

INSURANCE FRAUD AND CLAIMS INVESTIGATION

Insurance Law in Texas

Lorman Education Services

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INSURANCE FRAUD AND CLAIMS INVESTIGATION IN TEXAS

I. Introduction

Insurance fraud is big business in Texas. Recent estimates by the National Insurance Crime Bureau (“NICB”) indicate that three out of every ten property/casualty claims may involve fraud, and that fraudulent claims account for ten to thirty cents out of every claim dollar. The average American household pays an additional \$200 per year to make up the cost of fraud, while total fraud adds up to nearly \$120 billion a year. In fact, the NICB rates insurance fraud as the number two form of crime in America, next to tax

fraud. Recent news reports include arrests and indictments in “staged accident” schemes around the state. In January 1999, a federal grand jury in Dallas indicted 10 people, including several lawyers and chiropractors, for their alleged participation in a staged accident ring that reportedly resulted in more than \$6 million in fraudulent insurance claims from various carriers. State Farm has filed federal RICO lawsuits against the participants of that ring, alleging that the schemes resulted in more than \$2 million in claims payments. State Farm has also filed a similar lawsuit against a different group of defendants in Houston, alleging a scheme from 1992 to 1997 that resulted in 199 staged accidents with fraudulent claims of more than \$2.6 million.

Insurance fraud takes many forms, from the extreme examples of arson and staged automobile accidents to inflating injuries and losses due to real accidents. While fraud is widespread, most claims are legitimate. Careful and thorough claims investigations will help adjusters know the difference. Adjusters and investigators should be on the lookout for certain warning signs or “red flags” of fraud, including a reluctant or uncooperative insured or claimant; loss shortly after the inception of the policy period, immediately prior to expiration of the policy or soon after an increase in policy limits; financial difficulties; vague and inconsistent or unexplained sources of income; inconsistent statements by insured/claimant; altered documents; hand-delivered documents; or prior similar claims. There are other “red flags” specific to particular types of claims. Those warning signs are presumably familiar to most adjusters and attorneys and this paper will not discuss them in detail. Adjusters and investigators should not evaluate claims solely by looking for “red flags”, but should be especially vigilant when such warning signs are present.

II. Claims Investigation

A. Avoiding Extra-Contractual Liability

In investigating any claim, suspicious or not, an insurer must be careful to comply with its common law and statutory duties of good faith and fair dealing. An outcome-oriented investigation, or reliance on biased experts, could expose the company to extra-contractual liability. The deadlines imposed by Article 21.55 of the Texas Insurance Code also pose a risk of liability in excess of policy limits.

1. The Supreme Court Disapproves Outcome-Oriented Investigations

Ever since the Texas Supreme Court first recognized an insurer’s tort duty of good faith and fair dealing to its insured in *Arnold v. National County Mutual Fire Ins. Co.*, 725 S.W.2d 165 (Tex. 1987), Texas courts have struggled with the development and application of a workable standard that balances the insurer’s right to make erroneous coverage decisions without exposure to extra-contractual tort liability and the insured’s right to be compensated for unreasonable denials of coverage. *See Aranda v. Insurance Co. of N. Am.*, 748 S.W.2d 210, 213 (Tex. 1988) (“Carriers will maintain the right to deny invalid or questionable claims and will not be subject to [bad faith] liability for an

erroneous denial of a claim.”). The Texas Supreme Court most recently modified the “no reasonable basis” bad faith standard to hold an insurer liable “if the insurer knew or should have known that it was reasonably clear that the claim was covered.” *Universe Life Insurance Co. v. Giles*, 950 S.W.2d 48, 56 (Tex. 1997).

Under both the former and current articulation of the bad faith standard, a “bona fide dispute” regarding coverage precludes bad faith as a matter of law. See *Transportation Ins. Co. v. Moriel*, 897 S.W.2d 10, 17-18 (Tex. 1994) (“[A] bona fide dispute about the insurer’s liability on the contract does not rise to the level of bad faith.”). A dispute based upon a deficient investigation, however, will not shield an insurance company from liability.

In *State Farm Fire & Casualty Co. v. Simmons*, 963 S.W.2d 42 (Tex. 1998), the Texas Supreme Court opened the door for recovery in a bad faith case for merely “deficient” investigations, when it found that State Farm improperly denied the Simmonses’ fire claim by “targeting” the insureds while failing to investigate neighbors who already had burglarized and vandalized the Simmonses’ home. The *Simmons* majority concluded that State Farm breached its duty of good faith and fair dealing by conducting “a biased investigation intended to construct a pretextual basis for denial.” 963 S.W.2d at 44. The Court acknowledged (1) that “evidence establishing only a bona fide coverage dispute does not demonstrate bad faith” and (2) that “[a]n insurance company’s obligation to investigate is obviously not unlimited.” *Id.* The Court still concluded, however, that State Farm did not make a good-faith effort to investigate objectively, but instead engaged in an “outcome-oriented investigation designed to place the Simmonses at the center of an ‘arson triangle.’” *Id.*

In affirming “bad faith” for an alleged failure to investigate, the Court criticized State Farm for immediately deeming the fire loss “suspicious” just because the Simmonses had filed a previous theft claim that was paid. Additionally, State Farm’s adjuster had testified that revenge and spite were common motivations for arson and the Simmonses had identified five people who may have had grudges against them. *Id.* at 45. The Texas Supreme Court emphasized that State Farm never attempted to locate these individuals and the claims file listed locating these individuals as an unfinished item of investigation. *Id.*

The Court also noted that State Farm’s investigation did not objectively address the common indicators of fraud by arson, which include:

- (1) a recently purchased policy or a recently increased policy;
- (2) a policy that significantly exceeds the insured property’s value;
- (3) efforts by the insured to sell the property or other concrete indications that the insured intended to move;
- (4) prior fire losses;

- (5) a strong alibi for the insured;
- (6) unusual money problems, such as high medical bills or legal fees;
- (7) the removal of furniture or personal items before the fire; or
- (8) a “huge [financial] burden” resulting from the strain of meeting everyday expenses. *Id.* at 46.

None of the first six criteria were met for the Simmonses’ claim and State Farm’s information on the last two criteria was erroneous and thus did not provide a “reasonable basis” for denial. *Id.* To the extent there was a conflict on the amount of the Simmonses’ mortgage obligation, “the jury could have inferred that a reasonable insurer would have approached its insureds to resolve the apparently conflicting information and would have eventually concluded that the insureds lacked a sufficient motive to commit arson.”

In dissent, Justice Hecht emphasized that coverage for the Simmonses’ fire loss was the subject of a bona fide dispute. In large part, the undisputed evidence regarding two prongs of the arson triangle -- opportunity and motive -- came from the Simmonses themselves. Moreover, no party contested that the fire was intentionally set, the third prong of the arson triangle. Justice Hecht lamented that under *Simmons* “proof that an insurer’s investigation was deficient in some respect is enough for bad faith liability.” 963 S.W.2d at 49. (Hecht, J., dissenting). Hecht would have required proof “that the deficient investigation led the insurer to deny the claim when liability was reasonably clear.” *Simmons* will likely result in many bad faith cases going to a jury where previously summary judgment would have been appropriate and will certainly create more focus on the investigation of questionable claims.

2. Unreasonable Reliance on Experts May Create Extra-Contractual Liability.

The Texas Supreme Court has also recognized an exception to the bona fide dispute rule based on “unreasonable” reliance on expert reports. In *Lyons*, the court held that evidence an expert’s report was not objectively prepared or evidence an insurer’s reliance on such report was unreasonable may create fact questions for a jury to resolve. *Lyons*, 866 S.W.2d at 601. In *State Farm Lloyds v. Nicolau*, 951 S.W.2d 444 (Tex. 1997), the court followed this “*Lyons* exception” and affirmed a bad faith jury verdict because there was some evidence that the insurer’s expert lacked objectivity and that the insurer should have been aware of the alleged lack of objectivity. *Id.* at 448.

A recent, unpublished opinion from the Dallas court of appeals illustrates the problem that blind reliance on experts can create. In *State Farm Lloyds v. Johns*, 1998 WL 548887 (Tex. App.--Dallas 1998, no writ), the insured complained that her foundation had been damaged by a plumbing leak. State Farm hired Kenneth Bitting, a professional engineer, to inspect the house. Daly, the adjuster who hired Bitting, testified that he did not know what Bitting’s qualifications were, but nonetheless testified he “felt

very comfortable with [Bitting's] qualifications." 1998 WL 548887, at * 4. Daly had previously engaged Bitting more than ten times to analyze foundation claims, and Bitting had concluded damage occurred because of plumbing leaks on "one or two," although Daly could not remember the name of any policyholders whose foundation claims were paid. Bitting believed that foundation problems rarely occurred because of plumbing leaks. Most of Bitting's work came from State Farm and other insurance companies. *Id.* Bitting testified that his formal education was in mechanical engineering, but that he had studied soils since receiving his degree and believed he was qualified to evaluate foundation and soil problems. *Id.* Bitting also testified that he was an expert in fire investigations, structural engineering, and certain areas of electrical engineering. Bitting conceded, however, that his practice did not involve geotechnical engineering, which he understood to be an engineering field, "involved in soils." *Id.* Bitting inspected the house and concluded the problems were caused by normal foundation movement, resulting from the type of soil and variation in moisture content in the soil. *Id.*

The insured, Johns, hired a geotechnical engineer, Ronald Reed, to inspect her problems. *Id.* at *5. Reed, who specialized in engineering problems related to soil conditions, inspected the house and concluded the foundation distress was caused by plumbing leaks swelling the soil under the slab foundation. *Id.* Johns forwarded Reed's report to Daly, who forwarded it to Bitting for review. *Id.* Bitting told Daly that Reed's report was not thorough and too general. Bitting disputed Reed's conclusions and doubted that any leaks existed. *Id.* However, Bitting did not take any samples to investigate the moisture content of the soil underneath the slab. *Id.*

Although Daly admitted he had no engineering expertise to evaluate the dispute between the two engineers, Daly made the decision to "go with the report that Bitting had supplied" and denied Johns's claim for foundation damage. *Id.* The court affirmed that the jury's finding that Bitting's report was not objectively prepared and that State Farm's reliance on Bitting's report was unreasonable and that State Farm's conduct constituted a "knowing" violation of the Texas Insurance Code. *Id.* at *6, 8.

3. Article 21.55 of the Insurance Code

Another significant concern in a claims investigation involves compliance with the deadlines set forth in Article 21.55 of the Texas Insurance Code. An exhaustive discussion of Article 21.55 is beyond the scope of this paper. However, a quick reference to these deadlines follows:

First Fifteen Days. The insurer has 15 days after receipt of written notice of the claim to acknowledge the claim, begin its investigation and request all items, statements and forms that the insurer reasonably believes will be required from the claimant. Additional requests may be made during the investigation if necessary. §2(a).

Next Fifteen Business Days. Once the insurer has received all of the required "items, statements, and forms," the insurer has 15 business days in which to accept or reject the claim in writing, unless an extension is requested. §3(a). This period is

extended to 30 days in cases where the insurer has a reasonable basis to suspect arson. §3(b).

Extension of Time. The insurer may extend the time within which to make a decision by 45 days from the date notice of extension is given, but it must explain to the claimant why it needs additional time and must give the claimant notice of the extension within the initial period of time provided to give notice of a decision on the claim. §3(d)(e).

Sixty Day Maximum. The insurer has a maximum of 60 days from the date it receives all “items, statements, and forms, reasonably requested and required” to accept or reject a claim, with certain exceptions. §3(f).

Payment Within Five Days. The insurer must pay the claim within 5 business days after it has told the claimant it will accept the claim. §4.

Violation of these deadlines will subject the insurance company to an automatic penalty of 18% per annum of the amount of the claim, plus reasonable attorney’s fees. This penalty can be significant in large or protracted claims. However, insurance companies should keep in mind that their compliance or non-compliance with these deadlines might be irrelevant in the end. Most recent cases have found an automatic violation of Article 21.55 when a claim is initially denied and the insured prevails at trial or on appeal, even if the insurance company had a reasonable basis for the denial. *See, e.g., Higginbotham v. State Farm Mutual Automobile Ins. Co.*, 103 F.3d 456 (5th Cir. 1997) (“[a] wrongful rejection of a claim may be considered a delay in payment for purposes of the 60-day rule and statutory damages”); *Teate v. The Mutual Life Ins. Co. of New York*, 965 F.Supp. 891, 893 (E.D. Tex. 1997) (“[L]ate settlement damages under the Texas Insurance Code, with no exception for excusable neglect or justifiable delay, is a lay down hand.”); *Oram v. State Farm Lloyds*, 977 S.W.2d 163 (Tex. App.–Austin 1998, no pet.) (no bad faith by erroneous denial but, the fact that State Farm “chose to reject the Orams’ claim and failed to pay within 60 days of its receipt of all reasonably requested and necessary paperwork,” meant that it was liable for the 21.55 penalties). On the other hand, if the insurance carrier prevails on the contract claim at trial, then any breaches of the Article 21.55 deadlines will be irrelevant. “Claim” is defined in the statute as a claim “that must be paid by the insurer.” If it need not be paid by the insurer, then there is no claim upon which to award an 18% penalty.

B. Investigative Tools

1. Duty to Cooperate a Condition Precedent to Recovery

Claims investigation is critical to any claim and begins with the initial report of the claim. Adjusters and investigators should strive to give each claimant the benefit of the doubt, while carefully documenting every step in the investigation and all communications with the claimant. Red flags and fraud indicators may not appear immediately and it is difficult to know what seemingly insignificant occurrences may

become significant later in the claim. Insureds with questionable claims are often reluctant to cooperate in the investigation. Such insureds may need to be reminded that the policy requires their cooperation. The standard Texas homeowners' policy contains the following duties:

Your Duties After Loss.

* * *

- (5) as often as we reasonably require:
 - (a) provide us access to the damaged property.
 - (b) provide us with pertinent records and documents we request and permit us to make copies.
 - (c) submit to examination under oath and sign and swear to it.

The Texas personal automobile policy contains a similar duty to cooperate:

PART E - DUTIES AFTER AN ACCIDENT OR LOSS

A person seeking coverage must:

1. Cooperate with us in the investigation, settlement or defense of any claim or suit.
2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
3. Submit, as often as we reasonably require, to physical exams by physicians we select. We will pay for these exams.
4. Authorize us to obtain:
 - a. medical reports; and
 - b. pertinent records.
5. When required by us:
 - a. submit a sworn proof of loss;
 - b. submit to examination under oath.

These duties of cooperation are conditions precedent to recovery under the policy. *See, e.g., Rogers v. Aetna Cas. & Sur. Co.*, 601 F.2d 840, 844 (5th Cir. 1979) (compliance with proof of loss provision a condition precedent to coverage); *Welch v. Maxson Young Associates, Inc.*, 1999 WL 191683 (Tex. App.–Houston [1st Dist.] 1999,

no pet. hist.) (denial of theft claim reasonable as a matter of law where insured failed to satisfy the condition precedent of providing a proper proof of loss); *State Farm General Ins. Co. v. Lawlis*, 773 S.W.2d 948, 949 (Tex. App.–Beaumont 1989, orig. proceeding) (insured’s failure to submit to EUO abates claim).

2. Review of Pertinent Records

Records can be very important in the investigation of a claim. Insurance companies should always request authorization to obtain medical, financial, or other applicable records at the outset of the claims investigation. The insured’s prior claim history should be reviewed to assess evidence of prior claims, losses, and pre-existing injuries. Other helpful documents include bank records, credit card records, utility records, employment records, phone records (including cellular records), business income and expense records. Financial records often indicate economic distress, a consistent motivation for insurance fraud. In addition, such records could indicate that the insured lacked the means to acquire the items allegedly lost or destroyed. While income records are useful, “an insurer may not require an insured to provide income tax returns, except in a fire claim or claim of lost income or lost profits.” Tex. Ins. Code Ann. Art. 21.21 §4(10)(x) (Vernon Supp. 1999). A review of documents which require insureds/claimants to provide an inventory of possessions, such as proofs of loss in prior claims, bankruptcy petitions and divorce pleadings, can provide insurance companies with useful information regarding particular items claimed. In a fraudulent claim, these documents will often contain contradictory information regarding date and place of purchase, purchase price and value.

A careful review of a claimant’s medical records may reveal potential fraud. Doctor’s notes and reports could indicate prior injuries, overtreatment, or exaggerated injuries. In cases where a staged accident or a fraud ring is suspected, a review of medical clinic sign-in sheets could show that a claimant signed in for a series of visits all at one sitting. The Current Procedural Terminology (“CPT”) codes can reveal fraud through overuse or omission.

3. Witness Statements and Interviews

Recorded statements and witness interviews are also very important. In Texas, most policies give the insurance company the option of taking the insured’s examination under oath. An examination under oath will be more effective after a preliminary investigation of the claim. In contrast, the recorded statement is the first and perhaps best chance to get the insured’s version of events. The advantage gained by being the first to interview a party or witness after an event occurs is obvious. A well-organized and thorough recorded statement is an invaluable tool.

4. Examinations Under Oath

The Examination Under Oath (“EUO”) may be the most important tool available to the insurance company. The purpose of the EUO provision is to enable an insurer to

obtain all information and material in the possession of the insured regarding the claim. *See, e.g., Hudson Tire Mart, Inc. v. Aetna Cas. & Surety Co.*, 518 F.2d 671 (2nd Cir. 1975). At the same time, the EUO provides a convenient forum for the insured to present the insured's understanding of the events leading up to the claim and to supply information and documentation supportive of the claim and property valuations. Finally, the EUO discourages exaggerated and improper claims and may be employed to expose fraudulent or inflated claims. As the United States Supreme Court found more than one hundred years ago:

The object of the provisions in the policies of insurance requiring the assured to submit himself to an examination under oath, to be reduced to writing, was to enable the company to possess itself of all knowledge, and all information as to other sources and means of knowledge, in regards to the facts, material to the rights, to enable them to decide upon their obligations, and to protect themselves against false claims.

Claflin v. Commonwealth Ins. Co., 110 U.S. 81, 94-95, 3 S.Ct. 507, 515 (1884).

The EUO is a contractual right of the insurer and a condition precedent to any recovery by the insured. *See, e.g., United States Fidelity & Guar. Co. v. Wigginton*, 964 F.2d 487, 490 (5th Cir. 1992) (arson case holding that the insured's failure to submit to examination under oath precluded coverage under the policy as a matter of law). Texas law does provide however, that an insured's refusal to submit to an EUO merely abates but does not bar the insured's claim. *State Farm Gen. Ins. Co. v. Lawlis*, 773 S.W.2d at 949.

The insurance company triggers the EUO requirement by issuing a formal demand to the insured. The demand must expressly state the time and place for the examination and the person before whom it will take place. The request must be reasonable. *Humphrey v. National Fire Ins. Co. of Hartford*, 231 S.W. 750 (Tex. Comm. App. 1921, holding approved). A sufficient demand must schedule the examination under oath within a reasonable time after the loss and the submission of the proof of loss. Normally, the EUO should be taken in the county where the loss occurred.

While an EUO is similar to a deposition, it is broader in scope. Generally, "[t]he insurer is entitled to inquire into any matter which is 'material' to the existence or extent of the company's liability." *Gipps Brewing Corp. v. Central Mfrs. Mut. Ins. Co.*, 147 F.2d 6, 11-13 (7th Cir. 1945). In the case of a fire loss, the insurer may require the insured to divulge his whereabouts at the time of the loss, may question the insured concerning any removal of personal property prior to the fire, and, if arson is suspected, may request extensive financial information. *Edmiston v. Schellenger*, 343 So.2d 465, 466-67 (Miss. 1977) (whereabouts); *Mercantile Trust Co. v. New York Underwriters Ins. Co.*, 376 F.2d 502, 505-06 (7th Cir. 1967) (removal of property); *Powell v. U.S. Fidelity & Guaranty, Co.*, 88 F.3d 271, 272 (4th Cir. 1996) (financial information). Information about previous fire losses and cancellation of other policies is material as a matter of law. *Nationwide Mut. Fire Ins. Co. v. Dungan*, 634 F. Supp. 674, 682-83 (S.D. Miss. 1986)

aff'd, 818 F.2d 1239 (5th Cir. 1987). Although the insured may bring an attorney (or other representative), the attorney's ability to assist at the EUO is limited. The insured's attorney is not entitled to ask questions or make objections.

Refusal to answer questions in an EUO, whether based on the advice of counsel or not, amounts to non-compliance with the EUO provision. *Allison v. State Farm Fire & Cas.*, 543 So.2d 661, 662 (Miss. 1989) (affirming insurer's summary judgment for insureds' refusal to provide financial records or answer financial questions at EUO); *Happy Hank Auction Co. v. American Eagle Fire Ins. Co.*, 145 N.Y.S.2d 206, 211 (N.Y.A.D. 1st Dept. 1955), *aff'd as modified*, 154 N.Y.S.2d 570, 136 N.E.2d 842 (N.Y. 1955). Furthermore, although Texas courts have not discussed the issue, other jurisdictions have held that it is unreasonable for an insured to refuse to submit to an EUO because he or she is under indictment. *See, e.g., United States Fidelity & Guarantee Co. v. Wigginton*, 964 F.2d 487, 491 (5th Cir. 1992) (Mississippi law voided coverage under fire policy when insured refused to testify under oath until he could make a decision whether to waive his Fifth Amendment right against self-incrimination in the criminal proceeding pending against him); *but see Gruenberg v. Aetna Ins. Co.*, 108 Cal. Rptr. 480 (Cal. 1973) (insurer breached the duty of good faith and fair dealing by using failure to appear at EUO as pretense for denial of the claim when insurer knew that insured would not appear for any examination by insurers during the pendency of criminal charges against him).

5. Proofs of Loss

Compliance with the provision requiring a proof of loss is also a condition precedent to coverage in Texas. *Rogers v. Aetna Cas. & Sur. Co.*, 601 F.2d 840, 844 (5th Cir. 1979); *American Teachers Life Ins. Co. v. Brugette*, 728 S.W.2d 763, 764 (Tex. 1987) (accident disability policy). However, "substantial compliance" is all that is required to satisfy the condition, and an unverified proof of loss containing information about the circumstances of the loss constitutes "substantial compliance." *Henry v. Aetna Cas. & Sur. Co.*, 633 S.W.2d 583 (Tex. App.—Texarkana 1982, writ ref'd n.r.e.); *Dairyland County Mut. Ins. Co. v. Keys*, 568 S.W.2d 457, 459 (Tex. Civ. App.—Tyler 1978, writ ref'd n.r.e.). As noted by one commentator, "To most courts, substantial compliance means that the proof submitted by the policy holder is sufficient to put the insurer reasonably on notice as to the nature and magnitude of the claim and to provide the insurer with a springboard from which it can adequately investigate and process the claim." Jeffrey W. Stempel, *Interpretation of Insurance Contracts*, § 31.7 *Proof of Loss Formalities and Substance* at 747 (Little, Brown 1994). Policyholders may lose the benefit of this "liberal construction" and justify an insurer's denial if the proof of loss is "sketchy" or the policyholder's cooperation is "anemic." *Id.* at 748.

If the insurer takes the position that the proof of loss is defective, the company must "within a reasonable time, object to the proof and point out the defects so that the insured, if he desires, may correct the same." *Keys*, 568 S.W.2d at 459; *accord Henry*, 633 S.W.2d at 584. The insurer is entitled to sufficient information to enable it to determine the "nature and extent of the loss," but may not require unreasonable proof of

value such as bills or receipts. See *Fidelity Phoenix Fire Ins. Co. v. Sadau*, 178 S.W. 559, 561-62 (Tex. Civ. App.–Ft. Worth 1915, no writ) (citations omitted).

C. Working With Third Parties

Many claims cannot be resolved without the assistance of third parties. Insurance companies should be aware, however, that reliance on third parties will not shield them from extra-contractual liability. In addition, such agents should be specifically instructed as to the scope of their assignment. They should also be monitored, as their actions could expose the company to liability.

1. Experts

Experts are often critical in the evaluation of a claim, but must be chosen carefully. As discussed above, reliance on an expert report that was not objectively prepared could subject an insurer to bad faith liability. *Nicolau*, 951 S.W.2d at 448. The choice of experts has become even more important in the wake of the Supreme Court's ruling in *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), regarding the admissibility of scientific testimony. *Daubert* requires that the trial court render an "assessment of whether the reasoning or scientific methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue" before allowing an expert to testify. 505 U.S. at 592-93. Most recently, the Supreme Court ruled that the criteria governing the admissibility of scientific expert testimony applies equally to nonscientists, such as engineers. *Kumho Tire Co. v. Carmichael*, No 97-1709, 1999 WL 152455, – U.S. – (March 23, 1999). The relevant criteria include whether an expert's theory has been tested and subjected to peer review and publication. The Fifth Circuit has raised the bar even higher, holding that a magistrate judge abused his discretion by admitting a testifying physician's opinion without subjecting it to a *Daubert* analysis. *Black v. Food Lion*, 1999 WL 173001 (5th Cir. 1999). In *Black*, Dr. Mary Reyna testified that Black's 1993 fall at a Food Lion Store caused her to develop fibromyalgia syndrome. The Fifth Circuit, applying *Daubert*, concluded that Dr. Reyna's testimony on causation should not have been allowed. "[N]either Dr. Reyna nor medical science knows the exact process that results in fibromyalgia . . . Absent these critical scientific predicates, for which there is no proof in the record, no scientifically reliable conclusion or causation can be drawn." *Id.*

In a case of some concern to insurance companies, the Eleventh Circuit prohibited an insurer's fire cause and origin expert from testifying on *Daubert* grounds. In *Michigan Millers Mutual Insurance Corp. v. Benfield*, 140 F.3d 915 (11th Cir. 1998), the court of appeals affirmed the trial court's exclusion of the insurer's cause and origin expert. The court found that the expert's testimony was science-based and therefore subject to a *Daubert* inquiry regarding the reliability of the expert's opinion. Applying a "manifestly erroneous" standard of review, the Eleventh Circuit found no abuse of discretion by the trial court in excluding the expert's testimony when the expert had not conducted any tests or collected any samples and was unable to "rationally explain" his conclusion that the fire was intentionally set. *Id.* at 921.

It would certainly be unfortunate to predicate a claims denial on the opinion of an expert who was not allowed to testify at trial. Accordingly, insurance companies should carefully choose experts, mindful of the following considerations:

- the expert's specific field of expertise;
- the expert's education and training;
- the expert's reputation;
- the expert's experience, including work history; and
- whether the expert holds the proper licenses.

2. Private Investigators

Private investigators can be helpful in investigating suspicious claims. Videotape surveillance, for example, can highlight the extent or validity of a claimant's injuries for a jury. Improperly conducted surveillance, however, may expose the insurance company and the investigator to tort liability. These investigators are essentially an extension of the insurance company. Legal theories of agency, respondeat superior or vicarious liability may cause the insurance company to be liable for the investigator's conduct. In *Pinkerton National Detective Agency, Inc. v. Stevens*, 132 S.E.2d 119 (Ga. Ct. App. 1963), a Georgia court held that a private detective agency had violated a claimant's right to privacy by keeping her under surveillance for six months; peeping in the windows of her home several times; eavesdropping on conversations inside her house; going to her door pretending to be salesmen; following her in stores and public places. The detectives followed her so closely one night that she ran into the house in a panic, hit a piece of furniture, and knocked herself unconscious. Plaintiff's neighbors noticed the investigators and thought she was engaged in some wrongful activity and began to discontinue associating with her.

In *Unruh v. Trucking Insurance Exchange*, 498 P.2d 1063 (Cal. 1972) the California Supreme Court disapproved a "set-up" by a private investigators who befriended an insurance claimant and enticed her to go to Disneyland. The claimant allegedly suffered from a serious back condition which had required four surgeries. While at Disneyland, one investigator secretly filmed the claimant on a rope bridge while another investigator shook the bridge in an attempt to see the extent of her disabilities. The claimant learned of the deception and then suffered a nervous breakdown. The California Supreme Court held that the claimant could sue the investigators and the insurance company for assault and intentional infliction of emotional distress.

An insurance company should carefully check the background and qualifications of any investigators it hires and should monitor the investigator. In addition, the investigator should be specifically instructed to conduct surveillance in public; avoid communication with the claimant about the subject matter of the lawsuit; avoid intrusive surveillance or surveillance which might be considered harassing. Finally, the investigator should not "entrap" the claimant or encourage activity by the claimant.

D. Dealing With Law Enforcement Agencies

1. Reporting Requirements and Statutory Immunity

Insurance fraud is a crime, so the investigation of a suspicious claim often involves communications with governmental and law enforcement agencies. Most states, including Texas, have provisions that require an insurer who suspects arson to report that suspicion and other relevant information to a law enforcement entity, generally the fire marshal. Article 5.46 of the Texas Insurance Code provides that the State Fire Marshal, any fire marshal of a political subdivision, the chief of any established fire department or any peace officer, may request any insurance company investigating a fire loss of real or personal property in which damages or losses exceed \$1,000 to release information in its possession relative to that loss. Tex. Ins. Code Ann. Art. 5.46 (Vernon 1981). “The company shall release the information and cooperate with any official authorized to request such information pursuant to this section.” *Id.* Article 5.47 provides that an insurance company that fails to comply with the article can have its certificate of authority to transact business canceled. *Id.* at Art. 5.47. Finally, Article 5.46 provides that, “[i]n the absence of fraud or malice no insurance company or person who furnished information on its behalf is liable for damages in a civil action or subject to criminal prosecution for oral or written statement made or any other action taken that is necessary to supply information required pursuant to this section.” *Id.* at Art. 5.46. The Texas Insurance Code also provides an affirmative defense of immunity for all persons providing information on fraudulent insurance activities to law enforcement or governmental agencies. Specifically, the Code provides:

Sec. 6 (a) A person acting without malice, fraudulent intent, or bad faith is not subject to liability based on filing reports or furnishing, orally or in writing, other information concerning suspected, anticipated, or completed fraudulent insurance acts if the reports or information are provided to:

(1) a law enforcement officer or an agent or employee of a law enforcement officer;

* * *

(3) an authorized governmental agency or the department.

Tex. Ins. Code Ann. Art. 1.10D § 6(a) (Vernon Supp. 1998). The immunity extends to “civil liability for libel, slander, or any relevant tort, and a civil cause of action of any nature may not exist against that person based on those activities.” *Id.* § 6(b).

2. Avoiding Claims of Malicious Prosecution

The statutory immunity provided for fraudulent claims is consistent with the public policy disfavoring actions for malicious prosecution. *Smith v. Sneed*, 938 S.W.2d 181, 183 (Tex. App.--Austin 1997, no writ). In recognition of the strong public policy in favor of exposing crime, “individuals cannot be held liable where their purpose in making

an accusation was the socially beneficial one of bringing an offender to justice, without a malicious intent.” *Id.* at 184. For this reason, courts have specifically declined to expand the duty to include “negligent prosecution.” *Id.* at 184-85. The plaintiff in a malicious prosecution case must establish:

- the commencement of a criminal prosecution;
- initiation or procurement of the prosecution by the defendant;
- termination of the prosecution in the plaintiff’s favor;
- the plaintiff’s innocence;
- the absence of probable cause for the prosecution;
- malice in filing the charge; and
- damage to the plaintiff.

Richey v. Brookshire Grocery Co., 952 S.W.2d 515, 517 (Tex. 1997).

“Malice” in a malicious prosecution action is defined as “ill will, evil motive, or reckless disregard of the rights of others.” *McHenry v. Tom Thumb Drug Stores*, 696 S.W.2d 664, 666 (Tex. App.–Dallas 1985, writ dismissed). Absent evidence of an accuser’s ill will, evil motive, or reckless disregard of the rights of another, “an individual cannot recover for being wrongfully accused of a crime.” *Smith v. Sneed*, 938 S.W.2d 181, 184 (Tex. App.–Austin 1997, no writ). Simply reporting known facts to the proper authorities is insufficient proof of malice as a matter of law. *ITT Consumer Financial Corp. v. Tovar*, 932 S.W.2d 147, 160 (Tex. App.–El Paso 1966, writ denied); *Closs v. Goose Creek Consol. Indep. Sch. Dist.*, 874 S.W.2d 859, 878 (Tex. App.–Texarkana 1994, no writ) (holding that “[m]alice cannot be predicated upon acts which the actor had a legal right to do” and affirming summary judgment for defendant on absence of malice). As with its internal claims investigation, an insurance company needs to be sure that its dealings with law enforcement agencies evidence utmost objectivity and good faith.

E. Denying the Claim

Once the investigation has been completed, the insurance company should fairly and objectively evaluate the information that has been uncovered to determine whether the claim should be accepted or denied. If the insurance company was unable to complete its investigation due to a lack of cooperation by the insured, then the insured’s failure to comply should be set forth in the denial letter. In considering the information in its possession, the insurance company should ask the following questions:

- If there is evidence both for and against a claim, what evidence can be verified? By whom?
- If opinions are important in evaluating a claim, what is the personal knowledge of the persons expressing those opinions? If an expert opinion is relevant, what is the expert’s training, background, experience and expertise? What is the basis of the lay or expert opinion?
- Does the evaluation weigh the facts supporting the claim against those undercutting the claim?

If, after the evaluation, the insurance company decides to deny the claim, it is important to write a thorough denial letter, setting forth any refusals to cooperate by the insured; the factual bases underlying the denial; a statement of each policy provision (exclusion or other condition) supporting denial of the claim; and a statement of each legal reason supporting denial of the claim. The denial letter should be written in an objective and dispassionate tone. Adjusters should bear in mind that the denial letter will be a trial exhibit if there is litigation resulting from the denial. The insurance company's should make sure that the letter is an exhibit for the company and not the plaintiff.

III. Litigation of Insurance Fraud

A. Intentional Acts Exclusion

1. Arson is Implicitly Excluded

The Texas personal automobile policy contains an exclusion for "any person who intentionally causes bodily injury or property damage." Often fraudulent automobile claims, such as staged accidents, will fall within this exclusion. There is no similar exclusion for intentional acts or even for arson under the property coverage section of the Texas homeowner's policy. However, it is universally recognized and Texas courts have held that public policy will not permit recovery by an insured who knowingly burns, or causes to be burned, insured property in order to collect the insurance thereon. *Aetna Casualty & Insurance Co. v. Clark*, 472 S.W.2d, 649, 653 (citing *Ritter v. Mutual Life Ins. Co.*, 169 U.S. 139, 18 S. Ct. 300, 42 L. Ed. 693 (1898)).

An insurer who alleges arson has the burden of pleading and proving the three elements of the "arson triangle":

- the fire had an incendiary origin,
- the insured had opportunity to set the fire, and
- the insured had motive to set the fire.

State Farm Lloyd's, Inc. v. Polasek, 847 S.W.2d 279, 282 (Tex. App.-San Antonio 1992, writ denied). Because arson is usually planned and committed in secret, these elements are commonly proved by circumstantial evidence. *Id.*; see also *First State Bank of Denton v. Maryland Cas. Co.*, 918 F.2d 38, 43 (5th Cir. 1990) (evidence of fire's incendiary origin and insured's financial motivation to commit arson supported verdict, even absent direct evidence that insureds set the fire); *St. Paul Guardian Ins. Co. v. Luker*, 801 S.W.2d 614, 611 9 Tex. App.--Texarkana 1990, no writ); *Garrett v. Standard Fire Ins. Co.*, 541 S.W.2d 635, 638 (Tex. Civ. App.--Beaumont 1976, writ ref'd n.r.e.).

2. Innocent Co-Insured May Recover

Historically, Texas law did not allow either an innocent spouse or an innocent co-insured to recover insurance proceeds when community property was destroyed by the arson acts of her culpable spouse. *Saunders v. Commonwealth Lloyd's Insurance Co.*,

928 S.W.2d 322, 324 (Tex. App.--San Antonio 1996, no writ). In *Kulubis v. Texas Farm Bureau Underwriters Ins. Co.*, 706 S.W.2d 953, 955 (Tex. 1986), the court held that an innocent co-insured could recover under an insurance policy, when another culpable co-insured illegally destroys jointly owned non-community property. The Texas Supreme Court specifically reserved the issue of whether an innocent spouse could recover under the same circumstances if the destroyed property was community property. *Id.* at 955.

After *Kulubis*, the Fifth Circuit applying Texas law held that an innocent spouse did not have a right to recover insurance proceeds when community property was destroyed by the arson acts of the culpable spouse. *Norman v. State Farm Fire & Cas. Co.*, 804 F.2d 1365 (5th Cir. 1986); *see also Webster v. State Farm Fire & Cas. Co.*, 953 F.2d 222, 223 (5th Cir. 1992) (post-fire divorce between the innocent and culpable spouses, which decreed one-half of the insurance proceeds on the destroyed community property as the innocent spouse's separate property, still does not allow the innocent spouse to recover insurance proceeds for a pre-divorce arson fire).

Since *Kulubis*, *Norman* and *Webster*, Texas appellate courts have divided on the innocent spouse question. In *Chubb Lloyds Insurance Co. of Texas v. Kizer*, 943 S.W.2d 946, 952 (Tex. App. -- Fort Worth 1997, writ denied) the Fort Worth Court of Appeals followed the reasoning of the Fifth Circuit and denied recovery, holding that community property destroyed by a fire intentionally set by, or with the participation of, one spouse bars any recovery by the other spouse, innocent or otherwise. Similarly, the San Antonio Court of Appeals has held that an insurance company did not breach the duty of good faith and fair dealing by denying the fire claim of an innocent spouse based on arson. *Saunders v. Commonwealth Lloyd's Ins. Co.*, 928 S.W.2d 322, 325-26 (Tex. App.--San Antonio, no writ).

In contrast, in *Travelers Cos. v. Wolfe*, 838 S.W.2d 708, 712 (Tex. App.--Amarillo 1992, no writ), the Amarillo Court of Appeals held that an innocent spouse was *not* barred from recovering insurance benefits for community property destroyed by her arsonist ex-husband because the property had been converted to separate property by divorce by the time the innocent spouse had "established her claim." Likewise, the Houston Court of Appeals also allowed recovery of community property proceeds by an innocent spouse because there was a specific partition of the community property before trial. *Murphy v. Texas Farmers Insurance Co.*, 982 S.W.2d 79, 83 (Tex. App.--Houston [1st Dist] 1998, review granted). The Texas Supreme Court has agreed to review *Murphy* and address the question of when a spouse may recover fire insurance proceeds after an arson fire. *See Texas Farmers Ins. Co. v. Murphy*, 42 Tex. Sup. Ct. J. 91 (Oct. 31, 1998).

B. Concealment or Fraud Exclusion and Anti-Technicality Statutes

Texas insurance policies generally provide the following regarding fraud:

Concealment or Fraud. This policy is void as to you and any other insured, if you or any other insured under the policy has intentionally concealed or misrepresented

any material fact or circumstance, made false statements or committed fraud relating to this insurance, whether before or after a loss.

This policy language is modified by “anti-technicality” statutes. Article 21.16 of the Texas Insurance Code provides as follows regarding fraud committed in the application for insurance:

Any provision in any contract or policy of insurance issued or contracted for in this State which provides that the answers or statements made in the application for such contract or in the contract of insurance, if untrue or false, shall render the contract or policy void or voidable, shall be of no effect, and shall not constitute any defense to any suit brought upon such contract, unless it be shown upon the trial thereof that the matter or thing misrepresented was material to the risk or actually contributed to the contingency or event on which said policy became due and payable, and whether it was material and so contributed in any case shall be a question of fact to be determined by the court or jury trying such case.

Tex. Ins. Code Ann. Art. 21.16 (Vernon 1981).

In other words, in order to avoid a policy based upon a misrepresentation of the insured in the application for insurance, Texas law requires that an insurer show the following five elements:

- the making of a representation;
- the falsity of the representation;
- reliance by the insurer;
- intent to deceive on the part of the insured; and
- the materiality of the representation.

Mayer v. Massachusetts Mutual Life Ins. Co., 608 S.W.2d 612, 616 (Tex. 1980).

Intent to deceive may be conclusively shown by circumstantial evidence. *Sharp v. Lincoln American Life Ins. Co.*, 752 S.W.2d 673, 675 (Tex. App. -- Corpus Christi 1988, writ denied). Moreover, intent can be established -- as a matter of law -- where a misrepresentation is “so outrageous and removed from the truth that it must have been made with the intent to deceive.” *Id.* at 676; *Security Southwest Life Ins. Co. v. Gomez*, 768 S.W.2d 505, 510 (Tex. App. -- El Paso 1989, no writ); *First State Ins. Co. v. Mini Togs Inc.*, 841 F.2d 131, 134 (5th Cir. 1988) (insured’s failure to disclose prior loss history and fire code violations supported district court’s finding that insured “misrepresented and concealed material facts” thus voiding the policy); *Hartley v. Hartford Accident & Indem. Co.*, 389 F.2d 91, 92 (5th Cir. 1968) (affirming summary judgment for insurer and declaring insurance policy void *ab initio* because insured did not reveal misappropriation of bank funds in application for fidelity bond).

However, intent can sometimes be difficult to prove. Courts have been particularly reluctant to find intent in cases of misrepresentations in applications for

health insurance. *See Enserch Corp. v. Shand Morahan & Co., Inc.*, 952 F.2d 1485 (5th Cir. 1992) (even a material misrepresentation in an insurance application will not defeat recovery if it is made innocently and in good faith), *Albany Ins. Co. v. Anh Thi Qieu*, 927 F.2d 882 (5th Cir.), *rehg denied*, 934 F.2d 1263, *cert. denied* 112 S.Ct. 279 (1991) (negligence or carelessness in completing an application for insurance will not support an invalidation of the policy). Furthermore, an insured's mere knowledge of his undisclosed health condition is insufficient to prove his intent to deceive in the insurance application. *Flowers v. United Ins. Co. of America*, 807 S.W.2d 783, 786 (Tex. App. -- Houston [14th Dist.] 1991, no writ).

Materiality is also important and is viewed at the time that the policy is issued, not at the time of the loss. *Robinson v. Reliable Life Ins. Co.*, 569 S.W.2d 28, 30 (Tex. 1978). A material fact is any fact "the knowledge or ignorance of which would naturally influence an insurer in making the contract at all, or in estimating the degree and character of the risk, or in fixing the rate of insurance." *Fireman's Fund Ins. Co. v. Wilburn Boat Co.*, 300 F.2d 631, 640 (5th Cir. 1962), *cert. denied*, 370 U.S. 925, 82 S. Ct. 1562, 8 L.Ed.2d 505 (1962).

Insurance company sales representatives should be instructed regarding their role in defending against fraud. Insureds who have made misrepresentations often claim the sales representative completed the application. Sales representatives should avoid completing applications for applicants, and should certainly never sign the applications for the applicant. Sales representatives should stress the importance of reading the entire application to ensure its accuracy before signing the application. In addition, sales representatives should carefully inspect the property being insured and document all communications with the insured, even after the policy has gone into effect.

Article 21.19, which governs claims of fraud during the course of a claim, contains a similarly difficult standard of proof:

Any provision in any contract or policy of insurance issued or contracted for in this State which provides that the same shall be void or voidable, if any misrepresentations or false statements be made in proofs of loss or of death, as the case may be, shall be of no effect, and shall not constitute any defense to any suit brought upon such contract or policy, unless it be shown upon the trial of such suit that the false statement made in such proofs of loss or death was fraudulently made and misrepresented a fact material to the question of the liability of the insurance company upon the contract of insurance sued on, and that the insurance company was thereby misled and caused to waive or lose some valid defense to the policy.

Tex. Ins. Code Ann. Art. 21.19 (Vernon 1981).

Under Article 21.19, before an insurance company is allowed to use any provision in a policy which would render the policy void or voidable, it must prove

- misrepresentation or concealment;

- reliance;
- and the resulting loss of an otherwise valid defense to the policy.

Delta Lloyds Ins. Co. v. Williamson, 720 S.W.2d 232, 233 (Tex. App.–Beaumont 1986, no writ); *United States Fire Ins. Co. v. Skatell*, 596 S.W.2d 166, 168 (Tex. Civ. App.–Texarkana 1980, writ ref’d n.r.e.); *Fireman’s Fund Ins. Co. v. Reynolds*, 85 S.W.2d 826, 829 (Tex. Civ. App.–Waco 1935, writ ref’d) (construing section 21.19’s predecessor statute); *Fidelity-Phoenix Fire Ins. Co. v. Sadau*, 167 S.W. 334, 335 (Tex. Civ. App.–Amarillo 1914, no writ) (construing section 21.19’s predecessor statute).

The most difficult aspect of this statute is the requirement that the insurance company prove that it lost a valid defense as a result of the fraud. In *Aetna Casualty & Surety Co. v. Guynes*, 713 F.2d 1187 (5th Cir. 1983), the insureds sought to recover for a fire that destroyed their vacation home. Aetna denied the claim and raised affirmative defenses of arson and misrepresentations after the claim which voided the policy. The district court directed a verdict in favor of the Guynes on the misrepresentation issue, and the jury found in the Guynes’ favor on the arson issue. *Id.* at 1189. The court found that Aetna had not met the requirements of article 21.19, because Aetna was never misled by the Guynes’ declarations and did not waive or lose some valid defense to the policy. *Id.* at 1192. Aetna raised its arson defense and lost. Because article 21.19 applied, and because Aetna did not lose its arson defense, the judgment of the district court was affirmed. *Id.* Similarly, in *Stokes v. State Farm Lloyds*, 1997 WL 96608 (Tex. App.–Houston [14th Dist.] 1997, writ denied) (unpublished), the Houston Court of Appeals rejected State Farm’s argument that its insured’s misrepresentations had caused it to lose the defense of arson, because State Farm had the opportunity to assert the defense and to submit a jury issue on it. The fact that the jury found against State Farm did not constitute a “loss of defense” as contemplated by the statute. “Under article 21.19 a defense is lost when it cannot be presented or litigated by the insurer.” *Id.*

C. Recovering Attorneys’ Fees

In addition to a counterclaim for common-law fraud, a counterclaim for attorneys fees can be an effective deterrent to fraudulent claims. Both Article 21.21. of the Texas Insurance Code and the Texas Deceptive Trade Practices Act provide mechanisms for insurance carriers to recover their fees incurred in defending against claims that are groundless or brought in bad faith. *Yazdi v. Republic Insurance Co.*, 935 S.W.2d 875 (Tex. App.–San Antonio 1996, writ denied) involved a claim for theft of oriental rugs and other items under a homeowners’ policy of insurance. Republic denied the claim on the grounds of fraud. *Id.* at 877. Yazdi sued Republic for breach of contract, negligence, violations of the DTPA and Insurance Code, breach of the duty of good faith and fair dealing, fraud and misrepresentation. Republic counterclaimed for attorneys’ fees under the DTPA and Insurance Code on the basis that Yazdi’s claims were groundless and brought in bad faith. The jury was unanimous in its verdict for Republic on the fraud defense and awarded the company \$35,000 for its attorney’s fees and costs. The court of appeals affirmed the award, finding that the trial court had not acted arbitrarily or unreasonably in finding that the claim was groundless and b rought in bad faith and in

awarding the company's attorney's fees. The court cited the following evidence in support of the jury's findings. First, Yazdi's claim fit the pattern of questionable claims encountered by the insurance company investigators in the past, e.g., it occurred shortly before the policy expired; the insured could not produce receipts; the policy had excessive coverage limits; and the insured tried to hustle the insurance company to move quickly. Second, there were many inconsistencies in Yazdi's story. Third, various facts about Yazdi indicated that he had a history of deceit; for example, he consistently used different spellings of his name, different birthdays, different addresses, and different social security numbers. Fourth, he had filed at least two previous personal injury claims. Fifth, he had deportation proceedings pending against him, and sixth, he had been charged with petty theft several times. The court of appeals noted that the jury "clearly had no doubt" that Yazdi's claim was fraudulent, as it recommended that Yazdi be assessed punitive damages and charged with criminal fraud in addition to the attorney's fees it awarded. *Id.* at 879.

In other recent insurance fraud case, a Houston jury returned a \$35.8 million award in favor of an insurance company that had received claims arising from false robberies at a jewelry store. The insurance company paid \$295,000 on the first claim. It was later discovered that the items claimed to have been stolen included goods on consignment with other stores. Those items had not been stolen, but rather concealed by the owner of the store. Two years later, the store's owner again reported that his jewelry store had been robbed. This time his claim was denied and Jewelers Mutual Insurance Company filed a declaratory action against the owner, claiming common law fraud and other causes of action. After the trial, the jury awarded Jewelers Mutual \$634,000, including the \$295,000 the company paid as a result of the fraudulent 1991 claim. The rest of the award was for expenses the insurance company incurred in reviewing and investigating both the fraudulent 1991 and 1992 claims. The jury also awarded punitive damages totaling \$35 million and awarded the insurance company its attorneys fees and costs.

IV. Conclusion

Insurance fraud is expensive for policyholders and insurance companies. Texas laws imposing bad faith liability for unreasonable denials and deficient investigations mean that companies must use care in handling potentially fraudulent claims. However, companies should not be deterred from the fight against fraud. The same common-sense claims handling and investigation techniques that are applied to legitimate claims will uncover the fraudulent ones.