bureau in 1981. The Insurance Frauds Bureau has a longstanding commitment to combating insurance fraud. That commitment has continued as the Bureau became part of the new FFCPD within the new DFS.

The Insurance Frauds Bureau is part of the FFCPD's Criminal Investigations Unit. It is responsible for the detection and investigation of insurance and financial fraud and the referral for prosecution of persons or groups that commit these frauds. The Bureau is headquartered in New York City, with six additional offices across the State in Mineola, Albany, Syracuse, Oneonta, Rochester and Buffalo.

The Bureau's specialized units are Major Case, Arson, General, Auto, Workers' Compensation, Medical, No-Fault, Mortgage and Title, and Upstate. The Bureau provides in-service training for its staff and conducts training for law enforcement, the insurance industry and community groups. The Bureau also has a unit of insurance examiners who are responsible for insurer compliance with Article 4 of the New York Insurance Law and Department Regulation 95. The examiner staff may also perform market conduct examinations of insurer Special Investigations Units.

Operations and Activities

Suspected Fraud Reports/Investigations

The Bureau received 24,038 reports of suspected fraud in 2012. The vast majority of those reports — 23,453 — were received from licensees required to submit such reports to the Department and 585 were received from other sources, such as consumers and anonymous tips. The Bureau opened 841 new cases for investigation during the past year. Tables showing the number of fraud reports received, investigations opened, and arrests by type of fraud appear in the Appendices.

During 2012, the Bureau referred 268 cases to prosecutorial agencies for criminal prosecution. Prosecutors obtained 382 convictions in Bureau cases.

The Bureau has a fraud hotline and consumers are encouraged to report suspected insurance fraud. Calls to the hotline averaged 26 per week in 2012.

Arrests

Insurance Frauds Bureau investigations led to 595 arrests for insurance fraud and related crimes during 2012. Some of the notable arrests are discussed in detail below.

Civil Enforcement, Restitution and Forfeitures

Section 403 of the New York Insurance Law authorizes the Department to levy civil penalties of up to $5,000 plus the amount of the claim on individuals who commit fraudulent insurance acts. Under § 2133 of the Insurance Law, the Department is also permitted to levy a civil fine of up to $1,000 for possession of a fraudulent automobile insurance identification card and up to $5,000 for each additional card possessed.

Insurance Frauds Bureau criminal investigations resulted in $18 million in court-ordered restitution in 2012.

Multi-Agency Investigations

The Bureau conducted numerous multi-agency investigations during 2012. The Bureau teamed up with the NYPD's Fraudulent Accident Investigation Squad and Auto Crime Division, as well as local law enforcement agencies throughout the State, in the investigation of many no-fault and other auto-related fraud cases. The Bureau's Arson Unit investigators collaborated with the Bureau of Alcohol, Tobacco, Firearms and Explosives, the FDNY's Bureau of Fire Investigations and the NYPD's Arson Explosion Squad.

The Bureau also collaborated with the Workers' Compensation Board's Office of the Fraud Inspector General and the State Insurance Fund to crack down on fraud in order to reduce workers' compensation premium rates for New York's businesses.

The Bureau collaborates with numerous other agencies in the investigation of all types of insurance fraud. Among these agencies are local District Attorney's Offices, the U.S. Attorney's Offices, the New York State Attorney General's Office, the New York State Department of Motor Vehicles, the U.S. Postal Inspection Service, and many task forces and working groups of which the Bureau is a member.

Cases in which the Bureau pooled resources with fraud-fighting partners are summarized below in this Report.

Task Force/Working Group Participation

The Insurance Frauds Bureau is an active participant in numerous task forces and working groups designed to foster cooperation among the many agencies involved in fighting insurance fraud. Participation provides the opportunity for joint investigations, information sharing, networking and honing of investigative skills. Among the groups in which Bureau staff participated during the past year are the following:

- Western New York Health Care Fraud Task Force
- Central New York Health Care Fraud Working Group
- Monroe County Auto Crime Task Force
- FBI/U.S. Attorney Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force
- New York Anti-Car Theft and Fraud Association
- National Insurance Crime Bureau Working Groups
- Motor Vehicle Theft and Insurance Fraud Prevention Board (DCJS)
- High Intensity Drug Trafficking Area (HIDTA)
- High Intensity Financial Crimes Area (HIFCA)

- New York State Banking Department Mortgage Fraud Working Group
- Medicare Fraud Strike Force
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)
- Suffolk County District Attorney's Office Insurance Crime Bureau

The Bureau is a member of both the Upstate and Downstate Offices of the Drug Enforcement Administration Tactical Diversion Task Force. A Bureau investigator is assigned full time to each office of the Task Force to work side-by-side with other members. An investigation conducted by Downstate Office Task Force members resulted in the arrest in May of 14 defendants charged with participating in the distribution of illegally diverted prescription drugs oxycodone and oxymorphone. Successful investigations conducted by the combined Upstate/Downstate Task Force in 2012 led to 70 arrests.

The Task Force investigates organized drug diversion schemes, "doctor shopping," and forgery of controlled-substance prescriptions. Several other investigations conducted by the Drug Enforcement Administration Task Force are summarized below.

Life Settlements

A life settlement is the sale of a life insurance policy to a third party — the life settlement provider. The owner of the life insurance policy sells the policy for an immediate cash benefit. The life settlement provider becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

The Life Settlement Act, signed into law in 2009, marks the first time the life settlement industry has been regulated in New York. It provides a comprehensive framework for the Department to regulate the life settlement business, including providing enhanced consumer protections. The law also amended the Penal Law to create new crimes of life settlement fraud and aggravated life settlement fraud. The Bureau collaborates with industry and law enforcement in the investigation and prevention of life settlement fraud.

Life settlement providers must submit Fraud Prevention Plans with their licensing applications. In 2012, the Department licensed 19 life settlement providers and approved their Fraud Prevention Plans. Life settlement providers are required by § 411(e) to submit an annual report by March 15 of each year describing the provider's experience, performance and cost effectiveness in implementing the Plan, on a form prescribed by the Superintendent.

The Department has licensed 26 life settlement providers since 2010. A complete list of licensed life settlement providers with approved Plans on file appears in the Appendices.

Year in Review

Major Cases

The Bureau conducted its own investigations and was involved in a number of multi-agency investigations during 2012. These operations contributed to the total number of arrests and convictions

and the amount of court-ordered restitution for the year. Some of the noteworthy cases are summarized below:

- Sixteen suspects were arrested in March for their roles in staging auto accidents to collect insurance payouts. They allegedly conspired to stage nine accidents in Brooklyn from September 2009 to May 2011. In some instances, one group of defendants drove or were passengers in U-Haul trucks they had rented, while another group of defendants hailed a livery cab, driven by an unsuspecting driver, into which the U-Haul driver would crash. In another type of staged accident, the defendants pretended to be pedestrians struck by other defendants or by vehicles driven by unsuspecting drivers. The defendants collected $400,000 in insurance payouts as a result of fraudulent claims submitted to insurers. Most of the defendants allegedly agreed to participate in the accidents in exchange for money up-front and the promise of a bodily injury lawsuit settlement after they were treated at a medical clinic. Some of the defendants eventually received money from lawsuit settlements. Charges brought against the suspects included insurance fraud and grand larceny. An investigation conducted by the Insurance Frauds Bureau, the New York Attorney General's Office and the NYPD led to the arrests. The Bureau brought this case to the AG's Office based on referrals received from insurers alleging staged accidents involving U-Haul rental trucks and livery cars. IFB investigators obtained insurance company files, conducted interviews and secured copies of rental agreements from U-Haul.
- A long-term no-fault fraud investigation resulted to the arrest of two defendants in March, bringing the total number of arrests thus far in the case to 68. The first defendant, along with another suspect previously arrested, falsely reported to officers responding to his 911 call that a vehicle had hit his car and left the scene. He subsequently sought medical treatment for nonexistent injuries for which Permanent General Assurance Company was billed more than $34,000. The second defendant, with others previously arrested, altered a Police Accident Report by adding his name as a passenger in a car that was involved in an accident. He applied for benefits under the no-fault portion of his auto insurance and was treated at a local medical facility for injuries purportedly received in the accident. Hartford Insurance Company was later billed in excess of $3,000. The Bureau's investigators conducted surveillance, obtained claims data, issued subpoenas and participated in an undercover operation.
- Two former insurance agents who pled guilty to swindling eleven elderly clients by changing beneficiary information on annuity contracts were sentenced in April to jail time and restitution. One defendant received 1-to-3 years in prison and the other received 30 days in jail and five years' probation. As an investment advisor, one defendant encouraged her elderly clients to take money from their investments and buy annuities on which she earned commissions then, without the knowledge of her clients, named the other defendant as beneficiary. Three of the eleven victims died, allowing the defendants to collect approximately $400,000 in death benefits. The remaining eight victims were told of the scheme and the insurers underwriting the annuities have removed the defendant as a beneficiary on the outstanding annuities. Had the fraud not been discovered, the defendants stood to collect approximately $2 million in additional death benefits. The women had been arrested in December 2011.

- A Suffolk County contractor applied for and was issued a workers' compensation insurance policy by the State Insurance Fund. On the application he reported that his company had a payroll of $10,000 and no employees except for himself as a part-time worker. An audit of another State Fund policyholder, however, revealed a payment of $190,350 to the contracting business. In addition, sign-in documents at a Long Island business at which the contractor had done roofing work contained signatures of three workers from the contractor's company on one occasion and "a crew" on another occasion. As a result of the fraud, the contractor was arrested for avoiding payment of $37,753 in premiums owed to the State Fund. The Insurance Frauds Bureau and the State Fund jointly conducted the investigation that led to the arrest.
- A Saratoga Springs insurance broker was sentenced in October to six months in jail followed by five years' probation and ordered to pay $127,560 in restitution. In August, he pled guilty to grand larceny and attempted grand larceny. As part of his plea, he admitted that from February 2008 to June 2011, he schemed to defraud HealthyNY, a state-sponsored program created to provide low-cost health insurance for small businesses that cannot afford traditional health plans, and MVP Health Care of Schenectady. The broker earned commissions by falsely reporting that certain businesses were qualified to obtain the HealthyNY benefits. He told the businesses that, in order to obtain the coverage, they would have to join his National Business Owner's Association for which he charged them a membership fee. At the time of his sentencing, he paid $100,000 of the total restitution, all but $5,700 of which will used to reimburse the eight businesses for the fees they paid for membership in the bogus association. The remainder will be paid to the State for fraudulent claims that were paid out. He also agreed to surrender his insurance broker's license and not engage in any insurance business during his probation. During the probation, he must make monthly payments on the nearly $28,000 he will still owe the State. The Insurance Frauds Bureau was the lead agency in the investigation that led to the arrest.
- A Manhattan podiatrist was sentenced in November to one year in prison and was ordered to pay an unspecified amount in restitution to CIGNA Insurance Company. From 2008 to 2010, he filed hundreds of claims for treatments that he never provided and used patient information of at least five individuals to submit claims to CIGNA. In two instances, he accepted payment for claims he filed on behalf of patients, one of whom was in Europe and the other at Disney World when the treatments purportedly took place. In another instance, he contacted a CIGNA member and asked her to report that she had received treatment when she had not. CIGNA paid a total of $100,671 on the fraudulent claims. He was arrested in February 2011 as a result of the investigation conducted by the Insurance Frauds Bureau and subsequently pled guilty to grand larceny.
- A former Newburgh City Police Officer was sentenced in February to 1-to-3 years in prison and ordered to pay $13,000 in restitution to State Farm Insurance Company. After an eight-day trial in November 2011, he was convicted of insurance fraud and falsifying business records. The charges stemmed from his filing of an auto insurance claim in which he fraudulently reported that damage to his vehicle was caused by his hitting a deer while he was driving off-duty in October 2009. As part of the prosecution, Douglass's friend, a tow-truck operator who aided him in filing the false claim, was convicted of falsely testifying before the Ulster County Grand Jury as to the circumstances of the accident.

- An upstate licensed practical nurse (LPN) reported a back injury while employed at a local hospital and began collecting workers' compensation benefits. During the benefit period she submitted documentation to her insurer stating that her injury left her unable to work. An investigation by the Insurance Frauds Bureau, the Workers' Compensation Board's Office of the Fraud Inspector General and the Syracuse Police Department uncovered evidence that from 2006 to 2010, during the benefit period, she was employed as an LPN at two other medical facilities in the Central New York area and had collected $58,144 in benefits to which she was not entitled. She was arrested in February on charges of insurance fraud, falsifying business records and violation of the Workers' Compensation Law.
- Following a job-related injury in 1993, a Queens man began collecting workers' compensation benefits. During the benefit period, he reported to the State Insurance Fund that he was not working. He was arrested in February after an investigation by the Insurance Frauds Bureau and the State Fund revealed that he had been working as a custodian/handyman at a Yeshiva in Brooklyn since 2000 and had fraudulently collected $80,287 in benefits.
- A former licensed insurance broker, who was president and owner of two brokerages in Queens, was sentenced in March to five years of probation and ordered to pay $60,000 in restitution. She was arrested in 2010 for failing to remit $606,770 in premium payments that she had received from more than 400 clients between January and December 2009 and pled guilty to grand larceny in November 2011. Her actions defrauded four insurance companies — Maya Assurance, American Transit, Hereford and Fiduciary Insurance Company of America — of premiums owed. In addition, she submitted 43 checks totaling $121,750 to two of the insurers in an attempt to conceal the crime, however, the checks were returned because of insufficient funds.
- In March 2012, the Insurance Frauds Bureau initiated an investigation involving Medicaid fraud. Records showed that in February 2012, the suspect had telephoned a pharmacy stating that she was a doctor and requested a prescription for Tramadol, a common pain medication. The suspect subsequently picked up the prescription and paid for it with her Medicaid card. The pharmacist later called the doctor whose name the suspect had used in ordering the prescription for additional information for the Medicaid claim. The doctor informed him that she had not authorized a prescription for the suspect and in fact had never provided any medical care to her. The pharmacist reported the incident to the Rochester Police Department. Investigators contacted the Office of the Medicaid Inspector General for a listing of all paid prescriptions for the suspect. The listing showed a pattern of prescriptions for Tramadol and Percocet purportedly authorized by two doctors, both of whom provided statements that they had not prescribed any medications for the suspect. The pharmacist was able to identify the suspect from photos and she was called in for an interview. When questioned, she admitted misrepresenting herself as the two doctors to order several prescriptions during the prior year and using her Medicaid card to pay for them. She was arrested and charged with criminal impersonation as a result of the Bureau's investigation.
- A Monroe County resident reported to Liberty Mutual Insurance Company that his 2011 Mustang had been stolen, and that he had subsequently recovered it and was then involved in an accident. He filed a $10,639 claim for the loss. An investigation by the Insurance Frauds Bureau, the Rochester and Webster Police Departments and the Monroe County District

Attorney's Office as members of the Monroe County Auto Crime Task Force revealed that the man had lent his car out to repay a drug debt and the person to whom he had lent it had been driving at the time of the accident. When interviewed, the suspect admitted that he had falsely reported that the car had been stolen and fabricated the rest of the story to collect the insurance proceeds.

- An investigation by the Insurance Frauds Bureau and the U.S. Attorney's Office resulted in the April arrest of a defendant who was charged with mail and wire fraud for allegedly submitting 14 forged Variable Annuity Surrender Request forms in the name of his deceased grandmother in order to withdraw $37,175 from her annuity account. He had the money electronically transferred to his Internet bank account from which he could easily make withdrawals. During the investigation, the defendant admitted that he committed the fraud to pay for his drug habit.
- Two individuals were sentenced in May for participating in a scheme involving falsely reporting motor vehicle accidents, and were sentenced to 51 months and 21 months, respectively, in federal prison and ordered to pay $84,868 in restitution. From 2006 through May 2011, they filed claims for fictitious motor vehicle accidents to obtain compensation for damaged vehicles. The claims all essentially claimed that a commercial truck sideswiped an SUV, causing damage to the driver's side of the vehicle. The scheme included setting up numerous mail boxes and phone numbers, creating phony invoices from nonexistent auto repair shops, and submitting at least 83 claims totaling $168,531 to at least 22 different trucking companies. Thirty-five of the claims totaling $84,868 were paid. The claim checks were mailed to at least 34 commercial mail boxes in 15 states. An investigation by the Insurance Frauds Bureau, the U.S. Postal Inspection Service and the National Insurance Crime Bureau led to the individuals' arrests and guilty pleas in 2011.
- Several investigations by the Upstate Office of the Drug Enforcement Administration Tactical Diversion Task Force, of which the Insurance Frauds Bureau is a member, resulted in the arrests of 14 suspects in early May 2012. The charges included criminal possession of a controlled substance, criminal sale of a controlled substance and criminal possession of a forged instrument. The Bureau worked closely with the other members of the Task Force in the investigations that led to the arrests.
- An investigation by the Insurance Frauds Bureau and the Manhattan District Attorney's Office resulted in the May arrest of three suspects for allegedly submitting hundreds of fraudulent claims for mental health treatments they never received. Two of the defendants were policyholders of a mental health insurer — OptumHealth Behavioral Solutions (OHBS) — that requires claimants who receive treatment from out-of-network providers to pay for those treatments and then file claims with OHBS for reimbursement. From June 2009 to September 2011, the initial defendant, a practicing psychiatrist, filed 206 claims for treatments she never received. She also filed 19 claims for legitimate treatments but inflated the amounts she paid to her doctors. She was reimbursed a total of $32,428 for the fraudulent and inflated claims. The second defendant was accused of submitting more than 1,000 claims to OHBS from July 2010 to November 2011 seeking reimbursement for $257,000 in mental health services purportedly provided to her and her family by a doctor in Brooklyn. Investigators learned that this defendant allegedly fabricated both the services and the doctor. OHBS paid out more than $114,000 on the fraudulent claims. In November, she

pled guilty to grand larceny and was sentenced to 3-to-6 years in prison. From 2006 to 2011, the third defendant filed more than 1,700 claims with her employer for mental health treatments she never received and 38 claims in which she inflated the amounts paid to her doctor for treatments she did receive. She was paid $353,958 on the false and inflated claims. Moreover, she tried to steal an additional $33,000 by submitting several claims multiple times. Her employer fully funds its own employee health plan and was, therefore, liable for the financial loss.

- An investigation by the Drug Enforcement Administration Tactical Diversion Task Force led to the arrest in May of 14 defendants involved in the distribution of illegally diverted prescription drugs on charges of conspiracy to violate the narcotics laws of the United States and distribution and possession with intent to distribute oxycodone and oxymorphone. From April 2011 through at least May 2012, the defendants worked together to sell tens of thousands of pills in Upper Manhattan. During the execution of search warrants at five locations in the Bronx and Upper Manhattan, approximately 9,000 of the prescription pills, $24,000 in cash, and hundreds of bottles of HIV medications were recovered. The ongoing investigation is being conducted jointly by members of the Downstate Office of the Task Force, including the DEA, the U.S. Attorney for the Southern District of New York, the NYPD and the Insurance Frauds Bureau. The Bureau's investigator assigned to the Downstate Office of the DEA participated in search warrants and conducted numerous surveillances and interviews.

- The suspect in this case reported to Mid-State Mutual Insurance Company on Christmas 2011 that she had received a call from the fire department stating that her home had been destroyed by fire the day before. The suspect reported that she was at her daughter's home in Hornell, New York at the time of the fire. She subsequently filed a $136,000 claim for the loss and included documents purportedly signed by an acquaintance stating that the suspect had paid him rent so she could stay at his home following the fire. In February, the State Police requested the assistance of the Insurance Frauds Bureau in their investigation into the fire. The suspect stated that she did not know how the fire started but admitted to forging the name of her acquaintance on documents submitted to her insurer. In May, the suspect voluntarily surrendered to the State Police and admitted that she had set the fire after removing personal items. She was charged with insurance fraud, forgery and arson.

- The former owner of an Albany pub was sentenced in June to 1½ to 3½ years in state prison following his arson conviction for deliberately setting a fire at the pub in 2011. He was also ordered to pay $11,296 in restitution to Alterra Insurance Company. An investigation by the Insurance Frauds Bureau, the Albany Police Department and the New York State Office of Fire Prevention and Control revealed that the pub owner and another person were seen removing multiple items from the property the night before the fire. On the night of the fire, he was the only person in the pub, which had closed for the night. He reported that a grease fire started in the kitchen, but the investigation exposed multiple points of origin in the kitchen area where accelerants were detected and the fire was deemed incendiary. The pub was insured for $900,000 through Alterra.

- An investigation conducted by the Insurance Frauds Bureau resulted in the arrest in June of an upstate man on charges of insurance fraud and grand larceny for his role in a homeowners insurance fraud scheme. He was accused of filing four fraudulent claims with Allstate

Insurance Company for water, sewage and roof damage to his home. Allstate paid $19,130 on the claims.

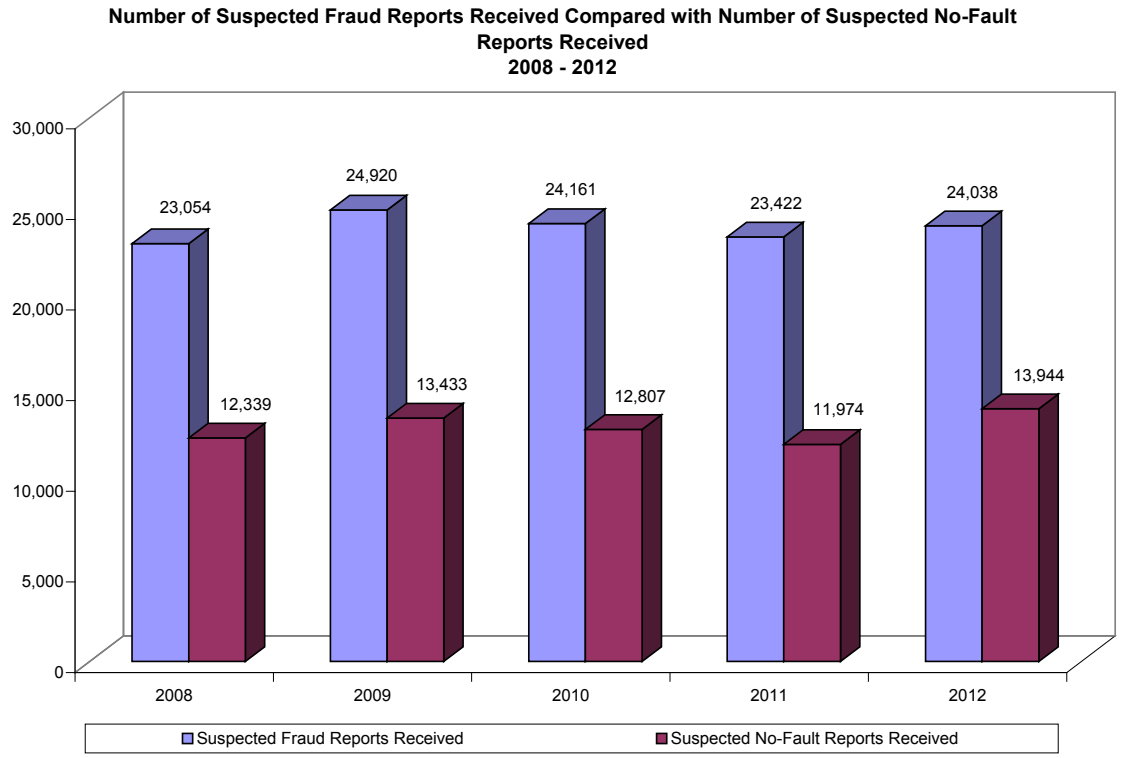
- A Manhattan man reported to Allstate Insurance Company and the NYPD in September 2011 that his 2005 Land Rover had been stolen. He filed a claim for the loss and received a check for $24,124 from Allstate. During an investigation by the Insurance Frauds Bureau and the NYPD's Auto Crime Division, documents obtained from the insurer revealed that the suspect had had the vehicle towed to a storage location because the engine had seized and could not be driven. He was arrested in June and charged with insurance fraud.
- Three individuals and a check-cashing business were charged in June for their alleged roles in a money-laundering scheme that violated the Bank Secrecy Act. According to the indictment, a check-cashing store in Flushing, its owner, and two other persons were charged with using the store to file false currency transactions reports (CTRs). The store's owner allegedly caused the business to fail to have an effective anti-money laundering program. He also was charged with conspiring to commit tax violations with respect to the fees the store received in connection with the scheme. As part of the scheme, which lasted from June 2009 through June 2011, the other defendants cashed checks at the store. The checks were written on accounts of shell corporations that appeared to be health-care related but which in fact did no legitimate business. The indictment alleges that the employees accepted the checks and provided cash to the defendants but never obtained identification documents or information. The store allegedly filed CTRs that falsely stated the checks were cashed by foreign nationals who set up the shell corporations. The two defendants cashed checks totaling more than $19 million during the course of the scheme. Approximately $32 million has been seized from the store's bank accounts. In addition to the Insurance Frauds Bureau, the the U.S. Justice Department; U.S. Attorney for the Eastern District of New York; the U.S. Immigration and Custom Enforcement; the FBI; IRS Criminal Investigation; and the U.S. Department of Health and Human Services collaborated in the investigation that led to the arrests.
- Thirty-three defendants were indicted in July following an investigation of a criminal enterprise that stole and sold motorcycles in New York City to local and international dealers, and trafficked in illegal firearms in the underground market. Twenty-eight defendants were charged with enterprise corruption under New York State's Organized Crime Control Act for their roles in the theft and resale of 63 motorcycles with an estimated value of close to $500,000, and the possession and sale of 15 firearms. The indictments are the result of an investigation that used a variety of law enforcement techniques, including undercover purchases by NYPD undercover officers, visual surveillance and court-ordered electronic eavesdropping. The investigation was conducted jointly by the Manhattan District Attorney's Office, the Joint Firearms Task Force comprising the NYPD, the Bureau of Alcohol, Tobacco, Firearms and Explosives, the Insurance Frauds Bureau, the New York Anti-Car Theft and Fraud Association and the Lojack Corporation.
- An upstate resident filed a claim with Farmers Insurance Company for damage to his 2002 Cadillac and was issued a check for the repairs. The man was arrested in July after an investigation conducted by the Insurance Frauds Bureau and the Town of Geddes Police Department revealed that the man had subsequently filed claims with Safeco Insurance Company in which he reported the same damage for which he had been reimbursed by Farmers and fraudulently collected $16,310 in insurance payments from Safeco.

- A long-term investigation conducted by the Insurance Frauds Bureau, the State Police Auto Theft Unit and the Westchester County District Attorney's Office resulted in the July arrest of the owner of a "target" auto body shop in Bedford. Investigators placed a sting vehicle in the defendant's shop for repairs. Evidence uncovered during the investigation indicated that the damage to the vehicle was enhanced by $10,000. The defendant was charged with grand larceny.
- A commercial property management company paid more than $648,000 in insurance premiums to the former president of a Long Island insurance agency, however, a joint investigation by the Insurance Frauds Bureau and the Nassau County District Attorney's Office uncovered evidence that the agency failed to remit the money to any insurer, leaving the management company without coverage and facing potentially serious liability issues. The former agent allegedly spent the money on country club memberships, luxury cars and gambling trips. He was arrested in August and charged with grand larceny and scheme to defraud.
- An investigation by the Insurance Frauds Bureau led to the arrest in October of a Queens man who applied for and was issued a workers' compensation policy by the State Insurance Fund. Investigators found evidence that the defendant had knowingly submitted materially false information in support of the application. As a result, he was charged with defrauding the State Fund of $50,000 in premiums.
- A woman supplied documents to the State Insurance Fund that she allegedly knew were false. An investigation by the Insurance Frauds Bureau, the State Insurance Fund and the Queens DA's Office revealed that she had lied about her contracting company sales figures, as well of the number of employees on her payroll. As a result, she avoided paying the Fund $114,127 in premiums. She was arrested in October and charged with grand larceny, insurance fraud and violation of the Workers' Compensation Law.
- Following an auto accident, the defendant began collecting lost-wage benefits. Beginning in May 2010 through mid-September 2011, he submitted 11 prescriptions for pain medication purportedly prescribed by his doctor. An investigation by the Insurance Frauds Bureau, the Niagara County District Attorney's Office and the Lockport Police Department revealed that the defendant was working while fraudulently collecting the benefits and had submitted forged or altered prescriptions and documentation stating that he was unable to work. State Farm paid him $13,700 in lost-wage benefits and $1,245 in prescription drug payments to which he was not entitled. The Bureau was the lead investigator in the investigation that resulted in the defendant's arrest in June on charges of grand larceny, insurance fraud, and criminal possession of a forged instrument.
- The Insurance Frauds Bureau worked closely with the FBI and the IRS in an investigation that led to the August arrest of an upstate resident who pled guilty to health care fraud and mail fraud. Her plea is part of an ongoing investigation into a staged-accident scheme involving a U-Haul truck in Utica. She was sentenced in February to 27 months in prison and ordered to pay more than $1.4 million in restitution to Progressive and Mutual of Omaha Insurance Companies.
- In October, the FBI New York Health Care Fraud Task Force, of which the Insurance Frauds Bureau is a member, was part of a takedown conducted by a nationwide strike force that

resulted in charges against 92 suspects in schemes to defraud the Medicare and Medicaid programs of $432 million. Of those arrested, 15 were suspects in three New York Task Force cases. In one New York case, nine people, including the manager and medical director of a medical facility in Brooklyn, were charged with conspiring to defraud the Medicare and Medicaid programs of more than $13 million by submitting fraudulent claims for physical therapy that was not provided or was medically unnecessary. In another case, four licensed chiropractors allegedly failed to provide chiropractic services to patients residing in assisted-living facilities, yet billed Medicare for $6.4 million. In a third case, the office manager of a Queens medical clinic and the owner of an ambulette service received $3 million from Medicare after claiming to provide physical therapy and diagnostic tests to patients who were paid cash kickbacks to use the defendants' medical and ambulette services. Charges brought against the suspects included health care fraud, wire fraud, violations of the kickback statutes, and money laundering. The Bureau played a major role in the cases by participating in search warrants, conducting interviews with claimants, witnesses and medical providers, and analyzing numerous bank records and insurance claim files.

No-Fault Fraud

The number of suspected no-fault fraud reports received by the Bureau increased by 16% from 2011 to 2012. Suspected no-fault fraud reports accounted for 58% of all fraud reports received by the Bureau in 2012, versus 51% in 2011.



Combating no-fault fraud is one of the Department's highest priorities. In early March 2012, Governor Cuomo announced a statewide initiative to stop deceptive health care providers and shut down medical

mills that plague New York's no-fault payment system and cost New Yorkers hundreds of millions of dollars in insurance costs.

DFS has carried out the initiative in three phases, with each phase consisting of a particular group of providers.

DFS will continue to utilize the procedures contained in § 5109 and Regulation 68-E to de-authorize providers who engage in unlawful conduct. Toward that end, each provider who violates § 5109 will be subject to a Departmental hearing to determine whether or not the provider should be barred from the no-fault system.

Mobile Command Center (MCC)

The Insurance Frauds Bureau oversees the deployment and operations of the MCC, a state-of-the-art vehicle equipped with the latest in computer and communications technology, including broadband and broadcast satellite, as well as police and ham radio communications.

Since early November, Department staff has traveled with the MCC to 70 sites throughout the State to meet with homeowners, renters and business owners to offer help with insurance-related issues stemming from damage caused by Storm Sandy. The storm hit New York on October 29, causing major flooding and extensive power outages, especially in coastal areas of New York City and Long Island. The Department assisted consumers in contacting their insurers if they had been unable to do so and answering insurance coverage questions. This deployment will continue as community needs warrant these visits.

In the wake of the storm, the Department activated Disaster Assistance Centers in locations hard-hit by flooding and staffed its Disaster Hotline to provide additional assistance to those consumers who were unable to travel to the MCC or the Disaster Assistance Centers. This Disaster Assistance initiative has continued into 2013.

The Bureau is currently reviewing fraud referrals which have been received as a result of Storm Sandy claims. These referrals involve auto, homeowners and other property claims related to the storm. The referrals are being reviewed and evaluated for further investigation. Those that are determined to be fraudulent will be thoroughly investigated to ensure that New York's homeowners, renters and business owners are not further victimized as a result of Storm Sandy.

Web-Based Case Management System

Insurers are required by § 405 of the Insurance Law to report suspected fraud to the Department. The Department's Web-based Case Management System, known as FCMS, allows insurers to submit reports of suspected fraud electronically. The system has been fully operational since the first quarter of 2007. In 2012, approximately 95% of the 24,038 fraud reports received by the Bureau were transmitted electronically and received remotely from insurers. Insurers have access to FCMS through the Department's portal using secure accounts.

The benefits of FCMS to insurers include automatic acknowledgment of receipt of fraud reports, and automatic notification of case assignments and eventual case disposition. Insurers also benefit from on-

line help screens and an on-line manual of operations, as well as search and cross-reference features. Department staff members regularly monitor the system and make improvements and changes as necessary.

THE CONSUMER ASSISTANCE UNIT (CAU)

As of October 3, 2011, the former Banking Department's Consumer Help Unit merged with the Insurance Department's Consumer Services Bureau to form the Consumer Assistance Unit of the Financial Frauds and Consumer Protection Division.

The Department's new complaint system, the New York Complaint Information System (NYCIS), was developed on a platform that allows improved electronic processing to minimize paper handling for complaint in-take and closure and allow companies to access the system and provide responses and documentation in real time. NYCIS is designed to save resources and ensure that documentation does not get lost or misfiled. It was expanded to increase efficiency and contain information for all complaints under the authority of the DFS, including insurance, banking, regulatory bureau review (Health, Property, and Life), as well as civil investigation files. Files will be easily moved and shared among the various units as necessary, which is particularly important because the Division has staff in several cities and physical locations. A system-wide full-text search tool was released in 2012. This function enhances consumer protection efforts by allowing staff to more easily identify potential problems and trends, as well as assist in large scale investigations when collecting documents and reviewing past complaints.

Among the improvements already implemented or currently in the process of being implemented are the following:

- **Complaint Resolution:** The Consumer Assistance Unit is focused on providing a hands-on approach to consumer issues through informal mediation and negotiation. When possible, CAU attempts to resolve issues that extend beyond strict violations of law to the satisfaction of all parties. The merger has also created opportunities to coordinate investigations where there are overlapping issues involving insurance and banking institutions.
- **Consolidation of Banking Complaint System into NYCIS:** The Department successfully migrated the AS 400 CAU banking complaint system into the more functional and advanced NYCIS system, which had already been is use by the former Insurance CAU. As discussed above, the system allows for enhanced automation of workflow, on-line complaint submission ability and tracking of complaints to enable FFCPD to identify trends and enhance the Division's enforcement efforts.
- **Complaint Triage:** Improvement of processes for triaging complaints and reevaluation of staff assignments have enabled CAU to route complaints more quickly and use resources and staff more efficiently depending on the level of complexity of the issues.
- **Consolidated Call Center:** DFS integrated its call center function with that of the Department of Tax and Finance (DTF). DTF operates a class leader call center that utilizes sophisticated computer software to provide superior customer service. DFS staff trained the

call center staff on insurance and banking issues and routinely provides updates and new information. CAU monitors call statistics and regularly updates the DFS web site with current FAQs so consumers can easily self-serve if desired. The call center partnership has been very successful. The consolidated call center began on January 27, 2012 and operates under a shared agency Memorandum of Understanding (MOU).

- The Call Center generally operates Monday through Friday during business hours, with extended hours as necessary during disasters such as Storm Sandy in the fall of 2012, when, at its peak, the Call Center was open 24 hours a day, seven days a week. Call Center customer service representatives handle phone calls and register electronically submitted complaints about insurance companies and financial institutions supervised by the Department, and field insurance and banking-related inquiries.
- **Consumer Assistance on "Gap" Products:** The FSL gave the FFCPD authority to handle additional "gap" complaints involving unregulated financial products and service providers, such as debt collectors, internet payday loans (illegal in New York), prepaid debit cards, financial products offered by retailers, student loans, and debt settlement complaints, among others. CAU is effectively working on training staff to handle such gap complaints, and is developing new procedures to ensure that these new complaints are processed and mediated expeditiously. FFCPD has hired and will be recruiting and training additional DFS Consumer Representatives to work on these complaints. Capacity to handle gap complaints will increase with the hire of new consumer representatives.

Operations and Activities

Insurance

CAU representatives respond to e-mails and correspondence from insurance consumers and licensees, and respond to e-mails and electronically submitted complaints from consumers needing immediate assistance, and more traditional correspondence via fax and U.S. mail.

The CAU also provides consumer information (via "News Releases" and other website postings on the Department's website.

In addition, the CAU handles complaints from consumers who visit the New York City office in person, and from other government agencies and public officials.

Non-Mortgage Related and Traditional Banking Products

CAU ensures that banks and other financial institutions chartered or licensed by DFS are in compliance with applicable laws and regulations in providing banking and other financial services, that consumers of those services are protected, and that financial institutions are practicing due diligence. To fulfill that mission, members of the examiner staff with the assistance of CAU representatives act as intermediaries between consumers and banks to resolve complaints and answer inquiries. Banking CAU's goals are to monitor bank activities that impact the general public; to receive and resolve complaints against supervised institutions; and to offer banking and financial information and education to the public.

CAU staff responsibilities include handling consumer complaints against financial institutions under the supervision of DFS, disseminating information and responding to consumer inquiries, and mediating and

resolving disputes that consumers would otherwise be unable to resolve on their own. CAU also acts as industry watchdog, promoting industry accountability by working closely with financial institutions to investigate and help correct patterns of consumer abuse and fraud.

Complaints and Inquiries

Complaints

Insurance

The CAU received 37,273 insurance complaints in 2012. The Unit processed 24,936 insurance complaints, and handled 1,813 insurance inquiries. Insurance complaints were closed as follows: 5,534 were upheld and/or transferred for prompt pay review; 3,621 were not upheld but adjusted; 10,361 were not upheld; and 5,420 were referrals, duplicates, withdrawn or suspended.

For approximately 20% of the closed files, the Unit successfully recovered monetary value for the consumer in the form of increased claim payment, reinstatement of lapsed coverage, payment for denied medical claims, or coverage of disaster-related claims that previously had been denied.

The specific breakdown is as follows:

Type	# of Complaints	Recovery
Property & Casualty	808	$13,138,524
Service Contracts	11	23,801
No-Fault	472	1,283,588
Health	1,144	8,117,514
Auto	571	2,690,303
Investigations	84	860,394
Life	92	2,297037
Prompt Pay	4,034	22,798,997
Total	**7,216**	**$51,170,158**

During 2012, CAU also required insurance companies to offer reinstatement to 7,078 policyholders as a result of CAU's discovery that the same insurer errors involved in individual cases had been made in numerous instances with respect to consumers who had not filed complaints.

Non-Mortgage Related Banking Complaints, Referrals and Inquiries

In 2012, the CAU processed an aggregate volume of 1,479 non-mortgage related complaints, referrals and inquiries, representing a 25% increase from 2011. A breakdown is set out below:

	12/31/2012	12/31/2011	Change %
Complaints	438	395	10.89%
Referrals	991	732	35.38%
Written Inquiries	50	53	-5.66%
Aggregate Volume	1,479	1,180	25.33
Phone Inquiries	63,395	45,744	38.59%

External Appeals

Under Article 49 of the Insurance Law, Utilization and External Appeal, consumers have the right to request a review of certain coverage denials by medical professionals who are independent of the health care plan issuing the denial. An external appeal can be requested when a health plan denies insurance coverage because it deems specific health care services to be experimental or investigational, not medically necessary, for treatment of a rare disease or for participation in a clinical trial. Additionally, consumers covered by an HMO may file for an external appeal when their requests for out-of-network exceptions are denied and the HMO offers an alternate in-network treatment.

CAU screens the appeals applications for completeness and eligibility. Eligible applications are randomly assigned to one of three external appeal agents screening for conflicts of interest. Once assigned, the Department monitors to insure a timely decision is rendered by the External Appeal Agent and that proper notice of the decision is provided.

This table summarizes the appeals received and the appeals closed for 2012 and the preceding seven years:

Summary of External Appeal Applications Received by Year						
Year	**Received**	**Closed**	**Ineligible**	**Voluntary Reversals**	**Insurer's Denial Upheld**	**Overturned***
2005	2475	2399	649	214	829	707
2006	2858	2764	787	287	867	823
2007	2987	2881	887	289	918	787
2008	3920	3926	1566	325	1145	890
2009	4260	4166	1783	350	1218	815
2010	4955	4600	1869	361	1430	940
2011	5469	5416	1754	362	2117	1183
2012	5796	5753	1874	360	2427	1092

Voluntary Reversals *- Plan overturned its denial before the appeal was submitted to a reviewer*

Ineligible *- The appeal was not eligible for an external review*

** includes decisions that overturned the denial in whole and in part.*

This table lists the number of external appeal determinations categorized by type of appeal:

External Appeal Determinations by Type of Appeal January 1, 2012 through December 31, 2012				
Type of Denial	**Total**	**Overturned**	**Overturned in Part**	**Upheld**
Medical Necessity	3307	843	174	2,290
Experimental/Investigational	202	70	1	131
Clinical Trial	4	2	0	2
Out-of-Network	3	1	0	2
Rare Disease	3	1	0	2
Total	**3519**	**917 (26%)**	**175 (5%)**	**2427 (69%)**

This table identifies the external appeal results by agent:

External Appeal Determinations by Agent January 1, 2012 through December 31, 2012				
Agent	**Total**	**Overturned**	**Overturned in Part**	**Upheld**
IMEDECS	1031	335	55	641
IPRO	1118	313	64	741
MCMC	1370	269	56	1045
Total	**3519**	**917**	**175**	**2427**

***IMEDECS**: Independent Medical Expert Consulting Services*

***IPRO**: Island Peer Review Organization*

***MCMC**: Managing Care. Managing Claims*

Outreach and Response Efforts in 2012

The Insurance CAU played a key role in the Department's response to the damage caused by Super Storm Sandy. Staff manned approximately 40 Disaster Assistance Centers (DAC) in the impacted areas to assist storm victims. The centers, open 7 days a week, provided "one-stop shopping" to the public by bringing together representatives from a wide array of federal and State agencies to inform the public about the services available to them in the wake of the disaster. Unit staff assisted consumers by answering questions and facilitating communication between consumers and insurers. For more complicated issues, DFS took formal complaints on computers deployed at DACs to activate the DFS complaint resolution process. The DACs remained opened as long as there was need in the specific area. DACs were operational well into 2013.

CAU personnel also staffed the Department's Mobile Command Center (MCC), a 36-foot-long van equipped with remote communications equipment. The MCC was deployed to provide disaster assistance where DACs had not been established or could not be established due to severely damaged infrastructure. The MCC was and continues to be deployed every day to areas in significant need. Many elected officials request MCC stops in their districts to assist their constituents,

In addition, the Department activated its Insurance Emergency Operations Center (IEOC). The IEOC originally was established in response to the World Trade Center disaster and more recently was activated during Tropical Storms Irene and Lee in 2011. The IEOC is a joint operation staffed by insurance company representatives and Department professionals at the Department's offices in New York City and Albany. The IEOC facilitates the exchange of information between the Department and insurance companies, and expedites insurers' handling of consumer complaints so that claims could be processed more rapidly. Consumer Assistance staff are critical to the success of the IEOC. DAC staff routinely relayed issues to the IEOC while consumers were at DACs or the MCC.

CAU participated in the Department's Rapid Response Team (RRT) initiative. RRTs are two-person teams consisting of a property insurance expert and an insurance fraud investigator (NYS peace officer) in DFS vehicles marked with official DFS decals. These teams go into the field to respond to insurance inquiries from homeowners and businesses or investigate issues that may benefit from an in-person visit and resolve disputes quickly. RRT staff also traveled to hard-hit communities to talk to residents and gather information on emerging insurance problems.

DFS activated a dedicated toll-free disaster hotline to answer insurance-related questions from the public and, when appropriate, to inform consumers about how to file complaints. During the initial months, phone coverage was available 7 days a week, 24 hours a day. The call center fielded a total of 9,256 calls from October through December 2012.

Finally, the Consumer Assistance Unit received 2648 complaints related to Storm Sandy disaster insurance issues. Many of the complaints concerned delays in property inspections by adjusters, delays in claims payments, and disputes over settlement amounts. Department staff worked closely with FEMA to help consumers navigate between state and federal authorities. CAU has closed over 1200 files; of those, CAU assisted 312 consumers recover a total of $5.3 million.

In addition to DAC and MCC outreach, DFS staff participated in fifteen "Town Hall" events to provide guidance and information to consumers

THE CONSUMER EXAMINATION UNIT (CEU)

Background

The mission of the Consumer Examination Unit (CEU) is to maintain and enhance consumer confidence in New York's banking system by ensuring that regulated institutions abide by the State's consumer protection, Fair Lending and Community Reinvestment Act (CRA) regulations; increase consumer access to traditional banking services in under-served communities by effectively administering the Department's Banking Development District program and other community development initiatives; and harmonize the FFCPD's examination and enforcement activities with those of the Department's federal counterparts.

Operations and Activities

Consumer Compliance Examinations

CEU's consumer compliance examinations promote consumer confidence in DFS-regulated depository institutions by monitoring institutions' compliance with consumer protection statutes and regulations through biennial onsite compliance examinations. Although consumer compliance examinations are not required by statute, performing periodic consumer compliance reviews positively impacts both the strength of regulated financial institutions and the financial well-being of consumers.

Approaches:

- Conduct intensive onsite consumer compliance examinations of regulated institutions.

- Improve compliance by identifying deviations from bank policy and/or industry "best practices" during the examination process.
- Create written, value-added examination findings that will help bank management implement strong compliance procedures.
- Ensure that examiners are trained not only to identify routine compliance issues but also to anticipate and detect new risks that surface as emerging technologies and products are adopted.

In 2012, CEU conducted 26 consumer compliance exams. As a result of these examinations all depository institutions have been required to develop and maintain a Consumer Compliance Management System (CMS). The examinations revealed that several depository institutions were subject to regulatory risk resulting from failing to incorporate into audit programs, training and policies all of the applicable New York State laws, regulations and supervisory procedures. These examinations also uncovered objectionable practices in regard to basic banking, maximum charges on returned items and imposition of higher service charges on inactive (dormant accounts) than on savings accounts. Consequently, CEU is pursuing restitution for affected consumers.

Fair Lending Examinations

The Department seeks to ensure that consumers who borrow money from DFS-regulated institutions are treated fairly and equitably in all aspects of the credit application, underwriting and servicing processes. The fair lending examination process includes onsite examinations, targeted examinations and in-depth investigations; processing and analyzing pertinent data from regulated entities; and guiding institutions on the content and implementation of their formal Fair Lending plans. The subject areas of these examinations extend to predatory lending, reviewing sub-prime loans for appropriateness, and supporting mortgage fraud investigations. Although fair lending examinations, like consumer compliance examinations, are not statutorily required, performing these examinations help to identify and correct potentially discriminatory lending and ensures consumers that the Department is committed to protecting them against discriminatory lending practices, as outlined in Executive Law § 296-a. The Department accordingly undertakes a diligent and strenuous examination process.

Approaches

- Initiate fair lending examinations of mortgage brokers to address the risks inherent in a segment of the industry that presents unique and potentially problematic fair lending risks. The need for these examinations is underscored by mortgage brokers' increasing role in the market as more and more banks exit the one-to-four family mortgage lending business;
- Coordinate with and perform examinations on behalf of the Community and Regional Banks, the Mortgage Banking Division and the Licensed Financial Services Unit to ensure that all DFS-regulated lenders are held to the same fair lending standards and expectations;
- Conduct advanced analyses to determine the relationship between exotic mortgage products and economic factors that lead to foreclosures.

In 2012, CEU conducted 28 fair lending exams and conducted reviews of approximately 70 fair lending plans — 50 for the Mortgage Banking Division and 20 for the Licensed Financial Services Unit. The

unit has commenced a process to require all depository and non-depository institutions to develop a tracking mechanism to indicate the military status of their consumers.

CRA Examinations

CEU also enforces § 28-b of the Banking Law and Part 76 of the General Regulations of the Banking Board to ensure that financial institutions reinvest in the communities they are chartered to serve. In particular, these examinations seek to ensure that regulated institutions are providing loans, investments and services to support the economic stability, growth and/or revitalization of the communities they serve, particularly in low-and moderate-income (LMI) neighborhoods. CRA examinations further seek to ensure that borrowers and businesses at all income levels have access to appropriate financial resources at a reasonable cost without straying beyond the bounds of safe and sound banking practices.

Through CRA examinations, CEU enforces New York State's CRA regulations (Part 76 of the General Regulations of the Banking Board) through intensive onsite examinations, supports banks' efforts to comply with Part 76 and issues examination ratings and reports that must be shared with the public.

Approaches

- Conduct onsite examinations of financial institutions' CRA performance in accordance with § 28-b of the Banking Law and Part 76 of the General Regulations of the Banking Board;
- Identify and incorporate community needs and market data, including information on distressed multifamily buildings and pre-foreclosure filings, to assess the performance of financial institutions in meeting community credit needs.
- Develop examiners' subject matter expertise to ensure that field staff can make nuanced but critical distinctions between poor CRA performance and performance that can be reasonably explained by local economic conditions and/or competitive pressures (i.e., so called "performance context issues);
- Generate high quality examination reports that assign appropriate ratings, provide solid support for the examiner's conclusions, treat comparable institutions in a consistent manner and are defensible before bank management, consumer advocacy groups and other outside parties, including other banks.

In 2012, the Consumer Examination Unit conducted 18 CRA exams.

Consumer Examinations Summary

The Consumer Examinations Unit is responsible for performing consumer compliance, fair lending and Community Reinvestment Act examinations. In 2012, the unit conducted 26 consumer compliance, 28 fair lending and 18 CRA exams.

Type of Exam	2012	Scheduled in 2013
Consumer Compliance	26	19
Fair Lending		
Depositories	28	12
Non-depositories	2	29
CRA	18	34

Community Development

Another objective of the Department is to facilitate the development and/or preservation of banking services in under-banked or LMI neighborhoods. To realize that goal, the Community Development Unit (CDU) researches and analyzes community demographic information to ascertain the financial needs of consumers, reviews the potential community impact of merger applications, bank applications and related matters and administers the Banking Development District (BDD) Program. In addition, CDU leads the Department's community outreach efforts, and fosters working relationships with community groups, financial institutions, municipal governments and agencies, and other regulatory agencies to ensure that residents, businesses and communities throughout New York State have access to the banking information, products and services they need.

Approaches

- Conduct research on community needs and banking services to inform the bank application process.
- Contribute to the development of regulatory, policy and programmatic initiatives that involve consumer-related concerns, affect LMI areas in the State, or both.
- Engage banks and community groups on select issues facing consumers and LMI communities, such as efforts to assist consumers avoid foreclosures and Storm Sandy recovery efforts.
- Implement changes to the BDD Program identified through the 10 Year Report process and through internal discussions to improve the effectiveness and impact of the program on underbanked communities.
- Continue building on the successes of the BDD program and work to strengthen the involvement of other agencies that can add value to the program. Work with select municipalities and community groups to identify under-banked areas throughout the state and present opportunities to banks in select markets or communities. Continue administering Annual BDD Reports and document the impact of BDDs on their communities.

Applications Processing

In 2012, CDU processed 120 branch applications of the following types: closings (24); branch openings – electronic facilities (41); limited purpose (1); branch openings (42); and relocations (12). In addition, the branch processed 36 specialized applications as follows: conversions (5); voluntary dissolutions (1);

transfer of shares (Section 134-a) (2); mergers (4); and acquisitions (3). Lastly, CDU issued 21 approval memos for Public Welfare Investment projects .

BDD Applications

CDU reviewed 18 BDD Request for Renewal of Deposit Applications, as well as the recommendations for renewal of deposits resulting from said reviews. The reviews resulted in 17 recommendations for renewal with no reservations, and 1 recommendation for renewal with one-year probation. The 18 renewals with no reservations include 3 branches for which probation was lifted due to the satisfactory accomplishment of BDD goals.

BDD Outreach and education

In May 2012, CDU collaborated with the Community and Regional Banks (CRB) Division in a presentation to community banks in Syracuse, NY. The purpose of the presentation was to highlight the state of community banks in the region, introduce community banks to the new agency, provide the Superintendent and the Executive Deputy Superintendent of the Banking Division with an opportunity to meet the banks and their representatives, and re-introduce the banks to opportunities, such as the BDD program. The CDU provided a general presentation on the BDD program, and made staff available to answer questions. CDU's participation resulted in interest from one bank to re-enter the BDD program, but no application has been received to date.

Community Outreach

CDU participated in a number of collaborative community development efforts in the state including Bank on Manhattan and the New York State Coalition for Excellence in Homeownership Education. CDU also continued to participate in the At-Risk Multifamily Building Data Sharing Initiative with NYC Housing Preservation and Development.

Interagency CRA Forums

CDU worked with the DFS CRA team as well as representatives from the FDIC, OCC and Federal Reserve Bank of New York to hold a forum for banks and community development financial institutions on current efforts to rebuild after Superstorm Sandy. The forum included panels on economic development, neighborhood revitalization and affordable housing, as well as a regulatory panel on CRA eligibility. Approximately 100 financial institution representatives attended the forum.

CRA Quarterly Mailings

CDU completed four quarterly electronic mailings for over 200 community groups across the state and worked with IT to update the CRA Quarterly mailing announcements on the website. CDU automated its mailing by replacing physical mailings with electronic mailings.

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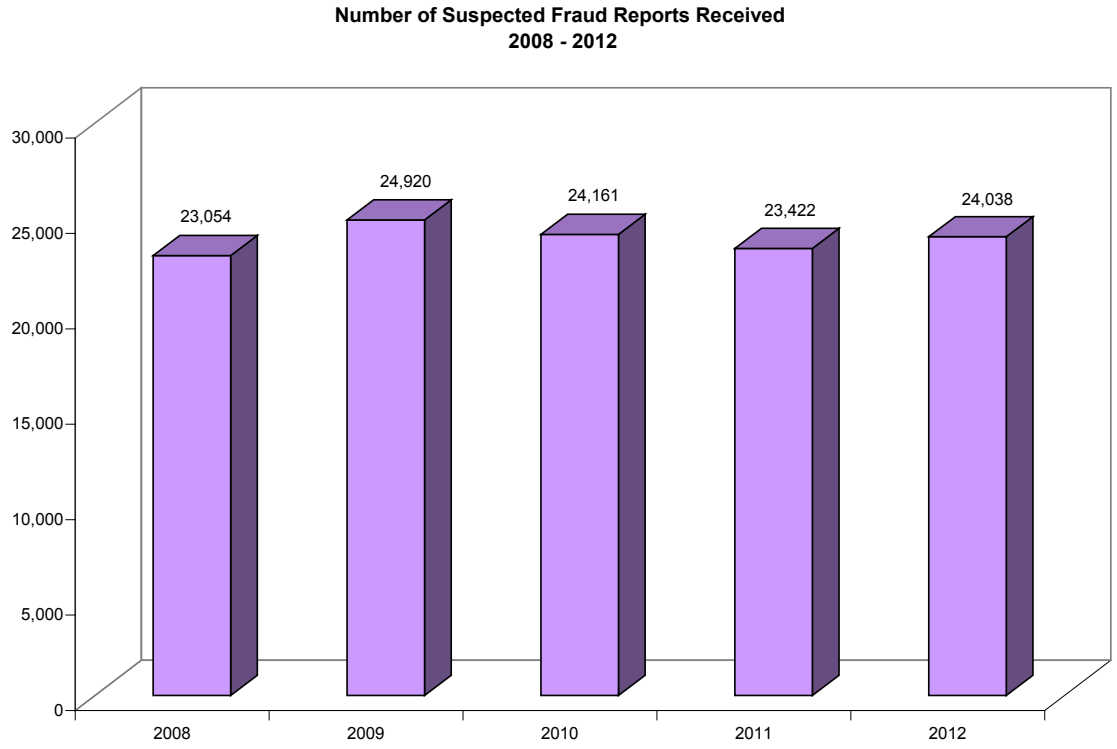
BUREAU APPENDICES – 2012 STATISTICS

After several years of decline, the number of suspected fraud reports received by the Insurance Frauds Bureau increased in 2012. The Bureau received 24,038 reports in 2012, up from 23,422 in 2011.

Number of Suspected Fraud Reports Received



Information Furnished By (IFB) Reports Received by Year

IFBs Received by Year	2008	2009	2010	2011	2012
Boat Theft	4	6	5	5	4
Auto Theft	1,610	1,429	1,084	922	877
Theft From Auto	38	34	33	28	23
Auto Vandalism	185	248	205	350	290
Auto Collision Damage	1,388	1,318	1,654	2,213	1,931
Auto Fraudulent Bills	79	114	98	114	37
Auto Miscellaneous	1,092	1,388	1,938	1,268	1,376
Auto I.D. Cards	10	5	11	9	13
Total - Auto	**4,406**	**4,542**	**5,028**	**4,909**	**4,551**
Workers' Compensation	1,428	1,486	1,352	1,584	1,255
Total - Workers' Comp	**1,428**	**1,486**	**1,352**	**1,584**	**1,255**
Disability Insurance	382	242	193	144	142
Health Accident Insurance	1,421	1,488	1,625	1,915	1,389
No-Fault Insurance	12,339	13,433	12,807	11,974	13,944
Total - Medical/No-Fault	**14,142**	**15,163**	**14,625**	**14,033**	**15,475**
Boat Fire	1	2	1	4	1
Auto Fire	444	399	278	243	186
Fire – Residential	180	213	170	149	120
Fire – Commercial	29	40	40	34	29
Total - Arson	**654**	**654**	**489**	**430**	**336**
Burglary - Residential	509	504	362	380	278
Burglary - Commercial	140	127	176	82	60
Homeowners	569	889	1,038	823	997
Larceny	44	45	33	36	65
Lost Property	254	154	108	219	108
Robbery	28	15	24	22	9
Bonds	8	9	15	6	6
Life Insurance	199	392	378	407	381
Ocean Marine Insurance	7	13	9	10	6

IFBs Received by Year	2008	2009	2010	2011	2012
Reinsurance	0	2	0	1	0
Appraisers/Adjusters	9	5	8	11	5
Agents	47	69	50	55	30
Brokers	72	106	100	50	40
Ins. Company Employees	12	5	3	3	0
Insurance Companies	34	27	23	42	69
Title/Mortgage	13	326	208	143	73
Commercial Damage	41	85	70	81	68
Unclassified	438	302	62	95	226
Total - General Unit	**2,424**	**3,075**	**2,667**	**2,466**	**2,421**
IFBs Received	**2008**	**2009**	**2010**	**2011**	**2012**
Auto Unit Totals	4,406	4,542	5,028	4,909	4,551
Workers Comp Unit Totals	1,428	1,486	1,352	1,584	1,255
Medical/No-Fault Unit Totals	14,142	15,163	14,625	14,033	15,475
Arson Unit Totals	654	654	489	430	336
General Unit Totals	2,424	3,075	2,667	2,466	2,421
Grand Total	**23,054**	**24,920**	**24,161**	**23,422**	**24,038**

Cases Opened by Year	2008	2009	2010	2011	2012
Boat Theft	0	2	3	0	2
Auto Theft	204	152	119	96	70
Theft From Auto	3	3	1	1	0
Auto Vandalism	16	19	14	9	6
Auto Collision Damage	62	66	63	65	38
Auto Fraudulent Bills	12	11	5	5	3
Auto Miscellaneous	25	85	61	39	25
Auto I.D. Cards	1	0	3	1	0
Total - Auto Unit	**323**	**338**	**269**	**216**	**144**
Workers' Compensation	445	717	537	1,042	467

Cases Opened by Year	2008	2009	2010	2011	2012
Total - Workers' Comp Unit	**445**	**717**	**537**	**1,042**	**467**
Disability Insurance	31	35	18	13	3
Health Accident Insurance	103	98	80	72	41
No-Fault Insurance	128	101	72	88	44
Total - Medical/No-Fault Unit	**262**	**234**	**170**	**173**	**88**
Boat Fire	0	2	0	1	0
Auto Fire	64	69	59	48	35
Fire – Residential	47	53	28	19	11
Fire – Commercial	7	12	12	12	6
Total - Arson Unit	**118**	**136**	**99**	**80**	**52**
Burglary – Residential	26	15	15	12	11
Burglary – Commercial	3	6	5	2	1
Homeowners	51	52	25	22	9
Larceny	15	9	13	8	13
Lost Property	7	3	4	1	2
Robbery	0	1	0	1	0
Bonds	2	3	4	2	3
Life Insurance	16	26	9	13	9
Ocean Marine Insurance	4	4	1	1	0
Reinsurance	0	0	0	0	0
Appraisers/Adjusters	5	2	2	2	1
Agents	11	28	18	12	4
Brokers	11	42	15	17	7
Ins. Company Employees	5	3	1	1	0
Insurance Companies	9	9	9	10	1
Title/Mortgage	3	18	21	8	4
Commercial Damage	3	8	7	6	4
Miscellaneous	48	53	12	38	21
Total - General Unit	**219**	**282**	**161**	**156**	**90**
Grand Total	**1,367**	**1,707**	**1,236**	**1,667**	**841**

Cases Opened by Year	2008	2009	2010	2011	2012
Auto Unit Totals	323	338	269	216	144
Workers Comp Unit Totals	445	717	537	1,042	467
Medical/No-Fault Unit Totals	262	234	170	173	88
Arson Unit Totals	118	136	99	80	52
General Unit Totals	219	282	161	156	90
Total	**1,367**	**1,707**	**1,236**	**1,667**	**841**

2008	IFBs	Cases	Arrests
Auto Unit Total	4,406	323	294
Workers' Comp Unit Total	1,428	445	159
Medical/No-Fault Unit Total	14,142	262	171
General Unit Total	2,424	219	69
Arson Unit Total	654	118	62
Grand Total	**23,054**	**1,367**	**755**

2009	IFBs	Cases	Arrests
Auto Unit Total	4,542	338	219
Workers' Comp Unit Total	1,486	717	184
Medical/No-Fault Unit Total	15,163	234	157
General Unit Total	3,075	282	110
Arson Unit Total	654	136	68
Grand Total	**24,920**	**1,707**	**738**

2010	IFBs	Cases	Arrests
Auto Unit Total	5,028	269	252
Workers' Comp Unit Total	1,352	537	119
Medical/No-Fault Unit Total	14,625	170	159
General Unit Total	2667	161	82
Arson Unit Total	489	99	56
Grand Total	**24,161**	**1,236**	**668**

2011	IFBs	Cases	Arrests
Auto Unit Total	4,909	216	225
Workers' Comp Unit Total	1,584	1,042	148
Medical/No-Fault Unit Total	14,033	173	210
General Unit Total	2,466	156	77
Arson Unit Total	430	80	43
Grand Total	**23,422**	**1,667**	**703**

2012	IFBs	Cases	Arrests
Auto Unit Total	4,551	144	164
Workers' Comp Unit Total	1,255	467	99
Medical/No-Fault Unit Total	15,475	88	195
General Unit Total	336	52	109
Arson Unit Total	2,421	90	28
Grand Total	**24,038**	**841**	**595**

2012 Data Call: Vehicle Principal Location Misrepresentations

2012 Summary of Data Reported Pursuant to December 28, 2012 Data Call Concerning Misrepresentations by New York Insureds of the Principal Place Where Their Vehicles Were Garaged and/or Driven

- Approximately 99% of the personal line automobile insurance market responded to the data call.
- The total number of reported New York insureds who misrepresented the principal place where their vehicles were garaged and/or driven in 2012 was 18,458.
- The total amount of reported premium lost in 2012 as a result of New York insureds who misrepresented the principal place where their vehicles were garaged and/or driven is $22,455,348.
- In 2012, 14,497 (79%) of the reported misrepresentations involved a location within New York State and 3,961 (21%) of the reported misrepresentations involved a location outside of New York State.

2012 Misrepresentations that Involved a New York State Location

- Total amount of reported premium lost in 2012 due to misrepresentations that involved a location (county) within New York State is $19,279,406.

Top reported New York counties where insureds **actually** garaged and/or drove their vehicles in 2012:	
Kings	31.79%
Queens	19.31%
Bronx	13.03%
Nassau	6.41%
New York	6.08%
Suffolk	5.32%
Westchester	4.64%
Monroe	2.20%
Richmond	1.18%
Erie	1.10%
Onondaga	1.03%

Top reported New York counties **used by insureds to misrepresent** where their vehicles were garaged and/or driven in 2012:	
Westchester	13.53%
Suffolk	12.53%
Nassau	9.38%
Queens	8.18%
Albany	6.07%
Monroe	4.63%
New York	4.55%
Greene	4.01%
Kings	3.58%
Broome	2.95%
Richmond	2.58%
Onondaga	2.24%
Erie	2.17%
Orange	1.89%
Niagara	1.88%
Bronx	1.82%
Essex	1.50%
Dutchess	1.33%
Rockland	1.31%

2012 Misrepresentations that Involved a Location Outside of New York State

- Total amount of reported premium lost in 2012 due to misrepresentations that involved a location outside of New York State was $3,175,942.
- The following table lists the top reported New York counties where insureds actually garaged and/or drove their vehicles in 2012:

Kings	21.21%
Queens	13.99%
New York	11.03%
Suffolk	10.10%
Nassau	9.77%
Bronx	7.93%
Westchester	4.54%
Richmond	3.26%
Erie	1.69%
Monroe	1.26%
Orange	1.11%
Rockland	0.98%

- The following table lists the top reported states that were used by insureds to misrepresent where their vehicles were garaged and/or driven in 2012:

Florida	42.49%
Pennsylvania	15.10%
Connecticut	5.23%
New Jersey	5.23%
South Carolina	4.27%
Georgia	3.38%
Maryland	3.21%
North Carolina	3.13%
Arizona	1.94%
California	1.84%
Vermont	1.54%
Virginia	1.19%
Ohio	1.09%

Approved Fraud Prevention Plans on File as of December 31, 2012 (135)

ACE USA Group of Companies
Aetna Life Insurance Company
AIG Companies
Allstate Insurance Group
Allstate Life Insurance Company of New York
Amalgamated Life Insurance Company
American Commerce Insurance Company
American Family Life Assurance of New York
American General Life Companies, LLC
American Medical and Life Insurance Company
American Modern Insurance Group
American Progressive Life and Health Insurance Company of New York
American Transit Insurance Company
Americhoice of New York, Inc.
Amex Assurance Company
Amica Mutual Insurance Company
AM Trust Financial Services Inc.
Arch Insurance Company
Assurant Group
AutoOne Insurance Company
Capital District Physicians' Health Plan
Central Mutual Insurance Company
Central States Indemnity Company of Omaha
Centre Life Insurance Company
Chubb Group of Insurance Companies
CIGNA Health Group
Cincinnati Insurance Company
CNA Insurance Companies
Combined Life Insurance Company of New York
Countryway Insurance Company
Country-Wide Insurance Company
CUNA Mutual Insurance Society
Dairyland Insurance Company
Delta Dental Insurance Company
Delta Dental of New York
Dentcare Delivery Systems
Eastern Vision Service Plan
Electric Insurance Company
EmblemHealth
Erie Insurance Group
Esurance Insurance Company
Eveready Insurance Company
Excellus BlueCross BlueShield
Farm Family Casualty Insurance Company
Farmers' New Century Insurance Company
Fiduciary Insurance Company of America
Fireman's Fund Insurance Company
First Ameritas Life Insurance Company of New York
First Central National Life Insurance Company of New York
First Rehabilitation Life Insurance Company of America
First Reliance Standard Life Insurance Company
Fort Dearborn Life Insurance Company of New York
GEICO
Genworth Life Insurance Company of New York
Gerber Life Insurance Company
Global Liberty Insurance Company of New York
GMAC Insurance
Great American Insurance Group
Guard Insurance Group
Guardian Life Insurance Company of America
Hanover Group
Harleysville Insurance Company
Hartford Fire and Casualty Group
Hartford Life Insurance Company
Health Net
HealthNow of New York Inc.
Hereford Insurance Company
HM Life Insurance Company of New York
IDS Property Casualty Insurance Company
Independent Health Association, Inc.
Infinity Property Casualty Company
ING Insurance Company of North America
Interboro Insurance Company
John Hancock Life Insurance Company of New York

Kemper
Lancer Insurance Company
Liberty Life Assurance Company of Boston
Liberty Mutual Insurance (Agency Markets)
Liberty Mutual Insurance (Commercial Lines)
Liberty Mutual Insurance (Personal Lines)
Life Insurance Company of Boston and New York
Lincoln Life & Annuity Company of New York
Magna Carta Companies
Main Street America Group
MAPFRE Insurance Company of New York
MassMutual Financial Group
Merchants Insurance Company
Mercury Insurance Group
Metropolitan Life Insurance Company
Metropolitan Property and Casualty Insurance Group
Mutual of Omaha Insurance Company
MVP Health Plan
National Benefit Life Insurance
Nationwide Insurance Group
New York Automobile Insurance Plan
New York Central Mutual Fire Insurance Company
New York Life Insurance Company
New York State Insurance Fund
Nippon Life of America
Northwestern Mutual Life Insurance Company
OneBeacon Insurance Company
Oxford Health Plans
Permanent General Assurance Corporation
Preferred Mutual Insurance Company
Presidential Life Insurance Company
Principal Life Insurance Company
Progressive Group of Insurance Companies
Prudential
QBE Insurance Group Limited
SBLI Mutual Life Insurance Company
Securian Financial Group
Security Mutual Life Insurance Company of New York
Selective Insurance Group, Inc.
Standard Life Insurance Company of New York
Standard Security Life Insurance Company of New York
State Farm Mutual
Sun Life Insurance and Annuity Company of New York
Torchmark
Tower Group of Companies
Transamerica Financial Life Insurance Company
Travelers
Tri-State Consumer Insurance Company
Trustmark Insurance Company
Ullico
Unicare Life and Health Insurance Company
Unimerica Insurance Company of New York, Inc.
Union Security Life Insurance Company of New York
United Concordia Insurance of New York
United Healthcare Insurance Company of New York
United Healthcare of New York, Inc.
Unum Provident Company
USAA Group
Utica National Insurance Group
Wellpoint, Inc.
Zurich North American

Approved Life Settlement Provider Fraud Prevention Plans on File

as of December 31, 2012 (26)

Abacus Settlements, LLC
Berkshire Settlements, Inc.
Coventry First LLC
EAGil Life Settlement Inc.
FairMarket Life Settlements Corp.
GCM Life Settlements LLC
Georgia Settlement Group
Habersham Funding, LLC
J. G. Wentworth Life Settlements, LLC
Legacy Benefits, LLC
Life Equity, LLC
Life Policy Traders, LLC
Life Settlements International, LLC
Life Settlement Solutions, Inc.
LifeTrust, LLC
Lotus Life, LLC
Magna Life Settlements, LLC
Maple Life Financial Inc.
Montage Financial Group, Inc.
Parcside Equity, LLC
Proverian Capital, LLC
Q Capital Strategies, LLC
SLG Life Settlements, LLC
Spiritus Life, Inc.
Viasource Funding Group, LLC
Wm. Page & Associates, Inc.