Department of Financial Services

Financial Frauds and Consumer Protection Report

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INTRODUCTION

This report, required under Section 409(b) of the Financial Services Law, summarizes the activities of the Financial Frauds & Consumer Protection Division (õFFCPDö) of the Department of Financial Services (õDFSö) during 2017 in combating fraud against entities regulated under the Banking and Insurance laws, as well as fraud against consumers; the Departmentøs handling of consumer complaints; and the Departmentøs examination activities in the areas of consumer compliance, fair lending, and the Community Reinvestment Act.

FFCPD Organization and Oversight

The FFCPD encompasses the units described below:

- **Civil Investigations Unit:** Investigates civil financial fraud and violations of consumer and fair lending laws, the Financial Services Law, the Banking Law and the Insurance Law;
- **Disciplinary Unit:** Addresses unlicensed activity and violations of the Insurance Law by entering into stipulations with insurance producers and non-producers for fines and disciplinary measures including corrective action, license suspension or revocation, conducts examinations, and brings disciplinary proceedings and conducts hearing against licensees for violations of the Insurance Law;
- **Student Protection Unit:** Protects students from fraud and misrepresentation in the market for financial products and services; monitors student-related financial practices in New York; and educates student consumers and their parents about available financial products and services.
- **Criminal Investigation Unit:** Handles banking, criminal investigations, and insurance fraud;
- **Consumer Assistance Unit:** Oversees insurance producer licensing and continuing education, and investigates complaints against regulated entities and individuals except those relating to mortgages; manages the deployment and staffing of the DFS Mobile Command Center;
- **Consumer Examinations Unit:** Conducts fair lending, consumer compliance, and Community Reinvestment Act examinations, and is responsible for the Banking Development District Program;
- **Holocaust Claims Processing Office:** Advocates on behalf of Holocaust victims and their heirs, seeking the just and orderly return of assets to their rightful owners.

Section 404 of the Financial Services Law provides that the Superintendent is authorized to investigate activities that may constitute violations subject to Section 408 of the Financial Services Law, or violations of the Insurance Law or Banking Law. In addition, where the Superintendent 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 is empowered to investigate or assist another entity with the power to do so.

CIVIL INVESTIGATIONS AND ENFORCEMENT ACTIVITIES

The Civil Investigations Unit investigates civil financial fraud and violations of consumer and fair lending laws, the Financial Services Law, the Banking Law, and the Insurance Law. Discussed below are some of the Unitøs investigations, activities, and initiatives in 2017.

Payday Lending Investigation

In September 2017, DFS announced a settlement with a payday loan debt collector, Total Account Recovery (õTARö), and a payday loan servicer, E-Finance Call Center Support (õE-Financeö). DFSøs investigation uncovered that TAR had attempted to collect on more than 20,000 payday loan debts of New York consumers and successfully collected payments on over 2,000 of those debts. The DFS investigation also found that TAR and E-Finance repeatedly called consumers at home and at work in attempts to collect on usurious payday loans, in violation of federal and state debt collection practices laws. Pursuant to the settlement with DFS, TAR and E-Finance, which have both ceased to operate, forgave more than $11.8 million in New York consumersø payday loan debts and paid a $45,000 penalty.

This settlement follows DFSøs comprehensive initiative to stop illegal online payday lending in New York. Various parts of the initiative have been detailed in prior FFCPD annual reports.

Bail Initiative

In 2016, the Civil Investigations Unit was investigating complaints that alleged that certain bail agents were retaining premiums when the criminal defendants had not been released from custody. In some instances, the practice was occurring even though the bail surety companies with which the agents were associated have standardized bail bond agreements that include express provisions making it clear that premiums are not earned until a defendant is released from custody. Some such agreements provided that õ[t]he premium for the Bond is fully earned upon Defendantøs release from custodyö or õ[t]he premium is fully earned upon your release from custody.ö Some insurers, however, did not ensure that their agents were using the forms of agreement that they were supposed to use or that they were providing those forms to indemnitors who paid the premiums for the bail bonds. At least one bail agent kept multiple premiums paid by successive indemnitors when the defendant was not released after one or more bail sufficiency hearings. During the course of its investigation, DFS learned that the United States Court of Appeals for the Second Circuit had certified a question of New York law to the New York Court of Appeals in a case that presented the same issue as that raised in some of the complaints. The Department requested leave to submit an *amicus* brief in the case because it presented issues of interpretation of the New York Insurance Law, and the Department licenses and regulates both surety companies that are authorized to do bail business in New York as well as bail agents. The New York Court of Appeals granted leave.

On June 27, 2017, the New York Court of Appeals issued its unanimous opinion in *Gevorkyan v. Judelson*, – NY3d –, 2017 N.Y. Slip Op. 05176 (June 27, 2017). Citing New York Insurance Law Article 68 and its legislative history, the *Gevorkyan* Court confirmed the Departmentøs view that neither a bail surety company ó the insurer ó nor its bail agent earns a premium for a bail bond if a court refuses to accept the bond following a bail source or bail sufficiency hearing. According

to the Courtøs analysis of the statute, and as argued in the Departmentøs amicus brief, an insurer is entitled to the premium only upon õgiving bail bondö under Insurance Law § 6804(a), and the bail bond õhas not been given if the court refuses to accept the bond after the bail source hearing.ö Slip Op at 5, 7. The Court noted that its determination is further supported by the Insurance Law principle that premium follows risk: õThe question before us ultimately turns on when a ÷premiumø is earned.ö *Id*. at 11. As the Court explained, õ[t]he use of the word ÷premiumø in section 6804(a) is significant because that term connotes a consideration paid to an insurer for assuming a risk. Risk, when used ÷with reference to insurance, describes the liability assumed as specified on the face of the policy.ö *Id.* In the Courtøs view, the insurer does not incur risk if the criminal defendant is not released and has no opportunity to jump bail. õIf the court disapproves the bail bond, the surety never runs the risk it contracted to insure.ö *Id*. at 12.

Following the decision, on August 29, 2017 the Department issued a circular letter to all insurers authorized to write surety in New York and all licensed bail agents explaining the *Gevorkyan* decision and stating that the premium or compensation on a bail bond for any defendant who is not released from custody after a criminal court does not accept a bail bond as the result of a bail sufficiency hearing must be returned to the persons who provided it as soon as possible after the criminal courtøs determination in the bail sufficiency hearing.

Lincoln Financial Group

In 2015, Lincoln National Corporation, doing business as Lincoln Financial Group, self-reported to DFS unfair claims settlement practices stemming from its 2006 merger with Jefferson Pilot Corporation. Technical issues arising from the merger caused Lincoln to lose track of numerous life insurance policies and, as a result, many beneficiaries of New York policies waited weeks, months, or years before receiving their life insurance payments.

DFSøs subsequent investigation found that executives failed to address adequately early red flags related to the problem. Despite performing an internal audit highlighting the claims processing issues, Lincoln did not take adequate steps to uncover and address the underlying problem of lost policies. The investigation also found that thousands of beneficiaries of New York policyholders were affected.

In March 2017, DFS entered a Consent Order with Lincoln Financial Group, pursuant to which Lincoln paid a $1.5 million fine for lost insurance claims and for unfair claims settlement practices. Lincoln Financial also agreed to pay out the remainder of more than $50.6 million in claims and interest to affected New Yorkers, and to injunctive terms intended to prevent such problems from arising in future mergers.

Unlicensed Life Insurance Business by Lloyd’s Of London, Clements & Company, and United Nations Federal Credit Union

In November 2017, DFS entered into a consent order with Clements & Company, Underwriters at Lloydøs of London, and the United Nations Federal Credit Union (õUNFCUö) for offering, marketing, and underwriting an unlicensed credit and debit card-based life insurance program for UNFCU members. The order required the parties to pay fines totaling $1.47 million for unlicensed life insurance business and to establish an insurance program with a DFS-licensed

insurer. The insurance program offered guaranteed-issue term life insurance to UNFCUøs members in more than 210 countries and territories. A total of more than 4,300 policies were sold, including to 804 members listing New York as their primary location.

The insurance offered and sold to UNFCU members did not meet New York standards for policies sold by insurers approved by DFS, including omitting a mandatory õconversion privilegeö under which insurers are required to update or renew a policy regardless of the insuredøs health. Additionally, the policy rates were not sufficient to support the program as required by the Insurance law. To bring the program into compliance and ensure that United Nations workers and alumni maintain their coverage for years to come, DFS required the parties to transfer the business to a New York-licensed insurer, Monitor Life Insurance Company of New York. Prior to the settlement, the program had been running at a severe loss and was unsustainable.

Zenefits

In April 2017, YourPeople Inc., doing business as Zenefits FTW Insurance Services, entered into a Consent Order with DFS in which it agreed to pay a $1.2 million fine and take all necessary actions to ensure that all of its employees and contractors acting as insurance producers in New York are properly licensed and have completed all required training and education. The company provides an online platform that integrates human resources, payroll, and benefits functions for businesses. It also offers insurance brokerage services for the purchase of group property, casualty, health, and life insurance policies for employees.

The settlement came after Zenefits, which is based in California, self-reported to DFS in November 2015 that its employees had engaged in insurance business in New York without licenses. A DFS investigation revealed that Zenefits permitted employees to solicit, negotiate, or sell insurance policies in New York without required licenses, did not maintain records necessary to verify compliance with New York Insurance Law, and failed to implement adequate compliance controls and employee training programs. In addition, the companyøs former CEO, Parker Conrad, wrote a software macro in 2013 that allowed employees to evade broker licensing education requirements.

Reforming the Title Insurance Industry

Following an investigation into industry practices and several comment periods, in October 2017 DFS adopted two new regulations to protect New Yorkers, provide greater transparency regarding closing costs, and address unscrupulous practices in the title insurance industry.

The first regulation sets forth rules for permissible marketing expenses, including meals and entertainment, and ancillary fees that title agents or title insurers may charge at the closing. DFSøs investigation revealed that title insurance companies and agents spend millions of dollars on inducements, referred to by the industry as õmarketing costs,ö which are included in the calculation of the premium that consumers pay. The regulation establishes clear guidelines of expenditures that are prohibited, as well as a list of permitted expenditures. It further requires title insurance companies to exclude all illegal expenses from the calculation of future rates, which will result in a reduction of title insurance premiums charged to consumers. Lastly, the

regulation limits the ancillary fees and expenses that may be charged to consumers for residential closings.

The second regulation requires title insurance companies and agents to provide certain disclosures to consumers. It further requires companies and agents that generate a portion of their business from affiliates to function separately and independently from any affiliate and be open for business from other sources.

Condor Capital Corporation

In April 2014, DFS commenced an action in the United States District Court for the Southern District of New York against Condor Capital Corporation, a domestic licensed sales finance company headquartered in New York that acquired and serviced subprime automobile loans, and its owner, Stephen Baron. The complaint alleged, among other misconduct, that Condor was hiding the existence of customersø positive credit balances and retaining them for itself, and sought restitution for consumers and the appointment of a receiver. This was the first legal action by a state regulator under Section 1042 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (õCFPAö). The court granted DFSøs motion for a preliminary injunction and appointed a receiver in May 2014. In December 2014, DFS reached a settlement with the defendants, and the court entered a Final Consent Judgment, under which Condor and Mr. Baron made full restitution, plus interest, to aggrieved customers nationwide (an estimated $8 million to $9 million) and paid a $3 million penalty. In addition, Condor admitted to violations of CFPA, the Truth in Lending Act, and the Banking and Financial Services Laws; Mr. Baron admitted to violating the CFPA by providing substantial assistance to Condorøs violations.

As part of the Final Consent Judgment, the receiver conducted an exhaustive sale process that culminated in the District Courtøs December 2015 order confirming the sale of substantially all of Condorøs remaining assets. In November 2016, the Court approved the receiverøs final report, discharged the receiver, and terminated the receivership. Mr. Baron filed numerous motions in the District Court, as well as appeals to the United States Court of Appeals for the Second Circuit, throughout the duration of the receivership seeking to enjoin or unwind the sale, all of which were dismissed. Following the termination of the receivership, Mr. Baron filed an appeal of the Courtøs final November 2016 order. The Second Circuit affirmed the District Courtøs final order in November 2017.

Initiative to Prevent Elder Financial Exploitation

DFS has continued its efforts to combat elder financial exploitation in 2017 and hosted a training for DFS investigators and examiners. The training educated professionals in the field how to identify elder financial exploitation and facilitate referrals to Adult Protective Services where necessary. In October, DFS staff spoke at the Federal Financial Institutions Examination Council Consumer Compliance Conference in Arlington, Virginia, alongside representatives from the Consumer Financial Protection Bureauøs Office of Older Americans, to discuss DFS initiatives in addressing elder financial exploitation. In late 2017, DFS held a training for New York-chartered banks and credit unions in White Plains that was attended by professionals from 16 institutions.

STUDENT PROTECTION UNIT

Governor Cuomo established the Student Protection Unit (õSPUö) as part of his 2014ó15 Executive Budget to serve as a consumer watchdog for New Yorkøs students. SPU is dedicated to investigating potential consumer protection violations and distributing clear information that students and their families can use to help them make informed, long-term financial choices.

In 2017, SPU conducted 72 workshops at schools, libraries, and community centers across the state. The workshops provided vital information to students, parents, and student loan borrowers about the best way to finance an education and available student loan repayment options. In addition, together with other DFS units, SPU attended the New York State Fair in August and answered questions and distributed brochures to help New York consumers better understand student loans.

SPU maintains and regularly updates a comprehensive õStudent Lending Resource Centerö on the Departmentøs webpage. The Student Lending Resource Center includes tips for prospective college students, their families, and graduates already in repayment to help them navigate decisions relating to financing college education.

SPU reviews and successfully resolves complaints regarding student financial products and services, including student loans, student banking products, student debt relief services, and student health insurance. SPU accepts complaints through DFSøs online complaint portal and by mail.

In 2015, Governor Cuomo signed Banking Law § 9-w, which required DFS to develop a standard student loan shopping sheet to be used by all New York schools of higher education. In 2016, DFS finalized the Financial Aid Award Information Sheet and enacted regulations that provide students and their families with a summary of what a school will cost, and available payment options. The standardized form makes it easy for students to compare the financial aid packages of different schools. DFS consulted with the Higher Education Services Corporation on the Financial Aid Award Information Sheet and answered questions from colleges as they incorporated the sheet into their financial aid award processes.

DISCIPLINARY UNIT

The Producers Unit oversees the activities of licensed individuals and entities that 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 DFS regulations. There are currently more than 305,000 insurance licensees in New York, including producers (agents and brokers), limited lines producers, independent and public adjusters, reinsurance intermediaries, bail agents, title agents, and life settlement brokers. The Unit, in collaboration with the Departmentøs Producer Licensing Unit, monitors the insurance marketplace and reviews licensing applications to determine if unlawful or unlicensed activity is occurring and, if necessary, take steps to ensure that individuals or entities either achieve compliance or cease activities.

When a violation of the Insurance Law is established, the Department may address the violation by imposing an administrative sanction resulting in license revocation or suspension, denying a pending application, or imposing a monetary penalty along with corrective action.

In 2017, the Department entered into approximately 143 stipulations imposing penalties on insurance producers. In addition, three licenses were revoked after administrative hearings, 11 licenses were surrendered with the full force and effect of revocation, and four waivers were approved pursuant to 18 U.S.C. §1033.

Stipulations in 2017

Type of Action	Total Requested	Total Completed	Fine Amount
Agent/ Broker	158	143	$544,000

Hearings in 2017

	Requested	Held	Pending
Agent/Broker/Applicant	13	8	5

CRIMINAL INVESTIGATIONS AND ENFORCEMENT ACTIVITIES

Criminal Investigations Bureau

Highlights of 2017

- Court-ordered restitution resulting from the Criminal Investigations Bureauøs (õCIBö) investigations totaled more than $3.1 million;
- The Mortgage Fraud Unitøs (õMFUøsö) investigations resulted in nine arrests, involving more than $21.5 million in losses to victimized homeowners and financial institutions;
- CIB conducted 122 investigations that resulted in nine convictions;
- Sixty-five new cases were opened for investigation.

Background

The CIB investigates possible violations of New York Banking Law and certain enumerated misdemeanors and felonies of the New York Penal Code, and takes appropriate action after such investigation. CIB also investigates violations of anti-money laundering laws and regulations, as well as crimes relating to residential mortgage fraud. In addition, CIB provides support to various operating units within DFS to ensure that applicants for licensing have the requisite character and fitness. In that capacity, CIB reviews applicantsø criminal histories to assist in determinations of whether applicants meet the statutory requirements to be licensed or registered. CIB also conducts due diligence reviews of applicants seeking licenses with DFSøs Banking Division.

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 CIBøs major focuses are the following areas:

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 to prevent money laundering and terrorist financing. 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

The Mortgage Frauds Unit (õMFUö) was created to combat mortgage fraud by providing investigative expertise and support to regulatory and law enforcement agencies. The MFUøs mission is to investigate mortgage fraud cases throughout New York 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. In 2017, mortgage fraud investigations resulted in nine arrests and nine convictions in cases involving more than $21.5 million in losses to victimized homeowners and financial institutions.

Mortgage Fraud Investigation Highlights

Former Controller of Mortgage Lender Charged with Multimillion Dollar Fraud

In December, the former controller of a mortgage lender was charged with bank fraud and mortgage fraud in connection with his participation in a $12 million scheme to defraud banks of money intended for individuals seeking loans to purchase or refinance their homes. As part of the scheme, the controller allegedly falsified documents, kept funding for mortgages that never closed, and acquired funding multiple times for the same loans. CIB joined the Federal Bureau of Investigations (õFBIö) in this investigation and referred the matter to the U.S. Attorneyøs Office for the Southern District of New York.

Top Executives at Long Island Mortgage Lender Arrested in $8.9 Million Fraud

Three senior executives at a Long Island mortgage lender were charged in August with conspiracy to commit wire and bank fraud in connection with securing more than $8.9 million of warehouse loans, which they allegedly misused to pay personal expenses and compensation, as well as to repay earlier fraudulently-obtained loans. The executives allegedly defrauded banks into lending them money by misrepresenting that the money would fund new mortgages or

refinance existing ones. CIB assisted the FBI and the U.S. Attorneyøs Office for the Eastern District of New York with the investigation.

Guilty Verdict and Pleas in Loan Origination Scheme

In July 2017, a jury in the Eastern District of New York found an individual guilty of engaging in a scheme in which he and his co-conspirators recruited straw buyers to purchase properties using fraudulent mortgage loan applications. The loan applications misstated the borrowersø incomes, employment histories, and amounts of money in their bank accounts. His co-conspirators pleaded guilty prior to the trial in May. The Federal Housing Finance Agency requested CIBøs assistance with the investigation. The matter was prosecuted by the U.S. Attorneyøs Office for the Eastern District of New York.

Attorney Sentenced to Prison for "Short Sale" Mortgage Fraud Scheme

A Long Island attorney who had admitted to defrauding Queens homeowners, financial institutions, and real estate buyers out of more than $2.3 million in mortgage loan proceeds through a õshort saleö mortgage fraud scheme was sentenced to 1 1/3 to 4 years in prison in May. He deceived homeowners into selling their properties by telling them that the underlying mortgages would be satisfied. He also deceived buyers and new mortgage lenders by representing that the purchased properties were free and clear of prior encumbrances when, in fact, the prior mortgages were still outstanding. CIB conducted the initial investigation and referred the matter to Queens District Attorneyøs Office.

Queens Paralegal Charged with Stealing from Clients of Law Firm

In June, a paralegal formerly employed at a law firm was charged with stealing $80,000, and attempting to steal an additional $44,000, by claiming he could help a firm client and another homeowner in danger of foreclosure with loan modifications on their mortgages. Between September 2009 and April 2012, while the paralegal was employed at a Queens law firm, he allegedly told the individuals that he could help them with loan modifications if they made monthly payments to him instead of to their mortgage servicers. The Queens District Attorneyøs Office requested CIBøs assistance with this matter.

Man Arrested for Impersonating a Lawyer

An individual was arrested in November for allegedly posing as an attorney to defraud a distressed homeowner out of more than $100,000. The individual misrepresented himself as an attorney to Brooklyn-based homeowners who sought legal representation regarding a foreclosure judgment and a mortgage modification on properties they owned. CIB conducted the initial investigation and referred the matter to the Nassau County District Attorneyøs Office.

Financial Fraud Investigation Highlights

Former Chief Lending Officer Pleas Guilty to Defrauding His Employer

In October 2017, the former chief lending officer of an Ulster County financial institution pleaded guilty to criminal possession of a forged instrument. He used the forged instrument to obtain a loan of more than $100,000 from the financial institution at which he worked. CIB initiated the investigation and referred the matter to the Ulster County District Attorneyøs Office.

Employee of Check Casher Arrested for Misappropriation of Money Orders

An employee of a check casher appropriated money orders of more than $12,000 from his employer and used the funds for his personal use. CIB conducted the investigation and referred the matter to the Bronx District Attorneyøs Office in November.

Two Employees of a Money Transmitter Arrested

Two employees of a money transmitter were arrested and charged with a scheme to defraud clients of the money transmitter in June. In 2015, the employees allegedly deceived clients into believing that the employees had transmitted approximately $53,000 as requested, but in fact the employees took the funds for their own use. CIB assisted the New York Police Departmentøs Financial Crimes Task Force in the investigation and the matter was referred to the Manhattan District Attorneyøs Office for prosecution.

Mortgage Loan Originator Licensing Support

CIB provides support to the Mortgage Banking Unitøs efforts to comply with the federal Secure and Fair Enforcement for Mortgage Licensing Act of 2008 (õSAFE Actö). Under the SAFE Act, states are encouraged to increase uniformity, enhance consumer protection, and reduce mortgage fraud through the establishment of a national mortgage licensing system. One key provision of the SAFE Act is the requirement of a criminal background check of each mortgage loan originator applicant. During 2017, CIB investigators reviewed 607 criminal history reports related to mortgage loan originator applications filed with DFS.

Due Diligence Support

CIB provides due diligence investigative support to DFSøs Banking Division to ensure that applicants for licenses have the character and fitness to be licensed by the Department. During 2017, CIB Due Diligence Unit processed 49 due diligence reviews.

CIB Task Force and 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
- New York Identity Theft Task Force
- Middle Atlantic-Great Lakes Organized Crime Law Enforcement Network
- New York State Mortgage Fraud Working Group
- National White Collar Crime Center
- New York External Fraud Committee
- Long Island External Fraud Committee

Insurance Frauds Bureau

Highlights of 2017

- The Insurance Frauds Bureau (õBureauö) opened 521 cases for investigation;
- Investigations led to $4.7 million in court-ordered restitution;
- Investigations resulted in 292 arrests, 105 of which were for healthcare fraud;
- Prosecutors obtained 226 convictions in cases in which the Bureau was involved;
- Suspected no-fault fraud accounted for 54% of all fraud reports received by the Bureau.

Background

The Bureau has a longstanding commitment to combating insurance fraud. It is responsible for the detection and investigation of insurance and financial fraud and the referral for prosecution of persons or entities that commit those frauds. The Bureau is headquartered in New York City, with offices in Garden City, Albany, Syracuse, Oneonta, Rochester, and Buffalo.

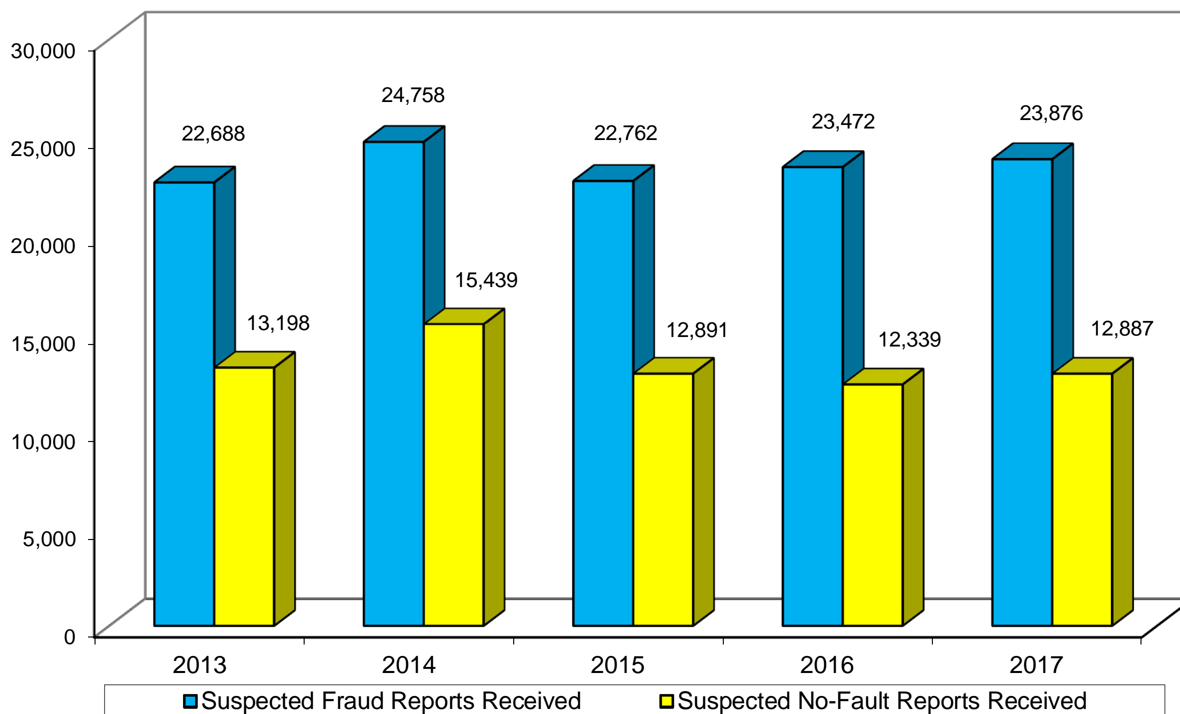
Reports of Suspected Fraud/Investigations

The Bureau received 23,876 reports of suspected fraud in 2017. The majority of those reports ô 22,823 ô were from licensees required to submit reports of suspected fraud to DFS. The remaining reports were from other sources, such as consumers or anonymous tips. The Bureau opened 521 cases for investigation in 2017. Tables showing the number of fraud reports received, investigations opened, and arrests by type of fraud appear in the Appendices.

In 2017 the Bureau referred 34 cases to prosecutorial agencies for prosecution and prosecutors obtained 226 convictions in cases in which the Bureau participated.

No-Fault Fraud Reports and Investigations

The number of suspected no-fault fraud reports received by the Bureau accounted for 54% of all fraud reports received by the Bureau in 2017.



Combating no-fault fraud is one of the DFSø highest priorities. Deceptive healthcare providers and medical mills that bill insurance companies under New Yorkø no-fault system cost New York drivers hundreds of millions of dollars. DFS maintained its aggressive approach to combating this fraud throughout the year.

Arrests

Bureau investigations led to 292 arrests for insurance fraud and related crimes in 2017.

Restitution

Criminal investigations conducted by the Bureau resulted in $4.7 million in court-ordered restitution.

Multi-Agency Investigations

In 2017, the Bureau conducted multi-agency investigations with the following government departments, agencies, and offices:

- New York Police Departmentø Fraudulent Collision Investigation Squad and Auto Crime Division
- Fire Department of New Yorkø Bureau of Fire Investigations

- Office of the WorkersøCompensation Fraud Inspector General
- New York State Office of Fire Prevention and Control
- New York State Insurance Fund
- District Attorneyøs Offices
- State and local Police and Sherifføs Departments
- U.S. Attorneyøs Offices
- New York State Comptrollerøs Office
- New York State Attorney Generaløs Office
- New York State Department of Motor Vehicles
- New York Auto Insurance Plan
- National Insurance Crime Bureau
- U.S. Postal Inspection Service
- U.S. Department of Labor
- Federal Bureau of Investigation
- U.S. Department of Health and Human Services
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)

Task Force and Working Group Participation

The Bureau is an active participant in 10 task forces and working groups designed to foster cooperation among agencies involved in fighting insurance fraud. Participation provides the opportunity for intelligence gathering, joint investigations, information sharing, and effective use of resources. 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
- Rochester Health Care Fraud Working Group
- FBI New York Health Care Fraud Task Force/Medicare Fraud Strike Force
- New York Anti-Car Theft and Fraud Association
- National Insurance Crime Bureau Working Group
- High Intensity Drug Trafficking Area
- Drug Enforcement Administration Tactical Diversion Task Force (Upstate/Downstate)

- Suffolk County District Attorneyøs Office Insurance Crime Bureau
- New York Alliance Against Insurance Fraud

Highlight of Task Force Participation

Bureau personnel assigned to the Drug Enforcement Administration Tactical Division Squad were part of an investigation of a doctor suspected of distributing oxycodone prescriptions without a legitimate medical need. In June, the investigation led to the arrests of the doctor and two others who allegedly steered people looking for illegal narcotics to the doctor who provided prescriptions with little or no examination and to a pharmacy that would fill the prescriptions. The amount of the alleged fraud was estimated to be more than $4 million. The case is being prosecuted by the U.S. Attorneyøs Office for the Southern District of New York.

Collection of Rate Evasion Data

DFS collected data from insurers that wrote at least 3,000 personal lines automobile insurance policies showing the number of instances in which individuals misrepresented the principal location where they garaged and drove their vehicles to obtain lower premiums in 2017. A summary of the data appears in the Appendices under the Section titled õ2017 Data Call: Vehicle Principal Location Misrepresentations.ö

Approval of Fraud Prevention Plans

Section 409 of the New York Insurance Law requires insurers that write at least 3,000 individual accident and health, workersø compensation, or automobile policies (or group policies that cover at least 3,000 individuals) issued or issued for delivery annually in New York to submit a Fraud Prevention Plan for the detection, investigation, and prevention of insurance fraud. Licensed health maintenance organizations with at least 60,000 enrollees must also submit a Fraud Prevention Plan. Plans must provide for a full-time special investigations unit (õSIUö) and that provides the following:

- Interface of SIU personnel with law enforcement and prosecutorial agencies;
- Coordination with other units of the insurer for the investigation and initiation of civil actions based on information received by or through the SIU;
- Development of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity;
- Allocation for the level of staffing and resources devoted to the SIU based on objective criteria;
- In-service training of investigative, claims, and underwriting personnel in identification and evaluation of insurance fraud; and
- Development of a public awareness program focused on the cost and frequency of insurance fraud and the methods by which the public can assist in preventing fraud.

Insurers may submit Fraud Prevention Plans for multiple affiliated insurers. A list of insurer Fraud Prevention Plans approved by DFS that were active as of December 31, 2017 appears in the Appendices.

Investigation of Life Settlement Fraud and Review of Fraud Prevention Plans

A life settlement is the sale of a life insurance policy to a third party, known as the life settlement provider. The owner of a life insurance policy may sell his or her policy for an immediate cash benefit, making the life settlement provider the new owner of the life insurance policy, which entails paying future premiums and collecting the death benefit when the insured dies.

The Life Settlement Act of 2009 brought the New York life settlement industry under regulation by DFS. The Act provides a comprehensive regulatory framework and creates the crimes for acts 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. Section 411(e) of the Insurance Law also requires that they submit an annual report by March 15th of each year that describes the providerøs experience, performance, and cost effectiveness in implementing its Plan. There were 23 licensed life settlement providers in New York as of December 31, 2017, each with an approved plan on file. A complete list of licensed life settlement providers with approved plans on file appears in the Appendices.

Major Insurance Fraud Cases in 2017

- Working with the N.Y. Attorney Generaløs office (õNYAGö), DFS conducted an investigation that led to the conviction of the mastermind of a massive scheme to fraudulently obtain discounted commercial insurance policies and New York State vehicle registrations for more than 100 vehicles by registering the cars with fake companies. Over the course of eight years, the defendant, along with nine co-conspirators who pled guilty, created fictitious business partnerships through false filings with the Kings County Supreme Court Clerkøs Office and then fraudulently obtained commercial automobile insurance for multiple vehicles under the names of the fictitious business partnerships. Among other misrepresentations, to obtain lower premiums they falsely represented that the insured vehicles would be engaged in low-risk businesses and falsely stated where the vehicles would be operated and garaged. The leader of the scheme was convicted of 29 felony counts including various degrees of grand larceny, insurance fraud, offering a false instrument for filing, criminal possession of a forged instrument and scheme to defraud. He will be sentenced in 2018.
- DFS, working with the Suffolk Countyøs District Attorneyøs Office, investigated an insurance broker who allegedly accepted payments for premiums from businesses seeking insurance coverage but never purchased the insurance for her clients and issued documents purporting to reflect coverage. She and her brokerage firm were indicted for more than $1 million in falsely financed insurance coverage. The investigation found that she and her firm had engaged in several distinct schemes to defraud a financing company, her clients, and several insurance carriers. After trial,

while awaiting sentencing, the broker continued her fraudulent activities and was re-arrested. She subsequently pled guilty to grand larceny and scheme to defraud, and was sentenced to 3-to-9 years and ordered to pay $1.8 million in restitution to her victims.

- A Brooklyn-based construction company and its owner pleaded guilty to grand larceny for stealing over $700,000 from workers by failing to pay the prevailing wage on public works projects financed by the New York City School Construction Authority and other government agencies. Between 2012 and 2015, the defendants were granted 15 public works contracts from three government agencies. The defendants inflated contract costs and submitted phony bills, defrauding the public while simultaneously failing to pay their workers the prevailing wage. DFS conducted the investigation in partnership with the Kings County District Attorneyøs Office. Under the plea arrangement, the owner will be sentenced to five yearsø probation, the company will receive a conditional discharge, and both will be barred from public works contracts for five years. The defendants also agreed to forfeit $2.5 million. They are scheduled to be sentenced in March 2018.
- A New Windsor business owner was sentenced to 1-to-3 years in prison and ordered to pay $64,136 in restitution after pleading guilty to attempted third-degree arson and insurance fraud. The plea followed a year-long joint investigation by DFS, the Newburgh Town Police, fire investigators from Newburgh, and the Orange County District Attorneyøs Office into a suspected arson at the defendantøs restaurant. The investigation determined that the defendant had intentionally set a fire and then filed fraudulent documents to support his insurance claim.
- A joint investigation by DFS, the U.S. Postal Inspection Service, the Internal Revenue Serviceøs Criminal Investigations Division, and the U.S. Attorneyøs Office for the Western District of New York resulted to the defendantøs guilty plea to mail fraud and tax evasion in October. While residing in New York, the defendant devised a scheme to defraud more than 100 companies that were holding unclaimed funds listed on the California State Controllerøs website. Using false identities, the defendant sent documentation of entitlement to unclaimed funds to the companies and had more than $400,000 in funds deposited into bank accounts he controlled. He also committed fraud by underreporting his income and avoiding paying more than $160,000 in taxes.
- A cold case homicide investigation concluded in the fall of 2017 after an Otsego County jury found the defendant guilty of murder in the second degree. He was sentenced to 25 years-to-life in prison. The defendant had been charged with intentionally running over his wife with a tractor trailer near the New York State border in Sayre, Pennsylvania, in January 2000. After her death, he made an insurance claim. The death was initially considered an accident, but after receiving information from the victimøs family, the case was reopened in early 2016. The Otsego County District Attorney, with the assistance of DFS, investigated and concluded the defendant had intentionally killed his wife.
- In June 2017, DFS, the NYAG, and the National Insurance Crime Bureau announced a 42-count indictment charging six individuals with participating in an auto insurance fraud scheme to defraud insurance carriers out of more than $120,000. The

defendants allegedly submitted fake property damage claims for high-end vehicles. Five of the six defendants have been arrested and charged with insurance fraud, identity theft, grand larceny, falsifying business records, scheme to defraud, and conspiracy. The case is pending in Kings County Supreme Court.

CONSUMER ASSISTANCE UNIT

Operations and Activities

The Consumer Assistance Unit (õCAUö) issues licenses for insurance companies, producers (brokers and agents) and non-producers (limited lines producers, independent and public adjusters, reinsurance intermediaries, bail agents, title agents, and life settlement brokers) and handles consumer complaints against those licenses, as well as other financial institutions and providers of financial products and services. The Unit also disseminates consumer alerts and information, responds to consumer inquiries, and mediates and resolves disputes that consumers may otherwise be unable to resolve on their own. In addition, the Unit manages the deployment and staffing of DFSøs Mobile Command Center (õMCCö), an important tool used to inform, engage and support communities throughout New York State, particularly in the event of emergencies such as flooding in the Lake Ontario Region in 2017. The CAU also acts as industry watchdog, promoting industry accountability by working closely with insurance companies and financial institutions to investigate and help correct patterns of consumer abuse and fraud.

The CAU employs a multifaceted approach to assisting consumers:

- **Complaint Resolution:** CAU provides 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. With the addition of Consumer Representatives to our staff, the CAU is able to mediate complaints in greater numbers, more efficiently, and thus provide an enhanced consumer experience.
- **Consolidation of Complaint System:** Using its enhanced complaint system, CAU staff can quickly track various types of financial complaints and identify trends. Once a trend or issue is identified, it is elevated to the Civil Investigations Unit to review and determine if a more complex review of the issue is needed, with the goal of benefiting a broad class of consumers.
- **Complaint Triage:** Improved processes for triaging complaints and reevaluating staff assignments have enabled the CAU to route complaints more quickly and use resources and staff more efficiently.
- **Consolidated Call Center (CCC):** To promote efficiencies, DFS integrated its call center function with that of the Department of Tax and Finance. DFS staff works with the CCC to provide updates and new information to assist callers. The call center operates from 8:30 a.m. to 4:30 p.m., Monday through Friday, with extended coverage during disasters.

- **Consumer Assistance on Financial Products:** The CAU also handles complaints regarding financial products and services such as payday loans, debt collection, prepaid debit cards, and debt settlement, among others. The CAU trains consumer representatives to handle gap product complaints and is developing new procedures to ensure that these complaints are processed and mediated expeditiously.

Complaints and Inquiries

Insurance Complaints

The CAU received 39,641 insurance complaints in 2017. The Unit processed 30,805 insurance complaints and handled 1,187 insurance inquiries. The processed complaints had the following dispositions: 5,977 were upheld or transferred for prompt pay review; 3,944 were not upheld but were adjusted; 9,465 were not upheld; and 11,419 were referrals, duplicates, withdrawn, or suspended.

For approximately 30% 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 for a previously denied disaster-related claim.

A more detailed breakdown is as follows:

Type	Number of Complaints	Recovery
Property & Casualty	910	$7,300,928
Service Contracts	9	7,151
No-Fault	310	678,217
Health	833	6,089,029
Auto	639	2,917,958
Investigations	35	198,807
Life	13	1,447,135
Prompt Pay	4,604	23,990,709
Total	**7,353**	**$42,629,934**

During 2017, the CAU also required insurance companies to offer reinstatement to 361 policyholders as a result of the CAUøs 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.

Banking Complaints, Referrals, and Inquiries (Non-Mortgage)

In 2017, the CAU processed 2,722 non-mortgage-related complaints, referrals, and inquiries, representing a .05% increase from 2017. A breakdown is set out below:

	December 31, 2017	December 31, 2016	Percent Change
Complaints	2,613	2,649	-1.4%
Referrals	76	135	-44%
Written Inquiries	33	44	-25%
Total/Aggregate Volume	**2,722**	**2,828**	**-3.98%**

External Appeals

Under Article 49 of the Insurance Law, consumers have the right to request a review of certain coverage denials by medical professionals who are independent of the healthcare plan issuing the denial. An external appeal may be requested when a health plan denies insurance coverage because it deems specific healthcare services to be experimental or investigational, not medically necessary, for the treatment of a rare disease, is for participation in a clinical trial, or require formulary exceptions or step therapy. Additionally, consumers covered by a health maintenance organization (õHMOö) may file 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 appeal applications for completeness and eligibility. Eligible applications are randomly assigned to one of three external appeal agents screened for conflicts of interest. Once assigned, DFS monitors the process to ensure that the external appeal agent renders a timely decision and provides proper notice of the decision.

The table below summarizes appeals received and appeals closed for 2017 and the preceding five years:

Summary of External Appeal Applications Received by Year						
Year	Received	Closed	Ineligible	Voluntary Reversal	Denial Upheld	Overturned*
2012	5,796	5,753	1,874	360	2,427	1,092
2013	7,868	7,725	2,734	483	2,987	1,521
2014	8,520	8,296	2,502	622	3,357	1,815
2015	9,771	9,867	2,499	721	4,121	2,526
2016	8,602	8,620	2,255	607	3,349	2,409
2017	7,909	7,879	2,311	511	3,208	1,849

Voluntary Reversalsô plan overturned its denial before the appeal was submitted to a reviewer
Ineligible—the appeal was not eligible for an external review
Overturned—includes decisions that overturned the denial in whole or in part

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

External Appeal Determinations by Type of Appeal in 2017				
Type of Denial	**Total**	**Overturned**	**Overturned in Part**	**Upheld**
Medical Necessity	4,775	1,539	177	3,059
Experimental/Investigational	233	110	3	120
Clinical Trial	1	1	0	0
Out-of-Network Service	1	0	0	1
Out-of-network Referral	39	16	1	22
Rare Disease	2	1	0	1
Step Therapy	1	0	0	1
Formulary Exception	5	2	0	3
Total	**5,057**	**1,669 (33%)**	**181 (3.6%)**	**3,207 (63.4%)**

As part of DFS oversight of the External Appeal program, the CAU reviews all external appeal decisions received to ensure that the appropriate number of clinical peer reviewers was used, the clinical peer reviewer was board-eligible or board-certified in the appropriate specialty, and that the review was conducted in accordance with the standards set out in Article 49 of the Insurance Law. When appropriate, DFS contacts the external appeal agent to obtain a response to medical questions and concerns raised by the consumer or provider.

2017 External Appeals Rejected as Ineligible	
Reason	**Quantity**
Applicant Withdrew Appeal	147
Contractual Issue	168
Coverage Terminated	2
Covered benefit issue	37
CPT Code	7
Duplicate Application	284
Failure to Respond	774
Federal Employees Health Benefit Program	10
Medicaid Fair Hearing	10
Medicare	93
No Internal Appeal	195

Non-Par Provider	1
Out-of-Network	4
Out-of-state Contract	54
Overturned on Internal Appeal	29
Provider Ineligible to Appeal	13
Reimbursement Issue	63
Self-Insured Coverage	302
Untimely	118
Total	**2,311**

Out-of-Network Law

Article 6 of the Financial Services Law protects consumers from õsurprise billsö (as defined by the law) when services are performed by a non-participating (out-of-network) doctor at a participating hospital or ambulatory surgical center in the consumerøs health insurance companyøs network, or when a participating doctor refers an insured patient to a non-participating provider. The law also protects insured patients from bills for out-of-network emergency services if patients have coverage through a health insurance company subject to New York State law by limiting the patientsø liability to his or her in-network co-payment, coinsurance, or deductible.

Independent Dispute Resolution Pursuant to the Out-of-Network Law

Under Article 6 of the Financial Services Law, a provider or health insurance company may dispute certain payments, charges for emergency services or surprise bills through a process called Independent Dispute Resolution (õIDRö). An Independent Dispute Resolution Entity (õIDREö) reviewer with experience in healthcare billing, reimbursement, and usual and customary charges will review the dispute in consultation with a licensed doctor in active practice in the same or similar specialty as the doctor providing the service that is the subject of the dispute. Insured and uninsured patients and patients with self-insured coverage may submit a dispute.

The tables below summarize IDR applications filed in 2017:

Summary of Independent Dispute Resolutions Received in 2017			
Emergency Services		**Surprise Bills**	
Total Received	**637**	**Total Received**	**476**
Not eligible	158	Not eligible	113
Still in process	50	Still in process	55
Decision rendered:		**Decision rendered:**	
Health plan payment more reasonable	181	Health plan payment more reasonable	44
Provider charges more reasonable	58	Provider charges more reasonable	128
Split decision	91	Split decision	73
Settlement reached	99	Settlement reached	63

Not eligible—dispute was not eligible for a review.
Split decision—health plan payment more reasonable for one or more code and the provider's charge more reasonable for the remaining codes.
Settlement reached—health plan and provider agreed to settle the dispute prior to a full review.

IDRs rejected as not eligible:

Independent Dispute Resolutions Rejected as Ineligible in 2017			
Emergency Services		Surprise Bills	
AOB not signed/submitted	7	AOB not signed/submitted	22
Application not received by IDRE	12	Application not received by IDRE	8
Application withdrawn	43	Application withdrawn	22
Date of service before 3/31/15	0	Date of service before 3/31/15	2
Duplicate submission	2	Duplicate submission	1
Exempt Emergency Room codes	4	Exempt Emergency Room codes	0
Essential Plan Coverage	1	Essential Plan Coverage	0
Facility Fees	1	Facility fees	3
Federal Employee coverage	5	Federal Employee coverage	1
Invalid date of service	0	Invalid date of service	0
Medicaid ER Services	4	Medicaid ER Services	3
Medicare	2	Medicare	0
No response to eligibility inquiry	2	No response to eligibility inquiry	4
Not a surprise bill	0	Not a surprise bill	28
Not emergency services	19	Not emergency services	0
Out of State coverage	12	Out of State coverage	3
Self-funded coverage	33	Self-funded coverage	7
Services not rendered by a physician	2	Services not rendered by a physician	2
Services received out of state	3	Services received out of state	3
Services rendered by a par-provider	1	Services rendered by a par-provider	0
Settlement reached before IDR filed	4	Settlement reached before IDR filed	1
Wrong insurer	1	Wrong insurer	3
Total	**158**	**Total**	**113**

Outreach and Response Efforts in 2017

The CAU participated in the New York State Fair and more than 50 outreach events in 2017 on topics including elder abuse, identity theft, and health issues. In addition, utilizing DFSøs Mobile Command Center, the CAU assisted homeowners and small business owners impacted by the Lake Ontario flooding.

Producer Licensing

The Producer Licensing Unit reviews applications, issues licenses, and processes renewals for insurance companies, as well as licensed producers, including agents, brokers, adjusters, bail bond agents, life settlement brokers, providers, and intermediaries.

Producer Investigations

In 2017, the Producer Licensing Unit issued 179,140 licenses and collected more than $20.1 million in fees. The Producer Licensing Unit also monitors, approves, and audits courses for continuing education.

The Producer Investigations Unit investigates license applicants and Section 1033 waiver applicants for approval for licenses or waivers. In addition, the Unit investigates licensed producers (agents and brokers) and non-producers (e.g. limited lines producers, independent and public adjusters, reinsurance intermediaries, bail agents, title agents, and life settlement brokers) that have criminal convictions, or have or had administrative or civil actions against them. The unit also investigates complaints filed against producers and non-producers, and helps gather and prepare evidence for administrative proceedings against producers and non-producers for license suspension or revocation, fines, and other administrative remedies.

CONSUMER EXAMINATIONS UNIT

Background

The mission of the Consumer Examinations Unit (õCEUö) is to maintain and enhance consumer confidence in New Yorkøs banking industry and protect the industryøs customers. CEU does this by ensuring that regulated institutions abide by the Stateøs consumer protection, fair lending, and Community Reinvestment Act (õCRAö) laws and regulations, as well as by increasing consumer access to traditional banking services in under-served communities by administering the Banking Development District program (õBDDö) and evaluating regulated institutionsø branching, investment, and merger applications for their performance records and community development objectives. Whenever possible, CEU harmonizes its examination and enforcement activities with those of federal counterparts.

Operations and Activities

Consumer Compliance Examinations

CEUøs consumer compliance examinations promote consumer confidence in DFS-regulated depository institutions by monitoring institutionsø compliance with consumer protection statutes and regulations through biennial on-site compliance examinations.

In 2017, CEU conducted 24 consumer compliance exams. The examinations revealed that most institutions have adequate compliance processes, although several depository institutions were subject to regulatory risk resulting from their failure to develop and/or properly implement trainings, policies, and procedures covering relevant New York State laws, regulations, and supervisory procedures. CEU examiners also uncovered objectionable practices committed by a number of institutions, including: improper fees charged in connection with loan servicing and origination; improper fees charged on deposit accounts, including fees on dormant savings accounts higher than those charged on active savings accounts, returned deposit item or insufficient fund fees higher than the legal maximum; improperly disclosed or calculated withdrawal and closure penalties; inconsistent disclosures made to consumers relating to loan pricing; lack of required disclosures (or disclosures made in improper form) including those mandated by the Truth in Lending Act, the Truth in Savings Act, those relating to the basic banking account or approved alternative account required by New York law, and those relating to safe deposit boxes; and improper retention of lender credits purchased by borrowers. CEU works with the institutions to improve their compliance practices.

CEUøs examination of Mortgage Research, LLC, doing business as VAMortgageCenter and Veterans Home Loans, identified improper retention of surplus lender credits. DFS entered into a consent order with the company in August 2017 that provided for approximately $604,000 in restitution to New York consumers and a $500,000 fine. CEUøs compliance examinations have also resulted in depository institutions refunding to 4,267 New York consumers a total of $146,947 in improper and/or illegal fees and interest.

Fair Lending Examinations

DFS seeks to ensure that New York borrowers are treated fairly and equitably in all aspects of the credit application, underwriting, and servicing processes. The fair lending examination includes on-site 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 written fair lending plans. The subject areas of these examinations extend to predatory lending, subprime loans, and mortgage fraud investigations.

In 2017, CEU conducted 25 fair lending exams of 24 depository institutions and 1 non-depository institution. CEU examiners discovered various improper practices, including: unlawful improper imposition of age limits in underwriting programs; inadequate fair lending training given to key lending personnel and failure to ensure training adequacy through testing; inadequate safeguards against fair lending violations committed by third parties involved in the lending process; and excessive discretion to individual lending personnel in approving/denying applicants and in pricing loans. Combining the expertise of its fair lending data analysts and

examiners, CEU identified and investigated the reasons for statistical disparities among borrowers of protected and non-protected classes. As a result, CEU has sought restitution for consumers and required improvements in fair lending risk monitoring and prevention. CEU also reviewed and recommended improvements to numerous institutionsø written fair lending plans.

Community Reinvestment Act ("CRA") Examinations

CRA examinations seek to ensure that regulated institutions are providing loans, investments, and services to support the economic stability, growth, and revitalization of the communities they serve, particularly for low- and moderate-income (õLMIö) individuals and small businesses and in LMI neighborhoods. CRA examinations also try to ensure that borrowers and businesses at all income levels have access to appropriate financial resources at a reasonable cost, consistent with safe and sound banking practices.

In 2017, the Consumer Examination Unit conducted 18 CRA exams. Through analysis of loan data, CEU assesses how well banks serve the credit needs of their communities. CEU conducts intensive on-site examinations to support banksø efforts to comply with New York Stateøs CRA regulations and issues examination ratings and reports that must be shared with the public.

Community Development Unit

The Community Development Unit (õCDUö) facilitates the development and preservation of banking services in under-served and LMI neighborhoods. CDU researches and analyzes community demographic information to ascertain the financial needs of consumers. CDU also reviews the impact on communities of applications to merge, convert charter, make community development equity investments, and open, close, or relocate branches. CDU also administers the Banking Development District program, which includes reviewing the requests of participating banks for the renewal of BDD deposits and making recommendations to the Office of the State Comptroller regarding those renewals. In addition, CDU fosters working relationships with community groups, financial institutions, municipal governments, and other regulatory and supervisory agencies to ensure that residents, businesses, and communities throughout New York State have access to the banking information, products, and services they need.

Banking Development District Applications

The Banking Development District (BDD) Program is a DFS priority, as it assists communities in obtaining better access to affordable financial services, and helps small businesses to develop and grow as part of New Yorkøs communities.

As part of this effort, CDU approved the designation of three new BDDs in 2017, in the Village of Sylvan Beach in the Town of Vienna, Oneida County, and in sections of the Bronx and Brooklyn, and received inquiries on behalf of 11 communities seeking to establish a BDD. As of December 31st, the inquiries resulted in five communities commencing the BDD designation application process.

CDU reviewed 15 BDD Request for Renewal of Deposit Applications and issued recommendations for the renewal of deposits resulting from the reviews. The reviews resulted in 13 recommendations for renewal with no reservations and two recommendations for nonrenewal of deposits. In addition, CDU reviewed two BDD Progress Reports for which it issued responses noting satisfactory progress.

Review of Applications for Community Impact

In 2017, CDU processed 63 branch applications for the following: 19 closings; 11 electronic facility (ATM branch) openings; 29 full branch openings; and 4 relocations. In addition, CDU processed 16 specialized applications, including nine basic banking account alternatives, two changes of control, two conversions, one merger, one acquisition and one sale of deposit business. Finally, CDU reviewed 18 community development equity investment notifications (including 11 requests for prior approval of investments and seven self-certification notifications), of which 17 were either acknowledged or approved, and one was referred to another operating unit at DFS for proper notification and filing.

Community Outreach and Special Projects

CDU continued to coordinate with New York Cityøs Department of Housing Preservation and Development and the University Neighborhood Housing Program to further DFSøs mission to protect tenants of multifamily properties in physical or financial distress through CRA examinations.

CDU actively participated in the CRA Interagency Group, composed of community affairs officials from the Federal Deposit Insurance Corporation, the Federal Reserve Bank, and the Office of the Comptroller of the Currency. CDU participated in the coordination and delivery of four CRA workshops for banks and two CRA workshops for community-based organizations.

Summary of Consumer Examination Unit

CEU conducted 24 consumer compliance, 25 fair lending, and 18 CRA exams, and made recommendations regarding 63 bank applications and 15 requests for the renewal of BDD branch deposits in 2017.

Type of Work	2017	Scheduled in 2018
Consumer Compliance	24	27
Fair Lending (FL)	25	34
FL Depositories	24	27
FL Non-depositories	1	7
CRA	18	28
CDU – applications	63	N/A
CDU – BDD request for renewal	15	13

HOLOCAUST CLAIMS PROCESSING OFFICE

The Holocaust Claims Processing Office (õHCPOö) helps Holocaust victims and their heirs recover assets deposited in banks, unpaid proceeds of insurance policies issued by European insurers, and artworks that were lost, looted, or sold under duress. The HCPO accepts claims for Holocaust-era looted assets from anywhere in the world and charges no fees for its services.

From its inception through December 31, 2017, the HCPO has received claims from 5,773 individuals from 46 states, the District of Columbia, and 40 countries. In total, the HCPO has successfully resolved 15,455 claims of 5,252 individuals in which an offer was presented, or the asset was deemed non-compensable.

To date, the HCPO has secured 9,161 offers, the combined total[1] of which for bank, insurance, and other losses amounts to $176,929,962. The office facilitated restitution settlements involving 140 cultural objects. In 2017, HCPO claimants received $2,001,593 in offers and the office coordinated settlements for 10 works of art.

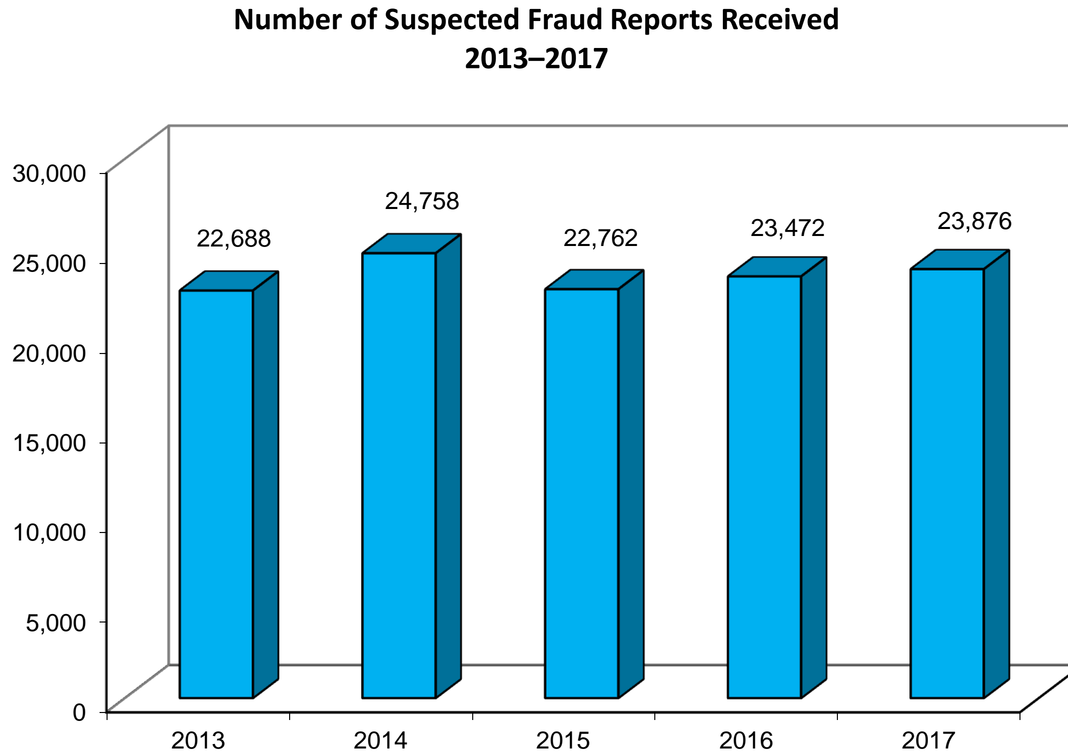
As required by Section 37-a of the Banking Law, HCPO submitted its 2017 Annual Report to the Governor and Legislature on January 16, 2018. The report is available on the Departmentøs website.

[1] Processes offer victims or heirs monetary compensation calculated on the value of the lost assets; however, the total amount of funds available to a claims agency may be limited and may not allow for full payment of loss. Thus, the actual payment may be substantially less than the value of the lost asset. The full value noted in a decision is important as it recognizes the actual loss and guides in determining the amount of payment when full payment is not possible. Therefore, the HCPO reports the full value. Sometimes victims do not consider the offer adequate and do not agree to settle. In other cases, the percentage of the full value that is offered is the amount paid.

APPENDICES—2017 STATISTICS

The FFCPD received 23,876 reports of suspected fraud in 2017, compared with 23,472 in 2016.

Number of Suspected Fraud Reports Received



Information Furnished By (IFB) Reports Received by Year

IFBs Received by Year	2013	2014	2015	2016	2017
Boat Theft	0	2	8	0	4
Auto Theft	751	693	721	613	559
Theft from Auto	29	18	26	22	28
Auto Vandalism	239	213	308	372	324
Auto Collision Damage	1,812	1,654	1,933	2,542	2,293
Auto Fraudulent Bills	80	219	201	111	114
Auto Miscellaneous	1,271	1,503	1,273	1,433	1,342
Auto I.D. Cards	11	6	8	4	6
Total—Auto Unit	**4,193**	**4,308**	**4,478**	**5,097**	**4,670**
Workers' Compensation	1,014	998	1,230	1,650	1,147
Total—Workers' Comp Unit	**1,014**	**998**	**1,230**	**1,650**	**1,147**

Disability Insurance	182	162	205	267	235
Health Accident Insurance	1,163	1,234	1,356	1,535	1,500
No-Fault Insurance	13,198	15,439	12,891	12,339	12,887
Total—Medical/No-Fault Unit	**14,543**	**16,835**	**14,452**	**14,141**	**14,622**
Boat Fire	0	0	1	2	0
Auto Fire	185	167	153	113	126
Fire—Residential	89	104	104	106	99
Fire—Commercial	21	40	23	24	36
Total—Arson Unit	**295**	**311**	**281**	**245**	**261**
Burglary—Residential	254	174	196	194	179
Burglary—Commercial	45	33	32	33	33
Homeowners	1,068	769	765	674	580
Larceny	79	77	83	125	214
Lost Property	109	172	190	478	1,027
Robbery	14	7	20	24	15
Bonds	9	3	1	3	3
Life Insurance	397	433	481	400	517
Ocean Marine Insurance	18	13	15	13	12
Reinsurance	0	1	1	0	1
Appraisers/Adjusters	5	8	17	9	5
Agents	56	90	84	83	71
Brokers	45	46	45	53	40
Ins. Company Employees	4	4	4	2	5
Insurance Companies	62	33	52	37	81
Title/Mortgage	38	11	4	8	17
Commercial Damage	103	77	123	110	287
Unclassified	337	355	208	93	89
Total—General Unit	**2,643**	**2,306**	**2,321**	**2,339**	**3,176**

IFBs Received	2013	2014	2015	2016	2017
Auto Unit Totals	4,193	4,308	4,478	5,097	4,670
Workers Comp Unit Totals	1,014	998	1,230	1,650	1,147
Medical/No-Fault Unit Totals	14,543	16,835	14,452	14,141	14,622
Arson Unit Totals	295	311	281	245	261
General Unit Totals	2,643	2,306	2,321	2,339	3,176
Grand Total	**22,688**	**24,758**	**22,762**	**23,472**	**23,876**

Cases Opened by Year	2013	2014	2015	2016	2017
Boat Theft	0	0	0	0	0
Auto Theft	55	56	85	22	55
Theft from Auto	0	2	2	0	1
Auto Vandalism	3	1	2	9	11
Auto Collision Damage	25	34	26	24	26
Auto Fraudulent Bills	2	4	4	0	1
Auto Miscellaneous	16	27	23	7	11
Auto I.D. Cards	0	0	0	0	2
Total—Auto Unit	**101**	**124**	**142**	**62**	**107**
Workers' Compensation	98	88	99	90	136
Total—Workers' Comp Unit	**98**	**88**	**99**	**90**	**136**
Disability Insurance	2	10	9	13	10
Health Accident Insurance	32	34	37	43	39
No-Fault Insurance	22	65	46	58	67
Total—Medical/No-Fault Unit	**56**	**109**	**92**	**114**	**116**
Boat Fire	0	0	0	0	0
Auto Fire	14	11	17	6	14
Fire—Residential	8	6	8	16	10
Fire—Commercial	6	9	5	5	6
Total—Arson Unit	**28**	**26**	**30**	**27**	**30**
Burglary – Residential	1	2	9	9	4
Burglary – Commercial	1	0	2	0	0
Homeowners	6	9	15	20	9
Larceny	14	11	20	26	13
Lost Property	0	1	2	6	3
Robbery	0	1	1	0	0
Bonds	5	0	1	0	0
Life Insurance	11	10	17	20	26
Ocean Marine Insurance	1	0	0	0	1
Reinsurance	0	0	0	0	0
Appraisers/Adjusters	2	0	1	0	0
Agents	9	15	10	6	10
Brokers	8	6	10	13	7
Ins. Company Employees	0	1	0	1	1
Insurance Companies	0	6	1	3	0
Title/Mortgage	2	1	0	0	0
Commercial Damage	2	7	0	4	1

Miscellaneous	48	26	38	48	57
Total—General Unit	**110**	**96**	**127**	**156**	**132**
Grand Total	**393**	**443**	**490**	**449**	**521**

Cases Opened by Year	2013	2014	2015	2016	2017
Auto Unit Totals	101	124	142	62	107
Workers Comp Unit Totals	98	88	99	90	136
Medical/No-Fault Unit Totals	56	109	92	114	116
Arson Unit Totals	28	26	30	27	30
General Unit Totals	110	96	127	156	132
Total	**393**	**443**	**490**	**449**	**521**

2013	IFBs	Cases	Arrests
Auto Unit Total	4,193	101	97
Workers' Comp Unit Total	1,014	98	85
Medical/No-Fault Unit Total	14,543	56	170
Arson Unit Total	295	28	17
General Unit Total	2,643	110	99
Grand Total	**22,688**	**393**	**468**

2014	IFBs	Cases	Arrests
Auto Unit Total	4,308	124	87
Workers' Comp Unit Total	998	88	71
Medical/No-Fault Unit Total	16,835	109	77
Arson Unit Total	311	26	18
General Unit Total	2,306	96	50
Grand Total	**24,758**	**443**	**303**

2015	IFBs	Cases	Arrests
Auto Unit Total	4,480	142	117
Workers' Comp Unit Total	1,230	99	38
Medical/No-Fault Unit Total	14,452	92	79
Arson Unit Total	279	30	32
General Unit Total	2,321	127	64
Grand Total	**22,762**	**490**	**330**

2016	IFBs	Cases	Arrests
Auto Unit Total	5,097	62	35
Workers' Comp Unit Total	1,650	90	33
Medical/No-Fault Unit Total	14,141	114	133
Arson Unit Total	245	27	14
General Unit Total	2,339	156	80
Grand Total	**23,472**	**449**	**295**

2017	IFBs	Cases	Arrests
Auto Unit Total	4,670	107	63
Workers' Comp Unit Total	1,147	136	38
Medical/No-Fault Unit Total	14,622	116	105
Arson Unit Total	261	30	9
General Unit Total	3,176	132	77
Grand Total	**23,876**	**521**	**292**

2018 DATA CALL: VEHICLE PRINCIPAL LOCATION MISREPRESENTATION

The 2018 Vehicle Principal Location Misrepresentation data call concerned misrepresentations by New York insureds of the principal place where their vehicles were garaged and/or driven during 2017.

Summary of Data Reported

- More than 99% (determined by market share) 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 2017 was 15,440.
- The total amount of reported premium lost in 2017 as a result of New York insureds who misrepresented the principal place where their vehicles were garaged and/or driven was $18,982,480.
- In 2017, 83% of the reported misrepresentations involved a location within New York State. The remaining 17% involved a location outside of New York State.

Misrepresentations Involving a New York State Location

- Total amount of reported premium lost in 2017 due to misrepresentations that involved a location (county) within New York State was $17,068,480.
- Top reported New York counties where insureds, who misrepresented the garaging/driving location of their vehicles, actually garaged and/or drove their vehicles in 2017:

Kings	25.76%
Queens	17.74%
Bronx	13.95%
Nassau	7.28%
Suffolk	5.25%
New York	4.11%
Westchester	3.80%
Monroe	3.25%
Onondaga	2.76%
Albany	2.08%
Erie	1.75%
Schenectady	1.19%

- Top reported New York counties used by insureds to misrepresent where their vehicles were garaged and/or driven in 2017:

Suffolk	11.56%
Westchester	8.76%
Nassau	7.78%
Monroe	5.75%
Albany	5.26%
Onondaga	4.04%
New York	3.72%
Queens	3.45%
Orange	3.35%
Erie	3.19%
Schenectady	3.07%
Broome	3.06%

Misrepresentations that Involved a Location Outside of New York State

- Total amount of reported premium lost in 2017 due to misrepresentations that involved a location outside of New York State was $1,914,436.
- Top reported New York counties where insureds, who misrepresented the garaging or driving location of their vehicles, actually garaged and/or drove their vehicles in 2017:

Suffolk	15.28%
Nassau	12.28%
Kings	12.25%
Queens	10.15%
New York	8.80%
Bronx	5.28%
Westchester	5.06%
Erie	3.37%
Richmond	3.18%

- Top reported states used by insureds to misrepresent where vehicles were garaged and/or driven in 2017:

Florida	55.39%
Pennsylvania	6.82%
Connecticut	4.49%
South Carolina	4.31%
New Jersey	3.26%
North Carolina	3.26%
Virginia	2.77%
Arizona	2.32%

Approved Fraud Prevention Plans on File as of December 31, 2017

Aetna Life Insurance Company

AIG Companies

Allstate Insurance Group

Allstate Life Insurance Company of New York

Amalgamated Life Insurance Company

American Family Life Assurance of New York

American Modern Insurance Group

American Progressive Life & Health Ins Co of NY

American Transit Insurance Company

Ameritas Life Insurance Corp. of New York

AMEX Assurance Company

Amica Mutual Insurance Company

Allianz Global Corporate & Specialty North America

AMTrust Financial Services Inc.

Anthem, Inc.

Arch Insurance Company

Assurant Group

AXA Equitable Insurance Company

Bankers Conseco Life Insurance Company

Capital District Physiciansø Health Plan

CareConnect Ins Co.

Central Mutual Insurance Company

Chubb Group of Insurance Companies

CIGNA Health Group

Cincinnati Insurance Company

CMFG Life Insurance Company

Commercial Travelers Mutual Insurance Company

CNA Insurance Companies

Countryway Insurance Company

Country-Wide Insurance Company

CSAA Fire & Casualty Insurance Company

Dairyland Insurance Company

Dearborn National Life Insurance Company of NY

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

Excellus BlueCross BlueShield

Farm Family Casualty Insurance Company

FarmersøNew Century Insurance Company

First Reliance Standard Life Insurance Company

First Symetra National Life Insurance Company

GEICO

Genworth Life Insurance Company of New York

Gerber Life Insurance Company

Global Liberty Insurance Company of New York

Guard Insurance Group

Guardian Life Insurance Company of America

Hanover Group

The Hartford Financial Services Group

HealthNow of New York Inc.

Healthplex Insurance Company

Hereford Insurance Company

HM Life Insurance Company of New York

IDS Property Casualty Insurance Company

Independent Health Association, Inc.

Interboro Insurance Company

Ironshore Indemnity Incorporated

John Hancock Life Insurance Company of New York

Kemper

Kingstone Insurance Company

Lancer Insurance Company

Liberty Mutual Insurance

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

Markel North American Insurance Group

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 General Insurance

National Liability and Fire Insurance Company

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

Philadelphia Indemnity Insurance Company

Preferred Mutual Insurance Company

Principal Life Insurance Company

Progressive Group of Insurance Companies

Prudential

QBE Insurance Group Limited

Renaissance Health Insurance Company of NY

SBLI Mutual Life Insurance Company

Securian Financial Group

Security Mutual Life Insurance Company of NY

Selective

ShelterPoint Life Insurance Company

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

Transamerica Financial Life Insurance Company

Travelers

Tri-State Consumer Insurance Company

Trustmark Insurance Company

Uniamerica Insurance Company of New York, Inc.

Union Labor Life Insurance Company

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.

USAA Group

Utica National Insurance Group

Unum Provident Company

Voya Retirement and Annuity Company

Zurich North America

2017 Approved Life Settlement Provider Fraud Prevention Plans on File

Abacus Settlements, LLC

Berkshire Settlements, Inc.

Coventry First LLC

Credit Suisse Life Settlements LLC

EAGil Life Settlement Inc.

EconoTree Capital INC.

FairMarket Life Settlements Corp.

Georgia Settlement Group

GWG Life Settlements, LLC

Habersham Funding, LLC

Imperial Life Settlements, LLC

Institutional Life Settlements, LLC

Life Equity, LLC

Life Policy Traders, Inc.

LifeTrust, LLC

Lotus Life LLC

Magna Life Settlements, Inc.

Maple Life Financial Inc.

Montage Financial Group, Inc.

Q Capital Strategies, LLC

SLG Life Settlements, LLC

Spiritus Life, Inc.

Wm. Page & Associates, Inc.