MARYLAND INSURANCE ADMINISTRATION	*	BEFORE THE MARYLAND
	*	
	*	INSURANCE COMMISSIONER
v.	*	
	*	
LAKESHA B. BROWN 5514 Cadillac Avenue Baltimore, Maryland 21207	*	CASE NO. : MIA-2017-12-030
	*	
	*	Fraud Division File No.: R-2017-3473A
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CONSENT ORDER

The Maryland Insurance Commissioner ("Commissioner") and Lakesha B. Brown ("Respondent"), enter into this Consent Order ("Order"), pursuant to §§ 2-108, 2-204 of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.)("Insurance Article"), to resolve the matter before the Insurance Administration ("Administration").

EXPLANATORY STATEMENT AND FINDINGS OF FACT

1. The Administration issued an Order against Respondent on December 19, 2017. In the Order, Respondent was found to have violated § 27-403 of the Insurance Article. An administrative penalty in the amount of $3,000.00 was assessed in accordance with § 27-408(c).

2. Respondent does not contest the allegations in the Order.

3. The facts and violations stated in the Order are incorporated herein by reference.

WHEREFORE, for the reasons set forth above, it is this 15th day of February 2018, **ORDERED** by the Commissioner and consented to by Respondent that:

A. Respondent shall pay an administrative penalty in the amount of $2,000.00 as follows:

i. $666.66 due by February 15, 2018;

ii. $666.67 due by March 15, 2018;

iii. $666.67 due by April 15, 2018;

B. Failure to pay as outlined in paragraph A, above constitutes a default. Notice of default is hereby waived by Respondent. Respondent agrees to pay the balance within 30 days of default, the balance will be sent to the Central Collection Unit of the Department of Budget and Management for collection.

C. The executed Consent Order and penalties shall be sent to the Maryland Insurance Administration to the attention of Steve Wright, Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Baltimore, MD 21202 and shall identify the case by number (R-2017-3473A) and name (Lakesha B. Brown).

D. Respondent waives any and all rights to any hearing or judicial review of this Consent Order to which she would otherwise be entitled under the Maryland Annotated Code.

E. Respondent has reviewed this Consent Order and has had the opportunity to have it reviewed by legal counsel of her choice. Respondent is aware of the benefits gained and obligations incurred by the execution of the Consent Order. After careful consideration, Respondent executes this Consent Order knowingly and voluntarily.

F. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Consent Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect the December 19, 2017 Order as well as this Consent Order.

G. This Consent Order does not preclude any potential action by the Administration, any other person, entity, or governmental authority regarding any conduct by Respondent, including the conduct that is the subject of this Consent Order.

H. This Consent Order shall be effective upon signing by the Commissioner or his designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

I. Failure to comply with the terms of this Consent Order may subject Respondent to further legal and/or administrative action. This Consent Order contains the **ENTIRE AGREEMENT** between the parties relating to the administrative actions addressed herein. This Consent Order does not supersede the Order dated December 19, 2017, except as to the payment and penalty amount. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

ALFRED W. REDMER, JR.
Insurance Commissioner

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

LAKESHA B. BROWN'S CONSENT

LAKESHA B. BROWN hereby CONSENTS to the representations made in, and terms of, this Consent Order.

2/9/2018
Date

signature on original
Lakesha B. Brown

IN THE MATTER OF THE	*	**BEFORE THE MARYLAND**
	*	
MARYLAND INSURANCE ADMINISTRATION	*	**INSURANCE COMMISSIONER**
	*	
	*	
v.	*	
	*	**CASE NO. : MIA-** 2017-12-030
LAKESHA B. BROWN	*	
5514 Cadillac Avenue	*	**Fraud Division File No.: R-2017-3473A**
Baltimore, Maryland 21207	*	
	*	

* *

ORDER

This Order is entered by the Maryland Insurance Administration ("MIA") against Lakesha B. Brown ("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 short-term disability insurance with American Family Life Assurance Company ("Aflac"), an authorized insurer. The policy was in effect from March 1, 2016 through May 15, 2017, when it was terminated at Respondent's request. The policy paid disability benefits at $20.00 dollars a day for each day of disability, up to the maximum benefits period of 90 days.

2. On June 6, 2016, Respondent submitted an initial Disability Claim Form to Aflac, accompanied by a Physician's Statement, which stated Respondent's symptoms occurred on May 1, 2015, she first consulted the physician on June 25, 2015, and was last treated on February 11, 2016.

3. On June 14, 2016, Aflac denied Respondent's claim as the condition was pre-existing; therefore, no coverage was afforded under the policy.

4. On June 14, 2016, Respondent re-submitted her disability claim but this time the Physician's Statement stated, Respondent's symptoms occurred on April 1, 2016; she first consulted the physician on April 25, 2016, and was last treated on May 23, 2016. Respondent signed the claim form immediately below the fraud warning, which stated:

> **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.**

5. On June 20, 2016, Aflac contacted the office of the treating physician identified on the claim Respondent submitted on June 14, 2016. The office provided Aflac with Respondent's treatment records which confirmed that the Physician's Statement was false. Respondent was not seen on April 25, 2016 or May 23, 2016.

6. On June 22, 2016, Aflac denied Respondent's claim that was accompanied by the altered Physician's Statement, stating that it was "unable to verify treatment/disability dates with your provider." Consequently, the claim was referred to Aflac's Special Investigation Unit ("SIU") for further investigation.

7. On January 11, 2017, Respondent submitted another disability claim to Aflac. This claim was accompanied by a Physician's Statement reflecting Respondent's symptoms occurred on January 9, 2017, and she consulted a physician on January 10, 2017. The Physician's Statement asked, "If patient has not been released, please provide the next appointment date." The handwritten response was "01/24/17." The Physician's Statement next asked, "Please also provide the date of expected release" "if patient has not been released." The handwritten response was "01/24/2017." The Physician's Statement was purportedly signed by

the treating physician and the claim form was signed by Respondent immediately below the fraud warning recited above.

8. On February 24, 2017, relying on the aforementioned Physician's Statement, Aflac issued Respondent a disability check for $280.00, in accordance with policy benefits calculated at $20.00 dollars a day for 14 days of disability beginning January 10, 2017.

9. On April 27, 2017, an Aflac investigator contacted the healthcare provider to validate Respondent's January 11, 2017 claim referenced in ¶7 above. A representative of the healthcare provider reviewed the Disability Claim Form and Physician's Statement. She advised by email that the forms Respondent submitted to Aflac contained "inaccurate information," and had "illegitimate signatures," and were not completed by a physician at the healthcare facility.

10. 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.

11. In the course of its investigation, MIA contacted Aflac and confirmed its handling of Respondent's claims.

12. On September 19, 2017, an MIA fraud investigator interviewed the healthcare provider identified on the Physician's Statement in Respondent's January 11, 2017 Aflac claim referenced in ¶7 above. The provider reviewed the Physician's Statement and concluded that she did not complete the document nor authorize anyone else at the facility to complete it, and the signature at the bottom of the document was not hers. The provider confirmed she examined the

Respondent on January 10, 2017, and released her to return to work the same day with restrictions, as opposed to the conflicting January 12 and January 24, 2017 dates Respondent entered on the Physician's Statement. In calculating the benefit actually paid, Aflac relied on the January 24 date as entered by Respondent when asked "the date of expected release."

13. On September 20, 2017, the MIA investigator interviewed the patient registrar for the healthcare provider identified on the Physician's Statements relating to claims Respondent submitted to Aflac for treatment on June 6, 2016 and June 14, 2016. The registrar reviewed the Physician's Statements related to those claims and advised that the June 6, 2016, Physician's Statement contained information consistent with the provider's records; however, the June 14, 2016 Physician's Statement was altered and falsely reflected when the symptoms first occurred, changed from "5/1/2015" to "4/1/2016," the patient first consultation, from "6/25/2015" to "4/25/2016," when the patient was last treated, from "2/11/2016" to "5/23/2016." The registrar stated Respondent was not seen by the doctor's office during the month of April, 2016, and was not treated on May 23, 2016.

14. On September 25, 2017, an MIA investigator interviewed the administrative assistant for the healthcare provider identified on the Physician's Statements in the claims Respondent submitted to Aflac for treatment on June 6, 2016 and June 14, 2016. She reviewed the Physician's Statement related to those claims and confirmed the information provided to MIA by the patient registrar. The administrative assistant added that Respondent called her after learning Aflac denied the claim for treatment provided on June 25, 2015, and asked her to change the date of service to April 25, 2016, which the administrative assistant refused to do.

15. On October 18, 2017, the MIA investigator received documentation from Respondent's employer that indicated Respondent worked January 9, 11, 12, 13, 18, 19, and 20,

2017; Respondent had claimed disability from January 9 through 20, 2017, for which Aflac paid disability benefits.

II. Violation(s)

16. 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, Respondent violated § 27-403. As such, Respondent is subject to an 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 premiums. 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. Having considered the factors set forth in § 27-408(c)(2) and COMAR 31.02.04.02, MIA has determined that $3,000.00 is an appropriate penalty.

22. Additionally, Respondent, Lakesha B. Brown is ordered to reimburse Aflac $280.00 which is the amount she fraudulently obtained from Aflac when submitting a falsified invoice in support of her disability claim.

23. Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number (R-2017-3473A) and name (Lakesha B. Brown). 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-2017-3473A) and name (Lakesha B. Brown).

25. This Order does not preclude any potential or pending action by any other person, entity or government authority regarding any conduct by 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 19th day of December 2017, **ORDERED** that:

(1) Lakesha B. Brown shall pay an administrative penalty of three-thousand dollars ($3,000.00) within 30 days of the date of this Order.

(2) Lakesha B. Brown shall pay restitution to Aflac in the amount of two hundred and eighty dollars ($280.00) 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 issued. 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 Respondent in a Final Order after hearing.