IN THE MATTER OF THE

MARYLAND INSURANCE ADMINISTRATION

v.

ROBERT FRANCIS CONNER
4356 Swindon Ter.
Upper Marlboro, Maryland 20772-6928

CASE NO.: MIA-2022-10-003

Fraud Division File No.: R-2022-1970A
R-2023-0262A

* *

ORDER

This Order is issued by the Maryland Insurance Administration (the "MIA") against Robert Francis Conner ("Respondent") pursuant to §§ 2-108, 2-201, 2-204[1] and 2-405 of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.) (the "Insurance Article").

I. RELEVANT MATERIAL FACTS

1. On March 19, 2018, Respondent applied for a Short Term Disability insurance policy (the "Policy") through his employer, the Washington Metropolitan Area Transportation Authority ("WMATA"), with American Family Life Assurance Company of Columbus ("AFLAC"), an authorized insurer. Respondent signed the policy application, attesting to the accuracy of the information on the application. Immediately above the signature line, the application included the following fraud warning:

> Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

2. Relying on the accuracy of the information provided in Respondent's application, AFLAC issued a short term disability coverage policy (the "AFLAC Policy") to Respondent, effective April 1, 2018.

3. The AFLAC Policy contained the following disability provisions:

G. DISABILITY:

[1] Unless otherwise indicated, all statutory references in this Order are to the Insurance Article of the Maryland Code.

1. TOTAL DISABILITY: being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, and not working at any job.
2. PARTIAL DISABILITY: being under the care and attendance of a Physician due to a condition that causes you to be unable to perform the material and substantial duties of your Full-Time Job, but able to work at any job earning less than 80 percent of your Annual Income of your Full-Time Job at the time you became disabled.
And
Notice to Buyer: This policy pays benefits for short-term Disability caused by Sickness or Off-the-Job Injury.

4. Between June 2018 and June 2021, Respondent submitted the following 20 temporary total disability ("TTD") claims under the AFLAC Policy, for which he was paid a total of $41,933.33 by AFLAC.

Claim Number	Amount Paid	Number of TTD days paid	Date Paid	Disability Dates
7527698	$1,600.00	24	6/8/2018	6/14/2018-7/7/2018
8152565	$2,133.33	32	7/9/2018	7/8/2018-8/8/2018
8767362	$1,933.33	29	8/7/2018	8/9/2018-9/6/2018
9768294	$3,133.33	47	9/24/2018	9/7/2018-10/23/2018
10931878	$3,200.00	48	11/16/2018	10/24/2018-12/10/2018
12454136	$2,533.33	38	1/31/2019	1/22/2019-2/28/2019
14722654	$2,133.33	32	5/13/2019	4/29/2019-5/30/2019
15151916	$2,066.67	31	6/4/2019	5/31/2019-6/30/2019
15799461	$2,133.33	32	7/3/2019	7/1/2019-8/1/2019
16393835	$2,000.00	30	8/2/2019	8/2/2019-8/31/2019
17163296	$2,666.67	40	9/11/2019	9/1/2019-10/10/2019
17794248	$1,000.00	15	10/14/2019	10/11/2019-10/25/2019
21460417	$933.33	14	4/14/2020	3/9/2020-3/22/2020
22938901	$4,466.67	67	7/14/2020	7/8/2020-9/12/2020
23584876	$533.34	8	8/20/2020	7/7/2020 & 9/13/2020-9/19/2020
27867451	$5,266.67	79	4/5/2021	1/30/2021-4/18/2021
28112050	$66.67	1	4/12/2021	4/19/2021
28259556	$1,800.00	27	4/20/2021	4/20/2021-5/16/2021
28776011	$2,333.33	35	5/20/2021	5/17/2021-6/20/2021
29348451	Denied		Denied	
Total TTD Paid	$41,933.33	629		

5. According to the claim forms submitted by Respondent, each of the Respondent's twenty TTD claims resulted from alleged injuries or illnesses that prevented him from working. Respondent signed each of the claim forms immediately beneath the following fraud warning:

> 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.

6. Five of the claims, nos. 27867451, 28112050, 28259556, 28776011, and 29348451, were accompanied by a "Physician's Statement," ostensibly signed by a treating physician, hereinafter Dr. P. Relying on the information contained within four of the five claims, AFLAC paid Respondent $9,466.67. Upon receipt of Respondent's fifth claim, no. 29348451, on June 28, 2021, an AFLAC representative contacted Dr. P.'s office and learned that the Respondent was not seen at Dr. P.'s office on any of the five aforementioned dates and Respondent was not placed on disability by Dr. P. Consequently, AFLAC denied Respondent's fifth claim, no. 29348451, and referred Respondent's claims to its Special Investigations Unit ("SIU") for further investigation.

7. On November 12, 2021, and July 6, 2022, AFLAC sent letters to Respondent requesting him to contact its investigator within three days to discuss his claims. Respondent failed to reply.

8. On December 6, 2021, an AFLAC investigator contacted Dr. P.'s office and confirmed that Respondent was not placed on disability by Dr. P., and Respondent's "medical chart" contained no disability records.

9. An AFLAC investigator examined Respondent's previous disability claims identified in paragraph 4, *supra*. The investigator contacted Respondent's employer, WMATA, to verify whether Respondent was on disability leave from work during each of the periods of alleged disability for which he had filed disability claims with AFLAC. A WMATA representative provided the AFLAC investigator with records

of Respondent's time and attendance for each of those periods of alleged disability (the "WMATA Records"). AFLAC compared Respondent's claims with the time and attendance records and made the following determinations.

- Respondent submitted disability claims nos. 7527698, 8152565, 8767362, 9768294, and 10931878, alleging that he was absent from work for 180 consecutive days, from June 14, 2018 to December 10, 2018. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $11,999.99 in TTD benefits with respect to those claims. According to the WMATA Records, Responded was injured at work on June 6, 2018. Respondent was absent from work for 12 days, from June 7, 2018 to June 19, 2018 as a result of that injury. Respondent had only sporadic absences between June 19, 2018 and December 10, 2018. The AFLAC policy does not cover disability resulting from work injuries.

- Respondent submitted disability claim no. 12454136, alleging that he was absent from work for 38 consecutive days, from January 22, 2019 to February 28, 2019. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $2,533.33 in TTD benefits with respect to that claim. According to the WMATA Records, Respondent was not absent from work on any of those days.

- Respondent submitted claims nos. 014722654, 015151916, 015799461, 016393835, 017163296 and 017794248, alleging that he was absent from work for 180 consecutive days from April 29, 2019 to November 3, 2019. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $12,000 in TTD benefits with respect to those claims. According to the WMATA Records, Respondent was at work during that period, with the exception of "sporadic" days absent.

- Respondent submitted claim no. 021460417, alleging that he was absent from work for 14 consecutive days from March 9, 2020 to March 22, 2020. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $933.33 in TTD benefits with respect to that claim. According to the WMATA Records, Respondent was at work during that time frame, with "sporadic" days absent, which were noted as COVID.

- Respondent submitted claims nos. 022938901, and 23584876, alleging that he was absent from work for 75 consecutive days from July 8, 2020 to September 19, 2020. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $5,000.01 in TTD benefits with respect to those claims. According to the WMATA Records, Respondent was at work during that period, with the exception of "sporadic" days absent, which were noted as COVID.

- Respondent submitted claims nos. 27867451, 28112050, 28259556, and 28776011, alleging that he was absent from work for 142 consecutive days from January 23, 2021 to August 27, 2021. Relying on the information and representations set forth in the claim forms submitted by Respondent, AFLAC paid him $9,466.67 in TTD benefits with respect to those claims. According to the WMATA Records, Respondent worked during that period, with the exception

of "sporadic" days absent. The submission of these claims also contained the physician's statements ostensibly signed by Dr. P., which was earlier refuted by a representative for Dr. P's office, paragraph 8, *supra*.

As a result of his review of the WMATA Records, the AFLAC investigator concluded that Respondent was not temporarily totally disabled during any of the periods of time for which Respondent had filed the twenty disability claims paid by AFLAC, that Respondent's written representations that he was totally disabled during those periods were false, and that Respondent was not entitled to TTD benefits under the terms of the AFLAC disability policy with respect to any of the aforementioned claims.

10. On December 9, 2021 and, again, on July 21, 2022, AFLAC advised Respondent by letter that it could not validate his disability claims and requested that he return the benefits paid.

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.

12. On December 9, 2021, and July 21, 2022, AFLAC, having a good faith belief that Respondent committed insurance fraud, referred the issues related to Respondent's claims to the MIA, Fraud Division.

II. THE ADMINISTRATION'S INVESTIGATION

13. Upon receipt of AFLAC's fraud referral related to claims submitted by Respondent, the MIA, Insurance Fraud and Producer Enforcement Division opened an investigation into Respondent's conduct.

14. As part of its investigation, an MIA investigator contacted WMATA and obtained Respondent's time, attendance, and pay records ("WMATA/MIA Records") for comparison with the dates identified by Respondent as dates on which he was disabled and unable to work in this AFLAC disability claim submissions.

15. During the period from June 7, 2018 to November 15, 2018, Respondent submitted an initial claim no. 7527698 and four subsequent claims for continuous TTD, claims nos. 8152565, 8767362, 9768294,

10931878, for an injury he purportedly sustained on June 7, 2018. Relying on the representations of Respondent in his claims submissions, AFLAC paid him $11,999.99 for 180 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 110 days, worked 196.03 hours of overtime, and was on paid leave for 176 hours.

16. On January 29, 2019, Respondent submitted claim no. 12454136 for an injury he purportedly sustained on January 21, 2019. Relying on the representations of Respondent in his claim submission, AFLAC paid him $2,533.33 for 38 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 27 days and was on paid leave for 16 hours.

17. During the period from May 10, 2019 to October 7, 2019, Respondent submitted an initial claim no. 14722654, and five subsequent claims for continuous TTD, claim nos. 15151916, 15799461, 16393835, 17163296, and 17794248, for an injury he purportedly sustained on April 27, 2019. Relying on the representations of Respondent in his claims submissions, AFLAC paid him $12,000.00 for 180 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 104 days, worked 256.2 hours of overtime, and was on paid leave for 232 hours.

18. On March 26, 2020, Respondent submitted claim no. 21460417 for an injury he purportedly sustained on March 8, 2020. Relying on the representations of Respondent in his claim submission, AFLAC paid him $933.33 for 14 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 7 days, worked 8.56 hours of overtime, and was on paid leave for 27.37 hours.

19. During the period from July 10, 2020 to August 18, 2020, Respondent submitted an initial disability claim no. 022938901, and a subsequent claim for continuous TTD, claim no. 0123584876, for

an injury he purportedly sustained on July 7, 2020. Relying on the representations of Respondent in his claims submissions, AFLAC paid him $5,000.01 for 75 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 31 days, worked 53.37 hours of overtime, and was on paid leave for 242.99 hours.

20. On March 19, 2021, Respondent submitted claim no. 27867451 for an injury he purportedly sustained on January 23, 2021. Relying on the representations of Respondent in his claim submission, AFLAC paid him $5,266.67 for 79 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 34 days, worked 52.97 hours of overtime, and was on paid leave for 152 hours.

21. During the period from April 5, 2021 to May 17, 2021, Respondent submitted an initial disability claim no. 28112050, and two subsequent claims for continuous TTD, claim nos. 28259556 and 28776011, for an illness that purportedly began on January 23, 2021. Relying on the representations of Respondent in his claim submissions, AFLAC paid him $4,200.00 for 63 consecutive days on TTD. An examination of Respondent's WMATA/MIA Records for this period revealed that Respondent actually worked 23 days, worked 12.85 hours of overtime, and was on paid leave for 16 hours. These claim forms contained the physician's statements ostensibly signed by Dr. P.

22. As part of the MIA's investigation, an MIA investigator contacted Dr. P.'s office. A representative for Dr. P.'s office examined the claim forms for claim nos. 27867451, 28112050, 28259556, 28776011, and 29348451 submitted by Respondent, and ostensibly signed by Dr. P. The representative for Dr. P.'s office advised the MIA that the claim forms were false, citing that neither Dr. P., nor anyone in his office, had signed the physician's statement, that Respondent had not visited Dr. P.'s office on the dates enumerated on the claim forms, and that no one from Dr. P.'s office had ever declared Respondent disabled.

23. A WMATA representative reported to the MIA that Respondent was not placed on any restricted/light duty status while working during the TTD claimed benefit periods which were the subject of this investigation.

24. On April 28, 2022 and May 2, 2022, an MIA investigator spoke with Respondent, who admitted to faxing the claim forms purportedly signed by Dr. P. to AFLAC, but denied committing fraud.

25. An AFLAC representative reported to the MIA investigator that if AFLAC had known that Respondent was actually working during the periods he claimed to be on TTD, AFLAC would not have paid Respondent benefits and that Respondent was not entitled to benefits under the provisions of the disability policy for any of the claims submitted.

III. VIOLATION(S)

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

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[.]

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
>
> * * *
>
> (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.

27. As described in detail above, Respondent violated § 27-403 by submitting twenty claims for disability benefits under the AFLAC Policy that were knowingly premised on false and misleading written assertions and, in some cases, forged and fraudulent medical certifications, that he was temporarily totally disable and unable to work on the days for which benefits were sought. As such, Respondent is subject to an administrative penalty pursuant to § 27-408(c) of the Insurance Article.

IV. SANCTIONS

28. 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 fraudulent claims has been submitted to an insurer. Ins. §§ 2-201(d)(1) and 2-405.

29. Having considered the factors set forth in § 27-408(c)(2), the MIA has determined that $3,000.00 is an appropriate administrative penalty against Respondent.

30. Administrative penalties shall be paid within thirty (30) days of the date of this Order to the Maryland Insurance Administration. Payment shall be made by immediately payable funds and shall identify the case by number (R-2022-1970A) and Respondent's name, (Robert Francis Conner). Payment of the administrative penalty shall be sent to the attention of: Joseph Smith, Acting Associate Commissioner, Insurance Fraud and Enforcement Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Unpaid penalties will be referred to the Central Collections Unit for collection.

31. Additionally, Respondent is ordered to reimburse AFLAC $41,933.33, which is the amount AFLAC paid Respondent for disability claims he submitted, later determined to be false.

32. Notification of reimbursement to AFLAC shall be made in writing to: Joseph Smith, Acting Associate Commissioner, Insurance Fraud and Enforcement 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-2022-1970A) and name (Robert Francis Conner).

33. 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 Respondent's right to request a hearing, it is this 6th day of October 2022, **ORDERED** that:

(A.) Robert Francis Conner shall pay an administrative penalty of three thousand dollars ($3,000.00) within 30 days of the date of this Order.

(B.) Robert Francis Conner shall pay restitution to AFLAC in the amount of Forty-one Thousand, Nine Hundred Thirty-three dollars and thirty-three cents ($41,933.33) within 30 days of the date of this Order.

KATHLEEN A. BIRRANE
Insurance Commissioner

BY: signature on original
JOSEPH SMITH
Acting Associate Commissioner
Insurance Fraud & Producer Enforcement 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: Melanie Gross, Executive Assistant to the Deputy Commissioner. 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