2020 Kansas Statutes

40-2,118. Fraudulent insurance act defined; amount involved defined; penalty; notification of commissioner, when; antifraud plan. (a) For purposes of this act a "fraudulent insurance act" means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

(b) An insurer that has knowledge or a good faith belief that a fraudulent insurance act is being or has been committed shall provide to the commissioner, on a form prescribed by the commissioner, any and all information and such additional information relating to such fraudulent insurance act as the commissioner may require.

(c) Any other person who has knowledge or a good faith belief that a fraudulent insurance act is being or has been committed may provide to the commissioner, on a form prescribed by the commissioner, any and all information and such additional information relating to such fraudulent insurance act as the commissioner may request.

(d) (1) Each insurer shall have antifraud initiatives reasonably calculated to detect fraudulent insurance acts. Antifraud initiatives may include fraud investigators, who may be insurer employees or independent contractors and an antifraud plan submitted to the commissioner no later than July 1, 2007. Each insurer that submits an antifraud plan shall notify the commissioner of any material change in the information contained in the antifraud plan within 30 days after such change occurs. Such insurer shall submit to the commissioner in writing the amended antifraud plan. The requirement for submitting any antifraud plan, or any amendment thereof, to the commissioner shall expire on the date specified in subsection (d)(2) unless the legislature reviews and reenacts the provisions of subsection (d)(2) prior to such date.

(2) Any antifraud plan, or any amendment thereof, submitted to the commissioner for informational purposes only shall be confidential and not be a public record and shall not be subject to discovery or subpoena in a civil action unless following an in camera review, the court determines that the antifraud plan is relevant and otherwise admissible under the rules of evidence set forth in article 4 of chapter 60 of the Kansas Statutes Annotated, and amendments thereto. The provisions of this paragraph shall expire on July 1, 2021, unless the legislature reviews and reenacts this provision prior to July 1, 2021.

(e) Except as otherwise specifically provided in K.S.A. 2020 Supp. 21-5812(a), and amendments thereto, and K.S.A. 44-5,125, and amendments thereto, a fraudulent insurance act shall constitute a severity level 6, nonperson felony if the amount involved is $25,000 or more; a severity level 7, nonperson felony if the amount involved is at least $5,000 but less than $25,000; a severity level 8, nonperson felony if the amount involved is at least $1,000 but less than $5,000; and a class C nonperson misdemeanor if the amount involved is less than $1,000. Any combination of fraudulent acts as defined in subsection (a) which occur in a period of six consecutive months which involves $25,000 or more shall have a presumptive sentence of imprisonment regardless of its location on the sentencing grid block.

(f) In addition to any other penalty, a person who violates this statute shall be ordered to make restitution to the insurer or any other person or entity for any financial loss sustained as a result of such violation. An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act.

(g) For the purposes of this section:

(1) "Amount involved" means the greater of: (A) The actual pecuniary harm resulting from the fraudulent insurance act; (B) the pecuniary harm that was intended to result

from the fraudulent insurance act; or (C) the intended pecuniary harm that would have been impossible or unlikely to occur, such as in a government sting operation or a fraud in which the claim for payment or other benefit pursuant to an insurance policy exceeded the allowed value. The aggregate dollar amount of the fraudulent claims submitted to the insurance company shall constitute prima facie evidence of the amount of intended loss and is sufficient to establish the aggregate amount involved in the fraudulent insurance act, if not rebutted; and

(2) "pecuniary harm" means harm that is monetary or that otherwise is readily measurable in money, and does not include emotional distress, harm to reputation or other non-economic harm.

(h) This act shall apply to all insurance applications, ratings, claims and other benefits made pursuant to any insurance policy.

History: L. 1985, ch. 155, § 1; L. 1994, ch. 43, § 1; L. 2006, ch. 128, § 1; L. 2006, ch. 194, § 29; L. 2007, ch. 150, § 4; L. 2011, ch. 11, § 6; L. 2011, ch. 91, § 22; L. 2015, ch. 45, § 4; L. 2016, ch. 82, § 7; L. 2019, ch. 46, § 4; July 1.