MINNESOTA DEPARTMENT OF COMMERCE

2016 Commerce Fraud Bureau Annual Report

I am pleased to present the annual report by the Commerce Fraud Bureau for calendar year 2016, pursuant to Minnesota Statute 45.0135, subdivision 5.

The Fraud Bureau is a law enforcement agency within the Minnesota Department of Commerce, which is under the leadership of Commissioner Mike Rothman. The Fraud Bureau has been established within the Department's Enforcement Division, which is led by Assistant Commissioner Martin Fleischhacker.

Our annual report summarizes the significant accomplishments of the Fraud Bureau during 2016. The Fraud Bureau focuses its criminal investigations on insurance fraud and other insurance-related criminal activity. During 2016, the Fraud Bureau initiated investigations into 2,227 cases.

This report is a tribute to the outstanding work done by the Agents and Analysts who work in the Bureau. This report showcases the extremely high level of commitment that our team brings to the job and the successful criminal investigations that were conducted during 2016.

The mission of the Fraud Bureau is "To protect Minnesotans from fraud by conducting aggressive criminal investigations in the pursuit of justice." The mission of the Fraud Bureau is so very important in protecting the economic security of our state and it is the driving force behind the Fraud Bureau.

I encourage you to review this report and learn more about what the Fraud Bureau has to offer. If you desire any additional information on the work of the Fraud Bureau, please do not hesitate to contact me at 651-539-1602. Thank you for your continuing support.

Respectfully submitted,

Michael W. Marben

Director

Introduction

The Commerce Fraud Bureau is a law enforcement agency within the Minnesota Department of Commerce. The Fraud Bureau is granted its authority under Minnesota Statute Section 45.0135

The Commerce Fraud Bureau continues to be the recognized leader in fraud and white-collar criminal investigations in the State of Minnesota. We are Minnesota's primary law enforcement agency responsible for conducting criminal investigations into cases involving insurance fraud and related criminal activity.

The Fraud Bureau completed its 12th year of operation in 2016. In furtherance of our mission, the Fraud Bureau collaborates with local, state and federal law enforcement agencies to bring criminals to justice and hold them accountable for their actions.

History

The Fraud Bureau was designated as a state law enforcement agency in April 2005 with a staff of three. During 2016, the Fraud Bureau was staffed by 15 professionals: a Director (Chief Law Enforcement Officer), two Supervisory Special Agents, 10 Special Agents and three Analysts.

Fraud Bureau Special Agents are licensed peace officers with extensive law enforcement backgrounds, training and experience. Our Special Agents are considered to be the leading experts in the field of insurance fraud. They are trained in criminal investigations and provide assistance as well as training for consumers, the insurance industry and our statewide law enforcement partners.

Our Analysts are highly-trained individuals who function in a non-sworn support role conducting research, analyzing data and producing reports in support of our Special Agents.

Purpose

The overall purpose of the CFB is to conduct criminal investigations and to enhance the effectiveness of law enforcement agencies throughout our state. Specifically, the unique skillset that the CFB Special Agents possess facilitates the investigation of crimes that require technical expertise that is generally beyond the knowledge base of our law enforcement partners. In addition, the CFB is equipped to deploy significant assistance to Greater Minnesota where investigative law enforcement resources may not be readily available.

The CFB assists our law enforcement partners by providing services such as:

- Computer forensic services
- Collection and analysis of evidence in financial crimes
- Surveillance support
- Technical expertise

Funding Sources

Funding for the Commerce Fraud Bureau comes from three major sources:

- An assessment on insurers.
- A legislative appropriation from the Minnesota Department of Labor and Industry to conduct investigations concerning workers' compensation fraud.

- An administrative fee to offset the costs associated with managing the Auto Theft Prevention Grant Program.

Insurance Fraud Assessment

The largest portion of the operating funds utilized by the Fraud Bureau is generated through an annual assessment authorized under Minnesota Statute 45.0135, subdivision 7. The assessment is levied on insurers that have been authorized to sell insurance in our state. We currently have 1,136 companies paying this assessment.

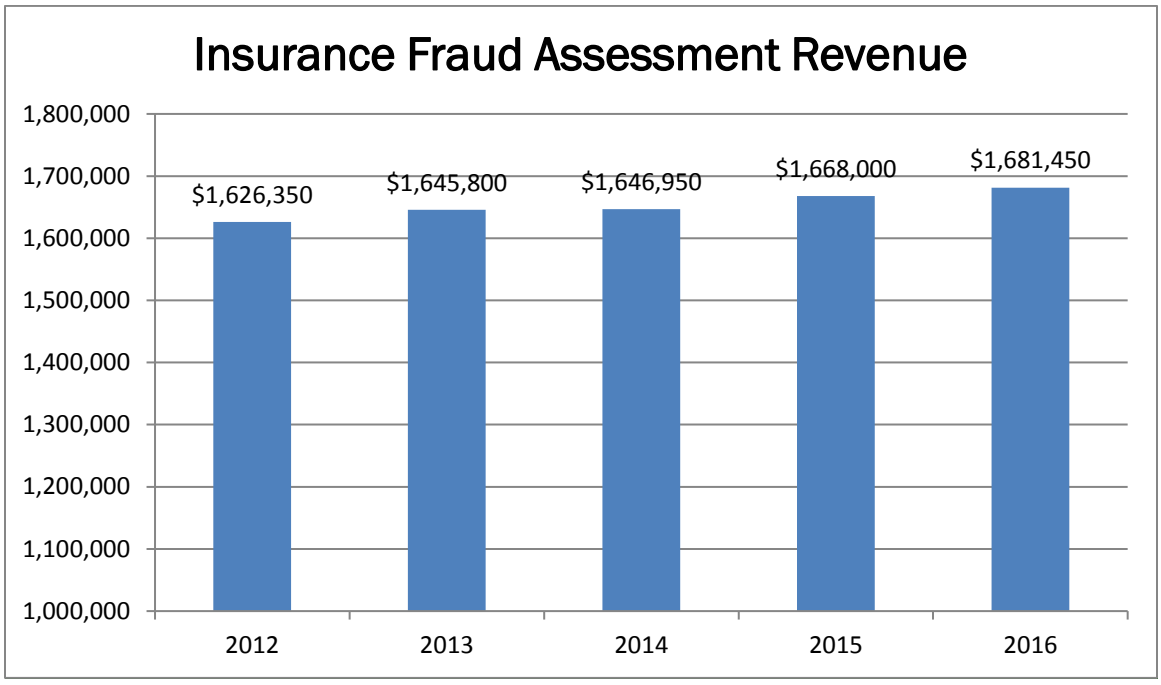
The assessment formula has remained unchanged since its inception in 2004. The assessment is calculated under the following formula:

Total Assets	Assessment
Less than $100,000,000	$ 200
$100,000,000 to $1,000,000,000	$ 750
Over $1,000,000,000	$ 2,000

Minnesota Written Premium	Assessment
Less than $10,000,000	$ 200
$10,000,000 to $100,000,000	$ 750
Over $100,000,000	$ 2,000

For example, an insurance company that has $150,000,000 in assets and writes policies that carry $90,000,000 in premiums would pay a total assessment of $1,500. It is important to note that the assessment is levied on the insurance company, not individual agents.

The following chart depicts the revenue generated by the assessment for the past five years:



The five-year average amount of revenue obtained through this assessment was $1,653,710.

Department of Labor and Industry Investigations

The Workers' Compensation Division is part of the Minnesota Department of Labor and Industry. All employers are required by Minnesota Statute 176.181, subdivision 2, to either purchase workers' compensation insurance to provide benefits to their employees for work-related injuries or they must obtain approval from the Commerce Department to self-insure if they have the financial ability to do so.

Individuals who collect workers' compensation benefits to which they are not entitled are committing insurance fraud. Through a legislative appropriation, the Department of Labor and Industry pays $198,000 annually to the Fraud Bureau to offset the costs associated with conducting investigations into workers' compensation fraud.

Automobile Theft Prevention Program Administration

In 1996, the Minnesota Legislature passed legislation under Minnesota. Statute 65B.84 which created the Automobile Theft Prevention Program (ATPP). This program is funded from a surcharge collected from automobile insurance carriers that provide comprehensive insurance coverage issued in our State. The amount of the surcharge is 50 cents per vehicle for every six months of coverage. Using this surcharge, the program provides funding to other law enforcement agencies through a competitive grant process for activities that address the problem of auto theft. Since 2009, the Fraud Bureau has managed this program.

This statute allows the Fraud Bureau to retain up to 10% of the funds collected under the ATPP to pay for the costs of administrating the program. In 2016, the CFB received $220,000 under the ATPP for program administration.

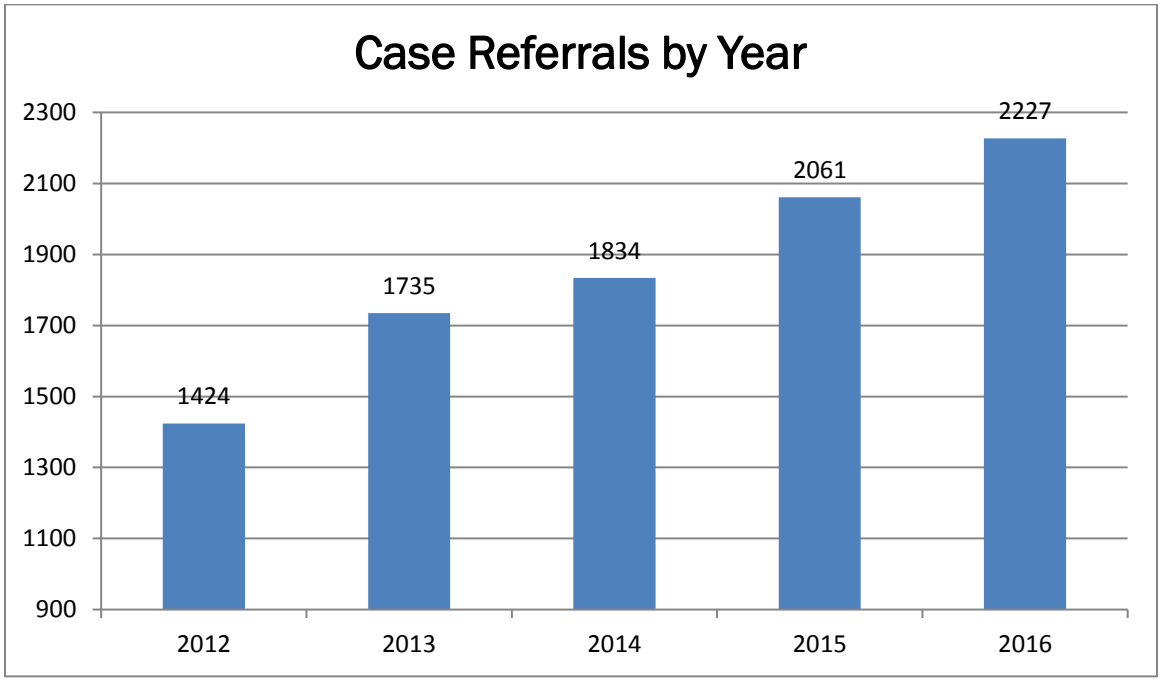
The total operational funding that is available to the Fraud Bureau has remained unchanged since 2009 when the administrative duties associated with the ATPP program were assigned to the Bureau. In 2016, the total budgeted funding for the grant program was approximately $2,099,450.

Investigative Requests

The primary responsibility of the Fraud Bureau is to conduct criminal investigations into insurance fraud. Fraud occurs when someone knowingly lies to obtain a benefit or advantage to which they are not otherwise entitled or someone knowingly denies a benefit that is due and to which someone is entitled.

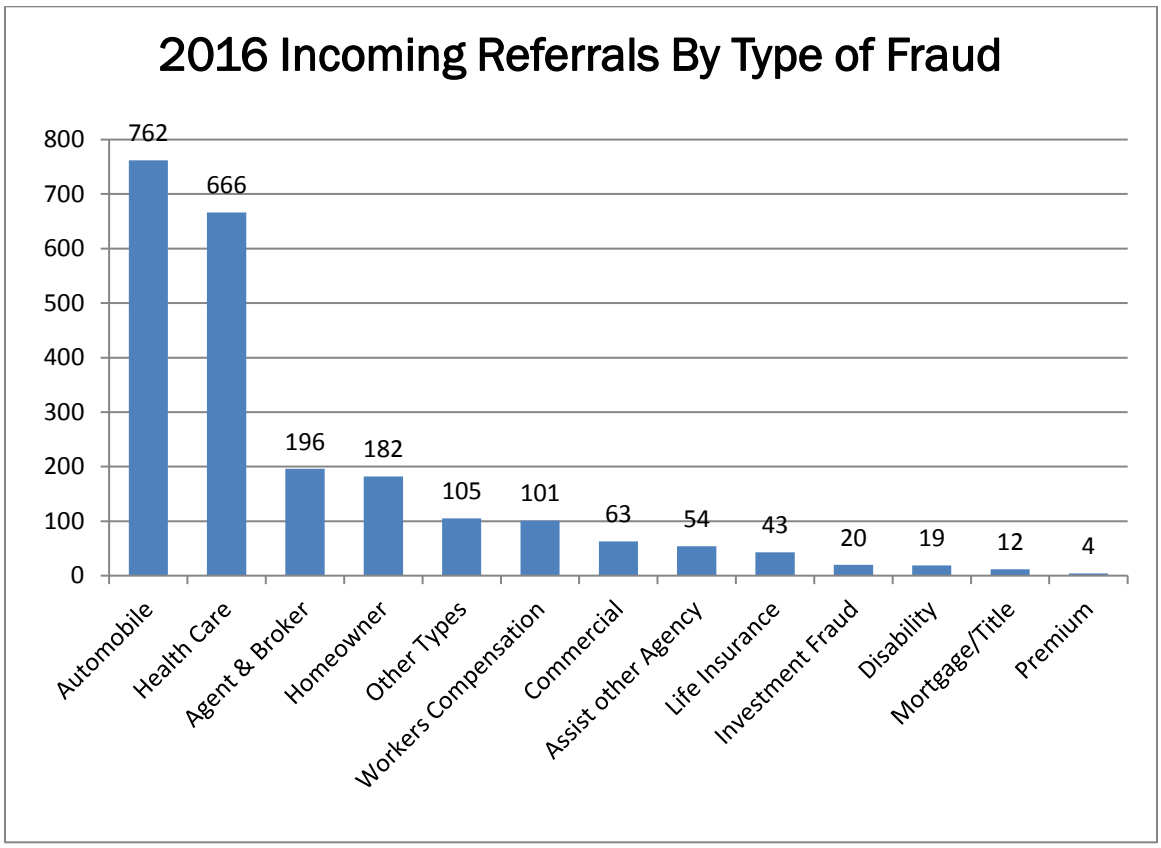
Cases for investigation are referred to the Fraud Bureau from four major sources: the general public, insurance companies, law enforcement agencies and other governmental regulatory agencies. The subject of the referrals varies from individuals to businesses suspected of committing insurance fraud. Each incoming case is carefully reviewed to determine if the information submitted articulates a sufficient basis for the Fraud Bureau to initiate a criminal investigation into the fraud allegation.

The following graphic represents the number of cases referred to the Fraud Bureau for investigation during the previous five years.



2007 was the first year the Fraud Bureau began tracking the total number of cases that were referred for investigation. In that year, a total of 909 cases were referred. By 2016, that number had increased to 2,227 cases, representing an increase of 145% during that nine-year time frame.

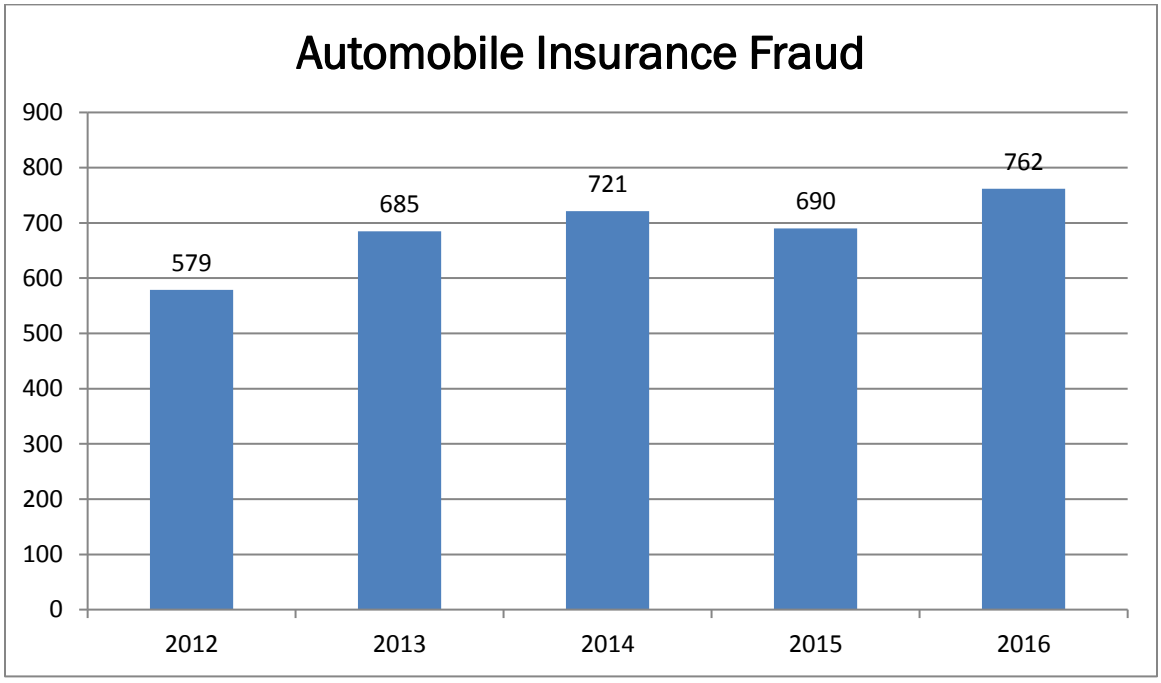
The increase in case referrals from 2015 to 2016 was 8%.



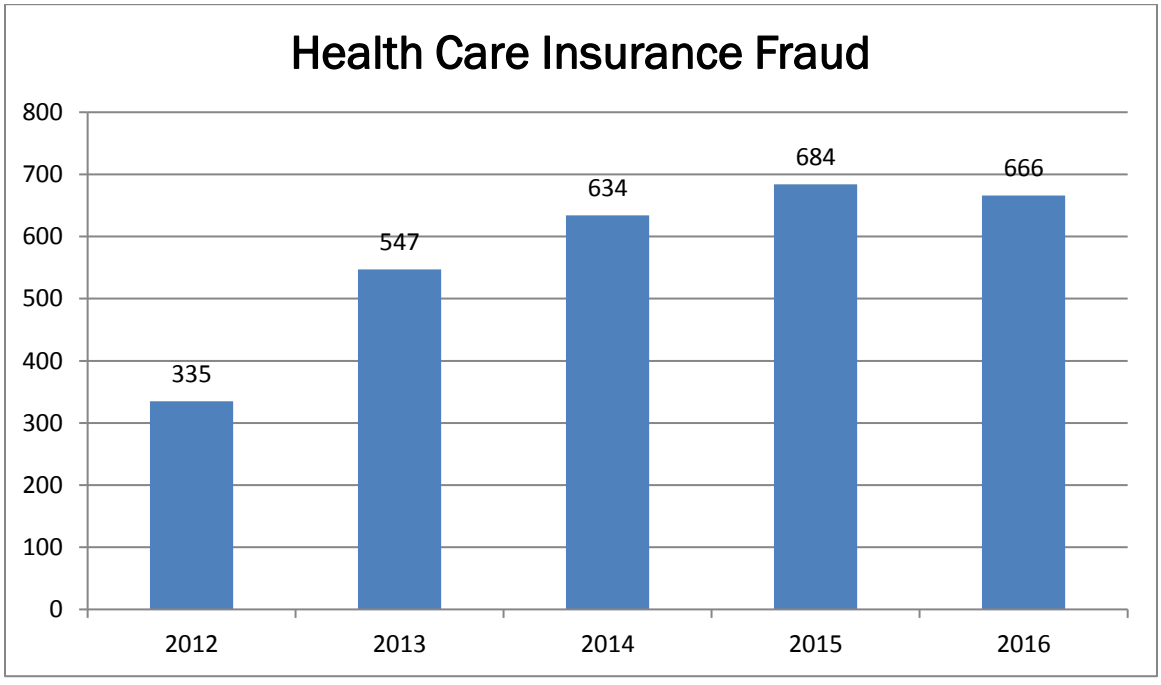
The five largest areas of suspected fraud being referred to the Fraud Bureau during 2016 were:

- Automobile Insurance
- Health Care Insurance
- Homeowners Insurance
- Commercial Insurance
- Workers' Compensation Insurance

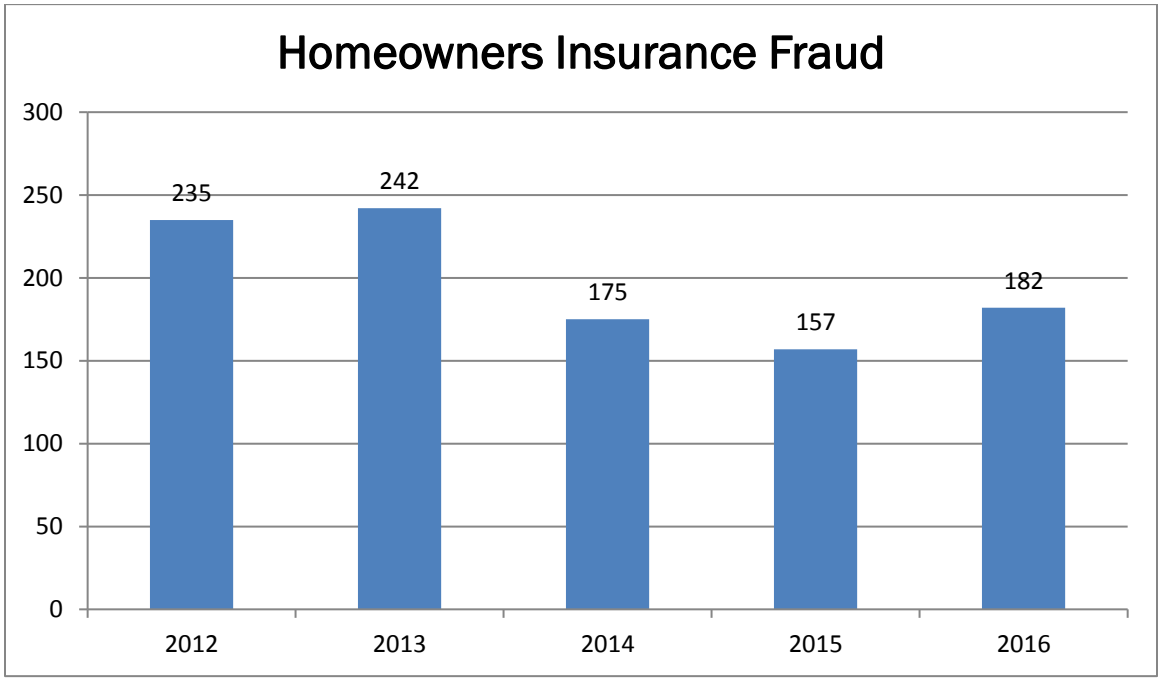
The following charts depict the changes in the number of referrals received during the previous five years for each of these areas.The data below indicates that the number of automobile insurance fraud cases is trending upwards after a slight reduction in 2015.



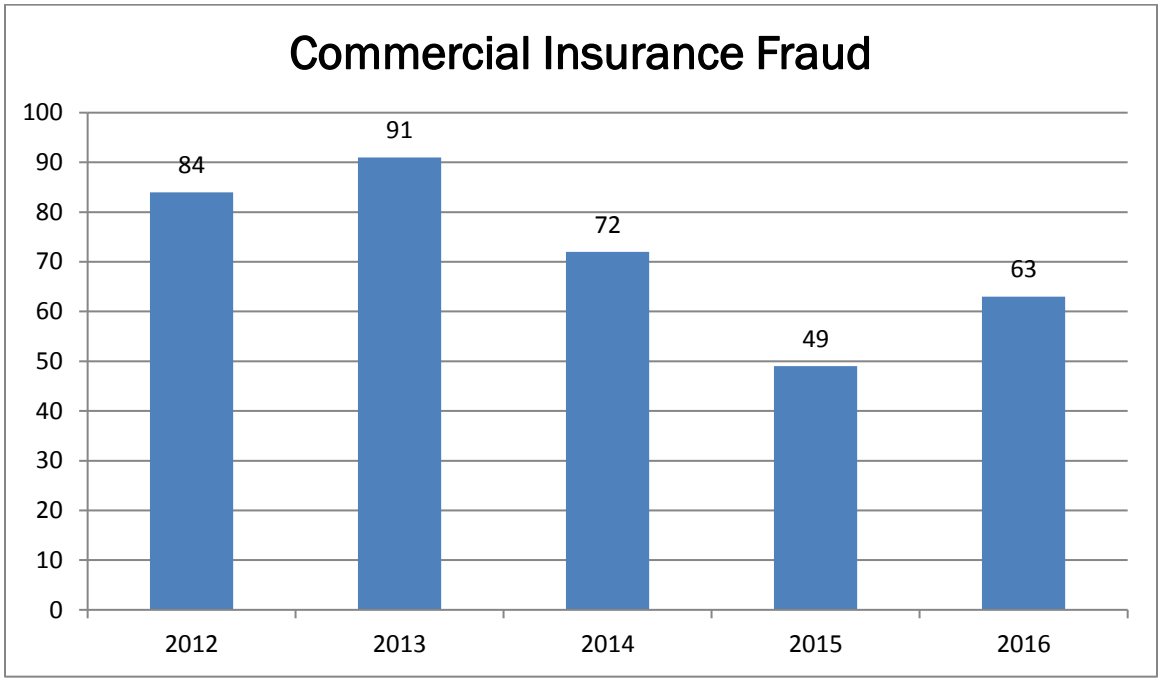
The data below indicates that the number of health care insurance fraud cases experienced a slight decline in 2016.



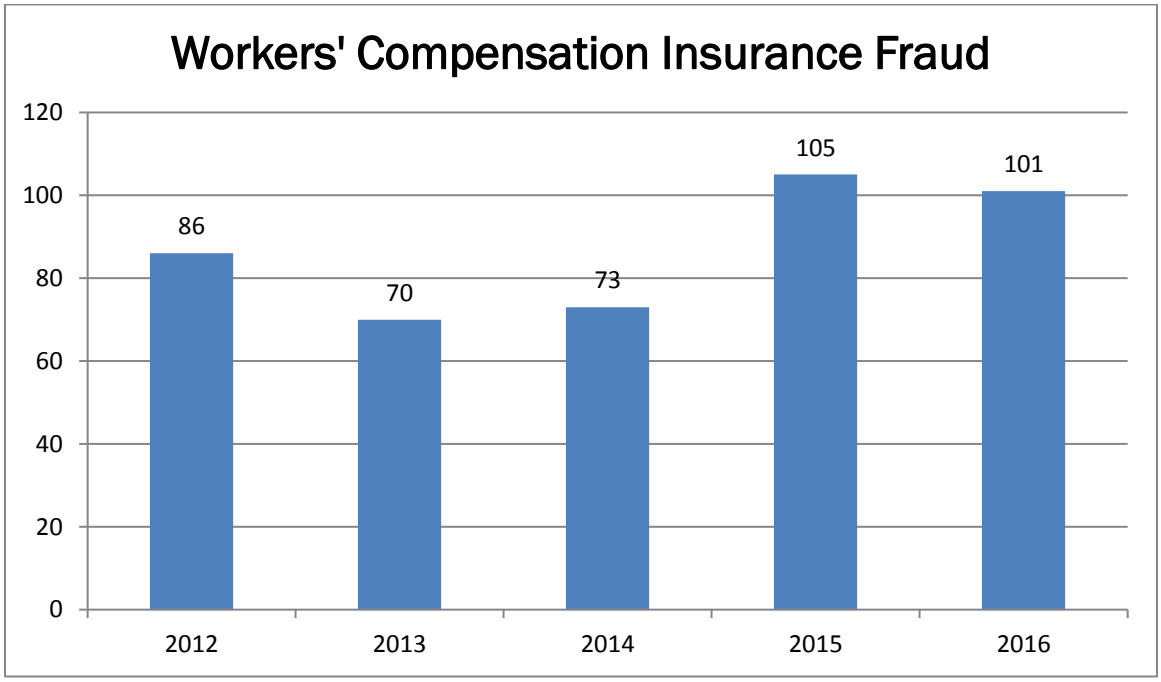
After a two-year reduction in homeowners insurance fraud cases, the data below indicate an increase in 2016.



Commercial insurance is insurance coverage for businesses for protection against potential losses through unforeseen circumstances such as theft, liability, property damage, and for coverage in the event of an interruption of business or injured employees. After a significant decline from 2013 to 2015, commercial insurance fraud rose in 2016.



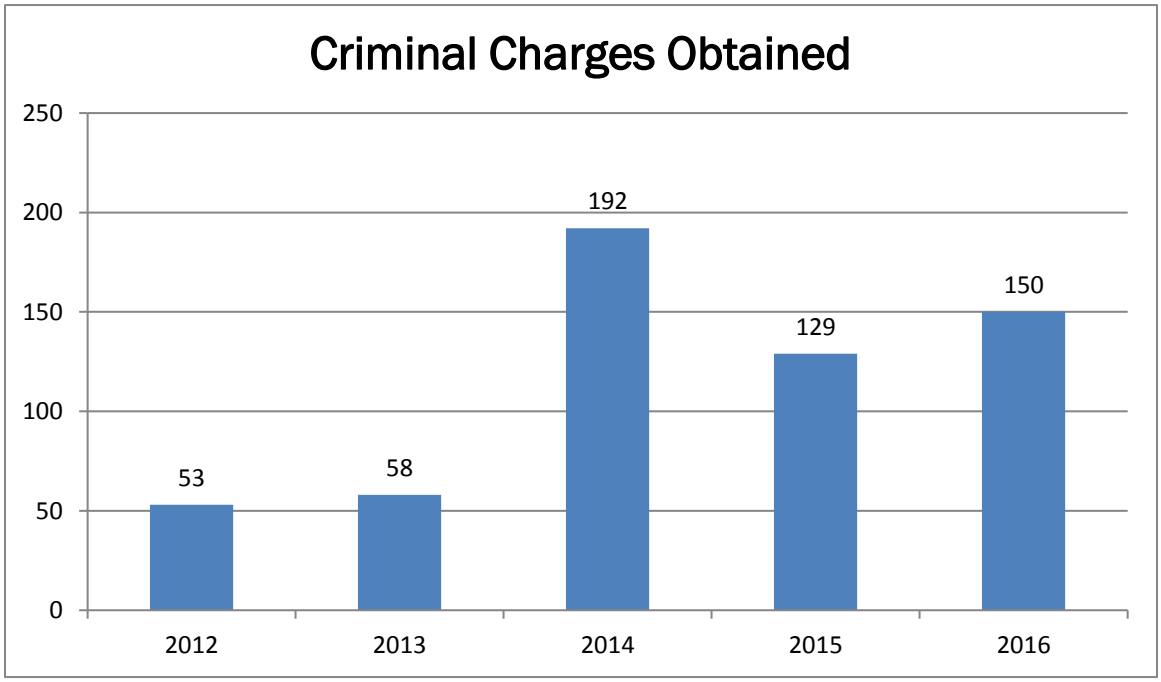
2015 showed a significant increase in the number of workers' compensation insurance fraud cases, and 2016 nearly mirrored that level.



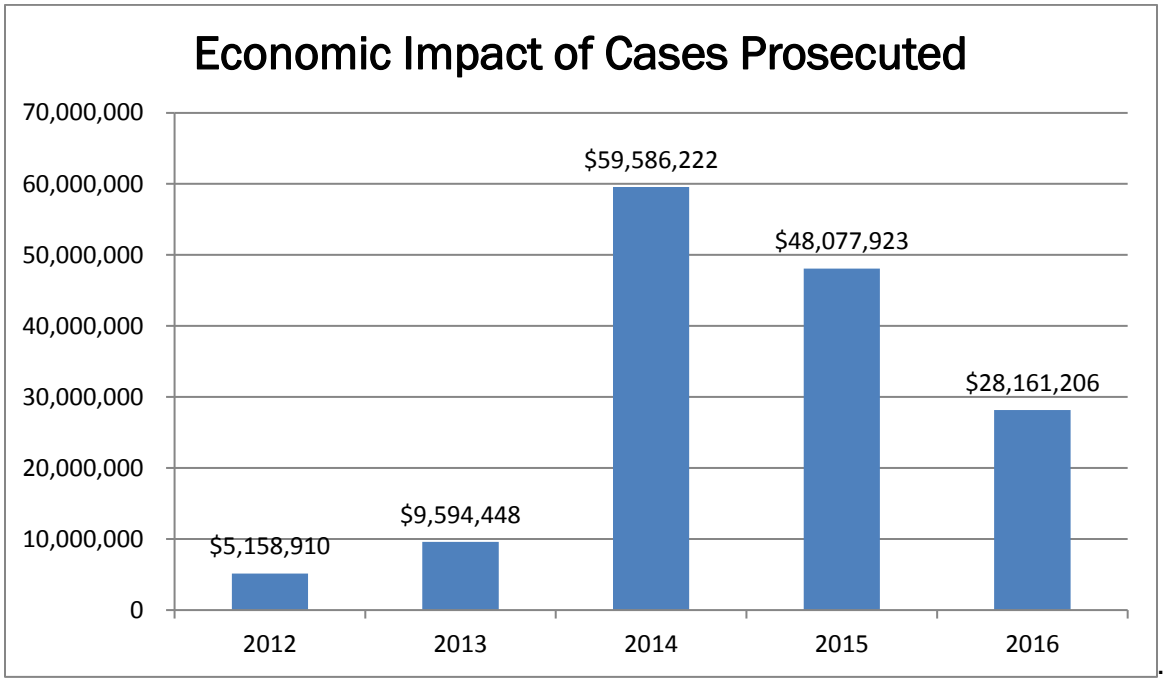
Prosecution

After gathering evidence and completing an investigation into a referral, the Commerce Fraud Bureau submits the results of those investigations for criminal prosecution. These investigations are referred to either a Minnesota County Attorney's Office or the United States Attorney's Office – District of Minnesota, depending on the jurisdiction and criminal violations applicable to the investigation.

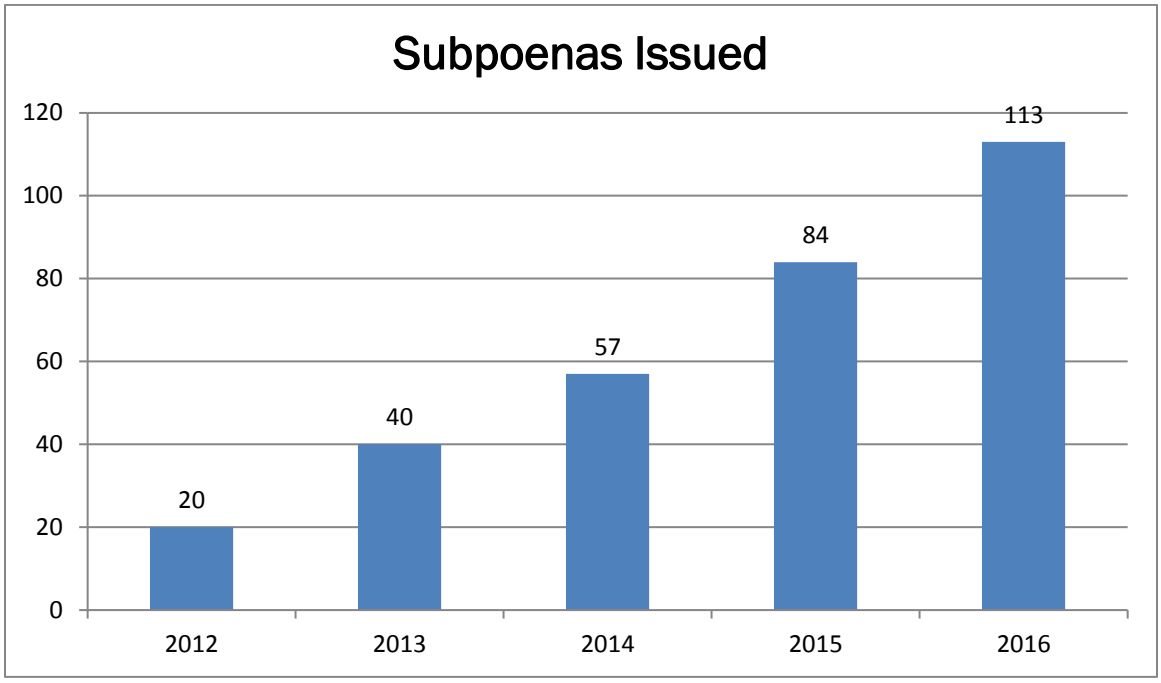
In 2016, Fraud Bureau investigations resulted in the filing of 150 state and federal criminal charges against defendants. The following graphic represents the previous five years of data concerning the number of criminal charges obtained against defendants. During the past three years, the Fraud Bureau obtained a total of 471 criminal charges against defendants. During the five year period 2012 – 2016, the Bureau obtained, on average, 116 criminal charges against defendants annually.



In 2016, Fraud Bureau investigations that resulted in the filing of federal criminal charges had an economic impact of $28,161,206. During the five-year period 2012 – 2016, the average annual economic impact of the cases charged through Bureau investigations was $29,083,960. The following chart represents the economic impact of the five years of cases that were prosecuted as a result of the investigative efforts of the Fraud Bureau.



One of the most important aspects in conducting investigations into complex fraud cases is evidence gathering. A large amount of the evidence required to obtain a successful prosecution of an offender relies upon securing evidence via the subpoena powers granted to the Commissioner. The following chart represents the number of subpoenas issued pertaining to investigations conducted during the previous five years.



Task Force Officer Program

During 2016, the Commerce Fraud Bureau entered into several agreements with federal law enforcement partners to enhance our investigations into insurance fraud. The agencies involved include the United States Postal Inspection Service, the United States Secret Service and Homeland Security Investigations.

Each of the agencies has a Task Force Officer (TFO) program. The TFO program is essentially a force multiplier whereby we leverage the Bureau's resources with our law enforcement partners. This program enables several of our Agents to be cross-designated as a Federal Law Enforcement Officer which allows the Agents access to various federal law enforcement data systems, personnel and other resources. This enables the Fraud Bureau to gain additional expertise and competency in conducting complex criminal investigations.

Participation in this program further elevates the Fraud Bureau in the eyes of Minnesotans and serves as a constant reminder to other law enforcement agencies of our available expertise and recognizes the Bureau as a leader and expert in our field.

Major Case Highlights

The following cases represent a portion of the investigations conducted by the Fraud Bureau during 2016 or were the result from cases that went to trial during 2016:

Chiropractic Insurance Fraud Conspiracy

On December 21st, United States Attorney Andrew M. Luger announced federal criminal charges filed against 21 defendants for conspiring to commit health care fraud, based upon a Fraud Bureau investigation. The defendants fraudulently billed insurance companies for millions of dollars over the course of the parallel conspiracies.

Under the Minnesota No-Fault Automobile Insurance Act, auto insurance policies must include a personal injury protection provision (PIP). The PIP provision carries a minimum coverage amount of $40,000 for expenses resulting from injuries sustained in an automobile accident, $20,000 of which may be used for medical expenses.

At various times between at least 2010 and 2015, chiropractors Preston E. Forthun, Angela A. Schultz, Huy Ngoc Nguyen, Adam J. Burke, and other Doctors of Chiropractic, engaged in schemes with others to defraud automobile insurance companies. The schemes, which were nearly identical fraud schemes largely carried out independent of one another, involved the submission of fraudulent no-fault insurance claims.

Chiropractors involved in the scheme would submit claims and receive reimbursements for chiropractic services that either were not medically necessary or were never rendered. Each chiropractor would prescribe and purportedly provide services that were not determined medically necessary by the physical condition of each patient, but were instead designed to fraudulently maximize reimbursement from the patients' automobile insurance companies.

In order to get more patients to come to chiropractic appointments for treatment they did not need, the chiropractors charged would make illegal payments to patient recruiters, known as "runners." Runners typically made upwards of $1,000 per automobile accident patient in exchange for bringing the patient into the chiropractor's office. Runners were often not paid, or paid only in part, until after the patient had attended a minimum threshold number of treatment sessions. In order to keep the patients coming back for medically-unnecessary appointments, the runners often paid illegal kickbacks to the patients.

Some of the charged chiropractors would conceal the kickback payments in various ways. For example, Forthun wrote checks to runners and falsely described those checks on the memo lines as payments for services such as "transportation" or "marketing." Burke encouraged runners to form corporate entities such as LLCs with names that sounded like legitimate businesses to which Burke made kickback payments. Nguyen tried to conceal kickback payments by making checks out to "cash" for several thousand dollars. He often wrote multiple such checks each week, falsely characterizing them as having been for "chiropractic supplies" or "office supplies."

Defendant Information:

Chiropractors

- Angela A. Schultz, 47 of Chaska.
- Preston E. Forthun, 38 of Bloomington.
- Huy Ngoc Nguyen, 42 of Brooklyn Park.
- Adam John Burke, 32 of Minneapolis.

Each Chiropractor was charged separately with:

- Conspiracy to commit health care fraud, 1 count
- Conspiracy to commit mail fraud, 1 count

Runners

Abdisalan Abdulahab Hussein, 48 of Minneapolis.

Sahal Ali Warsame, 35 of Minneapolis.

Hussein and Warsame were each separately with:

- Conspiracy to commit health care fraud, 2 counts
- Conspiracy to commit mail fraud, 2 counts

The remaining individuals listed below were each charged separately with:

- Conspiracy to commit health care fraud, 1 count
- Conspiracy to commit mail fraud, 1 count
    - Yahye Mohamed Herrow, 45 of Minneapolis.
    - Temitayo Ifeloju Olusholda Daniel, 35 of Minneapolis.
    - Merron Redi Samuel, 36 of Saint Paul.
    - Abrirahin Khalif Ibrahim, 25 of Saint Paul.
    - Dana Enoch Kidd, 35 of Elk River.
    - Samatar Hassan Omar, 28 of Edina.
    - Abdinasir Mayon Abikar, 31 of Minneapolis.
    - Ali M. Abikar, 28 of Edina.
    - Dana Stephen Comeaux, 57 of Brooklyn Center.
    - Carlos Patricio Luna, 48 of Minneapolis.
    - Jerome Tarlve Doe, 52 of Brooklyn Park.
    - Napolean Tutex Deah, 32 of New Brighton.

Sammany Rathy Spangler, 27 of Woodbury.All are currently awaiting trial.

Jeffrey Allen Gardner and Stuart Alan Voigt – Bank Fraud

Former Minnesota Vikings tight end Stu Voigt and Jeffrey Gardner were indicted in April 2015 on federal fraud charges stemming from a Ponzi scheme that swindled millions of dollars from investors. This matter went to trial in January 2016.

Stu Voigt, 66, of Apple Valley, and Jeffery A. Gardner, 61, of Hopkins, were charged with mail fraud, bank fraud and making false statements in loan applications. In addition, Voigt was charged with making false statements to the Federal Deposit Insurance Corporation (FDIC).

Voigt and Gardner raised funds from private investors through Gardner's company, Hennessey Financial, ostensibly for commercial real estate ventures with promised returns of 10 percent to 20 percent annually. Voigt and Gardner actually used the money to pay off previous investors and to pay pre-existing debts.

When Hennessey Financial began to fail, Voigt and Gardner created new companies, opened bank accounts in the names of new companies, transferred funds from Hennessey accounts and took other steps to hide income and assets from investors, creditors and the government.

Voigt knowingly engaged in monetary transactions of criminally-derived property, namely multiple payments exceeding $50,000 each drawn from a Hennessey Financial account and made payable to Voight. During this same time period, Voigt was the chairman of the board of First Commercial Bank (FCB). In order to keep Hennessey afloat and provide funds to funnel back to Voigt, Gardner and Voigt secured loans for Gardner from FCB without truthfully disclosing Gardner's financial situation. The defendants filed security interests and took other steps to allow another company to obtain Hennessey assets that Gardner had presented as security for the loans from FCB, thereby depriving FCB of collateral and reducing the likelihood that FCB would be made whole.

Voigt was found guilty in his role in the scheme and sentenced to six months in prison and ordered to pay a $100,000 fine. Gardner was sentenced to 90 months in prison and ordered to pay restitution to his victims.

Paul E. Kottke – Insurance Fraud

In February, the Dakota County Attorney's Office filed criminal charges against a former licensed insurance agent from Burnsville for defrauding and stealing from a senior client from Apple Valley. Paul E. Kottke, age 70, who now resides in Omaha, Nebraska, was charged with two felonies: one count of insurance fraud and one count of theft by swindle.

In 1995, the client provided Kottke with $10,000 to purchase a Certificate of Deposit (CD) on her behalf. In 2004, she provided Kottke with an additional $1,000 to add to the earlier investment. Kottke gave the client a handwritten investment statement and, over the course of the next nine years, sent her annual statements reflecting the principal and interest amounts on the CD. The final statement showed a total balance of $22,197. In March 2013, because of the client's deteriorating health, her family contacted Kottke and requested that her investment be liquidated to help pay for an assisted living facility.

Kottke told the family they had to wait to withdraw any funds and there would also be an early withdrawal penalty. Ultimately, Kottke failed to send any funds to the client or her family.

In May, Paul Kottke appeared in Dakota County District Court and pleaded guilty to Felony Theft by Swindle. He was ordered to pay $22,197 in restitution. Kottke was placed on felony probation for 3 years.

Levi David Lindemann – Ponzi scheme

Levi David Lindemann was a financial adviser and the owner of Gershwin Financial, Inc., a Minnesota-based investment management company that did business under the name Alternative Wealth Solutions.

Alternative Wealth Solutions was an investment management company owned and operated by Lindemann, through which he provided financial planning and asset management services, selling insurance annuities and investment products to clients in Minnesota and Wisconsin.

Beginning no later than in or about 2009 and continuing until November 2014, Lindemann devised and participated in a scheme to defraud and to obtain money by means of materially false and fraudulent pretenses, representations, and promises, and by concealment of material facts.

Lindemann solicited money from investors by falsely representing that he would use the invested funds to purchase secured notes or other legitimate investments when, in fact, he intended to and did use the invested funds to pay personal expenses and make Ponzi-type payments of promised returns to other investors.

Lindemann solicited approximately $4.3 million in investor funds from approximately 50 investor clients. Lindemann failed to invest all of his investor-clients' money in these legitimate investments, but instead used over $2.5 million in investor funds to pay personal expenses and to make Ponzi-type payments of promised returns to other investors.

In March, Lindemann admitted in federal court that he ran a Ponzi scheme that lasted at least five years and bilked investors out of about $2.5 million. In November, Lindemann was sentenced to 74 months in prison and ordered to pay over $1.9 million in restitution to his victims.

Paul M. Bardine – Insurance Fraud and Theft by Swindle

In March, Paul M. Bardine, 54, of Minnetrista, was charged by the Hennepin County Attorney with three counts of insurance fraud and three counts of theft by swindle. Bardine, who was a licensed insurance agent in Minnesota, convinced several of his clients to surrender a portion of the annuities he had previously sold them in order to make new investments.

After receiving the surrendered funds, Bardine convinced the clients to invest their money with one of his companies, O & B Investments. The victims gave personal checks to Bardine with the belief their money would be invested by Bardine and his companies. Rather than investing his clients' money, Bardine used the funds to pay personal expenses as well as make payments to other investors.

In September, Paul Bardine pleaded guilty in Hennepin County District Court to all three counts of theft by swindle and the corresponding insurance fraud charges. He was subsequently sentenced to 34 months in prison.

John V. Heath – Theft by Swindle and Identity Theft

In March, John V. Heath, 45, of Edina, was charged by the Hennepin County Attorney with theft by swindle and identity theft. Heathheld an insurance agent license and was registered as an investment adviser representative and broker-dealer agent. He convinced his 88-year old client to surrender portions of an annuity over the course of two months during the fall of 2015. Heath's longtime client, who lives with his daughter in Robbinsdale and is afflicted with Alzheimer's disease and the consequences of a stroke in 2013, set up an annuity with Jackson National Life that grew to $220,000.

Heath added a residential address in Edina and an e-mail account of hereistrouble1@gmail.com, both belonging to Heath, to the Jackson National Life annuity account. Without notifying his client, Heath then opened a checking account at Wings Financial in Edina using the man's Social Security number, birth date and driver's license number, along with Heath's home address and phone number, and the e-mail address.

In September 2015, Heath took out $18,500 from the annuity and deposited it into the Wings account. He made more withdrawals until cleaning out the final $194,172 from the annuity in late October 2015. Heath used the money to pay more than $20,000 on his credit card bill and withdrew more than $30,000 in cash. He also spent more than $2,500 of it at Target and another $636 in airport parking. Wings became suspicious of the number of transactions in such a brief time, closed the checking account and made a report to adult protection and law enforcement authorities.

In September, Heath pleaded guilty and received a 41-month prison sentence.

Adam Reichow – Theft by Swindle and Racketeering

In May, the Mille Lacs County Attorney filed multiple felony charges against Adam Richard Reichow for swindling 82-year-old Wayne Dalchow of Princeton out of $1,000,000. Reichow was hired by Dalchow as a general laborer at his seed business, Dalchow Seeds, in 2010. As Dalchow's health declined, Reichow assumed additional responsibilities at the business, which included managing accounts, sales and handling business funds.

In spring 2010, Dalchow gave Reichow $180,000 to purchase farm property with acreage and make improvements to the home. When the loans were discovered, Dalchow and Reichow were warned by Dalchow's attorney to advise legal counsel before entering into any additional large monetary transactions. Despite warnings from Dalchow's family and legal counsel, the two engaged in two more land purchases totaling $216,400.

The investigation found that, between 2010 and 2012, Reichow had issued himself checks from Dalchow totaling at least $350,000. Dalchow was unaware of the criminal activity until creditors began contacting him to collect on overdue bills. He then learned his accounts had been drained.

Reichow used the stolen money to make payments to Dalchow for the three separate farm properties as well as buildings, livestock, machinery and vacations.

Reichow is currently awaiting trial.

Gregory Hatch – Theft by Swindle and False Representation

In June, the Washington County Attorney charged Gregory Hatch in a two-count criminal complaint with theft by swindle and theft by false representation, both felony offenses.

Between August 2008 and August 2013, a group of three realtors known as The Hatch Group created a de facto partnership with HBG Solutions. The Hatch Group consisted of Sanford Hatch, Mike Hatch and Gregory Hatch. HBG Solutions consisted of Mike Boyce and Duane Griffith.

The Hatch Group located distressed homeowners and made offers to get them out of their property without any liability to their lender. The Hatch Group would then represent the seller and the "buyer" HBG Solutions throughout the transaction, without disclosing their business partnership with HBG to the seller or the lender. The Hatch Group would negotiate the short sale with the lender on behalf of the seller, knowing that the "buyer" HBG Solutions would benefit (as would The Hatch Group, given their business arrangement).

The Hatch Group would then turn around and sell the property for a significantly higher price without making any improvements, often prior to the close of the first transaction. Meanwhile, the marketing efforts on the property were directed towards the sale of the property by HBG for a substantially higher price than was paid to the lender. When the property was then sold to a third party, The Hatch Group would collect 60% of the profits on the flip as well as both commissions. Neither the original seller nor the lender was notified of The Hatch Group's partnership with HBG Solutions.

Hatch is currently awaiting trial.

Randy Miland – Ponzi scheme

In June, the United States Attorney issued a federal indictment charging Randy Miland, age 62, of White Bear Lake, with operating a Ponzi scheme through which he stole or attempted to steal more than $500,000 from his investors. Miland is charged with five counts of mail fraud and one count of money laundering.

Miland was convicted in 1999 in state court with theft by swindle and ordered to pay more than $1.5 million in restitution to the victims of his scheme. As of May 2016, Miland still owed nearly the entire amount to his victims.

Miland was also convicted in 2006 of fraud in federal court and ordered to pay more than $250,000 in restitution to the victims. As of May 2016, Miland owed approximately $124,000 in restitution.

Between 2010 and 2014, Miland fraudulently solicited approximately $575,000 from investors, telling them that he would use their money to invest in futures and other legitimate investments. Instead, he used their money to pay personal expenses, including court-ordered restitution to victims of his prior scams, and to make Ponzi-type payments to other purported investors.

Miland concealed from the new victims that he had been twice convicted of fraudulent conduct, that he was forbidden by the Minnesota Department of Commerce from offering or selling securities, and that he still owed more than $1.5 million in restitution to victims of prior schemes.

In September, Miland pleaded guilty to mail fraud and money laundering. He is awaiting sentencing.

Wilson Armando Molina – Insurance Fraud

The Hennepin County Attorney charged Wilson Armando Molina with two counts of insurance fraud. On June 10, 2013, a fire was reported at a multi-unit residential property located in Minneapolis that was owned by Molina.

An initial insurance claim was filed by telephone in June 2013 by Molina. Molina hired an insurance adjuster to work on his behalf during the insurance claim process. In November 2014, the adjuster contacted the insurance company regarding payment for any code updates required on the property. On November 26, 2014, the adjuster mailed the insurance company a Home Depot invoice that he had received from Molina via email. This invoice was in the amount of $74,495.93.

In July 2015, Molina emailed a receipt from Windows and Gutters LLC in the amount of $19,310.77 to the insurance company. The insurance company reviewed the document and suspected that it was not authentic.

Fraud Bureau Agents took the Home Depot receipt to a Home Depot Store in New Brighton. The Home Depot employee was able to locate an actual invoice in the amount of $1,457.62. The name on this invoice was Luis Molina. Home Depot had no record of a transaction for the $74,495.93.

Fraud Bureau Agents also reviewed the invoice from Window and Gutters LLC. The Agents determined that no such business exists and that the address was fictitious.

Agents questioned Molina regarding the invoices. Molina admitted that he had filed the initial claim and stated that the invoices were legitimate. After being confronted with the facts, Molina admitted altering the invoices using his laptop computer. He further admitted emailing one to the insurance adjuster and submitting the second himself. He stated that he was trying to get what he felt the insurance company owed him.

Christopher Robert Luedtke - Forgery

In August, the Dakota County Attorney's Office charged Christopher Luedtke with aggravated forgery. A victim contacted the Fraud Bureau regarding a forgery that had occurred in connection with a real estate title document for a residence in Apple Valley. The victim reported that she had been dating an individual she identified as Luedtke since 2013. The victim indicated she had purchased a home in July 2014 in Apple Valley. She was the sole person listed on the title and mortgage.

In August 2015, the victim agreed to add Luedtke to the title for the home and they drafted a Quit Claim Deed to add Luedtke. That document was filed with the county, but was rejected as the victim's name was misspelled, it contained an incorrect description of the property and it only listed the victim on the tax statement portion. After the rejection, the victim had second thoughts about adding Luedtke to the title for the residence and told him she did not want to add him.

In mid-October 2015, the victim opened mail that had been sent to her and Luedtke from Dakota County. She discovered that another Quit Claim Deed had been filed with the County, adding Luedtke to the title and giving him property rights to the residence. The victim noted that the signature on the paperwork was not hers. The victim confronted Luedtke about it and he stated because they were engaged and due to the prior rejection he could legally sign her name on the document.

In June 2016, during a recorded conversation, the victim and a friend attempted to get Luedtke to sign the residence back to the victim, but he refused. Luedtke admitted he had forged the victim's signature on the deed. Luedtke claimed that he was free to do so because they were engaged, and because the first deed had been rejected for errors. He also falsely claimed that the notary had told him he could sign for the victim.

Christine Mary Dieble – Auto Theft

In August, the Anoka County Attorney's Office charged Christine Dieble with auto theft. On June 25, 2008, Ms. Dieble reported to the Minneapolis Police Department that her 2003 Nissan 350Z had been stolen. Ms. Dieble also reported the loss to State Farm, her insurance carrier. On August 8, 2008, Ms. Dieble signed over the title to the vehicle to State Farm. Ms. Dieble along with the vehicle's lienholder, were then given payments from State Farm due to the vehicle's total loss.

On November 5, 2008, Ms. Dieble's stolen vehicle was recovered in an underground garage and impounded. That same day, Ms. Dieble retrieved it from the impound lot by signing a declaration that she was legally authorized to take possession of the vehicle. In November 2013, State Farm obtained information that the vehicle may have been recovered. State Farm contacted Ms. Dieble several times regarding their desire to retrieve the vehicle, but she never responded. Although Ms. Dieble had no rights to the vehicle, she remained in possession of it until her husband, contacted State Farm and advised the vehicle was being held in his garage.

Ms. Dieble acknowledged retrieving the vehicle from the impound lot although she had no rights of ownership. She also admitted she concealed the vehicle through several residence changes by keeping it in her garage and not driving it except when it was moved.

Barbara Jean Franklin - Forgery

In October, the Ramsey County Attorney charged Barbara Jean Franklin with three felony crimes relating to her forgery of life insurance documents and receiving loans against the policy.

Thrivent Life Insurance Company reported that Ms. Franklin took out loans totaling $15,000 against a life insurance contract belonging to Deloris Kern, Ms. Franklin's deceased mother, by forging the signature of two persons named on the contract.

Agents learned the life insurance contract was jointly owned by Franklin, Richard Kern, Judith Kiekhoefer (now deceased), and Kathleen Kern. Judith Kiekhoefer's surviving spouse, August Kiekhoefer, inherited Judith's portion. On a Values Distribution Request dated July 13, 2010, defendant forged the signatures of Judith Kiekhoefer, Kathleen Kern, and Richard Kern and took out a $5,000 loan against the life insurance contract, which was deposited into an account owned by Ms. Franklin.

On September 9, 2012, Franklin took out a $5,000 loan against the life insurance contract, which was deposited into an account owned by her. The signatures on the Values Distribution Request were of Judith Kiekhoefer, Kathleen Kern, and Franklin.

On a Values Distribution Request dated April 8, 2014, defendant forged the signature of Richard Kern and took out a $5,000 loan against the life insurance contract, which was deposited into an

account owned by Franklin. The Values Distribution Request also contained the signatures of defendant, Kathleen Kern, and Judith Kiekhoefer.

On June 23, 2014, Richard Kern signed an Affidavit of Unauthorized Transaction Request. On November 17, 2014, Thrivent Financial Services repaid the loan balance of $13,160.83 to the life insurance contract.

In February 2015, Franklin admitted she had withdrawn money from Deloris Kern's life insurance contract. Ms. Franklin stated she did not have permission to withdraw the funds and admitted she had forged the signatures of her siblings in order to withdraw the funds.

Kamal Yasin Ahmed – Insurance Fraud

In December, the Hennepin County Attorney's Office issued a complaint against Kamal Yasin Ahmed charging him with one count of insurance fraud – employment of runners.

In November 2010, Ahmed approached a chiropractor about being paid to bring people involved in motor vehicle accidents his clinic. The chiropractor agreed and he paid Mr. Ahmed $9,000 for a group of patients. The patients did not attend enough chiropractic sessions for the chiropractor to make money on the deal. He was not able to bill the no-fault insurance carrier more than what he paid Ahmed. As a result, he did not work with Ahmed again until 2013.

In 2013, Fraud Bureau Agents approached the chiropractor seeking information on people who were running patients to chiropractors. The chiropractor agreed to cooperate with the Agents. In November 2013, the chiropractor placed a recorded telephone call to Ahmed in which he asked Ahmed about working together again.

Ahmed agreed to sell patients to the chiropractor. Over the next several weeks, they had multiple recorded phone conversations about Ahmed bringing people involved in motor vehicle accidents to his clinic in exchange for money. On November 19, 2013, Ahmed brought a patient to the clinic and they had a recorded conversation about how much Ahmed would be paid. They negotiated a deal pursuant to which Ahmed would be paid $500 per week in exchange for 4 to 5 patients being brought to the clinic each month. He told the chiropractor that, in addition to paying him for the patients, he would need to "help out" the patients by paying them $1,500 after the patient had attended 10 chiropractic sessions.

In December 2013, the first patient that Ahmed sold to the chiropractor attended his 10th chiropractic session. This patient had a recorded conversation with K.O. about the fact that Ahmed brought him to the clinic, that Ahmedtold him he would be paid $1,000 after the 10th visit, and that he was supposed to give some of the money to Ahmed and/or others who work with Ahmed. This patient accepted the $1,000 check from K.O. and did not attend any further treatment sessions.

In total, Ahmed accepted three checks from the chiropractor, totaling $1,277.05, in exchange for bringing four patients to the clinic. Ahmed knew that the chiropractor was going to bill motor vehicle insurance plans for the care, and offered to help the chiropractor obtain the necessary claim forms and accident reports to facilitate that billing.