

IDENTIFYING POTENTIAL FRAUD

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RED FLAGS FOR AGENT FRAUD

By: Kevin Jacobson & updated by Brad Proctor 8/2015

- Unusual or significant changes in policy/account activity. Examples include:
 - Persistency/lapses
 - Surrenders
 - Cash withdraws
 - Policy loans
 - Movement of funds within existing business
 - Change of policyholder/account holder address coincident to policy/account activity
 - A dramatic and unexpected increase in sales
 - Customer complaints
 - Agent/staff complaints
 - Unexplained affluence – the agent appears to be living beyond his/her income.
 - Presence of cash or checks in the agent’s office, either from the customer or the company, especially those made out to the agent.
 - Undelivered policies and/or unprocessed paperwork in the agent’s office.
 - Existence of “pre-signed” documents – policy service requests, annuity forms, policies, etc.
 - Unusual documentation – “customized” client statements, business cards or letterhead with unfamiliar business names, evidence of undisclosed outside business activity.
 - Significant life events which might create financial pressures (e.g., divorce, bankruptcy, serious illness or death in the family, etc.)
- Overly aggressive agent
- Pattern of early duration death claims
- Writing or servicing agent a beneficiary (directly or indirectly)
- Prior SIU investigations into writing agent
- Customer loan(s) to agent
- Customer claims to have a contract/policy in which the Company has no record
- Customer’s address the same as agent’s address

No single indicator or group of indicators necessarily means fraud is present. However, ignoring such issues can allow fraud, or at the least poor business practices, to go unaddressed.

RED FLAGS FOR CALL CENTERS

By: Toni Mortensen & updated by Marcus Burdick 8/2015

- Unwarranted hesitation in providing identifying information (social security number, birth date, home address, spouse's name, etc.)
- Rustling papers - looking through documents for identifying information
- Voice does not fit the name
- Third party insists on speaking for client
- Uncooperative - unwilling to provide information
- Overly aggressive in attempts for information - threatens to contact insurance commissioner, attorney or superiors
- P.O. Box is used as residential address or "mail drop" used (Mail Boxes, Etc)
- All calls made via cell phone
- Caller is unusually familiar with insurance terminology and/or procedures
- Several policies or additions taken out/applied for over a 6 month/1 year time period
- Transaction requested after recent address change or increase in coverage
- Anonymous and/or frequent inquiries for status of pending transaction
- Alternate payee requested - no clear relationship to client or payee address is remote from client address
- Outside contacts - other companies - unwilling to provide name or telephone number
- The owner refuses to give written authorization or threatens attorney involvement.
- Calls asking about how to wire money out.
- Several calls made within a short period of time on a client's account.
- Answer security questions with incorrect answers but confident tone.

Disclaimer: General indicators of possible fraud are "red flags" only. Additional questions, investigation and other information are needed to prove a fraud exists.

RED FLAGS FOR CUSTOMER SERVICE

By: Walter Boyd & updated by Tina Marshall 8/2015

- Customer cannot provide proper identification
- Voice doesn't fit the name
- Client confused, unaware of recent activity
- Third party insists on speaking for customer
- Customer is unusually demanding or argumentative
- Address change followed by money transaction
- Request from agent to personally deliver a company check to a customer
- Request from spouse for loan, dividend or policy surrender
- Address changed to c/o agency or agent
- Insured calls after an application has been submitted, alleging he/she did not sign the application
- Insured's date of employment with an employer is within a period during which the insured was on disability
- Insured completed a new or increase application for coverage while on disability
- An individual calls requesting coverage for no apparent reason (applies to Group Coverage)
- Signatures on information purportedly received from an insured do not match the insured's signature on applications, or other documents
- Premium submitted does not match billing, annuity deposit and/or individual premium
- Agent who is not appointed signs applications or the agent signature appears altered or different from what is on file
- Alleged family involvement in forgery of withdrawals or loan documents
- Suspicious "Group" application

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RED FLAGS FOR LIFE and DEATH CLAIMS

By: Craig Williamson, and updated by Greg Mirabelli 9/2015

APPLICATION REVIEW

- Misrepresentation of medical history, date of birth, driving habits, criminal history, height, weight, smoking habits.
- Time lapse between App. Date and Paramedical Examination.
- Forgery by someone other than the applicant, and/or applicant unable to be physically present.
- Face amount of insurance is excessive compared to financial needs with or without accidental benefits added after original application date.
- Acquired a large amount of other life policies or ADB through different companies in a short period of time, especially just prior to death.
- No other insurance in force at time of application on middle to high income insured.
- Application was completed by someone other than the agent.
- Death occurred shortly after the insured, owner, or beneficiary contacted the agent to increase coverage. Policy not solicited by agent.
- Premiums were paid in cash, by money order or by someone other than the owner or beneficiary.
- Reinstatement of lapsed insurance policy, forgery on reinstatement form.
- Relationships, family names, agent names, physicians, etc. (i.e., agent is related to any party to the claim).
- Application and oral fluid test not performed on same date.
- Application not received within 4 to 7 days of completion.
- Difference in height and weight on application compared to paramedical examination.

BENEFICIARY

- Beneficiary does not have an insurable interest or there is a questionable insurable interest. (Although this is not necessary to issue policy owned by the insured).
- A beneficiary change shortly before insured's death or frequent owner or beneficiary changes.
- Beneficiary is in failing business
- Multiple beneficiaries listed by percentages.
- Viatical company is the owner/bene.
- Attending physician's name is the same as the last name of the insured or beneficiary.
- Writing agent is related to the insured.
- Beneficiary is uncooperative, unwilling to provide authorization for the release of information, or unable/unwilling to produce original death certificate.
- Attorney pressuring for fast settlement or threats of quick legal action are made.

- Inducements for quick settlement.
- Anonymous and/or frequent telephone inquiries from the beneficiary regarding the status of the pending claim. Other person impersonates beneficiary during status calls.
- Overly aggressive in attempts for quick payment of claim, threatens to contact insurance commissioner, attorney or superiors if payment is not made immediately; especially on foreign or contestable claims.
- Claim form missing pertinent medical information or vague or ambiguous details on claim forms.
- Answers “N/A” or skips questions on Health Statement form or claim form.
- During interview beneficiary is vague or unclear about medical, employment and insurance history or circumstances leading to death.

PROOF OF LOSS

- False identification documents, i.e., Social Security Number, driver’s license number, birth date and/or death certificate counterfeited, falsely made or altered.
- Disappearance of insured where there is no body and/or evidence of death, no doctor in attendance, body cremated without any religious services.
- Cause of death from disease which progresses slowly.
- Cause of death ruled “undetermined”.
- Death by self-inflicted injury, GSW, Carbon Monoxide, overdose and the ruling is accidental.
- If drowning, the body is not located.
- Body is not identifiable, i.e. decomposed, burned or dismembered.
- Unexplained or unusually long delay in submission or notice of claim.
- Unsolicited medical records submitted by the claimant.
- Body identification is in question or cannot be identified. Beneficiary never saw remains.
- Circumstances of death are vague or incomplete.

DOCUMENTS

- Signature discrepancy evident in file, forgeries, printing of name as opposed to cursive signature on documents, misspellings, alterations, erasures, white-out, stamps.
- Beneficiary submits an extensive number of documents.
- Handwriting similar on all the documents.
- Death occurs shortly after issue date or during underwriting.
- Death Certificate handwritten
- No witnesses to a Motor Vehicle Accident (MVA)
- Claim is received with a demand letter from an attorney.
- Dates inconsistent with normal course of business days, holiday, in consideration of health, employment, death, etc.

- Handwritten medical receipts, billing, hospital records and medical records that appear too brief.
- Medical providers cannot locate records
- Post office box is used as residential address, or “mail drop” used (Mail Boxes USA, etc.).
- Unsolicited documents or excessive number of documents.
- Absence of independent/verifiable documents, i.e.: Death Certificate, police report, medical examiner/coroner report.
- Limitations placed on the use of authorization, wants to amend/alter authorization.
- Conflicting descriptions of course of illness or accident.

FOREIGN DEATH OR FOREIGN NATIONAL

- Insured is new to the U.S., a foreign national, or little time is spent in the U.S.
- Any death occurring outside of the U.S./Canada (including U.S./Canadian citizens).
- Medical records from foreign hospitals, doctors and clinics.
- Documentation is in English when English is not the primary language of that country.
- Death certificates from many foreign governments.
- Death claims on children “visiting” foreign countries.
- Information concerning foreign travel is inconsistent or vague, details unknown to family.
- Insured travels to foreign country by way of another foreign country – not the U.S.
- Translation sent with documents
- Beneficiary resides abroad
- Receipts are in U.S. currency
- U.S. Citizen buried or cremated in foreign country
- Claim submitted with an abundance of documents, photos, videotapes, medical records and police reports.
- Foreign national dies in homeland while “visiting”.
- Only a one way ticket
- No traveling companions
- Disposition of body is contrary to local customs.

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RED FLAGS FOR DISABILITY CLAIMS

By: Bob Dean & updated by Tina Marshall 8/2015

There are several indicators of potential fraud, which can be considered as “red flags”. A claim with two or more of these indicators present may indicate that further investigation is warranted. These indicators include, but are not limited to, the following:

- Recent increases in benefits or indication of multiple coverage.
- Failure to sign an authorization or altering of an authorization.
- An injury or illness coincides with a lay-off, plant closing or job termination or retirement.
- Signature of attending physician is similar to the claimant’s signature.
- Claimant provides inconsistent accounts of disability or accident.
- Claimant is active in sports or other strenuous activities.
- Claimant frequently cancels medical appointments, or refuses to attend independent medical exams.
- Disability stems from subjective complaints such as back pain, strain, headache, depression, or soft tissue injury.
- Claimant is near retirement age.
- Disability extends beyond normal length of time.
- Claim is submitted shortly after the contestable period has expired.
- Difficulty reaching claimant at home or claimant is reached at his office while disability is being claimed.
- A pattern where several claimants are using the same doctor and/or attorney.
- Claimant has filed previous claims for other disabilities.
- Attending physician continually extends disability each time forms are sent.
- Claimant indicates an extraordinary knowledge of claim procedure and insurance language.
- Pressure from claimant for quick decision and immediate threats of complaints to an Insurance Department or attorney. Threats or contact made to Senior Management such as Owner, CEO, etc.
- Claimant has a pager number, or answers the phone using a business greeting.
- Claimant uses P.O. Box, or refuses to divulge actual address.
- Attending physician is not certified in the field or specialty for treatment of injury or illness claimed.
- Company receives a copy of the same claim form each month.
- Unwitnessed injuries – especially if on private property.
- Claimant moves out of the U.S.
- Self-employment – small business.
- APS has misspelled words.
- Claimant handles everything in person or by phone, wants to avoid the U.S. mail.
- Diagnosis provided does not indicate a need for disability.

- Claims are submitted shortly after the effective date of coverage.
- Altered information on claim forms or bills, erasures, strike-overs, white-out, super-imposed material, different types of inks, or handwritings.
- Statement reportedly completed by the physician is handwritten or typed on a blank sheet of paper, rather than on business letterhead.
- Physician's signature is not in the usual format. Example: Dr. John Doe, instead of John Doe, MD.
- Medical information is written in layman's terms.
- Provider and claimant have the same last name.
- Treatment dates on holidays or weekends.
- Multiple accidents.
- Claimant incurs soft tissue injuries from unwitnessed accidents.
- Claimant's signature on the claim forms does not match his/her signature on the application for coverage.
- Frequent address changes.
- Frequent changing of physicians, especially when documentation of disability is being pursued.
- Claimant makes calls that provide more information than requested to facilitate claim processing.
- Claimant demands special handling of claim, such as same-day payment.
- Claimant faxes required claim forms from a business different from that which the insured was employed at the time the claim was made.
- Faxes received directly from the insured that include information that was directly requested from the physician or employer.
- Revised or additional information provided by insured or provider on a declined claim that would allow the claim to be paid.
- In medical records, type of testing is not compatible with diagnosis.
- Provider is located a long distance from the claimant.

RED FLAGS FOR LONG TERM CARE INSURANCE

By: Carmen Russo and updated by Mark Lanford 8/2015

INVESTIGATIVE SERVICES MISSION STATEMENT

The mission of Investigative Services is to perform investigations that achieve high expectations for quality, timeliness, cost competitiveness and customer service. The results of these investigations will significantly increase corporate profits through prevention and detection of fraud, market conduct abuses, and company policy violations.

*The fraud indicators contained in this document will help you to identify potential fraud and/or misrepresentation. However, even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud is being committed or has been committed. Indicators of possible fraud are **Red Flags**, not actual evidence. Red Flags are circumstances that are unusual and vary from normal activity. When Red Flags exist, an investigation should always be pursued prior to making any final determinations. At the same time, the absence of fraud indicators does not mean that fraud has not or might not occur.*

LONG TERM CARE

Long Term Care insurance is a rapidly growing and changing product that provides a wide range of medical and support services for people with a degenerative condition or cognitive disorder.

Fraud and/or misrepresentations made by agents, providers and/or insureds can be costly for insurance companies.

Provider/Physician Red Flag Indicators

- Provider and insured have same address and/or telephone number
- Provider uses a social security number instead of a tax identification number
- Same provider using multiple tax identification numbers
- Provider's invoice is not printed on letterhead or appears to be self-made
- Amount billed is not consistent with charges seen for similar services in the same geographic area
- Wording on the bill is not consistent with standard industry language
- Facility is not licensed
- Insured describes a lower level of service than is being provided
- Physician's credentials are not documented and cannot be verified
- Physician's certification is vague or appears inconsistent with diagnosis
- Physician's certification is not signed
- Certification form has possible alterations or edits
- Invoices consistently submitted for the maximum daily benefit
- Provider or physician is related to the insured

- Insured advises that the rate negotiated is different than the one actually billed to the insurance company
- Provider is familiar with policy provisions and benefits
- Provider working 24/7 with no relief
- Provider is not there when case manager calls insured.

Insured Red Flag Indicators

- Activities of Daily Living or diagnosis does not fit criteria for LTC coverage
- Second opinion claim submitted soon after the first claim is denied
- Additional disabling conditions are added to subsequent medical reports
- Someone other than applicant signs the application for coverage
- Claim submitted more than 60 days after start of care
- Claims submitted within the two year contestable period or shortly thereafter
- First claim submitted within six months of issue and a lingering or long term pre-existing condition applies
- Letter of legal representation accompanies the submission of claim
- Insured demands immediate payment of claim
- Delays by insured, provider, or POA to remit information, medical authorizations or medical records
- Insured is younger than 55 years of age
- Ninety day certification received from physician for a condition that usually does not have a ninety day duration
- Suspected or possible omission of medical history on application
- Insured taking medications for a condition not disclosed on application or during the personal interview
- Pending doctor appointments listed on medical records received at the time of underwriting
- Insured's provider changes regularly
- Insured lists P.O. Box as address and will not provide residential address
- Insured requests dropping the claim shortly after it is submitted
- Claimant's condition is not severe enough to render them ADL dependent
- The plan of care never changes
- Insured not as residence when case manager calls

Agent/Broker Red Flag Indicators

- Overly aggressive sales tactics
- Insured not told about elimination or waiting periods
- Agent does not report obvious health impairments
- Signature discrepancies
- Indications of agent pressuring paramedical firm or examiner for "clean" exams
- Misstatement of insured's weight/height
- Evidence that shows the agent was not present for taking of application

- Agent has history of suitability violations
- Agent usually submits applications with no medical disclosures

UNDERWRITING

Insurance underwriting, regardless of the line of business, is subject to misrepresentations by various parties, such as: the proposed insured; the agent; the marketing representative; and/or other information providers. It is extremely important that the Company have complete and accurate information for review before making a decision to accept or decline a risk. In addition, there are other factors that need to be considered to protect the Company from regulatory actions.

The Company is closely monitored by the individual State Departments of Insurance and is also subject to regulatory actions from various federal agencies including the Securities & Exchange Commission, National Association of Securities Dealers and the Department of Homeland Security.

Applicant Identification/Applicant Behavior Red Flag Indicators

- Applicant is “walk-in” business, and is not well-known to the agent
- Applicant offers a P.O. box or Mail Drop as their address
- Applicant does not reside or work near the agency of record
- Applicant’s given address is inconsistent with their stated occupation/income
- Applicant has lived at their current address for less than six months
- Applicant has no home phone number or provides a cellular phone number as their home phone number
- Applicant provides a temporary, recently issued, or out-of-state driver’s license
- Applicant denies foreign travel but there is evidence that the applicant recently moved to the United States and/or has family still living outside the U.S.
- Applicant is nomadic and/or serves as a seasonal worker
- Applicant is resistant to personal contact with Company representatives
- Applicant provides a place of contact that is a motel, hotel, tavern or location that is neither their residence nor place of employment
- Applicant had a significant break in coverage with previous life insurance policies
- Applicant fails to complete portions of the application forms
- Applicant is unusually familiar with insurance terms and procedures
- Applicant is reluctant to utilize the mail when communicating with insurance company representatives
- Applicant information shows inconsistencies throughout document examination
- Pressure and/or threats made to John Hancock by the applicant or by their representative
- Other life policies are in force or pending but are not disclosed by the applicant

Financial Suitability/Life Insurance Redundancy Red Flag Indicators

- Applicant attempts to make the first premium payment in cash or by money order

- First premium check comes from a “starter account” or new account
- Applicant seeks an amount of insurance that falls just below the threshold amount that would require a medical exam and/or other additional evidence of suitability
- Applicant’s prospective monthly insurance premium will meet or exceed the amount of his/her monthly rent or mortgage
- Any evidence that a variable contract is over funded
- Applicant is unemployed or self-employed in a transient occupation
- If self-employed, the insured is vague about the business and actual responsibilities
- Financial inquiries reveal depletion of the applicant’s bank accounts and/or investments
- Applicant requests increasing benefits and/or premiums for the first few years of the new policy
- Multiple life insurance applications have been submitted to various carriers

Agent/Broker Red Flag Indicators

- Other life policies are in-force or pending but are not disclosed by the agent/broker
- Any evidence that the application was not signed in the presence of the writing agent/broker
- The applicant intends to replace an appropriate existing life policy with the new JH policy
- Agent/broker has a history of complaints from his/her clients
- Agent/broker has a history of censure by the Office of Business Conduct and/or regulatory agencies
- Agent/broker has a high lapse ratio
- Any unexplained lapses of time between the signing of the application and the paramedical exam and/or the delivery of the policy
- Pressure and/or threats made to John Hancock by the agent/broker
- Attending Physician’s Statement (APS) shows that the agent/broker requested only non-derogatory medical records related to the applicant
- Agent/broker is a close personal friend or relative of the applicant
- Agent/broker has an outside business interest that involves the applicant, directly or indirectly
- Agent does not report obvious health impairments such as wheel chair status
- Agent/broker submits a revised application to replace one previously submitted
- Handwriting on application information and signature appear different or application is completed in more than one ink

Prior Medical Condition Red Flag Indicators

- Evidence of substitution during the paramedical exam (inconsistent height and weight, date of birth, signatures, etc.)
- No family physician is named on the application or during the paramedical exam
- Applicant answers “no” to every application or paramedical question regarding prior medical issues (particularly notable when the applicant is of a mature age)

- Paramedical exam and/or lab work is conducted on the same day that the application is completed
- Paramedical examiner is provided with questionable identification by the applicant, such as a temporary/recently issued/out-of-state driver's license
- Evidence of incomplete medical records from attending physicians
- Information included in the application and/or paramedical report conflicts with the information contained within the Telefacts report and/or the client profile
- Applicant's handwriting or signatures on the application/paramedical forms are shaky and/or inconsistent

Miscellaneous Red Flag Indicators

- Unusual assignment of policy owner (insurable interest) or beneficiary
- Unusual payor relationship
- Beneficiary resides outside of the United States (particularly notable if the applicant denies foreign travel)
- Designated beneficiaries are parents of the insured
- Letter of legal representation accompanies the policy application

RED FLAGS FOR HEALTH CLAIMS

By: David Grannan & updated by Tracee Martin 8/2015

Remember no single indicator or combination of indicators is a sure bet a fraud has been perpetrated. It requires an investigation to determine if fraud has been perpetrated

TIME AND POLICY ADMINISTRATION CONSIDERATIONS

- A claim shortly after the policy was issued
- Check dates of service
- Check diagnosis
- Check the amount of the claim
- A claim shortly after the contestable period expires
- Check dates of service
- Check diagnosis
- Compare the address the provider shows for the insured with the address we have on our system
- Difficulty reaching an insured at the address we have listed
- Returned mail
- Look for indicators of other insurance
- EOB from another company
- Large dollar bills paid completely or partially
- Long delay in submission of a claim, especially high dollar claims
- Work related

CLAIMANT ACTIONS

- Claimant very pushy for quick payment of a claim
- Threatens to contact the insurance commissioner
- Threatens to hire an attorney
- Threatens to contact your superior
- Claimant submits a claim or supporting documentation in person
- Uses the overnight carriers, rather than US Mail
- Claimant submits photocopies of high dollar claims with no assignment of benefits
- Claimant submits police reports, ambulance reports or other documentation without said documentation being requested
- Claim forms and claim filing information is requested shortly before a claim for an accident is filed
- Claimant offers too much information.

- Claimant cannot recall details of the incident/accident
- Hypothetical questions
- Claimant submits claims originating outside the United States

SUSPICIOUS CLAIM DOCUMENTATION

Address on claim forms are different than the address we have on file Claimant Statement and Authorization form is filled out completely, except the question regarding other insurance-it is left blank.

- Claimant Statement and Authorization form too sketchy about the illness/injury
- Handwriting on bills looks very similar to the claimant's handwriting
- Altered information
- Date of service
- Diagnosis
- Amount of bill
- Claimant name
- Insurance information
- Provider information
- Credibility statements across the face of the bills
- Paid in Full, Paid by Me, Paid by Insured
- Handwriting not consistent with the rest of the bill
- Different pen
- Handwriting off the "base line"
- Handwriting outside of the given areas for the information
- Obvious use of correction fluid
- Base lines missing or partially destroyed
- Buildup of correction fluid shows up in photocopy or electronic image as shadows

SUPPORTING CLAIM DOCUMENTATION

- Police reports do not substantiate the claimant was involved in the automobile accident
- Police report actually states that the claimant was not injured.
- Police report lists insignificant mechanical damage to the vehicles
- Police report was not completed at the scene of the accident
- No police report available
- No medical records for the provider listed on the bills
- Cannot find a listing for the provider listed on the bills
- Cannot locate a license for the Provider listed on the bills

HEALTHCARE PROVIDER BASED CONCERNS

- Billing for services not rendered
- Billing continues after treatment ceases

- Claimant was never seen by provider
- Claimant received one test, bills submitted for multiple tests
- Unnecessary Services
- Cosmetic surgery-bills and records altered to conceal cosmetic nature of treatment
- Performing advanced treatment before attempting more conservative treatment
- Child claimant with bee sting, billed for throat culture and urine tests
- Unbundling
- When components of a global code are billed individually
- Add-ons
- Lab work
- Upcoding
- Claims submitted for more expensive services than were actually performed
- Services billed in units of time, but the time spent is exaggerated
- Services billed required more skill or complexity than those actually performed
- Billed for higher-priced name brand, but dispensed generic equivalent
- Change in Diagnosis/Treatment
- Claim with “routine” diagnosis resubmitted with diagnosis not routine
- Provider submits bills with a diagnosis that closely relates to the primary complaint, but not relating to the policy exclusionary rider

BROKER RELATED CONCERNS

- Broker is adamant that our company employees not contact his clients
- Hypothetical questions about coverage issues
- Broker is aggressive regarding getting a claim paid

RED FLAGS FOR UNDERWRITERS

By: Toni Mortensen & updated by Marcus Burdick 8/2015

- Out of state residence and/or request for mail delivery.
- The applicant's address is inconsistent with employment/ mailing/ home address.
- Employment address is a P.O. Box.
- The applicant resides/ works/ spends a great deal of time in a foreign country.
- Employment address is same as home address (if inconsistent with occupation).
- The applicant is a recent arrival to the U.S.
- No telephone number is provided or number provided is a mobile/ cellular phone.
- Applicant cannot provide driver's license or other identification or has a temporary, recently issued, or out-of-state driver's license.
- All transactions take place over the telephone; no personal meeting is ever made.
- Premiums are being paid by someone other than the owner or beneficiary and the minimum amount is paid/ collected.
- The applicant's income is not compatible with the amount of insurance requested.
- The applicant's employment history or income is vague or job duties are inconsistent or misrepresented, especially in combination with self-employment.
- Applicant questions underwriter closely on claim handling procedures or is unusually familiar with insurance terminology and/ or procedures.
- Medical history reported is inconsistent, missing or none reported - age/ lifestyle taken into account.
- Several policies or additions taken out/ applied for over a 6 month/ 1 year period of time.
- Inconsistency in signatures.
- Inconsistencies in height, weight, physical descriptions, license numbers, social security numbers.
- Acquisition of a large amount of insurance and/ or ADB through different companies in a short period of time.
- Relationship between the applicant and agent.
- Beneficiary does not have an insurable interest.
- Requests for "special" handling of the underwriting process by the agent due to:
 - speed/ time of exams/ issue due to expected travel
 - waiver of physical/ blood/ exam due to religion, culture or other reasons
- Medical exam is done out of sequence/ prior to the application or CAP process.
- Limitations are placed on the use of authorization.
- Inordinate pressure from the agent or applicant for a quick policy acceptance.
- A "lack of candor", reluctance or evasiveness in response to normal application and underwriting questions.
- Group census includes numerous family members, employees outside normal working age or do not live near policyholder's business.

- Business owner provides inconsistent information about nature of business.
- Salary is much higher or lower than would be expected for a given job.
- Premium is paid from a checking account not belonging to the policy owner or the check appears to be a bank counter check.
- Applicant fails to sign and date the application.
- High dollar amounts on “key man” policies in mom and pop operations.
- There is a relationship between the applicant and agent, especially at year’s end.
- Beneficiary does not have an insurable interest.
- Starter check accompanies the application.
- Insurance policies with values that appears to be inconsistent with the buyer’s insurance needs.
- Forming companies or trusts with no apparent business purpose.
- Information in application cannot be verified.
- Medical exam is done out of sequence/prior to the application process.
- Inconsistency with information provided on earlier applications.
- Medical history is vague or ambiguous.
- The physician’s report is very vague on details of past medical history and doesn’t coincide with the information shown on the applications.
- MIB history exists though applicant indicates “no” other insurance in force.
- Same trustee, or address for trustee, appears on applications from other clients.
- Producer has a pattern of sales to over Age 70, in large face amounts.

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