Life Insurance Wagering Contracts And Identity Fraud: A Deadly Combination

How Perpetrators Penetrate Insurance Companies and How to Defeat Them

Nicolas A. Novy, Esq.
Kevin C. Glasgow, FLMI, FLHC, CLU®, CFE

Overview

Life wagering contracts are nothing new – they have been around since the advent of life insurance. While illegal, wagering contracts represent an extremely lucrative way to earn a profit with a relatively small investment and minimal risk of negative consequences even if caught. A small investment can result in millions of dollars in profit, so it is easy to understand the sentiment of "Why rob a bank when one can defraud an insurance company?" Coupling wagering contracts with identity fraud can yield even higher returns for the schemers. In this paper, we:

- define wagering contracts,
- discuss the types of schemes employing these contracts,
- examine how fraudsters perpetrate these acts at time of underwriting and claim,
- provide mitigants to prevent the fraud, and
- discuss the legal remedies after a policy is issued.

Wagering Contracts Defined

Life insurance is intended to protect the beneficiaries from a financial loss should the insured die unexpectedly. Some of the key elements include an event whose timing is unknown (death) and a beneficiary's interest in the continued life of the insured.[1] Except for limited situations such as between a minor child and a parent, the insured must be part of the contract application.

In a wagering contract, the policy is purchased solely for the purpose of profit by an investor who has no interest, pecuniary, familial, or otherwise, in the insured's continued life. In fact, the investor has an interest in the insured's early death since this would result in less investment spent on premiums and a quicker payout of the death benefit.

The legislative and public policy history against wagering contracts dates back to at least the Eighteenth Century when Great Britain enacted the Life Insurance Act of 1774.[2] Prior to this time,

[1] As it relates to a non-pecuniary insurable interest, McGills Legal Aspect of Life Insurance, 10th Edition, Beck and Hopkins, 2016, p. 4.10 states that "Among blood relationships, only parent and child, grandparent and grandchild, and siblings have been recognized as sufficiently close to establish insurable interest. [As to] marital ties, only the relationship between a husband and wife is sufficient…. Beyond these four narrow categories, it is the majority role that that sentimental attachment based upon relationship alone is insufficient."

[2] https://www.legislation.gov.uk/apgb/Geo3/14/48

insurers in Great Britain were experiencing people purchasing life insurance policies on public figures and others without the insured's knowledge, hence wagering that the insured would meet an early death. Often, the ones wagering would know more about the insured's mortality risks than the insurance company – including the risk of being murdered. To prevent the abuse of wagering contracts, the Act required that beneficiaries of life insurance policies have a financial interest in the insureds' continued lives.

In 1815, in one of the earliest American life insurance cases on insurable interest, the Massachusetts Supreme Court opined that a contract would be valid where the beneficiary had a familial or pecuniary interest in the life of the insured, and failing such an interest, "it would be a mere wager-policy" and "void." *Lord v. Dall*, 12 Mass. 115, 118 (Mass. 1815). The *Lord* court was in accord with an 1803 decision from the Supreme Court of Pennsylvania, which held that the principles of the Life Assurance Act had been adopted in the United States. *See Pritchet v. Ins. Co. of N. Am.*, 3 Yeates 458, 460, 1803 WL 757 (Pa. 1803) ("An insurance amongst us, is a contract of indemnity. Its object is, not to make a positive gain, but to avert a possible loss. A man can never be said to be indemnified against a loss which can never happen to him. There cannot be an indemnity without a loss, nor a loss without an interest. A policy therefore made without interest, is a wager policy, and has nothing in common with insurance, but name and form.").

By the latter half of the nineteenth century, the public policy against human life wagering policies was solidified in dozens of jurisdictions and led one court to conclude that it was the common law of "all the states except where it has been altered by statute." *Lemon v. Phoenix Mut. Life Ins. Co.*, 38 Conn. 294, 299 (1871) ("[A]ll policies of insurance in favor of parties who had no interest in the life of the insured were wager policies, and null and void."); *see also, e.g., Ruse v. Mut. Ben. Life Ins. Co.*, 23 N.Y. 516, 526-27 (1861) (concluding that wagering upon lives was "so obviously repugnant to the plainest principles of public policy, that it is somewhat surprising that it should ever have existed. My conclusion, therefore, is, that the [Life Assurance Act of 1774], avoiding wager policies upon lives was simply declaratory of the common law, and that all such policies would have been void, independently of that act."); *Bevin v. Connecticut Mut. Life Ins. Co.*, 23 Conn. 244, 251 (Conn. 1854) (noting that the Life Assurance Act was "in affirmance" of the principle of common law).

Today, 47 states have a statutory or common law insurable interest requirement and 45 states have a statutory or constitutional prohibition on wagering, gambling, or the like.

Types of Wagering Contracts

There are multiple schemes involving wagering contracts as described below. These include STOLI, wagering on younger family members who are engaged in high-risk activities, wagering on strangers who are in poor health, and wagering on fictitiously created persons. Nearly all wagering contracts involve fraud, and except for STOLI, involve the perpetrator impersonating the insured when applying for coverage.

Stranger Originated Life Insurance: Beginning in the early 2000's, the insurance industry saw an influx of a type of wagering contract that came to be known as Stranger Originated Life

Insurance (herein referred to as "STOLI"), sometimes also referred to as Investor-Owned Life Insurance ("IOLI").

In STOLI schemes, investors financially induce insureds into consenting to these transactions that are ultimately intended to benefit third parties, without insurable interest. Agents and brokers often incentivized the insured's participation through a lump sum payment, the promise of future financial gains, or "free" insurance for two years. Brokers representing the investors would present the target insured with a large volume of documents to sign, including insurance applications and medical releases, in exchange for the incentive. Premiums were often paid through non-recourse premium financing. The investors targeted senior citizens who were in acceptable health and were unlikely to die during the two-year contestability period. Most insureds were likely not aware of the full extent of the insurance purchased nor the implications of the investors' actions. The total amount of insurance procured by investors on the life of the insured often totaled millions of dollars. The amount of insurance was often justified to the insurers with fraudulent financial statements and misrepresentations regarding the insured's intent, prepared by the broker and rarely seen by the insureds who typically signed the documents in blank. The coverage was also sometimes spread over multiple insurers so that the investors could hide the true amount of insurance being purchased.

Differentiating STOLI from other wagering contract schemes, the insureds on STOLI policies were financially induced to consent to the transaction. These schemes were ripe with financial fraud and gross over-insurance (although, the insureds' health was generally not one of the items misrepresented). STOLI schemes resulted in a vast amount of litigation by insurers against the agents and investors, and litigation continues to this day (more on this later). State regulators began recognizing the negative implications of STOLI and began passing legislation limiting these types of activities by investors in circa 2007.[3]

Wagering on Family Members Involved in High-Risk Activities: Many insurers are reporting an increase in the number of death claims involving an insured minor or young adult who ends up the victim of a drug overdose, homicide, or other violent death. Often, the beneficiaries of the policies are the insured's parents, grandparents, siblings, or others close to the insured who knew (or should have known) that the insured was involved in criminal activities, gangs, and / or drugs. In extreme cases, we have seen family members apply for coverage on insureds who were reported as missing at the time of the application, incarcerated, already dead, or incapacitated.

To obtain coverage, the family member impersonates the insured to purchase coverage on the insured's life (or finds someone similar to the insured's appearance to pose as the insured if the application is taken in person). Another option is to corrupt an agent to participate in the scheme. This scheme, however, is most easily accomplished using an on-line application process since it would not require that others be involved in the plot. Because the insureds are generally young, criminal records may be protected, and it is common for troubled youths to forego medical visits hence there may be few medical records to document any illicit substance abuse or risky activity.

[3] For more information on STOLI, see additional reading, STOLI – What You Don't Know May Cost You.

Wagering on Unhealthy Persons and Stolen Identities: One of the most common and long-standing types of wagering contracts is to purchase life insurance on an unhealthy person by stealing their identity and posing as them when applying for coverage. This type of wagering contract is most commonly associated with nomadic groups and other closed-community groups, but schemes like this have become far more common outside of these groups. Contributing to the rise in numbers is that more fraudsters have apparently learned how to perpetrate such schemes, and the insurance industry has changed underwriting controls and standards, often leaving gaps for fraudsters to exploit. As an example, in one such scheme, Diligence uncovered that home health care workers were stealing the identity of their patients and then posing as them to obtain life insurance. In other cases, Diligence has seen neighbors and friends who have posed as persons who are unhealthy, apply for insurance, and then list themselves as the beneficiary to the dismay of the insured's family when the plot is discovered.

Wagering on Made-Up, or Synthetic, Identities: Another type of wagering contract is to create a digital identity of a fictitious person and then purchase insurance on that identity. Perpetrators may spend years cultivating these false identities for many nefarious purposes, only one of which is insurance fraud. Often, perpetrators will take one piece of real information such as a social security number ("SSN") and then pervert it with other pieces of information such as a different name and date of birth. SSNs from children and the elderly are more at-risk for being stolen and used since the real owners of the SSN are not as likely to be actively engaged in credit related activity. These synthetic identities look real, and even the credit bureaus have a difficult time differentiating between actual people and digitally created identities. In 2021, Forbes reported that synthetic identity fraud is a $6 Billion issue.[4] Synthetic identity fraud is so large that Federal Reserve published a white paper on the topic in 2019.[5]

Unfortunately, the cost of synthetic identity fraud is more visible in the banking industry than in the insurance industry. In the banking industry, synthetic identity fraud results in loan losses that are very visible. For the insurance industry, the losses are buried in what appear to be routine mortality experience. Perpetrators know that insurance claims are rarely investigated when they occur outside of the two-year contestable period, so deaths are staged beyond this period resulting in an otherwise normal appearing claim.

Getting through underwriting

At its core, every wagering contract discussed except for STOLI involves identity fraud or the perpetrator impersonating the intended insured, hence tricking the insurance company into thinking it is dealing with the insured. Historically, impersonating an insured required the

[4] McKay, R., *The $6B Synthetic Identity Fraud Problem and Assessing Customer Identity*, Forbes (May 18, 2021), *available at* https://www.forbes.com/sites/forbestechcouncil/2021/05/18/the-6b-synthetic-identity-fraud-problem-and-assessing-customer-identity/?sh=4396cf83253b

[5] *Synthetic Identity Fraud in the U.S. Payment* System, The Federal Reserve (July 2019), *available at* https://fedpaymentsimprovement.org/wp-content/uploads/frs-synthetic-identity-payments-fraud-white-paper-july-2019.pdf

corruption of an insurance agent, but today, it is much easier to purchase insurance without an agent. Impersonations are done through clever use of contact information and knowledge of how to pass a credit bureau ID verification check while not raising suspicions on the digital medical-related tools such as EHRs, Rx checks, and medical lab summaries. Techniques used vary, and they include the following:

- Use of a synthetic identity in which the perpetrator knows all the proper information to get through security questions. Since these identities have been cultivated over years, these identities will appear real to most identity verification services. If the identity doesn't pass, the perpetrator may continue to cultivate the ID until it does pass.

- For stolen identities, slightly altering the name, address, date of birth or SSN so that it is consistent enough to pass through an identity verification check while returning a "no hit" for the medical data searches which tends to be much less tolerant of inaccurate identifiers.

- Within closed communities, members commonly have multiple identities. Some may be used for medical purposes whereas others are used for other activity – such as life insurance. As a result, the identification checks often come back verifying an identity is real, but the medical records check comes back with a "no hit" or with limited information.

- Use of perverted contact information allows the perpetrator to control the communication between the insurance company and the insured. Instead of the contact information being for the insured, it often is associated with the perpetrator. Email addresses, for example, are easily created using the insured's name so that it appears to be the insured's email address. Compounding this, email addresses and phone numbers are often used to set up on-line access to the policy for future policy changes.

- Clean sheeting[6] applications is common so that the insurance company will have no knowledge of the true medical history and no perceived need to obtain medical records.

- Often, perpetrators will list an attending physician for the insured on the application for coverage with a notation that they have annual exams which are all normal. This gives credibility to the application and the health of the insured when, in reality, the physician has never seen the insured.

- Perpetrators may build a profile of the security questions asked when applying for coverage using a stolen identity. There's no penalty for repeated failed attempts, and each time security questions are asked, it allows the perpetrator to record and analyze the possible responses to the questions thus leading to the correct answers. Even if the

[6] Clean sheeting is a term used to describe taking out an application for insurance without admitting to any medical history, hence, the medical information is "clean."

perpetrator is blocked from one company, they can simply use the information they have gained from the failed attempts and then apply with another company.

- The perpetrator will often name themselves as the beneficiary and misrepresent their relationship with the "insured." Common relationships used to falsely convey an insurable interest at underwriting are cousins, nieces, nephews, business partners, fiancé, etc. In some instances, the perpetrators may name a true family member of the insured, but then they will change the beneficiary once the policy is issued.

- While more difficult for perpetrators, utilizing a life insurance agent who is willing to participate in an imposter scheme either for increased sales (commissions) or for a piece of the profit is still ongoing. It may also be the life insurance agent who is the instigator of the fraud.

In addition, digital medical checks have a built-in latency to them which allows fraudsters to take advantage of the timing in which adverse medical data is available. This delay is a concern for both reactionary and systemic fraud. This can be an issue when an otherwise healthy person suspects a problem and goes to the physician for assistance. If the person's health history is otherwise clean, the visit itself may not be reflected in the digital tools until there is a prescription filled or the labs have been completed. While not entirely a new risk as there will always be asymmetrical information in favor of the applicant, the digital tools make the latency period greater hence more risk of anti-selection and fraud against the insurer.

Getting through claims

To think that all fraudulently issued policies will be identified by claim examiners is a fallacy. In actuality, the life insurance industry disputes less than one half of 1% of the claims presented to it per information gathered by the ACLI.[7] Getting the policy issued is the difficult part relative to getting the claim paid.

For most companies in the United States, paying claims outside of the two-year contestable period is a mere administrative function instead of a fraud-detecting function. In recent years, many companies have also adopted an "express" claims process whereby a death certificate may not be required if the policy is at least two years and one day old.

Several techniques are used to get claims through the payment process including:

- For stolen identities, simply wait for the insured to die and report the death. If the death occurs outside of the contestable period, it is likely that the insurance company will

[7] ACLI 2022 Life Insurers Fact Book states that in 2021, $301 million of new claims were in dispute due to suicide, material misrepresentation, or no proof of death (chapter 7, page 92), compared to $100 billion in death benefits paid (chapter 5, page 72). This compares to the property casualty lines which some estimate as many as 10% of the claims contain fraudulent information.

neither investigate the death nor the information contained in the application. The perpetrator nets the death benefit less the premiums paid for the policy.

If the death occurs within the contestable period, often the beneficiary cannot sign an authorization for the release of information thus confounding the collection of medical records. This forces the insurer to involve the next of kin who may or may not be sympathetic to the insurer's plight even if found. Also of note is that New York law states that an insurer cannot compel a beneficiary to cooperate in a contestable claim investigation. If the insurers do discover material misrepresentation, the most common solution is to refund the premiums received for the policy to the perpetrator.

- Switch the identity of the non-insured deceased person with the identity of a person who has insurance. This technique is frequently used amongst closed community members. The information contained within a death certificate typically comes from the funeral home, and is provided by the people handling the affairs of the deceased. If those individuals are involved in the plot, then switching the identity is simply a matter of providing the hospital and / or funeral home with the identity of a person within the community that has an insurance policy aged beyond the contestable period. The death certificate issued will be legitimate, but the information within will be inaccurate. Diligence has often found medical records for deceased individuals who had a different SSN, date of birth, or even name listed on the death certificate albeit it can be challenging to find such records given that the credentials identifying the insured do not fully match the records. In extreme cases, fingerprints taken by coroners have been successfully used to identify the deceased when the deceased had a criminal past and multiple identities.

- Find a deceased body and claim it as the insured. Many cases have been documented where the perpetrator claimed the body of an unidentified deceased person, usually a homeless person, as the insured. Like switching identities as described above, the authorities, unaware of the insurance angle, are often willing to accept a person's identification of an otherwise unidentified body.

- Stage the death in a foreign country where properly registered albeit fraudulently obtained death certificates are easy to obtain. This applies to nearly all foreign countries, even "Tier 1" countries.[8] Death kits which contain all the necessary documents to file a death claim are easily available for purchase in many locations.

[8] Insurance companies often apply tiers to countries based upon their perception of fraud within the country. Developing countries who have few controls over their industries including death registrations may be referred to as a "Tier 3" country whereas a developed, Western country may be designated as a "Tier 1" country.

Stopping the fraud before it happens

The most effective way to prevent wagering contracts is at underwriting. Once a policy is issued, the chances of identifying the fraud and defending a claim diminish significantly.

Preventing wagering contracts from becoming policies requires that the underwriting company definitively know the identity of the person applying for coverage and not just who they represent themselves to be. Verifying the existence of the insured's credit record is insufficient. Some of the best practices include:[9]

- Ensure the identifiers such as name, date of birth, and SSN for the insured are completely accurate. Slight deviations can allow the fraudsters to pass identity-verification services while defeating digital medical history detection tools used in underwriting.

- Examine the address, phone number, and email address information to ensure that it reverses back to the proposed insured. If the contact information does not match back to the proposed insured, determine who it does match back to. If it is a wagering contract, chances are that the information maps back to the perpetrator.

- Obtain the physical address of the device from which the application is being taken. IP addresses are good to collect but they can be spoofed using VPNs. In addition, IP addresses are often recycled and reassigned by the IP provider hence making determining an address unreliable.

- Analyzing the physical address of the device and the address on the application to determine if either of these addresses are associated with high-risk locations such as commercial businesses, temporary residences, adult care facilities, prisons, etc.

- Analyze beneficiary information on the current application against past applications to determine if the same person(s) or entities are beneficiaries of other policies insuring people who are seemingly unrelated.

- Check for insurable interest on the application. If the beneficiary does not appear to have an insurable interest, question this.

- If the application is taken by telephone, record the call and question inconsistencies. For example, if the proposed insured is supposedly 60 years old yet the person on the phone sounds like they are in their 20's and perhaps hesitates when answering questions, escalate the sales process and require further identification.

- If the application is taken electronically, use the devices camera (with permission) to take a picture of the applicant along with a picture of their government-issued identification.

[9] Diligence International Group offers a suite of tools that integrate into a digital application process to seamlessly integrate many of these practices for a real-time evaluation of the applicant and potentially fraudulent activity.

- Conduct a brief, recorded video conference with the applicant as part of the application process, even on cases solicited by an agent.

- Track policy premium payment information to identify cases in which the same bank account or credit card is being used to pay for policies insuring seemingly unrelated people.

- Track agent activity to ensure the agent isn't involved with suspicious applications.

- When fraud is discovered, pursue this with the appropriate regulatory authority as required by most states.

Insurance companies and their processes are tested constantly. Once a perpetrator finds a gap in a company's underwriting process that can be exploiting, this information is often shared with others, and the insurer may become a target for many such policies. Conducting periodic block reviews to identify trends in beneficiaries, payment accounts, etc. can be valuable to uncovering fraud. Services exist at minimal costs that will conduct a more thorough block review by analyzing the insured's identifiers, address history and other contact information, beneficiary information, etc. to identify trends and inconsistencies in the application data compared to other sources. This can be augmented by "customer satisfaction" calls using the insureds' true phone numbers to determine if the insured was a party to the insurance application.[10]

Identifying the fraud at time of claim

The first step to mitigating the risk of fraud at time of claim is training, and that includes accepting that even with the best underwriting processes, preventing all fraud at time of underwriting is not reasonably possible. Not all fraud begins at underwriting, and fraudsters are constantly using new techniques and technologies to test insurers and determine the practices utilized. The claims area is the last line of defense against paying unwarranted claims. Some of the other best practices to identifying fraud include the following:

- Investigate all claims within the contestable period. This includes speaking with the beneficiary to determine the circumstances of death, and when applicable, who was present when the policy was issued. Often, if a policy was fraudulently procured, details are obtained from interviews that will point to the fraud scheme. Only obtaining medical records, while valuable, may miss leads to detect fraud.

- Review all claims within 5 years of issuance. While the contestable period is only a two-year period, fraudsters know to orchestrate their schemes such that the claims will occur beyond this period (when possible). Comparing the data on all early claims against the information provided at underwriting may uncover inconsistencies that lead to fraudulent

[10]Please contact Diligence International Group, LLC, for more information on active block reviews and how to conduct them effectively.

activity, and even if that specific policy is not voidable, the discovery may lead to other policies that are voidable. As discussed below, many states allow fraud defenses to be raised by insurers outside of the two -year contestable period.

- Question inconsistencies in the data collected at time of claim compared to the application. Investigations are like puzzles and data are the puzzle pieces. The data should fit together. If there are pieces that do not fit together, seek clarification.

- Evaluate all foreign claims beyond simply checking to see if the death certificates were properly registered. Nearly all fraudulent foreign death claims will have a perfectly registered and "legal" death certificate albeit containing inaccurate information.

- Track beneficiary information to find trends such as the same beneficiary being named on policies insuring seemingly unrelated persons.

- When fraud is uncovered, report it to the appropriate state authorities even if the claim cannot be declined. This is required by most states, and it allows the states to track nefarious activity for more effective prosecution should that become the chosen course of action.

Legal remedies to wagering contracts

Wagering contracts come in all different shapes and sizes. When fraud is uncovered, legal remedies exist to void the policies—even outside the contestability period. For the purpose of this article, we discuss the variety of defenses that have been recognized to challenge the validity of a wagering contract after the expiration of the contestability period.

Every state has enacted different laws and policies to prevent fraud and wagering contracts. But just as wagering contracts and the underlying fraud in each take many forms, there is no one-size-fits-all approach to challenging the validity of wagering policies. In reality, a number of different post-contestability defenses exist across many states to protect the insured (and the public) from wagering contracts that violate public policy. Not all of these challenges are available in each state, but they are also not mutually exclusive. The state's Constitution, statutes, case law, and the language in the policy itself will dictate whether a post-contestability challenge is viable. Depending on the state, one or more of the following defenses may be available to contest an illegal wagering policy, regardless of the contestability period.

Insurable Interest Provisions:

Nearly all states have a statutory or common law insurable interest requirement, which means that the beneficiary must have an interest in the continued life of the insured. In Delaware (and many other states) the statute permits an insured to procure a life insurance policy on his or her own life, and name whomever they choose as the beneficiary.[11] However, no person "shall procure or cause to be procured" any life insurance policy on the life of another *unless* the policy's benefits are payable to someone with an insurable

[11] Del. Code Ann. tit. 18, § 2704

interest.[12] This prevents a stranger from procuring a life insurance policy on an individual and receiving the death benefits. But what if the proposed insured is bribed by a stranger investor and consents to the transaction? Although it can be argued that these transactions may *technically* comply with the language of the insurable interest requirement, human life wagering has been prohibited and condemned for hundreds of years. Indeed, to prevent such transactions, many states have codified their insurable interest requirements. Many courts have held that technical compliance with the insurable interest requirement is not enough if the policy was always intended to benefit strangers from the outset.

Constitutional and Statutory Prohibitions: Several states have enacted constitutional or statutory prohibitions against illegal gambling or wagering. For example, Delaware has a general wagering prohibition in its Constitution.[13] Therefore, any reading of the insurable interest statute that would permit wagering contracts is incompatible with the Constitution, which is exactly what the Delaware Supreme Court held in 2011.[14] Many other states have statutory prohibitions against gambling to the same effect. Although a statutory backstop against gambling is not the same as a constitutional backstop, these statutes can also be interpreted to limit a literal reading of a state's insurable interest statute that otherwise would permit wagering contracts, and lead to unintended consequences. When a wagering policy is in violation of a state's Constitution or public policy, courts have held that a carrier can contest that policy, even outside of the two-year contestability period.[15]

If, for example, a proposed insured is bribed and consents to the procurement of the policy that benefits a third-party beneficiary lacking insurable interest, the third party is merely feigning compliance with the insurable interest statute in order to do indirectly what he or she cannot do directly—wager on the proposed insured's life. This is the classic STOLI scheme. Constitutional and statutory prohibitions, coupled with the state's insurable interest requirement, generally prohibit such wagering on human life (even if the insured is bribed and consents to the transaction).

Imposter Defense: Several states have permitted post-contestability challenges to policies where an individual (usually the beneficiary) impersonates the proposed insured during the application process, and applies for the policy on the insured's behalf and without the insured's knowledge or consent. This is a direct (and illegal) wager on the proposed insured's life. Instead of bribing the individual in order to obtain their consent, the beneficiary defrauds the insurance company to issue the policy by impersonating the insured. Many states prohibit such a transaction, regardless of the contestability period. Although the nomenclature of this defense differs from state-to-state, the defense is essentially the same: a third party cannot take out a

[12] *Id.*
[13] DEL. CONST. art. II, § 17.
[14] A
PHL Variable Ins. Co. v. Price Dawe 2006 Ins. Tr., ex rel. Christiana Bank & Tr. Co., 28 A.3d 1059, 1071 (Del. 2011) ("*Price Dawe*")
[15] *Id.*

policy on the insured's life, for the benefit of the third party, without the insured's knowledge or consent.

For example, the Washington Supreme Court recently held that a policy procured by an imposter, without the consent of the insured, is challengeable after the contestability period. [16] The policy is void if the carrier can prove that the insured "never consented to the contract in writing."[17] Similarly, in Illinois, carriers can challenge the policy after the contestability period if the proposed insured was unaware that the policy was procured because there was "no meeting of the minds" between the insured and the insurer to begin with.[18] In Pennsylvania, an imposter defense is also viable even if the beneficiary was impersonating a close family member.[19] A Pennsylvania court held that the policy was void *ab initio* when the imposter-beneficiary defrauded the insurance company by impersonating her sister, who was confined in an asylum.[20] Therefore, the contestability period did not bar the insurer's right to contest the policy. [21]

The imposter defense is an important post-contestable tool (in many jurisdictions) for weeding out a variety of fraudulent schemes. First, it can be utilized to challenge policies on individuals who are involved in high-risk activities, including crime and drug use. Even if the individual who procured the policy is a close family member (such as a mother or a father), it can often be challenged post-contestability if the insured did not consent. Wagering on an individual's life who is involved in a life of crime or drugs is exactly the type of wagering policy that has been condemned for hundreds of years. The imposter defense is the easiest hook for the insurer to challenge the policy after the contestability period. Second, nomadic schemes often wager on unhealthy persons in closed-community groups. A common denominator in these schemes, however, is the impersonation of the insured, or the beneficiary, or both. Finally, the imposter defense can also be utilized to challenge policies involving stolen identities and synthetic individuals. Again here, if the individual is not real, he or she could not have consented. And in the case of synthetic identities, there could not have been a "meeting of the minds" between the insurance company and individual who never existed in the first place.

Statutory Carveouts for Fraud: Even when a state does not have great case law on the post-contestability of an insurable interest challenge or imposter defense, it may have a carveout for fraud as an exception to the contestability period. In these states, the carrier must take care to ensure that its policy's language permits it to take advantage of that carveout.

In Ohio, the legislature has specifically identified "fraud" as an exception to the contestability provision.[22] But whether a carrier can bring a post-contestability challenge for fraud turns on whether the fraud is deemed to be a "representation" or a "warranty," where a breach of

[16] New York Life Ins. Co. v. Mitchell, 528 P.3d 1269, 1280 (Wash. 2023); *see also* Wash. Code § 48.18.060.
[17] *Id.*
[18] *Obartuch v. Sec. Mut. Life Ins. Co*., 114 F.2d 873, 878 (7th Cir. 1940)
[19] *Ludwinska v. John Hancock Mut. Life Ins. Co*., 317 Pa. 577, 580, 178 A. 28, 30 (Pa. 1935).
[20] *Id.*
[21] *Id.*
[22] Ohio Code § 3911.07.

warranty renders the policy void *ab initio* (as if it never came into existence), and a misrepresentation can only be challenged within the contestability period.[23] Consistent with its fraud carveout, Ohio law requires all carriers to include "a provision that all statements made by the insured in the application shall, *in the absence of fraud*, be deemed representations and not warranties."[24]

Fraud can be a good defense to nomadic schemes, where fraud is pervasive throughout the entirety of the application. Individuals that perpetuate nomadic schemes often defraud more than just the insurer—including hospitals, funeral services, and even local governments. Even if a state does not generally permit challenges after the contestability period, nomadic fraud may be challengeable through a fraud carveout in the policy or specifically as contemplated by statute.

Material Misrepresentations: Some states, such as Texas and New Jersey, permit post-contestable challenges for misrepresentations. In Texas, a misrepresentation is grounds to contest a policy after the contestability period if the representation was fraudulently made, material, and it misled the insurer and caused it to waive or lose a valid defense to the policy.[25] New Jersey has suggested that an insurer may deny a claim if the insured committed fraud in the policy application, even after the contestability period.[26] If an insurer issued a policy in one of these states, a thorough investigation of the death claim should be conducted if there is any evidence of wagering.

Challenging a Wagering Policy: Imagine an 18-year-old applied for a large insurance policy and named their close friend or distant relative as the sole beneficiary. The proposed insured claimed to make $100,000 a year as a barber. Shortly after the contestability period, the proposed insured dies. What should the carrier do?

First: Investigate the facts of death, especially for young individuals. Confirm death through a public records search, when possible.

Second: Examine the application (and amendments to the application) for inconsistencies or suggests that the individual applying for the policy was *not* the insured. Examine whether there are any inconsistencies regarding the insured's date of birth, social, contact information. These are red flags that suggest someone other than the insured applied for the policy. Next, examine who actually paid the premiums. If the insured did not pay the premiums, there is a good chance it was procured and originated by a third party.

---

[23] *Ramsey v. Penn Mut. Life Ins. Co.*, 787 F.3d 813, 819 n.3 (6th Cir. 2015) (applying Ohio law).
[24] Ohio Code § 3915.05(D) (emphasis added).
[25] Texas Code § 705.104
[26] *Ledley v. William Penn Life Ins. Co.*, 138 N.J. 627, 635, 651 A.2d 92, 95 (1995) (citing *Paul Revere Life Ins. Co. v. Haas*, 137 N.J. 190, 644 A.2d 1098 (1994))

Third: Verify income/occupation. The insured may have an income of $100,000, but if he or she never worked at a barber shop, it's possible this income was illegitimate and this insurer would not have (and could not have) considered it when justifying the value of the proposed policy.

Fourth: Who is the beneficiary? How did he or she know the insured? Is the beneficiary's relationship with the insured sufficient to establish an insurable interest? Did the insured actually procure the policy or consent to its origination?

Fifth: Remember that every state is different. Best practice is to provide the above information to legal or outside counsel to analyze whether the state's constitution, insurable interest laws, statutory scheme, or an imposter defense is viable to succeed on a post-contestability challenge. Here, the beneficiary likely does not have an insurable interest in a distant relative and the policy was likely procured by the beneficiary on behalf of the insured (without his knowledge). But even if the policy was actually procured by the insured, the insurer may have a viable challenge within the contestability period (and outside of the contestable period in a handful of states) based on any material misrepresentation regarding the insured's health or income. This would be especially true if the insured listed illegitimate income to justify the amount of the policy's death benefit that would otherwise be unjustifiable.

Authors:

Nicolas A. Novy, Member, Cozen O'Conner. Mr. Novy is a seasoned commercial litigator, trial attorney, and a leading expert in the defense of wagering contracts.

Kevin Glasgow, Vice President Investigation Solutions, Diligence International Group, LLC. Mr. Glasgow has managed insurance risks for nearly four decades with direct insurance and reinsurance companies, and most recently working with Diligence to develop solutions to prevent identity fraud.

Additional reading

United States Attorney's Office, Northern District of Illinois Press Release, 23 Defendants Charged with Participating in $26 Million Life Insurance Fraud Scheme, June 2, 2022, https://www.justice.gov/usao-ndil/pr/23-defendants-charged-participating-26-million-life-insurance-fraud-scheme

Diligence International Group, Diligence Insights, From Fraud Experts: How Modern Wagering Schemes Work – and How To Stop Them, January 23, 2023, https://digroup-us.com/blog/from-fraud-experts-how-modern-wagering-schemes-work-and-how-to-stop-them

The State, John Monk, Court hears inner workings of SC Irish Travelers' multimillion-dollar insurance scan, December 8, 2018, https://www.thestate.com/news/local/crime/article222781445.html

Cozen O'Conner, STOLI – What you Don't Know May Cost You. Michael J. Miller, Gregory J. Star, Kevin C. Glasgow, 2018. https://www.cozen.com/news-resources/publications/2019/stoli---what-you-don-t-know-may-cost-you-munich-re-