NEBRASKA DEPARTMENT OF INSURANCE
FRAUD PREVENTION DIVISION

# Insurance Fraud Detection Hints

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## Conclusion

It is important to remember that the hints listed are merely possible "red flags" that there may be some evidence consistent with an insurance fraud scheme. Any one or two of these by themselves may not raise your suspicion; however, when you have several of these hints present or a pattern begins to emerge, you should investigate further or forward your suspicion to the Insurance Fraud Prevention Division.

OUT96085 Rev. 01/13



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## Insurance Fraud Is A Crime

*Neb.Rev.Stat. §44-6601 through 44-6608; and §28-631

Nebraska statutes allow for civil remedies as well as criminal penalties for violations of the Nebraska Insurance Fraud Act.

**Immunity**, "in the absence of malice, fraudulent intent, or bad faith, any person or entity is immune from civil liability for furnishing any report of information relating to suspected fraudulent insurance acts to the Fraud Division." See Neb.Rev.Stat. §44-6605(1) (Reissue 1998).

**Mandatory Reporting**, "Neb.Rev.Stat. §44-393, provides that "[e]very insurance company, agent, solicitor, or broker, and every person or party having knowledge of violation of any of the provisions of this chapter, is required to promptly report the facts and circumstances pertaining thereto to the Department of Insurance, which report and the name of the informant may be held confidential by the department, its officers, assistants and employees, and not be made public."

**Available on the Insurance Fraud Prevention Division's Website: www.ReportInsuranceFraud.ne.gov*

Division Chief Starr's comments:
"There are several contributing factors that may encourage insurance fraud to occur: an opportunist taking advantage of an individual claim, organized criminal elements, and little or no incentive to encourage insurers to detect and report fraudulent insurance activity. These factors lead to the tremendous overall costs associated with insurance fraud and are passed directly to the consumer."

"Only a combined effort by the consumer, the insurance industry, and law enforcement will have an impact on this nationwide problem."



4. "Similarities" of reports or evaluations of specific or several patients.
5. Vague medical reports and/or records, missing information and inconsistent information.
6. Double-billing for the same service.
7. Improper CPT coding for treatment.
8. Change in or unusual billing pattern.
9. Indications of altered or manufactured document.
10. Similarities in "doctors' notes" regarding office visits or treatment.
11. Signs of excessive treatment or referrals.
12. Unbundling and billing of services.

## Insurance Fraud Schemes Committed by Professionals

Insurance fraud is a lucrative business. Quite often there will be very organized activity in committing specific schemes with a network of "conartists." Individuals involved in the scheme may actually include an attorney, medical provider, capper, manager, insurance company insider; i.e. claims adjuster, appraiser, etc.

### Cappers

Some lawyers and medical providers use "cappers" to entice individuals to accept their services. The capper may be compensated on a percentage or flat-fee basis. The legality of "cappers" varies among jurisdictions. This form of "advertising" is open for abuse and is often found as a form of insurance fraud committed by the professional criminal.

### Lawyer

The unscrupulous lawyer has the opportunity to be a principle part of an insurance fraud scheme due to his/her representation of clients whether there is a legitimate loss or not. Lawyers may be in the position to actually "settle" a claim unbeknownst to their clients. Lawyers often will work on a contingency basis, so many times there will be incentive to exaggerate losses.

1. May develop a pattern of using "cappers" or "steerers."
2. Reputation for handling suspicious claims.
3. Pattern of relationships between suspicious medical providers.
4. Often deals in cases involving subjective injuries or questionable losses.
5. Often wants quick settlements.
6. Client often ill-informed as to status of claim.

### Medical Provider

The best way to lend authenticity to an injury is to find a medical provider willing to prescribe unneeded treatments.

1. Medical diagnosis inconsistent with treatment.
2. Reputation of similar claims or representation.
3. Pattern of relationships with lawyers or cappers.



## What is Insurance Fraud?

***Insurance fraud*** is any deliberate deception committed against or by an insurance company, insurance agent, or consumer for the purpose of unjustified financial gain. This occurs during the process of buying, using, selling and underwriting insurance.

**Fact:** ***Insurance fraud*** is the second largest economic crime in America, exceeded only by tax evasion.

**Fact:** ***Insurance fraud*** costs each American family nearly $1,000 a year. These are direct costs, which raise the price of health insurance premiums, auto and homeowners' premiums, and increase the price you pay for goods and services.

## What are the Different Types of Insurance Fraud?

***Insurance fraud*** falls into two basic categories:

1. **External Fraud Schemes** are directed against a company by individuals or entities as diverse as policyholders, medical providers, beneficiaries, vendors and career criminals.

2. **Internal Fraud Schemes** are those perpetrated against a company or its policyholders by agents, managers, executives, or other employees.

# Insurance Fraud Prevention Division

## Mission Statement

*The mission of the Insurance Fraud Prevention Division is to confront the problem of insurance fraud by prevention, investigation, and prosecution of fraudulent insurance acts in an effort to reduce the amount of premium dollars used to pay fraudulent claims.*

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1. Injury may occur late or early in the workweek.
2. Accident will be unwitnessed.
3. Vague and indescribable injuries.
4. Injury not promptly reported to management.
5. Soft tissue type injuries.
6. Injury may be in relation to potential early retirements, cutbacks or layoffs.
7. Alleged restrictions contradict actual activities of claimant.
8. History of work-related or prior soft tissue type injuries.
9. Medical examinations provide conflicting evaluations.
10. Claimant frequently changes medical providers.
11. Indications of outside employment.
12. Rumors from fellow workers as to accident or injury.
13. Claimant wants quick cash settlement.
14. Excessive medical treatment with subjective complaints.
15. Claimant uses medical and legal representation in which a pattern of relationships has developed.
16. Claimant may present documentation that appears to have been altered or manufactured.

# Workers' Compensation Insurance Fraud Schemes

## Workers' Compensation Premium Fraud Schemes

Individuals may fail to secure workers' compensation insurance for employees and instead choose to alter or forge documents to show coverage is in effect. In addition, during the application or auditing process, employees may go unreported or perhaps be misclassified in order to reduce premiums. Some employers may choose to use "temporary employees" who may be employed by them under a different corporate name and who may not be properly classified as to their job description.

1. Documents appear to have been altered or may appear to be incomplete.
2. Poor quality documents presented.
3. Small payrolls by large companies.
4. Discrepancies found in auditing of employees.
5. Actual workers' compensation claim appears inconsistent with employee's job description.
6. Anonymous information regarding employee's job description/classification.
7. Inaccurate information on application of insurance.

## Double Dipping

Depending on the type of claim and payment, a claimant may be required to report "earned income." In some cases, a claimant may attempt to conceal this fact in order to continue and receive compensation for a work-related injury. The claimant may be:

1. Difficult to reach during various times throughout the day.
2. Works "off-the-books" and receives cash or payment through another employee or vendor.
3. Self-employed or working in a cash business.
4. Consistently uncooperative.

## Malingering

In some cases, the claimant may look at a work-related injury as a golden opportunity or early retirement and may actually exaggerate or perhaps fake injuries.



# Referral Procedure

If a matter involves any type of insurance fraud, fraudulent insurance act, insurance-related theft scheme, or a violation of the Insurance Code, which carries criminal penalties, the matter should be referred to the Fraud Prevention Division for review per state statutes.

**Referral procedures for the insurance industry:**
*On-line Referral*: A company may submit an on-line referral through the National Association of Insurance Commissioners (NAIC) or through the National Insurance Crime Bureau (NICB). The company is responsible to make sure the referral is received by the Fraud Prevention Division. A letter confirming receipt of the referral will be sent to the company.

*Paper Referral*: (1) Request a "suspected fraudulent claim report" by contacting the Fraud Prevention Division via telephone, letter, facsimile, email or visit our website: www.ReportInsuranceFraud.ne.gov; (2) Provide copies of documents that establish the claimant was insured (i.e., policy declarations); (3) Submit copies of documents showing the claim was submitted and, if applicable, that payment was made to the claimant (i.e., claim form, settlement check - front and back, etc.); (4) Supply copies of documents that support the belief the claim may be fraudulent; (5) Highlight any specific details that should be brought to the Division's attention (i.e., false statements, altered figures, inconsistencies, etc.).

All original documents, along with the postmarked envelopes in which they were received, should be retained in the company's file. In some cases, it may be necessary for an insurance fraud investigator to have access to the entire claim file. In these instances, the Division will make an official request in writing or by telephone to the insurance company representative for the entire file.

**Referral procedures for consumers:** (1) Request a "suspected fraudulent claim report" from the Fraud Prevention Division by contacting the Division via telephone, letter, facsimile, email or visit our office; (2) Provide copies of documents or other evidence that supports the belief that the claim may be fraudulent. Maintain original documents unless otherwise instructed by an insurance fraud investigator.

**Referral procedures for law enforcement agencies:** (1) Law Enforcement Agencies may call, write, email or visit our office concerning referrals, investigative assistance, or information.

## Hints for Insurance Fraud Detection

The following compilation has been prepared to assist with the detection of fraud. Many such lists exist as "fraud indicators" but we do not wish to suggest that the presence of any of these circumstances necessarily "indicate" that insurance fraud has been committed. Rather, we offer this compilation as potential warning signs or "red flags" that might prompt you to study the matter more carefully.

One should keep in mind that “red flags” and/or “fraud indicators” are somewhat static in nature. The criminal has an ideal opportunity to learn by his/her mistakes simply due to the nature of insurance fraud. These indicators are ever-changing as the criminal adapts and learns. The investigator must have the adaptability to change and ability to recognize “indicators” to criminal activity.

The value of recognizing “fraud indicators” lies in the questions and answers, which may result upon further investigation. “Fraud indicators” should elicit questions requiring direct answers. These answers will assist in making a determination on whether or not to continue to pursue the facts surrounding a particular claim. This, in turn, may lead to the discovery of additional “fraud indicators.” It is this process of questions and answers that may ultimately lead to the successful resolution of a claim or insurance fraud scheme.



## Life Insurance Fraud Schemes

There are a variety of schemes committed to defraud insurers. The fraudster may provide a fictitious death certificate or perhaps try to “post date” the application to insure one already deceased. Another variation may be having someone other than the insured take any required physical should health concerns come into play. Perhaps the medical provider and/or agent themselves are in on the scheme.

1. Deceased not well known by relatives and lived alone. In some cases, deceased may be a transient or perhaps have chemical dependencies.
2. Policies tend to be for small coverage which are many times available in mass offerings, i.e., in magazines, mail-in and television advertisements.
3. Agent's "loss ratios" appear unusually skewed, considering size of market and types of people insured.
4. Numerous life insurance policies purchased on the victim.
5. Coverage amount not commensurate with social position of the deceased; e.g., loss income clerical worker has life insurance estate of millions.
6. Unusually large number of death certificates obtained by the beneficiary.

1. Front company will often not show a physical address.
2. Company or individual may be difficult to contact and will quite often use cellular numbers or transfer calls.
3. Payments may appear to have been transacted on accounts with different names or locations differing from that as indicated on the invoice.
4. Problems quite often in making physical contact other than through the suspected agent/broker/vendor.
5. In cases where a service is actually provided, actual provider may be a different company than that listed on the invoice.



## Red Flags Applying to the Insurance Policy

- Policy is relatively new in relationship to the date of loss.
- Policy is due to expire shortly.
- Agent may have been contacted recently by the insured regarding questions concerning “coverage.”
- May be duplicate, multiple policies.
- May be recent changes of coverage such as amendments to a policy to insure a scheduled item.
- Excessive or unusual coverage. In the case of life insurance, rarely are policies sought where a physical exam is required and quite often there will be numerous “small coverage” policies.
- Online policy applications are susceptible to abuse due to their anonymity.

The investigator may request additional information should one or a combination of red flags become apparent. Often the application will provide valuable information. The information may be incomplete, vague or perhaps erroneous. Numerous databases are available that may provide previous claims history for individuals and/or property, which in turn, may provide valuable investigative information.

## Red Flags Applying to the Insured

- May often pay premiums in cash.
- May often use an agent or agency, which may show a somewhat unusual pattern of claims by his/her clients.
- May show an extensive "claims history" not especially pertaining to the same type of loss; however, then may again show very similar losses.
- May show losses relative to times in which they are experiencing financial hardships or perhaps "premiums" are due.
- May show losses during times in which there may be issues pertaining to rented or leased vehicles or property. Excessive mileage or perhaps damaged property may very well cause additional fees to be incurred by the insured.
- May be very well versed on the claims process and/or terminology.
- May exhibit an unusual demeanor.
- May seem over willing to accept a small settlement to stop processing of the claim.
- May exhibit inability to recall specific facts regarding the loss, very often will be vague on details.
- May be hesitant to submit to an examination under oath or to specific questioning.
- May fail to mention "medical injuries" until they have acquired legal representation.
- May have the skills to restore a vehicle that has been "totaled in a hail storm" to look like new with a little dry ice.

There are numerous clues to look for when analyzing the claim. As noted previously, the application for the original policy is a good place to begin. Look for information that may be misleading, incomplete or vague. Review the insured's claim history to see, if perhaps, a pattern of losses develops. When possible, check prior documentation of property to see if there has been a loss history. Direct questioning and examinations under oath provide valuable tools to insurance personnel, which may not be readily available to law enforcement.



## Agent, Third Party Vendor, or Broker Fraud Schemes

Not unlike any profession, the insurance industry also has unscrupulous individuals working within the industry. Every effort should be made to keep these individuals from being able to work within positions of trust.

### Pocketing Premiums

An agent may collect "premiums", however, fail to forward them to the insurance company. In some cases, these premiums may have been collected for new business or perhaps an amendment to an existing policy.

1. Agency may employ a rather large staff, however, has only one agent who seems to be absent quite often.
2. Insureds may quite often be young or perhaps not familiar with insurance products.
3. Agent may often request direct payment of premiums in cash or by money order.
4. Irregular processing of the application.
5. Policy not received by insured or perhaps agent delivers the policy.
6. Billing information/annual statements coming directly from the agent with enclosed envelope for payment showing agent's address or post office box number.
7. Suspicious looking policy or applications. Documents may appear to be copies or fashioned in such a way that they do not seem to go together.
8. Policy information or binder does not contain complete information. In some cases, there may be an indication that the policy or change is "pending".

### Front Companies or Services

An individual may form a phony company to bill for services in which they are the agent, adjuster or administrator. The individual will then forward the invoice to the insurance company for payment. The insurance company may reimburse the phony vendors for services which may not have been performed or which may be inflated.

## Phony Liability Insurance Fraud Schemes

Businesses may often fall prey to fraudulent insurance liability claims. Quite often businesses are willing to readily settle these claims to avoid undue negative publicity. Restaurants may fall victim to allegations of consuming foreign objects. All businesses face the risk of being victim to "slips and falls." In addition to those "indicators" noted under the heading of "claimant", the following may apply:

1. Witness quite often may be a family member or friend.
2. May not be supporting evidence of the claim.
3. History of similar "liability" claims.
4. Claimant may often be willing to settle quickly.
5. Professional "claimants" will often show numerous addresses.
6. Rarely will there be an unrelated witness to the entire incident.
7. Injuries will often be of the "soft tissue" type.



## Red Flags Applying to the Claimant

- May be somewhat elusive. Claimant may use a post office box, multiple addresses, hotel or motel, or perhaps a "drop box" as an address. Often provides a cell phone number, in which use of "voice messaging" is common.
- May provide names of witnesses who are just as elusive.
- May provide witnesses who are over enthusiastic or perhaps provide scripted statements.
- May emphasize his/her willingness to accept quick reduced settlements.
- May threaten extended medical treatment or "seeing" an attorney.
- May be unusually familiar with medical care, vehicle or home repair, or insurance terminology.
- May be experiencing personal, financial, or business difficulties.
- May refuse or become evasive when asked specific questions.
- May have an extensive or somewhat unusual claims history.
- May represent "unsolicited" business to the agent. Since "fraudsters" communicate among each other, the agent may very well become a pawn and have a history of "clients" with similar claims.
- May approach an agent sometime prior to a loss with specific questions regarding coverage.
- In the case of an automobile accident, claimant's vehicle may not be available for inspection.
- May be hesitant to be examined by an independent medical provider.
- May be hesitant to submit to an examination under oath.
- May use medical and legal providers who may themselves show questionable claims provider histories.
- May have waited several weeks prior to seeking medical treatment.
- May have sought treatment for "soft tissue" type injuries and/or extensive chiropractic treatment.

- May provide “differing” lists of damaged/stolen property regarding an insurable loss.
- May provide questionable “proof” of purchase for expensive items.
- May provide invoices or estimates that appear to be “inflated” and/or altered.

Regardless of the type of claim, there may be similarities among the fraud indicators as shown by the claimant. The claimant may show an extensive history in one type of insurance claim having a lot of similarities or may again show a quite variable claims history.

In general, two types of fraudulent claimants may exist. One may be the professional claimant who very well makes his livelihood through the insurance industry. They may show an extensive claims history, which may be very progressive as far as the loss amounts are concerned. This professional may quite often surface as a related party to another claimant, perhaps as a witness or representative, once the claims process has been mastered.

The second type of fraudulent claimant may be an individual who is an opportunist. This individual may be attempting to take an opportunity from a legitimate loss by possibly inflating a loss or exaggerating an injury.

Both types of claimants emphasize the need for diligent investigation on the part of claims or investigative personnel. Both also emphasize the need for diligent reporting to law enforcement should there be a potential law violation.



## Phony Losses

The loss itself may also be part of the “scheme” such as an “arson for profit” or loss of a business, etc. Additional “red flags” to those previously noted include:

1. Existence of more than one policy on the same property.
2. 2. Recent change of coverage or perhaps the addition of scheduled items.
3. Over-insured property.
4. Personal property (photos, etc.) and/or pets may be absent at the time of loss.
5. Property may have been for sale at the time of loss.
6. Property is in need of extensive repairs.
7. Unusual circumstances involving time, method, extent of the loss.
8. Indications of arson.
9. Forensic evidence does not substantiate the “obvious” signs of loss.
10. Claims history appears to be similar to this particular loss.
11. Business owner may be nearing retirement age or perhaps the business is failing.
12. 12. Certain property was recently removed from the home/business.
13. Crime scene is not compatible with the losses noted by the insured.
14. Evidence suggests use of an accelerant.
15. Fire with multiple points of origin.

# Property Loss Insurance Fraud Schemes

## Inflated Losses

Property owners have been known to "inflate" monetary claims on legitimate losses. The reasoning is endless, premiums paid for years, etc.

1. Insured is deeply in debt or in bankruptcy.
2. Insured is recently divorced or separated.
3. Insured is unusually calm.
4. Unusual documentation of property inventory.
5. Initial police reports may often be supplemented at a later time with additional losses.
6. Insured's demeanor changes radically during the claims process.
7. No apparent sign of forced entry.
8. Neighbors report movement of items out of home/building prior to loss being reported.
9. Large, outstanding utility bills or property taxes.
10. Building and/or contents for sale at time of loss.
11. Property is part of divorce settlement, argument, or agreement.
12. Property in disrepair, condemned, or to be demolished.
13. Property, normally close to premises, is moved just prior to loss.
14. Large losses, due to recent purchases, which appear out of the norm.
15. Excessive "cash" loss.
16. Scripted property loss with high-valued items perhaps not consistent with the "insured's" business, income or interests.
17. Excessive losses of property not necessarily required to be "scheduled" items per the policy.
18. Inaccurate receipts or invoices, no store logo, incorrect sales tax, amounts "rounded off", same format such as copies, calendar day of the week, one in which the retailer is open for business, etc.
19. "Insured" seems overly concerned about providing detailed information regarding the loss and may be somewhat reluctant to provide an examination under oath.



# Automobile Insurance Fraud Schemes

## Staged Accidents

Although it may not be necessary to actually "stage" the accident, quite often this appears to be the preferred technique.

1. Either no police report or a "belated" report filed sometime after the alleged accident.
2. Strongly conflicting statements among drivers or witnesses.
3. Similar or scripted statements by those "in" on the scheme.
4. Rental vehicles may often be used.
5. May have been media coverage of safety issues pertaining to a particular vehicle or perhaps a hazardous traffic location.
6. Vehicle involved may have an extensive claims history itself and quite often will show several changes in ownership.
7. Vehicle may be a "leased" vehicle with excessive mileage or wear.
8. Vehicle may show an attempt to perhaps "clean" a salvaged title.
9. Difficulty in locating previous owners of vehicles involved in the accident.
10. Large outstanding lien or inability of claimant to pay loan payments.
11. Vehicle is a total loss however claimant wants to maintain salvage.
12. Purchase of vehicle is undocumented or in cash.
13. Hasty repairs may have been made to the vehicles.
14. Short time span between inception of coverage and loss.
15. Vehicles in question repaired at the same facility.
16. Analysis of the accident scene conflicts with statements given by parties involved.

## Past Posting

On occasions an individual may become involved in an accident or perhaps become a victim of an auto theft when insurance is not in place. The individual may decide to take a chance at "past posting" in order to have insurance in effect for the loss.

1. Either no police report or a “belated” report filed sometime after the alleged loss.
2. Insurer or agent did not inspect the vehicle.
3. Individual will often attempt to obtain coverage through companies allowing “online” application.
4. “Insured” may attempt to change coverage or perhaps add coverage on an existing policy.
5. Loss will often be within a short time of securing coverage.
6. “Insured” has no record of prior insurance; there may have been a short lapse in coverage.

## Personal Injury/Bodily Injury Claims

“Soft tissue” injuries as a result of an automobile accident are quite often legitimate claims requiring medical attention. This same type of claim, however, can be open for abuse since this type of injury is often somewhat subjective in nature. This type of fraud is quite often initiated by the use of a “staged accident” as noted earlier and may also include additional participants such as legal and medical providers that may very well be involved in the scheme.

1. No police report.
2. Police report indicates no injury at time of accident.
3. Claimant/insured has a history of injury claims.
4. No claims for automobile repair made even though injury claims were filed as a result of an automobile accident.
5. Discrepancy between number of vehicles or people involved in the accident.
6. Conflicting statements as to cause of accident.
7. Extensive medical treatment associated with minor collision damage based on diagnosed subjective injuries.
8. Incidents involve rental or leased vehicles.
9. Three or four unrelated people in either vehicle.
10. Accident is a rear-end collision caused by a sudden, unjustified stop by claimant's vehicle.
11. Accident has no witnesses and/or no debris or skid marks at the scene.
12. Uniform treatment of all people involved in an accident for similar complaints by the same provider.
13. All claimants submitted medical bills from the same doctor or medical facility.



14. Treatment extends for a lengthy period without any interim bills.
15. Medical bills contain alterations or additions.
16. Attorney's letters and medical specials arrive several months after the claim was reported.
17. Attorney involved is frequently involved in questionable cases.
18. Claimant is represented by counsel at initial contact with insurance company.
19. Medical provider referred by attorney or vice versa.
20. Same attorney/doctor for everyone in claimant's vehicle.
21. Physician's bill and report, regardless of the varying accident circumstances, is always the same.
22. Treatment prescribed is always the same in duration and type of therapy, regardless of the varying accident circumstances.
23. All injuries are subjective, such as soft tissue strains and sprains that don't heal in normal medically acceptable time.
24. Medical reports indicate inconsistent versions of the accident.
25. Diagnosed injuries are subjective, i.e., whiplash, headaches, spasms, and persist for weeks or months without improvement.
26. Claimant waited several weeks before seeking treatment.
27. Claimant underwent extensive chiropractic treatment.
28. Recovery is prolonged.
29. Major portion of expense is for diagnostic tests.
30. Claim is for the policy limit of coverage. Get paid what he/she can, not expenses.

## Automobile Theft and Fire or Related Losses

The motive for such a loss can be as variable as the loss itself. An individual may attempt a financial gain or perhaps may be attempting to avoid a financial loss.

1. Vehicle may be in need of expensive financial repairs.
2. Leased vehicle may show excessive mileage or wear.
3. Vehicle has a substantial lien.
4. Vehicle is a total loss such as a fire or otherwise destroyed.
5. Forensic analysis contradicts what appears to be obvious loss damage.