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## EXPOSING THE FAKE CLAIM RACKET

Frank A. Muscolina

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The casualty insurance business has experienced a rapid and remarkable growth in the last 25 years. As the industry grew and expanded, it attracted that segment of society whose livelihood is derived in the main by resort to connivance, deceit, and trickery. For some years, the member insurance companies of the Association of Casualty and Surety Companies had been endeavoring individually to protect their policyholders against unmeritorious claims. Their efforts were united, however, on January 1, 1938, when the Claims Bureau of the Association was organized<sup>1</sup>—it having become evident that fraudulent and exaggerated personal injury and other damage claims was becoming a real "racket." The companies realized that if unfounded or unjustified claims were permitted to go unchecked, both the industry and the general public, the policyholders, would suffer. Although the fake claims presumably were directed against the casualty insurance companies, the persons really hit hardest were the policyholders, who paid for these misdeeds in their insurance premiums. Claims of this character had increased to such an extent in some cities that many companies, unwilling to take further risks, discontinued writing business in those localities.

As a rule, commercial organizations look to the regularly constituted law enforcement agencies for protection against criminal abuses, and too, protect themselves through insurance itself. The insurance business, however, must protect itself against claim frauds because of their highly specialized character. So the Claims Bureau detects its own frauds and gathers its own evidence, and then brings the facts to the attention of the appropriate prosecutive authorities. This authority may be a federal, state, or county prosecutor, or a Grievance Committee of a Bar Association or Medical Society.

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1. The man selected to direct the investigative efforts of the newly-formed division of the Association was Wayne Merrick, who for three years had been Chief Investigator for Thomas E. Dewey during the Rackets Investigation in New York City and formerly served as a Special Agent for about nine years with the F.B.I. Under his direction, the Claims Bureau has made considerable progress toward punishing and reducing corrupt and fraudulent claim practices.

The investigative work of the Claims Bureau is performed by its force of Special Agents, the majority of whom are former F.B.I. Agents—men well grounded for their jobs through training and experience. The sifting of evidence, the determination of the probable credibility of witnesses, are time-consuming tasks. After the facts have been accumulated by investigation and it has been determined that they constitute a crime, the evidence must be presented in legally provable form. In many fake accident cases, only the claimant or a relative or friend of the claimant are eye witnesses. Resort must be had, therefore, to circumstantial evidence and to admissions made by claimants to third parties. In most cases, the proof is developed to such a point of conclusiveness that the prosecutor is willing to present it to a grand jury immediately. It must be emphasized, however, that the Claims Bureau is not itself a prosecutive or disciplinary agency. Its investigators are private citizens with no authority beyond that possessed by any other citizens. It has no power of subpoena and cannot compel the testimony of witnesses or the production of documentary evidence. All it can do is analyze cases, aided by the criminal investigative experience of the Special Agents, and gather the evidence. When the proof is obtained, the case is then presented to the appropriate authority.

While the Claims Bureau has many other duties, only one phase of its activities, namely, its fraud investigation work, will be discussed in this article. The task to which most of the Bureau's energy is directed is that of ferreting out and exposing those persons who seek to defraud casualty insurance companies through fake claims and unethical practices, the latter being done by a very small segment of professional men. Investigations undertaken by the Claims Bureau are generally confined to claims arising under casualty insurance coverages, such as workmen's compensation, public liability, products liability, and automobile liability.

Honest claims present no problem. The insurance companies have a definite obligation to pay all just claims. They have an equally definite obligation, however, to protect the insurance buying public from increased costs due to fraudulent or non-meritorious claims. The loss ratio is a factor which is considered in determining insurance rates; consequently, eliminating payments on fraudulent or non-meritorious claims tends to reduce the loss ratio, and this is reflected in lower premiums to the benefit of the insurance buying public. It is impossible to estimate how many claims are faked from their inception. Fraud cases are mixed with a multitude of legitimate claims. It sometimes happens that the fraudulent nature of a claim becomes apparent only after a settlement has been made. The individuals who seek to prey upon casualty insur-

ance companies comprise a motley group indeed, ranging from neophytes to professional claimants possessing assorted criminal records. Some prefer to operate alone, while others band together in so-called "rings."

Realizing that fraudulent claim activities are not confined to one particular area but rather are widespread, to more effectively cope with the problem field offices have been set up by the Claims Bureau in designated cities throughout the country. At the present time, the Claims Bureau has eight field offices.

An effective arm of the Claims Bureau in its campaign against frauds is its Index Division, which gathers, classifies, and indexes all personal injury accident claims reported by its subscribers. These subscribers include insurance companies, railroads, public utilities, self-insurers, and municipalities. The Index Division also maintains bureaus in strategic sections of the country, thus assuring practically nation-wide coverage for its subscribers, which is extremely important, especially when dealing with transient claimants. A Soundex method of filing is used which provides for filing names by phonetic code numbers, making it possible to file together all names that sound alike, even though they are spelled differently, and thus reduces to a minimum the risk that a filed prior claim record will evade discovery. At the present time there are on file in the Index Division about ten million personal injury claim records. The Index Bureaus daily send thousands of reports to subscribers. These reports, termed repeat notices, invite attention to the previous claim records of individuals filing current claims for personal injuries. Through this service, suspicious and fraudulent claims can be detected and legitimate claims expedited. Knowing an individual's past claim history is of inestimable value to a claims adjuster in evaluating that particular person's current claim. Very often habitual claimants will not press a claim when they become aware that their prior record is known. These reports often disclose that the latest alleged injury really occurred prior to the date of the accident in question or at a place other than where the claimant states. Frequently, an attorney for a claimant, upon learning that his client has an extended record, discontinues his connection with the case. A further aid is the use of bulletins. Since many professional claim fakers constantly travel from city to city, across the country, efforts are made by means of bulletins to apprise claims men and place them on notice of the possible presence of these individuals in their territories. A bulletin usually contains the person's name and known aliases, previous addresses, descriptive data such as physical appearance, distinguishing characteristics and marks together with a record of his known claim activities. These bulletins have been instru-

mental in the apprehension and successful prosecution of itinerant fakers.

This is an age of specialization for the claim fakers, too. A common practice of the claim faker is to fall beside a passing automobile, which he does so cleverly that to bystanders it looks as if he actually was hit. These fakers are known as "flop artists" or "flopers." Some "flopers" also scout certain parts of a city for openings or defects best suited for causing an "accident," such as an open cellar door, a broken step, a defective sidewalk coal chute cover, or a broken vault light. Locating such a spot, the flopper will purposely get his foot wedged in a jagged crevice and pretend to fall. Others learn how to throw their joints out of place and give an excellent imitation of suffering severe pain, which attracts volunteer witnesses. Some drop foreign substances into their food in dining rooms and restaurants. These persons order a meal at the busiest hour, then suddenly leap up screaming and pointing to something they have "found in the food." It may be anything from a false tooth in the soup to a cockroach in the mashed potatoes. It is there for all to see, but what no one saw was the screamer putting it there himself. Then, there are those intrepid fellows who make an art of stumbling, usually over hotel furnishings. They are called "tumblers." They can do a most realistic tumble in any place of their choosing. They faithfully practice on mattresses, in front of mirrors, in order to master their technique. Some have malformed joints which they can dislocate at will or other deformities which are cleverly manipulated to even deceive doctors into believing that they are serious new injuries. Often they use every possible pretense to delay a physical examination by the insurance company to determine the true extent of the alleged injuries—even to the point of having themselves placed in casts or of immobilizing the injured member of the body to cause a convenient lapse of time between the date of the alleged injury and the date of a medical examination by the insurance company. This is done to make it appear plausible that the "victim" had recovered from his injuries before the insurance company examination.

Claim fakers, as a rule, however, are not very ingenious. It has been said that no one as yet has been able to conceive and commit a perfect crime. The claim faker is no exception. He does not anticipate beforehand each and every possibility that may or may not arise in the course of perpetrating a fraud. Try as he may to arrange circumstances of the alleged accident so as to allay suspicion, he is bound to leave some clue which can be uncovered by a detailed and thorough investigation. They may change their names, addresses, doctors, and attorneys, but invariably they repeat the character or form of accident—their *modus*

operandi and alleged injuries generally are the same. Sometimes these fakers cast themselves in different roles. Once, one will be the injured person and another will testify as a witness to the alleged accident. Then they reverse their positions, the witness becomes the accident victim and the other the witness.

Somehow, the average person, other than the professional claimant, does not regard "chiseling" from an insurance company as an offensive form of crime. A surprising number of otherwise honest people, as well as some not so honest, consider insurance companies open game if they can cheat and defraud by any means which they feel reasonably sure will escape detection. A succession of these undetected frauds soon conditions them to the point where they regard these practices as clever techniques. Eventually, it becomes an accepted habit and persons who otherwise might not stoop to such crimes begin to follow suit. The general public does not realize that the direct cost of settling these claims must be paid by that very same public through insurance premiums.

There is no set rule by which fraudulent claims can be detected. We have found in our work though, that there are certain characteristics by which fraudulent claims may be recognized. The mere existence of one or more of these characteristics in any given claim does not necessarily mean the claim is fraudulent. Every claim should be treated at its face value. When several of these characteristics are grouped together, however, they should signal the claim adjuster to scrutinize carefully the facts of the case with reference to the accident and injury, so as to proceed with caution and be on the alert for conclusive evidence of fraud. Among these characteristics or indicia of fraud are: 1) No witnesses to the accident; 2) accident occurs in an isolated place; 3) notice of the claim is filed a long time after the alleged occurrence; 4) the case involves an attorney or physician who has the reputation of having been involved in previous claims which have been fraudulent; 5) the claimant brings with him some x-ray plates; 6) the claimant is anxious to get out of town; 7) the claimant says he is from out of town; 8) the claimant is unable to give a definite address or has rented a room shortly before the accident; 9) the claimant, in some prior case, was a witness for a person who is now offered as a witness for him.

There are many people who have never filed a damage claim, while some may have had one claim at most. Of course, there are a few individuals who, because of their hazardous occupations, unfortunately sustain repeated accident injuries. In these cases, the mere fact that claims have been made on repeated occasions is not of itself a sufficient basis to conclude that the claims are fraudulent. Many claims arise from bonafide

accidents, but the injuries are exaggerated. It is not at all uncommon for grossly exaggerated and built-up claims to follow in the wake of minor automobile accidents. It is most difficult to expose these claims when they are supported by apparently reputable medical witnesses. Physicians may rightly differ in their conclusions because of a difference in diagnosis. There are claims also which, on the surface, appear to be legitimate, but the injuries are faked; for example, where a person collects time and again on the basis of some injury of long standing which in no manner is attributable to the current accident in which the claimant allegedly may have been involved.

Fraud of itself is a most comprehensive term. It covers all the diverse means which human ingenuity can devise to cheat or deceive another by false representation. The forms it may assume and the means by which it may be practiced are as varied as the mind of man can devise. There is no such crime as fraud *per se*. Only a fraud which can be classified as larceny, forgery, perjury, or some other specific crime named in the Penal Statutes, constitutes a crime. A large percentage of the cases arising out of false claims fall into the category of larceny by false pretenses. The legal requisites of a *prima facie* case are that a false representation of a material fact relevant to the subject matter of the claim has been made and that the insurance company, in reliance thereon, paid the claim. Oftentimes, a repeat claimant will, during the civil court trial of his personal injury claim, while under oath, give false testimony on cross-examination as to his previous claims. He thereby leaves himself open to possible criminal prosecution for either perjury or false swearing. If subsequent investigation develops that this person committed perjury at the behest or suggestion of another, then that other person is liable to prosecution for subornation of perjury. When expedient, the Federal mail fraud statute has been invoked to terminate effectively the fraudulent claim activities of those who have used the U. S. mails in furtherance of their scheme to defraud insurance companies. In these cases, the correspondence sent through the mails, together with the envelopes bearing the cancelled postage stamps, comprise the evidence necessary for prosecution.

The great majority of the members of the legal and medical professions are thoroughly honest and ethical, but as in most lines of endeavor there are some few lawyers who make a living by prosecuting unwarranted damage suits. These lawyers usually associate with a few unprincipled doctors who give professional or technical testimony which supports fictitious, grossly exaggerated or built-up personal injury claims. Attorneys and physicians who make it a practice to build up their cases,

sooner or later engage in practices which make them more vulnerable. Such attorneys may indulge in ambulance chasing, faking of liability, or misuse of their clients' funds; while such physicians may associate themselves with the presentation of cases that are completely faked. Rogues may intrude into any profession, but their rascality is not to be imputed to the rest of the worthy and ethical members of the legal and medical professions. In some states, it is a criminal offense for an attorney to solicit legal employment. In states where there is no such criminal statute, conduct of this kind is in violation of the Canons of Professional Ethics of the American Bar Association and affords grounds for professional discipline whether it be disbarment, suspension, or censure.

The Claims Bureau believes there should be no compromise with fraud. While it does not hope to detect every fraudulent claim, it will vigorously resist unwarranted claims so as to discourage the claim racket. There will always be fraud and some occasionally will escape detection. The job of ferreting out insurance frauds is a continuous one. The Claims Bureau will continue to wage an unceasing struggle to protect its member companies, the policyholders and the public, from those hostile and inimical forces which seek to wrest their livelihood through fake claims.