IN THE MATTER OF THE	*	**BEFORE THE MARYLAND**
	*	
MARYLAND INSURANCE ADMINISTRATION	*	**INSURANCE COMMISSIONER**
	*	
v.	*	
	*	**CASE NO. : MIA-** 2017-10-026
SHAWANDA BENSON	*	
19 Maybin Circle	*	**Fraud Division File No.: R-2017-1677A**
Owings Mills, Maryland 21117	*	

* *

ORDER

This Order is entered by the Maryland Insurance Administration ("MIA") against Shawanda Benson ("Respondent") pursuant to §§ 2-108, 2-201, 2-204 and 2-405 of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.)("the Insurance Article").

I. Facts

1. Respondent had an accident insurance policy with American Family Life Assurance Company of Columbus ("AFLAC"), an authorized insurer. The policy took effect on December 1, 2014, and provided coverage for Respondent and her daughter.

2. Between July, 2015, and February, 2016, Respondent filed thirty-eight (38) claims against her AFLAC accident policy for herself and her daughter for treatment purportedly received at University of Maryland Medical Center ("UMMC"), Sunshine Rehabilitation Center ("Sunshine"), and Mercy Medical Center ("Mercy"), as well as treatment provided by a dentist. Relying on claim information provided by Respondent, AFLAC paid her $5,550.00 in benefits.

3. Each of the claim forms identified the Respondent as the policyholder and the majority of the claim forms were accompanied by supporting documentation to ostensibly validate the purported treatment by the respective provider. Respondent was identified as the patient on twenty-two (22) claim forms and her daughter was identified as the patient on sixteen (16) claim forms. AFLAC denied three of the thirty-eight claims prior to making payment to

Respondent. Each claim form contained the following fraud warning immediately preceding the policyholder signature line:

> *Any Person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.*

4. On January 11, 2016, an AFLAC claims specialist attempted to validate a claim submitted by Respondent for treatment she purportedly received on January 10, 2016, at UMMC. The claims specialist called UMMC and was advised that Respondent was not seen on that date. Therefore, the claims specialist forwarded Respondent's claims to AFLAC's Special Investigations Unit ("SIU") for further investigation.

5. On September 7, 2016, an AFLAC investigator contacted the UMMC billing department to validate claims submitted by Respondent for treatment she purportedly received on October 1, 2015, December 2, 2015, and December 23, 2015. A UMMC representative advised there was no record of Respondent being treated at UMMC in 2015.

6. On November 11, 2016, another AFLAC investigator contacted the UMMC billing department and learned that Respondent was last treated there in September, 2016, and the most recent treatment date prior to that was in 2011. Further, Respondent's daughter was last treated at UMMC in 2013.

7. On November 11, 2016, an AFLAC investigator sent Respondent a letter requesting she contact the investigator within ten days to discuss her claims. Respondent failed to contact the investigator.

8. On November 16, 2016, an AFLAC investigator contacted Mercy and was advised that Respondent was not treated at Mercy on the dates indicated on the AFLAC claim forms and treatment documents.

9. On November 17, 2016, an AFLAC investigator contacted Sunshine. A representative advised that Respondent was never treated at the clinic and that her daughter was not treated on the dates purported in the claims Respondent submitted to AFLAC.

10. On November 28, 2016, an AFLAC investigator sent Respondent a letter advising that during the course of its investigation, it was "unable to validate information submitted in the claim(s). As a result, benefits were paid to you erroneously. At this time, AFLAC requests that the total amount of benefits you received in the amount of $5,550.00, be paid back as soon as possible."

11. Section 27-802(a)(1) of the Maryland Insurance Article states,

> An authorized insurer, its employees, fund producers, or insurance producers, ... who in good faith has cause to believe that insurance fraud has been or is being committed shall report the suspected insurance fraud in writing to the Commissioner, the Fraud Division, or the appropriate federal, State, or local law enforcement authorities.

AFLAC, having a good faith belief that Respondent committed insurance fraud, referred the matter to the MIA, Fraud Division.

12. During the course of its investigation, MIA contacted AFLAC and confirmed its handling of Respondent's claims.

13. On August 8, 2017, an MIA investigator met with the owner of Sunshine. He examined all claim forms and therapy treatment notes Respondent submitted to AFLAC for treatment she and her daughter purportedly received at Sunshine. He reported that all of the documents were altered and although Respondent's daughter was once a patient, her treatment

predated all of the claims submitted to AFLAC. Additionally, Respondent herself was never a patient at Sunshine.

14. On September 12, 2017, an MIA investigator contacted the Vice President and Deputy General Counsel ("General Counsel") for UMMC and requested verification of claims and medical treatment verification documents submitted to AFLAC by Respondent for treatment she and her daughter purportedly received. General Counsel advised that UMMC records do not reflect any patient with either Respondent's name or her daughter's name as having received treatment at UMMC on any of the dates indicated in the treatment documents Respondent submitted to AFLAC.

15. On September 19, 2017, an MIA investigator contacted the office manager for the dentist identified on claim forms Respondent submitted to AFLAC for treatment she purportedly received. The manager advised that:

1) Respondent was not a patient of the dental practice;
2) The documents were not legitimate; and
3) The documents appeared to have been altered.

16. On September 21, 2017, an MIA investigator contacted the billing department at Mercy to verify claims Respondent submitted to AFLAC reflecting treatment she purportedly received at Mercy. The billing supervisor advised there are no records of Respondent receiving treatment and she could not find any record for the specific dates of service noted in the AFLAC claims.

II. Violation(s)

In addition to all relevant sections of the Insurance Article, the Administration relies on the following pertinent sections in finding that Respondent violated Maryland's insurance laws:

17. § **27-403**

It is a fraudulent insurance act for a person:

(2) to present or cause to be presented to an insurer documentation or an oral or written statement made in support of a claim...with knowledge that the documentation or statement contains false or misleading information about a matter material to the claim.

18. § **27-408(c)**

(1) In addition to any criminal penalties that may be imposed under this section, on a showing by clear and convincing evidence that a violation of this subtitle has occurred, the Commissioner may:

(i) impose an administrative penalty not exceeding $25,000 for each act of insurance fraud; and

(ii) order restitution to an insurer or self–insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

* * * * * * *

(2) In determining the amount of an administrative penalty, the Commissioner shall consider:

(i) the nature, circumstances, extent, gravity, and number of violations;
(ii) the degree of culpability of the violator;
(iii) prior offenses and repeated violations of the violator; and
(iv) any other matter that the Commissioner considers appropriate and relevant.

19. By the conduct described herein, the Respondent violated § 27-403 and is subject to administrative penalty under the Insurance Article § 27-408(c).

III. Sanctions

20. Insurance fraud is a serious violation, which harms consumers in that the losses suffered by insurance companies are passed on to consumers in the form of higher premium. The Commissioner may investigate any complaint that alleges a fraudulent claim has been submitted to an insurer, Insurance Article §§ 2-201(d)(1) and 2-405.

21. Respondent submitted thirty-eight claims to AFLAC, which were accompanied by supporting documents, ostensibly verifying treatment at the respective treatment facility for herself

and her daughter. All providers confirmed the documents were fraudulent. Having considered the factors set forth in §27-408(c)(2) and COMAR 31.02.04.02, the MIA has determined that $6,300.00 is an appropriate penalty.

22. Additionally, Respondent is ordered to reimburse AFLAC $5,550.00, which is the amount she fraudulently obtained from AFLAC when submitting false Claims.

23. Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number (R-2017-1677A) and (Shawanda L. Benson). Unpaid penalties will be referred to the Central Collections Unit for collection. Payment of the administrative penalty shall be sent to the attention of: Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202.

24. Notification of reimbursement to AFLAC shall be made in writing to the Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Such notification shall include a copy of the money order or cancelled check issued to AFLAC as proof of reimbursement and identify the case by number (R-2017-1677A) and name (Shawanda L. Benson).

25. This Order does not preclude any potential or pending action by any other person, entity, or government authority, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

WHEREFORE, for the reasons set forth above, and subject to the right to request a hearing, it is this 18th day of October 2017, **ORDERED** that:

(1) Shawanda L. Benson shall pay an administrative penalty of six thousand three hundred dollars ($6,300.00) within 30 days of the date of this Order; and

(2) Shawanda L. Benson shall pay restitution to AFLAC in the amount of five thousand five hundred dollars ($5,550.00) within 30 days of the date of this Order.

ALFRED W. REDMER, JR.
Insurance Commissioner

BY: signature on original
STEVE WRIGHT
Associate Commissioner
Insurance Fraud Division

RIGHT TO REQUEST A HEARING

Pursuant to § 2-210 of the Insurance Article and Code of Maryland Regulations ("COMAR") 31.02.01.03, an aggrieved person may request a hearing on this Order. This request must be in writing and received by the Commissioner within thirty (30) days of the date of the letter accompanying this Order. However, pursuant to § 2-212 of the Article, the Order shall be stayed pending a hearing only if a demand for hearing is received by the Commissioner within ten (10) days after the Order is served. The written request for hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Attn: Hearings and Appeals Coordinator. The request shall include the following information: (1) the action or non-action of the Commissioner causing the person requesting the hearing to be aggrieved; (2) the facts related to the incident or incidents about which the person requests the Commissioner to act or not act; and (3) the ultimate relief requested. The failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of your rights to contest this Order and the Order shall be final on its effective date. Please note that if a hearing is requested on this initial Order, the Commissioner may affirm, modify, or nullify an action taken or impose any penalty or remedy authorized by the Insurance Article against the Respondent in a Final Order after hearing.