Chapter 6 Unfair Methods of Competition and Unfair or Deceptive Acts and Practices

Since the late 1800s, the U.S. government has been concerned with the manner in which businesses compete with each other and price their products and services. In 1914, Congress passed the Federal Trade Commission Act, which pertains in part to unfair or deceptive acts and practices. Specifically, federal law considers an act or practice to be unfair if it:

-Causes serious harm to consumers, or has the potential to do so

-Cannot be reasonably avoided by consumers

-Is not offset by more advantageous benefits to consumers or the competitive marketplace

In 1973, the state of Florida enacted the Florida Deceptive and Unfair Trade Practices Act, which mirrors the contents of its federal equivalent. It considers trade and commerce to mean the advertisement, solicitation, provision, offering, or distribution of any goods or service, including tangibles and intangibles.

Because the insurance industry is regulated even more strictly than many other types of business industries, the insurance industry is also governed by its own unfair trade practices rules—the Unfair Insurance Trade Practices Act. The act defines and prohibits more than 30 practices as unfair methods of competition and unfair or deceptive acts or practices. The following prohibited practices are of special concern to Florida adjusters.

Misrepresentation and False Advertising

Misrepresentation occurs when an adjuster knowingly provides a claimant with information that is untrue, deceptive, or misleading. Among other things, misrepresentation can include the following acts, when committed intentionally in order to obtain an advantage:

-Making false statements about the benefits, terms, or conditions of an insurance policy

-Describing the type of policy, by name, to misrepresent its true nature

Misrepresentation also includes the publication or circulation of a false, deceptive, or misleading statement about the insurance business or about anyone involved in the insurance business. More specifically, this means that advertisements may not:

-Conceal the true identity of the insurer

-Mislead the public as to the true role of the licensee

-Misrepresent the product as something other than insurance

-Provide incorrect information regarding a product’s features or benefits

In some cases, an adjuster may unintentionally make a misrepresentation and believe he or she is being truthful. However, an adjuster's ignorance of facts or the law is not a defense against liability for misrepresentation. Essentially, adjusters are responsible for the statements they make because they have an ethical duty to understand the coverage provided by the policy for the losses and claims they adjust, and to present those coverages truthfully and accurately.

Free Insurance Prohibited

Adjusters, agents, and insurers are also prohibited from advertising, offering, or providing

free insurance as an inducement to purchase or sell real or personal property or services connected with such real or personal property.

In Florida, "free insurance" means:

-Insurance for which no identifiable and additional charge is made to the purchaser of such real property, personal property, or services

-Insurance for which an identifiable or additional charge is made in an amount that is less than the cost of such insurance as to the seller or other person, other than the insurer, providing the same

Adjusters, agents, and insurers also cannot use the word "free" or other words that imply insurance will be provided at no cost in any advertisements.

Deceptive Use of Name

It is also unlawful to use the name or logo of a financial institution when marketing or soliciting customers if such advertising materials are used without the written consent of the financial institution and in a manner that would lead a reasonable person to believe that the material or solicitation originated from, was endorsed by, or is related to the financial institution.

Use of Designations

The use of certifications and professional designations is regulated by the state of Florida not only when marketing, soliciting, and selling insurance but also when giving insurance advice. This regulation is designed to protect consumers from dishonest, deceptive, misleading, and fraudulent trade practices. However, the Department does not endorse any professional designation.

Licensees (including adjusters) are only permitted to use designations from an organization that maintains standards for assuring that its certificants are competent on specific subject matters. In addition, licensees cannot use:

-Designations if they have not actually earned them or are ineligible to use them

-Nonexistent or self-conferred designations

-Designations that indicate or imply a level of occupational qualifications obtained by education, training, or experience that the person does not actually have

A licensee may not use terms such as financial advisor or financial planner to falsely imply that he or she is licensed or qualified to sell or recommend financial products other than insurance products. Licensees are also prohibited from falsely implying that they are qualified to recommend or sell securities or other investment products in addition to insurance products.

However, it is not unlawful for a licensee to inform customers that he or she holds a designation as a certified financial planner (CFP), chartered life underwriter (CLU), chartered financial consultant (ChFC), or life underwriter training council fellow (LUTC), or holds a license to sell securities from the Financial Industry Regulatory Authority (FINRA).

Defamation

Defamation is both an unethical practice and a prohibited trade practice. It occurs when an adjuster knowingly makes any type of statement—in writing or verbally—that is false or maliciously critical to any person and does so with the intent to harm that person. Derogatory comments about insurers or agents during the process of adjusting claims, if they have a negative outcome to the insurer or agent, would be considered defamatory.

Defamation can include both written (libel) and spoken (slander) statements about a third party in the insurance industry.

Boycott, Coercion, and Intimidation

To ensure that there is competition within the marketplace, Florida prohibits practices that inhibit or eliminate competition. Adjusters are prohibited from entering into an agreement to boycott, coerce, or intimidate anyone that results in the unreasonable restraint of, or monopoly in, the insurance business. Boycott, coercion, and intimidation are also regulated by the federal government under antitrust statutes.

False Statements and Entries

Because insurers rely upon the accuracy of the information included on claim documents and reports submitted by adjusters when making claim payments, it is essential for adjusters to be scrupulously honest in the documentation of their work. The intentional filing and making of any document that contains a materially false statement is prohibited. This includes filings with supervisory and public officials and the delivery of such statements to any person or before the public.

Rebating

In some industries, it is customary to give gifts to individuals who refer customers and potential customers. In the insurance industry, however, giving gifts, inducements, or rebates can lead to ethical problems. As a result, Florida law states that it is unlawful to offer anything of value to induce someone to buy insurance, including a rebate of premium, dividends, or stocks and securities. In addition, it is unlawful to knowingly receive or accept such a rebate.

The giving and receiving of "finder's fees" often constitutes a violation of this prohibition. It is considered both illegal and unethical for an adjuster to receive compensation for referring claimants to specific businesses, such as auto body repair shops, glass vendors, and building contractors.

However, the law does allow giving insureds and prospective insureds the following promotional or advertising gifts, as long as the items have a total value of $100 or less per insured or prospective insured in any calendar year.

-any article of merchandise

-goods

-wares

-store gift cards

-gift certificates

-event tickets

-anti-fraud or loss mitigation services

Making charitable contributions, as defined by the Internal Revenue Code (IRC), on behalf of insureds or prospective insureds, is also permitted under the same terms.

Complaint-Handling Procedures

Insurers are also required to establish and maintain complaint-handling procedures so consumer complaints can be handled promptly when they arise. It is considered an unfair trade practice for insurers to fail to maintain complete records of all written complaints they receive since the date of their most recent examination by the Office of Insurance

Regulation. Adjusters should therefore forward any complaints to their carriers and/or appointing entities as soon as they are received, along with all known facts and documentation concerning the complaint.

Twisting

A person cannot make a false or misleading statement or comparison about an insurance policy in order to induce someone to lapse, surrender, terminate, retain, or convert an insurance policy or buy a policy with another insurer. In addition, such practices are also considered unethical if they are used to induce a consumer to purchase a new policy with a different insurer (i.e., such as the insurer represented by the adjuster).

False Claims

Submitting false claims is not only unethical, it is also considered unlawful. Under some circumstances, submitting a false claim may be considered fraud and/or a federal crime. Any person who knowingly presents a false claim for payment to an insurer commits a prohibited trade practice and is guilty of a second-degree misdemeanor. In addition to penalties imposed by the Department, filing a false claim may also subject an individual to criminal penalties.

Sliding

Most insurance contracts come with offers of additional coverage, generally in the form of optional endorsements the insured may choose for an additional premium. Sliding occurs when an adjuster:

-Tells a claimant or insured that a specific policy feature or optional coverage is required by law when it is not

-Tells a claimant or insured that an additional product or policy feature is included at no additional cost when there is an additional charge

-Orders the insurer to add a product or provision to the policy, which results in a premium charge, without obtaining the policyholder's consent to do so

Fraudulent Signatures

As mentioned previously, insurers rely upon the accuracy of the information included on claim documents and reports submitted by adjusters. One of the most important aspects of insurance policy-related documents is the insured's signature. A signature indicates an individual's knowledge, approval, and acceptance of the statements made in the document(s) to which that signature is affixed.

The signatures contained on insurance applications affirm the conditions under which coverage is issued. The signatures contained on claim documents affirm the circumstances of the loss and the insured's demand for payment under the policy.

If an adjuster willfully submits to an insurer a document that contains a false or fraudulent signature, he or she has committed an unfair trade practice. At all costs, adjusters should avoid signing the insured's name on claim documents. In addition, they should not allow other individuals, including a spouse or family member of the named insured, to affix a signature that is not their own.

Unfair Discrimination

In Florida, insurers underwriting automobile policies and covering other property and casualty risks may exclude intentional acts by the insured. At the same time, they are

prohibited from taking any of the following actions because an insured or applicant has either sought (or should have sought) medical or psychological treatment in the past as a resulting of being abused by a household member, or because of the potential for future claims due to such abuse:

-Refusing to issue, reissue, or renew a policy

-Refusing to pay a claim

-Canceling or otherwise terminating a policy

-Increasing rates

Refusal to Insure

Unfair discrimination can also occur if an insurer refuses to insure (or continue to insure) a person or risk solely based one of the following reasons:

-Race, color, creed, marital status, sex, or national origin

-The person's residence, age, or lawful occupation or the location of the risk (unless there is a reasonable relationship between these factors and the coverage issued or -to be issued)

-The insured's or applicant's failure to agree to place collateral business with an insurer, unless the coverage applied for would provide liability coverage that is excess over that provided in policies maintained on property or motor vehicles

-The insured's or applicant's failure to purchase noninsurance services or commodities, including automobile services

-The fact that the insured or applicant is a public official

-The insured was previously denied coverage by the same insurer, if this second denial is done as a general business practice (determined by frequency of occurrence), and not because of factors specific to the case at hand

Personal lines property or personal lines automobile insurers are also prohibited from:

-Refusing to insure, reissue, or renew a policy, cancel or terminate a policy, or charge an unfairly discriminatory rate based on the lawful use, possession, or ownership of a firearm or ammunition by the insurance applicant, insured, or member of the applicant's or insured's household

-Disclosing that an insurance applicant, insured, or household member of the applicant or insured lawfully owns or possesses firearms to a third party or an affiliated entity of the insurer, unless the insurer informs the applicant of the specific need to disclose such information and the applicant or insured consents to the disclosure (An insurer may also disclose this information if the disclosure is necessary to quote or bind coverage, continue coverage, or adjust a claim.)

Excessive Charges

Florida also protects consumers by making it unlawful for insurers and licensees to knowingly collect any sum as a premium or charge for insurance that is not provided for in the policy or to collect more than the amount of premium stated in the policy.

A person who overcharges consumers may be fined:

-Up to $5,000 for each non-willful violation (up to $20,000 total for all violations arising out of the same action)

-Up to $40,000 for each willful violation (up to $200,000 total for all violations arising out of the same action)

Prohibited Extra Premium Charges for Motor Vehicle Insurance

It is also unlawful for insurers or agents to collect or impose an additional premium or refuse to renew a policy of motor vehicle liability, personal injury protection, medical payment, or collision insurance solely because the insured was involved in a motor vehicle accident unless the insurer's file contains information from which the insurer in good faith determines that the insured was substantially at fault in the accident.

If an insurer imposes a surcharge or refuses to renew a policy, the insurer must, in conjunction with sending the notice of premium due or notice of nonrenewal, notify the insured that he or she is entitled to be reimbursed for the surcharge or have the policy renewed if the insured demonstrates that the operator of the vehicle involved in the accident was:

-Lawfully parked

-Reimbursed by, or on behalf of, a person responsible for the accident or has a judgment against such person

-Struck in the rear by another vehicle headed in the same direction and was not convicted of a moving traffic violation in connection with the accident

-Hit by a "hit-and-run" driver, if the accident was reported to the proper authorities within 24 hours after discovering the accident

-Not convicted of a moving traffic violation in connection with the accident, but the operator of the other vehicle involved in the accident was convicted of a moving traffic violation

-Finally adjudicated not to be liable by a court

-In receipt of a traffic citation that was dismissed or not prosecuted

-Not at fault as evidenced by a written statement from the insured establishing facts demonstrating lack of fault, which are not rebutted by information in the insurer's file -From which the insurer in good faith determines that the insured was substantially at fault

In addition, an insurer may not fail to renew a policy if the insured has had only one accident in which he or she was at fault within the current three-year period.

An insurer may not impose an additional premium or refuse to renew a motor vehicle insurance policy solely because the insured committed a noncriminal traffic infraction unless the infraction is:

-A second infraction committed within an 18-month period or a third or subsequent infraction committed within a 36-month period

-A violation for exceeding the lawful speed limit by more than 15 miles per hour

If requested by the insured, the insurer and agent must give the insured proof of fault or other criteria which justifies the additional charge or cancellation.

An insurer may not charge an additional premium for motor vehicle insurance, cancel or refuse to issue a policy, or refuse to renew a policy because the insured or applicant is handicapped or physically disabled, as long as the handicap or physical disability does not substantially impair the person's mechanically assisted driving ability.

An insurer may not, with respect to premiums charged for motor vehicle insurance, unfairly discriminate solely on the basis of age, sex, marital status, or scholastic achievement.

An insurer may not impose an additional premium, cancel a policy, or not renew a policy because of a traffic infraction when adjudication has been withheld and no points have been

assessed against the insured. However, this does not apply to traffic infractions involving accidents in which the insurer has incurred a loss due to the insured's fault.

It is also illegal for insurers to charge an extra premium for automobile insurance or refuse to renew a policy solely because the insured or applicant was convicted of one or more traffic violations which did not involve an accident or did not cause the insured's driving privileges to be revoked or suspended, without proof of a direct and objective relationship between the violation and the increased risk of highway accidents.

Insurers are also prohibited from canceling or otherwise terminating an automobile insurance policy after the insured has paid premiums on the policy for five years or more solely because the insured is involved in a single traffic accident.

Unfair Rate Increases for Military Personnel

Insurers are prohibited from charging an increased premium for reinstating a motor vehicle insurance policy that was canceled or suspended by an insured solely because the insured was transferred out of state while serving in the U.S. Armed Forces or on active duty in the National Guard or U.S. Armed Forces Reserve. It is also considered an unfair trade practice for an insurer to charge an increased premium for a new motor vehicle insurance policy if the applicant was previously insured with a different insurer and he or she canceled that policy solely because he or she was transferred out of state while serving in the U.S. Armed Forces or on active duty in the National Guard or U.S. Armed Forces Reserve.

Use of Credit Reports and Credit Scores by Insurers

Florida regulates and limits insurers' use of credit reports and credit scores for underwriting and rating purposes in the case of personal lines motor vehicle insurance and personal lines residential insurance, which includes homeowners, mobile home owners' dwelling, tenants, condominium unit owners, cooperative unit owners, and similar types of insurance.

Insurers must inform applicants or insureds that a credit report or score is being requested for underwriting or rating purposes. If the insurer makes an adverse decision based in whole or in part on a credit report, the insurer must provide a copy of the credit report, at no charge, to the applicant or insured or give the applicant or insured the name, address, and telephone number of the consumer reporting agency from which the credit report may be obtained. The insurer must also notify the consumer, explaining the primary reasons for the adverse decision and cannot use generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score."

An insurer may not request a credit report or score based upon the race, color, religion, marital status, age, gender, income, national origin, or place of residence of the applicant or insured.

An insurer may not make an adverse decision solely because of information contained in a credit report or score without consideration of any other underwriting or rating factor.

An insurer may not make an adverse decision about an applicant or insured if based, in whole or in part, on:

-The absence of, or an insufficient, credit history

-Collection accounts with a medical industry code, if so identified on the consumer's credit report

-Place of residence

Any other circumstance that the Financial Services Commission determines, by rule, lacks sufficient statistical correlation and actuarial justification as a predictor of insurance risk

Unfair Claims Settlement Practices

One of the most important concerns of policyholders is the processing of claims. When a claim is presented, the policyholder is asking the insurer to fulfill the promise the policy represents. Although claims are generally administered by adjusters through a claims department of an insurance company's home or regional office, policyholders frequently look for assistance from the agent who sold them the policy. Indeed, some insurance companies promote the involvement of their agents at claims time in their advertisements.

With these facts in mind, adjusters should familiarize themselves with the guidelines of their insurers and appointing entities with respect to handling claims as well as with Florida's laws concerning unfair claims settlement practices. Florida law addresses unfair claims settlement practices in four categories:

-Attempting to settle claims on the basis of a policy document or binder that was altered without the consent or knowledge of the insured

-Making a material misrepresentation to an insured or other party having an interest in an insurance policy for the purpose of securing a claim settlement on a less favorable basis than is provided by the policy

-Committing or performing any of the following acts or practices with such frequency they constitute a general business practice:

-failing to use standards to promptly investigate and settle claims

-misrepresenting pertinent facts or policy provisions relating to coverages at issue

-failing to promptly acknowledge communications about claims

-denying claims without conducting reasonable investigations

-failing to affirm or deny coverage of claims within 30 days after proof of loss statements have been completed

-failing to provide a reasonable explanation of the basis in the policy for denying a claim or offering a compromise settlement

-failing to promptly notify the insured that additional information is needed to process a claim

-failing to clearly explain why additional information is needed to process a claim and the nature of the information requested

-failing to pay personal injury protection insurance claims within certain prescribed times

-failing to pay, within 90 days of receiving a notice of claim and affirming coverage, claim amounts that are undisputed unless such payment is prevented by an act of God, the impossibility of performance, or behavior on the part of the insured or claimant that constitutes fraud, failure to cooperate, or intentional misrepresentation with respect to the subject claim

Few adjusters work strict nine-to-five schedules. They must juggle multiple claims and, on a daily basis, field numerous telephone calls from claimants, insureds, agents, attorneys, and repair vendors. Therefore, it is important for adjusters to adopt measures and procedures that will help them avoid the pitfalls of behavior that fall squarely in midst of prohibited claims settlement practices.

The maintenance of a claim log and a claims diary is one method used by ethical and diligent claims adjusters. Because all entries are dated, the adjuster is better able to avoid behavior that might indicate a lack of compliance with requirements for conducting business in a timely fashion. In addition, because all phone calls, conversations, and recommendations

are also entered into the log and diary, it is less likely for the adjuster to overlook a required step or duty of the adjustment process.

Earlier in the course, we discussed bad faith. It is important for Florida adjusters to understand and be familiar with Florida's bad faith laws as they pertain to insurance. These laws allow an individual to recover damages for injuries from an insurance company that failed to settle an insurance claim in good faith when it was able to do so.

Florida statutes allow both insureds and third parties to file bad faith actions against insurers. A party alleging bad faith must provide the insurer with 60 days' written notice before filing an action, and the insurer has an additional 60 days to either pay damages or rectify the situation that prompted the allegation of bad faith. The majority of first-party bad faith claims (those filed by policyholders against their own insurers) assert the insurer denied coverage improperly, delayed payment unfairly, or settled a loss for less than its fair value.

If an insurer (or adjuster) is found guilty of bad faith, it is responsible for damages, court costs, and reasonable attorney's fees incurred by the plaintiff. In addition, punitive damages may be awarded if the allegations made against the insurer were committed with such frequency they indicated a general business practice and they were:

-Willful, wanton, and malicious

-In reckless disregard for the rights of any insured

-In reckless disregard for the rights of a beneficiary under a life insurance contract

Unfair Claim Settlement Practices Relating to Motor Vehicle Insurance

Florida law also addresses unfair claim settlement practices relating specifically to motor vehicle insurance. Insurers must comply with the following requirements:

-When liability and damages owed under a policy are reasonably clear, an insurer may not recommend that a third-party claimant make a claim under his or her own policy solely to avoid paying the claim under the policy issued by that insurer. However, an insurer may identify options to a third-party claimant relating to the repair of his or her vehicle.

-An insurer that elects to repair a motor vehicle and specifically requires a particular repair shop for vehicle repairs must cause the damaged vehicle to be restored to its physical condition as to performance and appearance immediately prior to the loss at no additional cost to the insured or third-party claimant other than as stated in the policy.

-An insurer may not require the use of replacement parts in the repair of a motor vehicle which are not at least equivalent in kind and quality to the damaged parts prior to the loss in terms of fit, appearance, and performance.

-When an insurance policy provides for the adjustment and settlement of first-party motor vehicle total losses on the basis of actual cash value or replacement with another of like kind and quality, the insurer must use one of the following methods:

-The insurer may elect a cash settlement based upon the actual cost to purchase a comparable motor vehicle, including sales tax.

-The insurer may elect to offer a replacement motor vehicle that is a specified comparable motor vehicle available to the insured, including sales tax, paid for by the insurer at no cost other than any deductible provided in the policy and betterment. A comparable motor vehicle is one that is (1) made by the same manufacturer, of the same or newer model year, and of similar body type and

that has similar options and mileage as the insured vehicle, and (2) in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured's residence.

-When a motor vehicle total loss is adjusted or settled on a basis that varies from the prior two methods just noted, the determination of value must be supported by documentation, and any deductions from value must be itemized and specified in appropriate dollar amounts. The basis for such settlement must be explained to the claimant in writing, if requested, and a copy of the explanation must be retained in the insurer's claim file.

-Any other method agreed to by the claimant.

-When the amount offered in settlement reflects a reduction by the insurer because of betterment or depreciation, information pertaining to the reduction must be maintained with the insurer's claim file. Deductions must be itemized and specific as to dollar amount and must accurately reflect the value assigned to the betterment or depreciation. The basis for any deduction must be explained to the claimant in writing, if requested, and a copy of the explanation must be kept with the insurer's claim file.

-If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer must supply the insured a copy of the estimate upon which the settlement is based.

-Every insurer must provide notice to an insured before termination of payment for previously authorized storage charges, and the notice must provide 72 hours for the insured to remove the vehicle from storage before terminating payment of the storage charges.

-If a claimant will incur sales tax upon replacement of a total loss or upon repair of a partial loss, the insurer may defer payment of the sales tax unless and until the obligation has actually been incurred.

Claim Settlement Practices Relating to Property Insurance

Unless the policy provides otherwise, if a homeowner's insurance policy provides for the adjustment and settlement of first-party losses based on repair or replacement cost, the following requirements apply:

-When a loss requires repair or replacement of an item or part, any physical damage incurred in making such repair or replacement that is covered and not otherwise excluded by the policy must be included in the loss to the extent of any applicable policy limits. The insured may not be required to pay for betterment required by ordinance or code except for the applicable deductible, unless specifically excluded or limited by the policy.

-When a loss requires replacement of items and the replaced items do not match in quality, color, or size, the insurer must make reasonable repairs or replacement of items in adjoining areas. In determining the extent of the repairs or replacement of items in adjoining areas, the insurer may consider the cost of repairing or replacing the undamaged portions of the property, the degree of uniformity that can be achieved without such cost, the remaining useful life of the undamaged portion, and other relevant factors.

Investigations and Hearings

The Department has the power to investigate and examine the affairs of every person involved in the insurance business in Florida in order to determine whether he or she has

engaged in any unfair or deceptive acts or practices. If the Department has reason to believe that the insurance laws have been violated, it may conduct a hearing on the matter.

Persons may be compelled by subpoena to appear at a hearing, and they may be ordered to disclose information pertinent to the investigation. Statements of charges, notices, and orders issued in the course of the investigation may be served in the same manner as service of process in civil actions or by certified mail sent to the person's residential or business address. Anyone who fails to comply with a subpoena to appear or an order of discovery may be fined up to $1,000 per violation.

Penalties
Any person who commits an unfair trade practice or unfair method of competition is subject to the following penalties:

-A fine up to $5,000 for each unintentional violation (a total of $20,000 for all violations arising out of the same act)

-A fine up to $40,000 for each willful violation (a total of $200,000 for all violations arising out of the same act)

Certain prohibited practices are also considered crimes:

-Twisting and churning are first-degree misdemeanors and are punishable by imprisonment up to one year and an administrative fine up to $5,000 for each unintentional violation and up to $75,000 for each willful violation. (Churning occurs when a person's existing and replacement policy are both issued by the same insurer, and replacement is recommended solely to boost an agent's commissions.)

-Willfully submitting a fraudulent signature on any insurance policy-related document is a third-degree felony that is punishable by up to five years' imprisonment and an administrative fine up to $5,000 for each unintentional violation (up to $75,000 for each willful violation).

Anyone who intentionally submits insurance applications or policy-related documents with fraudulent signatures commits a felony of the third degree and may be fined up to $5,000 for each nonwillful violation ($75,000 for each willful violation).

Administrative fines imposed for violations may not exceed aggregate amounts of $50,000 for all unintentional violations arising out of the same action and $250,000 for all willful violations arising out of the same action.

Insurance Fraud

One of the most serious problems facing the insurance industry today is insurance fraud. In Florida, the Division of Investigative and Forensic Services enforces the state's criminal laws with respect to insurance transactions. Investigators are certified law enforcement officers with the authority to bear arms and make arrests. The division serves and safeguards the public and businesses in Florida against acts of insurance fraud and the resulting impact of those crimes on taxpayers.

In the state of Florida, a person commits insurance fraud if he or she:

-Makes a statement when submitting a claim that contains false, incomplete, or misleading information

-Helps another person make a statement in connection with a claim that contains false, incomplete, or misleading information

-Knowingly submits an insurance application containing false, incomplete, or misleading information or conceals information that is material to the application

Required Statements
To discourage fraud, all claim and application forms must contain the following statement:

> -Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In addition, all proof of loss statements must prominently display the following statement:

> -Pursuant to s. 817.234, Florida Statues, any person who, with the intent to injure, defraud, or deceive any insurer or insured, prepares, presents, or causes to be presented a proof of loss or estimate of cost or repair of damaged property in support of a claim under an insurance policy knowing that the proof of loss or estimate of claim or repairs contains any false, incomplete, or misleading information concerning any fact or thing material to the claim commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, Florida Statutes.

Immunity
In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or other torts for reporting information about insurance fraud that is required by law or by the Department or Division. Those who report insurance fraud or suspected insurance fraud are immune from civil actions if they provide information about the suspected fraud, in good faith, to:

> -Law enforcement officials
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> -Other licensees
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> -The Department, the Division, the National Insurance Crime Bureau, the National Association of Insurance Commissioners, or any local, state, or federal enforcement officials or their agents or employees

Those who report suspected insurance fraud are also immune from civil liability for other actions taken in cooperation with any of these agencies or individuals in the lawful investigation of suspected fraudulent insurance acts.

Penalties
If a person is found guilty of insurance fraud, the insurer may recover compensatory damages as well as its investigation and litigation expenses, including attorneys' fees, from such person.