

Texas Department of Insurance
Fraud Unit
Annual Report to the Commissioner



December 2014

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EXECUTIVE SUMMARY

Texas Insurance Code, §701.101 requires the Fraud Unit to annually report the number of completed cases and any recommendations for new regulatory or statutory responses to the types of fraudulent activities encountered by the Fraud Unit in writing to the insurance commissioner.

FY 2014 STATISTICS

- Fraud reports received – 13,341
- Cases opened for investigation - 740
- Matters referred for prosecution – 188
- Matters referred to other law enforcement for handling 34
- Estimated amount of fraud identified in referred cases - \$9,911,329.17
- Indictments resulting from investigations - 113
- Judgments from cases referred - 75
- Restitution assessed by courts on Fraud Unit cases – \$24,435,501.62
- Subpoenas issued – 268
- Public Information Act Requests – 157

NOTEWORTHY ACCOMPLISHMENTS

- Received 13,341 fraud reports, the highest number in the unit's history
- Hosted the 16th Annual Fraud Conference for 393 attendees and exhibitors, the largest in the history of the event
- Obtained 75 convictions and orders for deferred adjudication from referrals to prosecutors
- Received court orders for \$24,435,501.62 in restitution
- Made 32 presentations to industry partners, law enforcement officials, and citizen's groups
- Completed peace officer and attorney mandated training

TOP ADJUDICATED CASES

This report summarizes ten investigations that resulted in criminal prosecutions and convictions. The fraud schemes are associated with agent fraud, adjustor fraud, claimant fraud, and mortgage fraud.

LEGISLATIVE RECOMMENDATIONS

There are two recommendations for legislative changes in this report. The recommendations relate to grant acceptance and fraud investigations.

FRAUD UNIT OVERVIEW

The purpose of the Texas Department of Insurance (TDI) Fraud Unit is to enforce laws relating to fraudulent insurance acts.¹ The unit protects the public from economic harm by investigating criminal insurance fraud allegations. Responsibilities include receiving and reviewing fraud reports; initiating inquiries; and conducting investigations when evidence shows insurance fraud may have been or is being committed. The Fraud Unit actively seeks criminal indictments, makes arrests, and assists in prosecutions to deter insurance fraud in Texas.

The Fraud Unit is comprised of investigators, management, fraud prosecutors, and administrative support. Investigative positions are staffed with commissioned peace officers and civilian investigators. The chief investigator supervises and directs all peace officers and coordinates and oversees all investigations conducted by the Fraud Unit.²

FRAUD UNIT PHILOSOPHY

- We practice the highest ethical standards of law enforcement.
- As peace officers, we promise to obey the oath of office and to adhere to the Law Enforcement Code of Ethics.
- All members of the unit conduct themselves according to the highest principles of their professions and in an exemplary manner.
- We protect and serve the people of the State of Texas.
- We educate and assist the public, the insurance industry, and other law enforcement agencies in efforts to identify and combat insurance fraud through enforcement of applicable statutes.

FRAUD REPORTING

Insurance fraud is a significant problem in Texas. Since 1996, the Fraud Unit has tracked the number of fraud reports it receives. In fiscal year (FY) 2014, the Fraud Unit received a record high 13,341 reports. The unit strives to enhance its outreach and education initiatives to create awareness and emphasize the importance of reporting suspected fraudulent activity. During FY 2014, the Fraud Unit gave 32 presentations to industry partners, law enforcement officials, and citizen's groups concerning insurance fraud detection, reporting, and investigation.

The Fraud Unit receives reports through several different methods and from many different entities, including insurance carriers, the National Insurance Crime Bureau (NCIB), National Association of Insurance Commissioners (NAIC), consumers, and businesses.

The Fraud Unit encourages everyone to report suspected insurance fraud. Fraud report submissions may be made via email, by phone, or via online at www.tdi.texas.gov/fraud/tdifraud.html. The unit maintains the Fraud Report Hotline, which allows people to report fraud by speaking to a Fraud Unit Investigator.

¹ Texas Insurance Code §701.101(a)

² Texas Insurance Code §701.104(b)

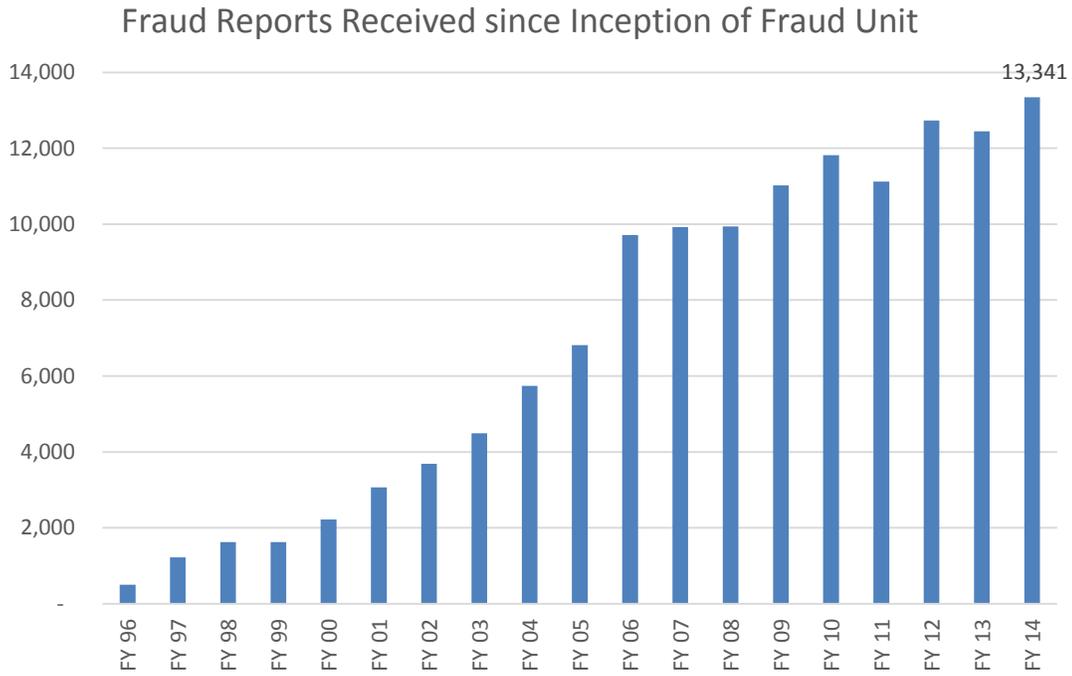


Figure 1: Fraud Reports Received since Inception of Fraud Unit

Fraud Reporting Transmission Channels FY 2014

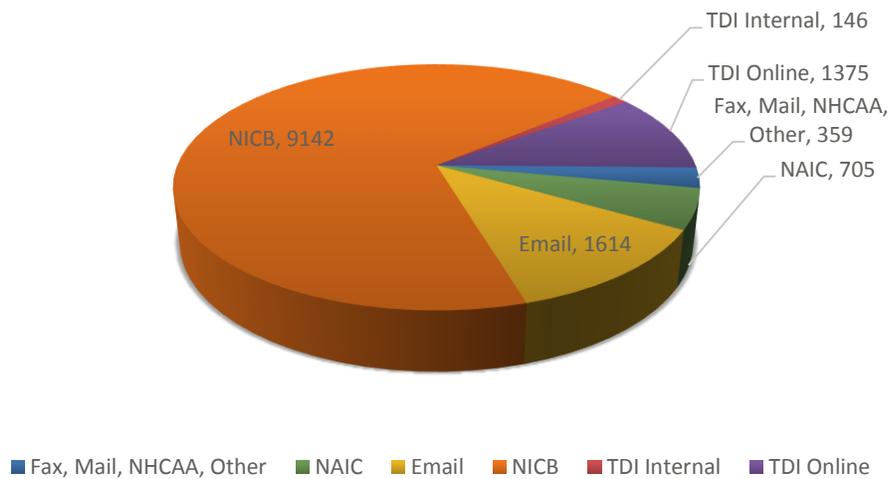


Figure 2: FY 2014 Fraud Reporting Transmission Channels

Fraud Schemes	2012 (12,965 reports)	2013 (12,583 reports)	2014 (13,341 reports)
Adjuster Fraud	0.24%	0.30%	0.26%
Agent Conversion	0.62%	1.03%	0.81%
Agent Fraud	1.79%	1.90%	1.72%
Arson for Profit	1.27%	1.40%	1.59%
Auto Body Shop Fraud	0.86%	0.69%	0.79%
Auto Burglary	1.26%	0.52%	0.50%
Auto Theft	8.15%	8.07%	7.32%
Cargo Theft	0.07%	0.06%	0.01%
Company Employee Fraud	0.07%	0.03%	0.07%
Company Officer Fraud	0.01%	0.11%	0.08%
Disaster Adjuster Fraud	0.01%	0.01%	0.00%
Disaster Claim Fraud	0.07%	0.02%	0.02%
Discount Health Plan	0.05%	0.00%	0.00%
Escrow/Fee Attorney	0.02%	0.00%	0.00%
Extensive Loss History	0.38%	0.64%	0.92%
Faked Death	0.02%	0.02%	0.02%
Faked Injury	5.75%	7.22%	7.81%
False Billing	0.20%	0.25%	0.51%
False Claim Documents	17.49%	15.87%	16.42%
False Statement(s)	11.96%	13.18%	19.47%
Fictitious Insurance Card or Certificate	0.31%	0.35%	0.42%
Hail Damage	4.34%	4.49%	3.55%
Identity Theft	0.39%	0.33%	0.37%
Inflated Claim	4.98%	4.16%	3.64%
Jump In	1.00%	1.27%	1.09%
Life Settlement Fraud or Viatical	0.04%	0.01%	0.00%
Man Made Roof Damage	1.36%	1.07%	0.52%
Medicaid or Medicare Fraud	0.03%	0.03%	0.02%
Mortgage Fraud	0.80%	0.23%	0.04%
Organized Crime	0.31%	0.46%	0.54%
Owner Give Up	0.22%	0.27%	0.31%
Paper Accident	3.78%	5.21%	3.73%
Policy Application Fraud	7.35%	7.32%	7.14%
Premium Fraud	1.16%	0.75%	0.79%
Provider Billing Fraud	5.56%	6.98%	4.98%
Runner/Capper	0.76%	0.52%	0.46%
Slip & Fall	1.62%	1.24%	1.33%
Soft Tissue Injury	0.04%	0.00%	0.03%
Staged Accident	2.36%	1.84%	1.49%
Theft	7.47%	7.90%	6.99%
Theft from Elderly	0.02%	0.03%	0.05%
TPA Fraud	0.02%	0.02%	0.02%
Undetermined or no scheme entered	3.12%	1.64%	1.22%
Unlicensed Agent or company	0.55%	0.47%	0.36%
Vendor Fraud	0.66%	0.91%	1.27%
Water Damage – HO or Mold Claim	0.32%	0.39%	0.56%
Working & Drawing	1.14%	0.82%	0.73%

Count of Fraud Reports by Fraud Type/Line of Coverage FY 2014

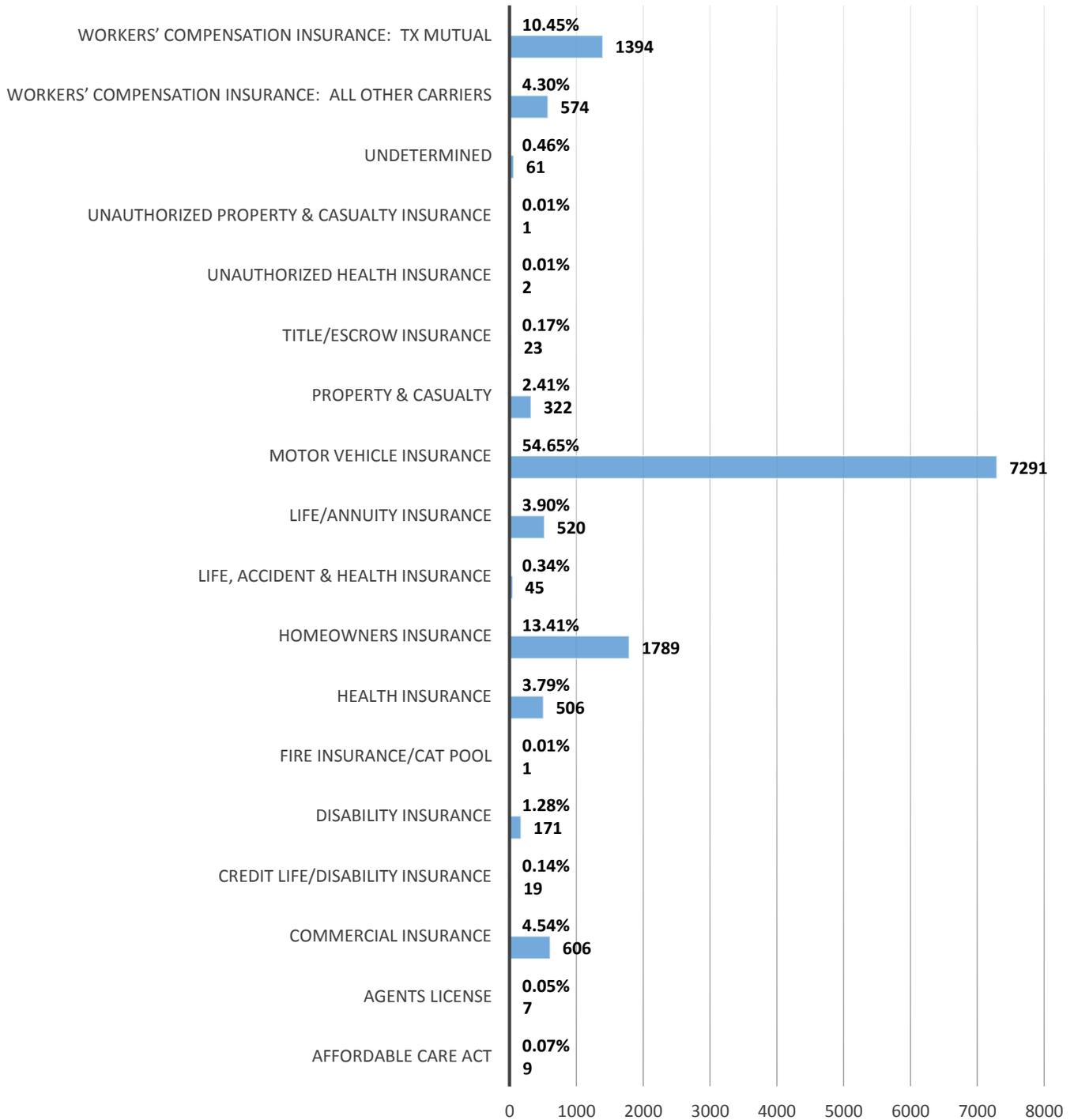


Figure 3: FY 2014 Fraud Reports by Type/Line of Coverage

In FY 2014, 740 reports of fraud were opened as investigations. Below is a table that represents that information and includes the Fraud Type/Line of Coverage. Please note that the Travis County District Attorney has a special prosecutor that is assigned to handle workers' compensation fraud cases for a specific carrier according to a statutory provision.

Fraud Type/Line of Coverage	# of reports received	# opened	% opened as compared to # received
Affordable Care Act	9	0	0%
Agents License	7	1	14%
Commercial Insurance	607	50	8%
Credit Life/Disability Insurance	19	1	5%
Disability Insurance	171	49	29%
Fire Insurance/Cat Pool	1	0	0%
Health Insurance	506	39	8%
Homeowners Insurance	1789	100	6%
Life, Accident & Health Insurance	45	10	22%
Life/Annuity Insurance	520	36	7%
Motor Vehicle Insurance	7292	316	4%
Property & Casualty	322	43	13%
Title/Escrow Insurance	23	6	26%
Unauthorized Health Insurance	2	0	0%
Unauthorized Property & Casualty Insurance	1	0	0%
Undetermined	62	2	3%
Workers' Compensation Insurance: TX Mutual Ins	1394	0	0%
Workers' Compensation Insurance: All other carriers	574	84	15%

Count of Fraud Type Referred to Prosecutors in FY 2014 (188 referrals in 123 cases)

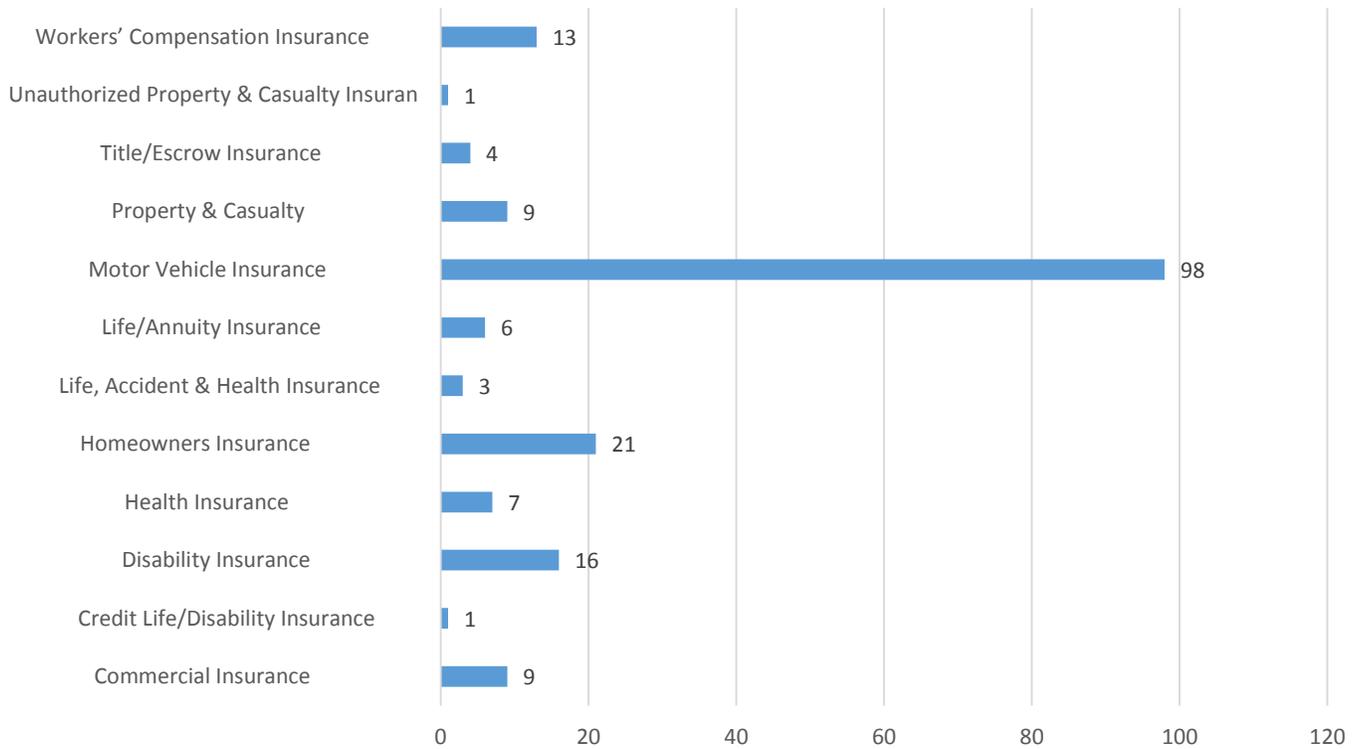


Figure 4: FY 2014 Referrals by Fraud Type

Referrals by Fraud Type (Line of Coverage)	2012	2013	2014
Commercial Insurance	22	10	9
Credit Life/Disability Insurance	4	1	1
Disability Insurance	17	13	16
Health Insurance	16	7	7
Homeowners Insurance	21	24	21
Life, Accident & Health Insurance	11	11	3
Life/Annuity Insurance	12	7	6
Motor Vehicle Insurance	59	85	98
Property & Casualty	12	9	9
Title/Escrow Insurance	8	40	4
Undetermined	0	1	0
Unauthorized Property & Casualty Insurance	1	0	1
Workers' Compensation Insurance	32	13	13*
*Assisted U.S. Postal Inspector OIG with investigation involving 23 suspects. The assistance not counted as referral.			

FY 2012-FY 2014 Dollar Amount of Fraud Identified in Referrals

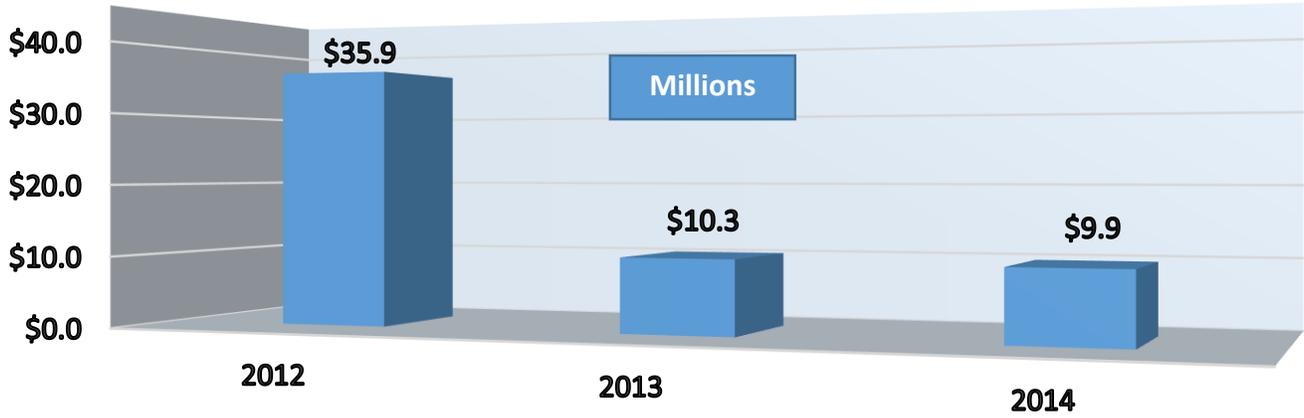


Figure 5: FY 2014 Dollar Amount Identified in Referrals

FY 2012-FY 2014 Court Actions

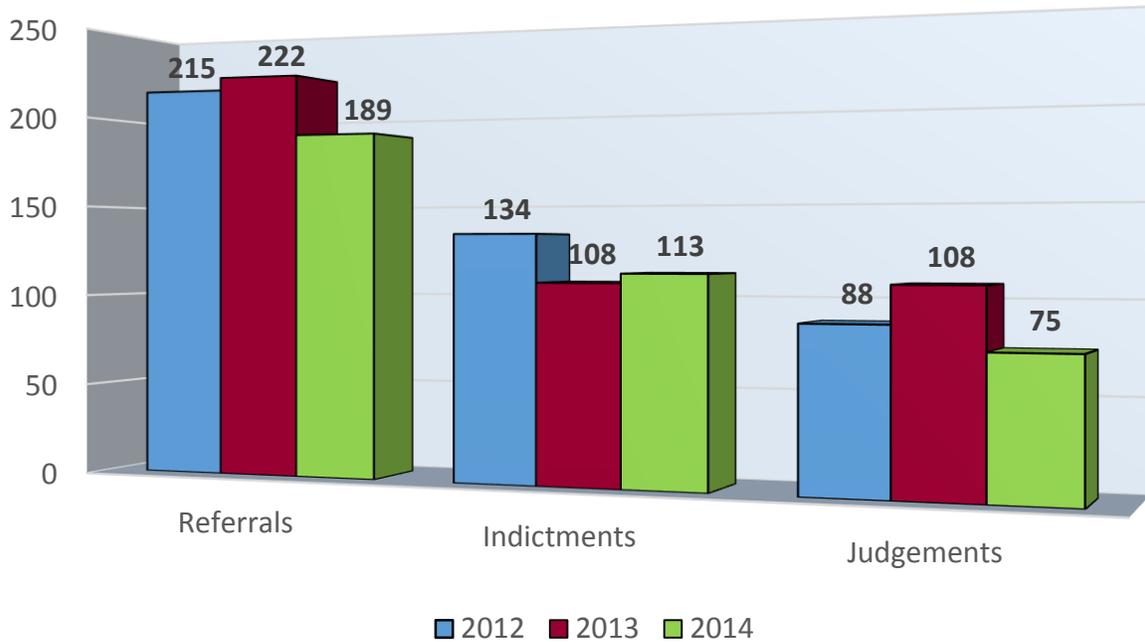
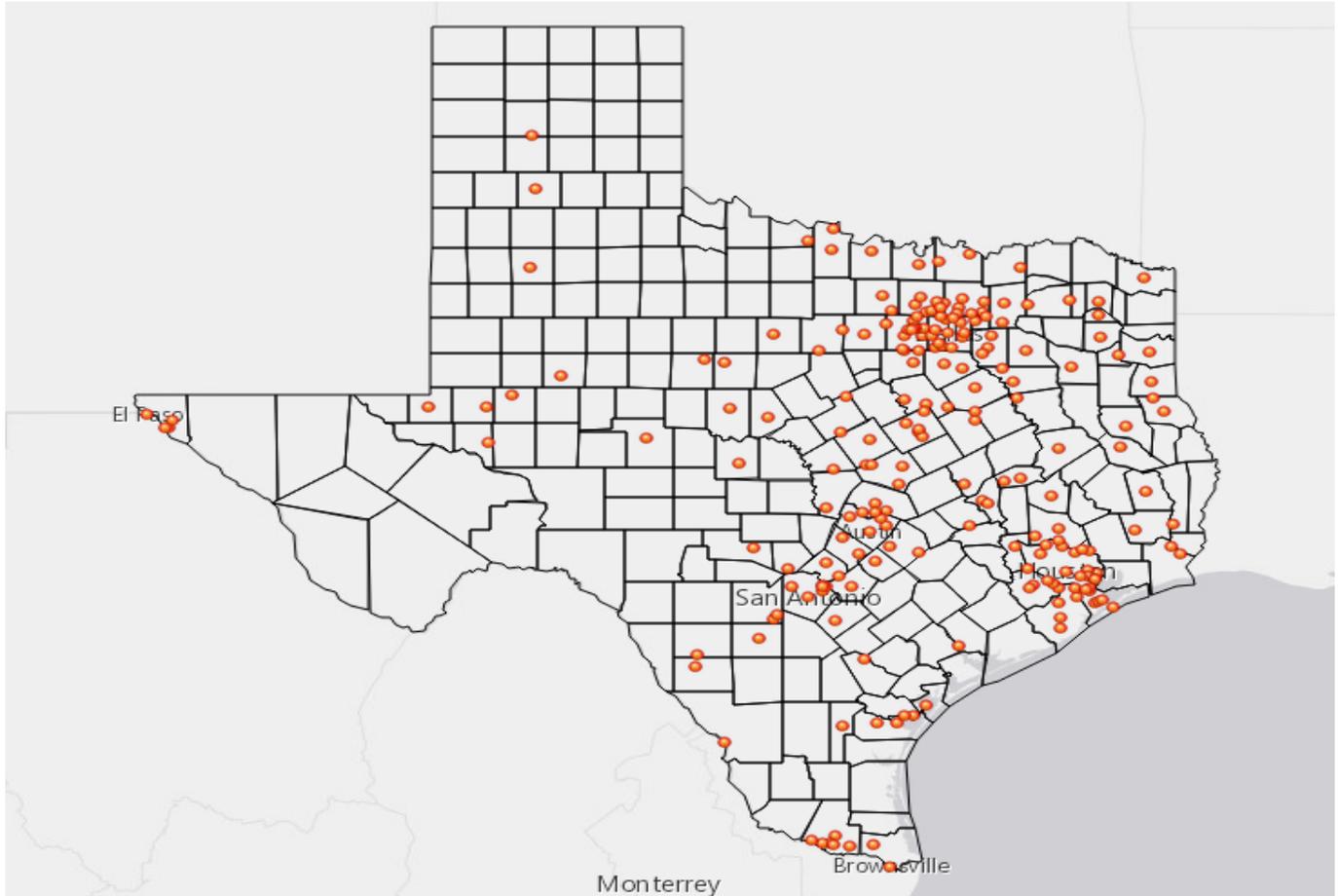


Figure 6: FY 2012-14 Court Actions

FRAUD UNIT BEGINS BID TO REGIONALIZE INVESTIGATIVE FUNCTIONS

As the number of fraud reports continued to increase across the state, the Fraud Unit began examining the possibility of placing investigators in field offices. While instances of fraud are traditionally associated with densely populated urban areas, reports have also been coming in from more geographically remote areas. By the end of FY 2014, there were 855 active investigations pending in 215 cities across the state.



Because of the widespread increase in activity, investigators are traveling more in the course of their daily activities. Due to the size of the state, some cases involve work that requires the investigator to travel for 6 to 8 hours just to reach the destination. This results in less time spent conducting investigations. It also results in additional costs for lodging, travel, and per diem expenses.

To address this matter, the unit began looking into the feasibility of creating regionalized offices, placing investigators throughout the state, rather than housing everyone in Austin. The unit has had investigators placed in the three major metropolitan areas outside of Austin and has had success with this placement. The investigators have been placed in the Dallas, Houston, and San Antonio areas.

In addition to reducing travel related costs, this concept helps foster more relationships with fraud victims, as well as local law enforcement agencies who may not be as familiar with the intricacies of this type of financial crime. Local authorities have shown a great interest in developing working relationships with the unit.

ADMINISTRATIVE TEAM

The dedication of the Administrative Support Section staff drives much of the success the Fraud Unit experiences as a whole. It is with this team that the entire investigative process begins.

Administrative team members review every incoming fraud report and start the data entry process. The report's information is compiled and provided to members of management so a decision can be made whether or not to proceed with a formal investigation. Once that determination has been made, all reports received are entered into the unit's case management system for future reference.

The administrative team researches investigative databases and files for any clues relevant to cases, and provides findings to investigators for use in their investigation.

The team oversees open records requests, archived files, distributes and recovers supplies, processes travel requests, addresses personnel issues, tracks budgetary matters, processes subpoenas, maintains evidence, monitors referred case progress, and oversees scheduling for Fraud Unit management.

The team has one certified project manager on staff who is often tasked with developing reports, charts, and graphs to illustrate the activities of the unit. In FY 2014, this individual also oversaw the unit's efforts in obtaining a new case management system, working with staff throughout the agency.

The team also includes two criminal analysts who tackle the monumental task of entering and analyzing vast amounts of financial data into meaningful graphics so it may be used by prosecutors to illustrate the flow of money associated with various insurance fraud schemes. The criminal analysts also work to develop link charts to show the relationships between all parties involved.

INVESTIGATION TEAMS

An investigator's primary goal is resolving insurance fraud criminal allegations. While some investigations may pertain to an isolated offense, others involve many suspects engaged in elaborate schemes to defraud countless victims.

The Insurer Fraud Section investigates fraud schemes involving insurance companies, agents, and other TDI licensees (including third-party administrators, escrow and title insurance companies, and agents), and eligible surplus lines insurers, as well as fraud schemes involving unlicensed insurance operations. These investigations may involve securing the execution of documents by deception, misappropriation of fiduciary funds, and forgery.

The Claimant and Provider Fraud Section investigates various claim fraud schemes, such as inflated claims, false claims for property loss, staged accident rings, fake burglary claims, staged slip-and-fall cases, and other suspicious liability insurance claims. Investigators also examine reports of fraudulent billing by health care providers, as well as reports of unlicensed providers and fraud rings involving health insurance claimants, providers, and attorneys. Fraudulent billing may include instances of over-billing, double billing, and billing for procedures not performed. Investigators within the Claimant and Provider Fraud Section are also tasked with conducting investigations of major fraud allegations that involve complex transactions and/or significant losses.

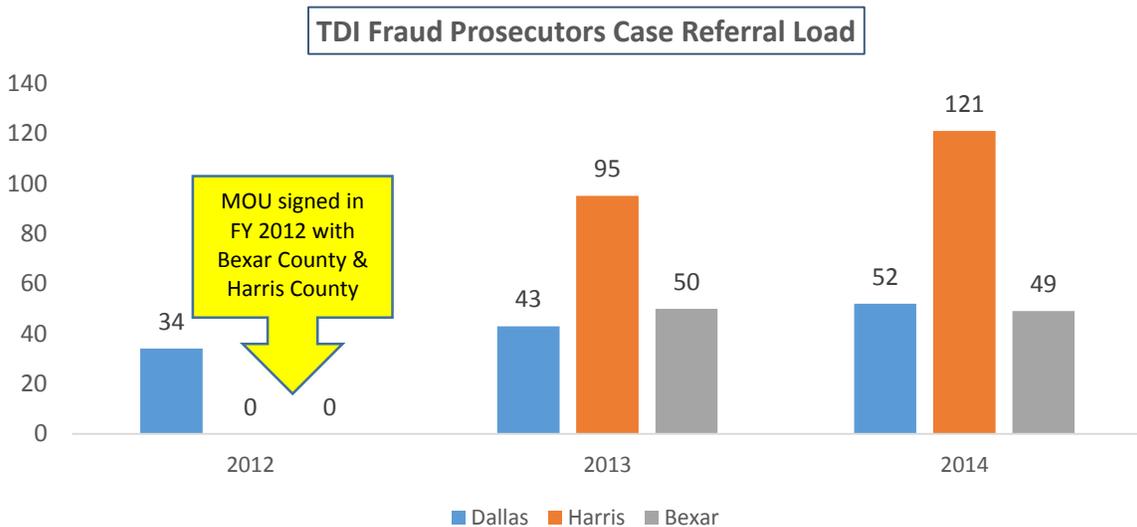
The Workers' Compensation Fraud Section investigates suspected workers' compensation fraud reports involving claimants, providers, and employers. Workers' compensation insurance fraud schemes may include a claimant receiving benefits while working at another full-time job, malingering, or may include a provider over-billing for services or billing for treatments never rendered. It may also include an employer who misrepresents payroll or employee classifications in the procurement of workers' compensation insurance.

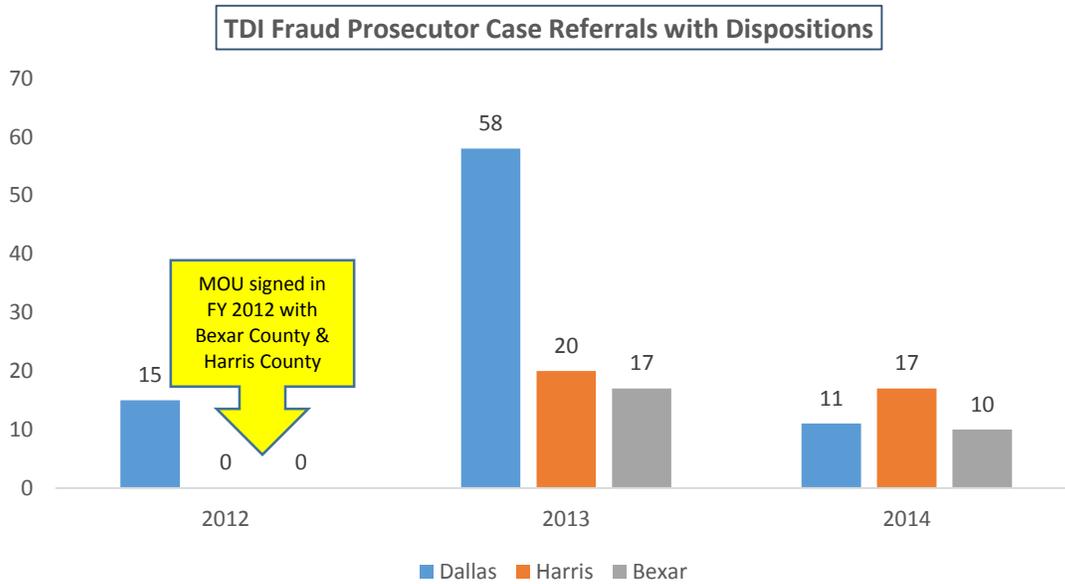
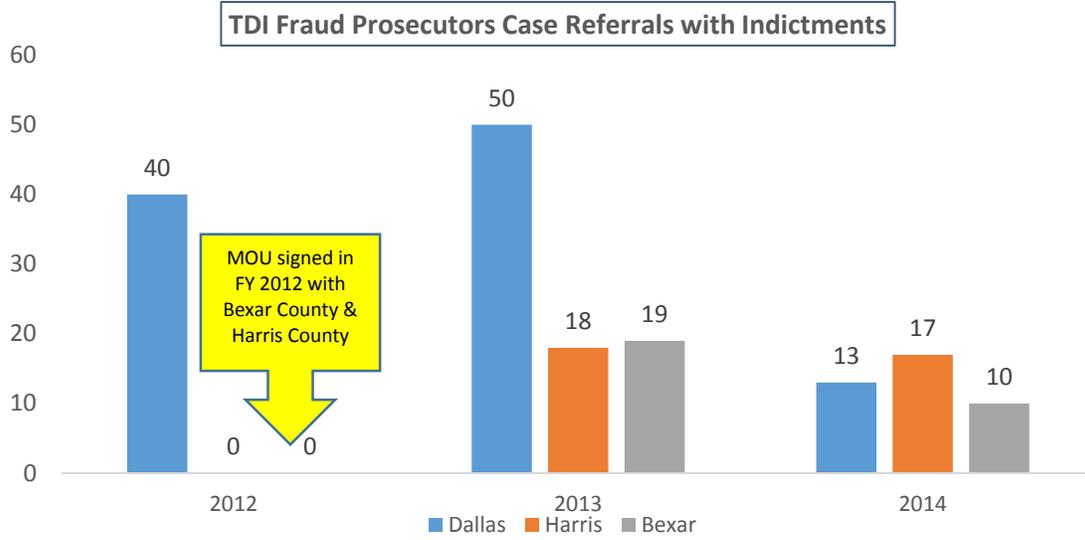
While all investigations carry some commonality in the steps needed to prove or disprove the allegations at hand, the means and methods to resolve those allegations vary by type of offense. TDI works to maintain close contact with local, state, and federal law enforcement agencies, as well as industry partners and other TDI divisions. Investigators use the agency's subpoena authority given under TIC §701.106 to gather documentary evidence and conduct interviews with victims, witnesses, and suspects. Occasionally, investigators will conduct surveillance in order to locate a person of interest in a case.

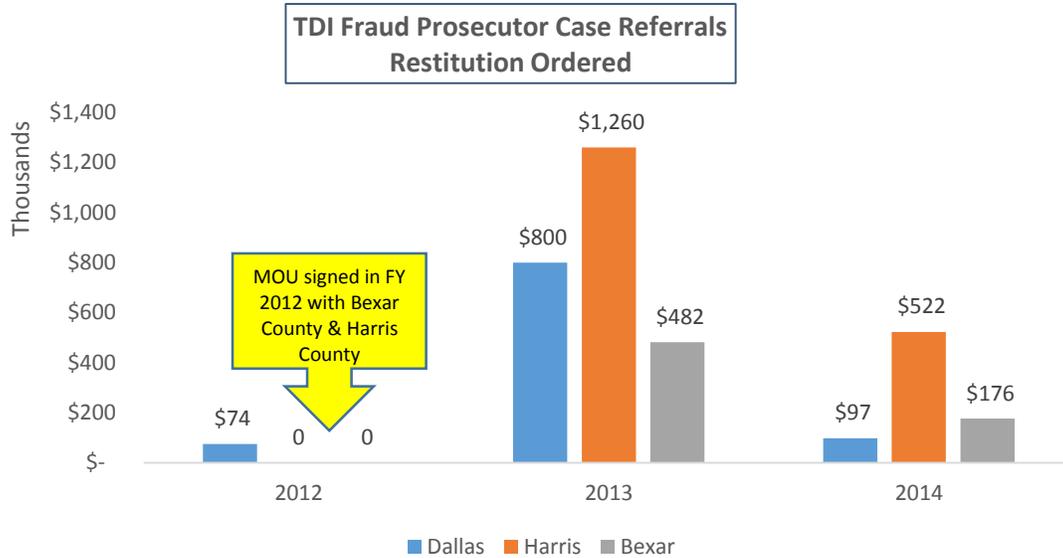
PROSECUTION TEAM

The Fraud Unit has three dedicated prosecutors who are employed by TDI but are deputized as assistant district attorneys in Dallas, Bexar, and Harris County district attorney's offices. This initiative began in 2005 through a memorandum of understanding with the Dallas County District Attorney's Office, and was so successful, that TDI expanded the program to include Harris and Bexar counties in 2012.

The prosecutors work with TDI Fraud Unit peace officers; local, state, and federal law enforcement; and the insurance industry to effectively prosecute all types of insurance crimes.







TOP 10 ADJUDICATED CASES

- 1) In U.S. Federal Court-Southern District, George Black pled guilty to mail fraud. Black, the owner of Infinity Surety, sold performance and surety bonds in several states, including Texas, without a license. The victims were oftentimes performing multi-million dollar construction projects on which Black’s purported bonds were issued. This case was a joint investigation between the TDI Fraud Unit and U.S. Postal Inspector’s Office. Black was sentenced to 30 months confinement and 36 months’ probation upon release.
- 2) In Bexar County, Jennifer Marez pled guilty to second-degree felony theft. Marez, a licensed adjustor, issued 19 fraudulent checks to herself, husband, and son from legitimate claim files from other insureds. Marez would issue the checks and deposit them into her personal account. She fraudulently issued and negotiated the checks, totaling more than \$150,000. As result of her actions, Marez received 120 months’ probation and was ordered to pay \$157,726.60 in restitution.
- 3) In Galveston County, Christopher Murphy pled guilty to third-degree felony theft. Murphy owned and operated an insurance agency in League City, Texas and received payment for insurance premiums for homeowner’s and windstorm policies. Murphy converted the money to his own personal use, and did not remit the premiums to the insurance companies or the Texas Windstorm Insurance Association. He was sentenced to 48 months confinement and was ordered to pay \$75,119 in restitution.
- 4) In Harris County, McKinley Shumate pled guilty to a first-degree felony for misapplication of fiduciary property. Shumate, a licensed agent, accepted premium payments from insureds, but failed to forward premiums to the insurance companies. Shumate also submitted premium finance agreements to premium finance companies on behalf of insureds, was funded directly from the premium finance companies, and failed to forward premium finance money to insurance companies, causing the insureds’ policies to be canceled for non-payment of premium. Shumate also submitted fraudulent premium finance agreements in name of businesses that did not exist, used false addresses and phone

numbers, and received premium finance money. Shumate was sentenced to 120 months confinement and was ordered to pay \$469,351.68 in restitution.

- 5) In Lubbock County, Jess Stephens pled guilty to a third-degree felony for misapplication of fiduciary property. Stephens, a licensed agent, owned and operated an insurance company in Lubbock, Texas. Stephens approached several apartment and condo owners offering to insure their properties. He then accepted premium money from the property owners to insure their properties. TDI's investigation revealed that the premium money paid by the property owners was converted by Stephens for his personal use. Stephens received 120 months deferred adjudication and was ordered to pay \$42,564.54 in restitution.
- 6) In Collin County, Tessa Harley pled guilty to securing execution of a document by deception, a state jail felony. Tessa's husband was involved in a motorcycle accident, and the motorcycle was deemed a total loss. During the time of the accident the policy had lapsed for non-payment of premium. Harley contacted the insurance company after the accident occurred, renewed the policy, and stated there had been no loss. Harley was paid 3 checks totaling \$19,715.00. Once the police and medical reports were received, it was determined that the loss occurred during the policy lapse and Harley filed a fraudulent claim. Harley was sentenced to 36 months deferred adjudication and was ordered to pay \$19,715.00 in restitution.
- 7) In San Saba County, Kevin Keeney pled guilty to a second-degree felony for misapplication of fiduciary property. Keeney, a licensed insurance agent, owned and operated Howell Doran Funeral Home in San Saba, Texas. Keeney sold pre-need funeral insurance policies to his clients, but did not forward the premiums to the insurer. This left his clients at risk of not having their funeral services paid at their time of their death. Keeney received 120 months deferred adjudication and was ordered to pay \$155,026.00 in restitution.
- 8) In U.S. Federal Court – Eastern District, David Diggles pled guilty to conspiracy to commit mail fraud relating to mortgage fraud schemes. Diggles, and his co-conspirators, schemed to defraud mortgage companies of millions of dollars by fraudulently representing the purchase and subsequent sales of multiple residential properties. Diggles was sentenced to 97 months confinement and was ordered to pay \$7,308,559.00 in restitution.
- 9) In Dallas County, Trent Gildon pled guilty to a first-degree felony for engaging in organized criminal activity. Gildon purchased a family coverage insurance policy and began submitting fraudulent injury claims with the carrier. Gildon submitted fictitious claims on himself, his wife, and his son. He was paid over \$42,000 by his insurer for these fictitious claims. Gildon received 84 months deferred adjudication, a \$3,000 fine, 340 hours of community service, and was ordered to pay \$42,410 in restitution.
- 10) In Dallas County, Patricia Garcia pled guilty to arson, a second-degree felony and insurance fraud, a state jail felony. Garcia arranged for an individual to stage the theft of her vehicle and have her vehicle taken and burned. Garcia subsequently made a stolen vehicle claim with her insurance company. Garcia was sentenced to 8 years confinement in the Texas Department of Corrections.

LEGISLATIVE RECOMMENDATIONS

Fraud Prevention Education Grants

Background

Insurance fraud is a multi-billion dollar problem in the U.S., and the costs of fraud are borne by policyholders through premium increases. According to the FBI, the total cost of non-health related insurance fraud is estimated to be over \$40 billion per year, costing the average U.S. family between \$400 and \$700 per year in increased premiums.

The Texas Legislature created Chapter 701 of the Texas Insurance Code to address insurance fraud and identity theft. The Fraud Unit is a law enforcement entity established under this chapter and housed at TDI to protect Texans from insurance fraud. The Fraud Unit consists of 28 investigators, including 26 commissioned peace officers. The investigators are divided into three sections that investigate (i) consumer and provider fraud, (ii) insurer fraud, and (iii) workers' compensation fraud. TDI's Fraud Unit investigates criminal cases throughout the state and when necessary, refers cases to district and county attorneys for prosecution. Additionally, the Fraud Unit employs three attorneys that serve as assistant district attorneys in the Bexar, Dallas, and Harris counties' district attorney offices.

Over the past three years, the TDI Fraud Unit has helped secure millions of dollars in restitution for insurance fraud victims in Texas. The Fraud Unit referred 188 criminal cases for prosecution in FY 2014. The cases included over \$9 million in alleged fraudulent criminal activity and as a result of their investigative and prosecutorial efforts, courts ordered more than \$24 million in restitution to be repaid to victims.

Despite these successes, insurance fraud continues to grow at an alarming rate. In FY 2014, TDI's Fraud Unit opened 728 cases, resulting in 858 active investigations, a 55 percent increase from three years ago.

There is good news, though. Education and improvements in technology have proven to be effective tools in combating insurance fraud. Public education about insurance fraud helps Texans identify fraud and protect themselves from becoming victims. Similarly, improvements in crime fighting technology help TDI's Fraud Unit and local law officials detect and investigate fraudulent insurance activity and take appropriate action quickly.

Issues

Although the TDI Fraud Unit has been successful, the growth of insurance fraud has created a situation in which the funding available to combat fraud has not kept pace with the fraudulent activity in the state. TDI's LAR requested additional Fraud Unit funding as one method for addressing this trend, but TDI is also looking for other sources of revenue to complement that request. Grants are one possible source of additional funding.

Texas law, however, does not currently permit the Fraud Unit to seek or accept grant funds. If the Fraud Unit is given authority by the Legislature to accept grants, the unit can better meet its statutory obligations. With these additional resources, the Fraud Unit can also obtain better crime fighting technologies and enhance its annual educational conference. The funds will additionally support the Fraud Unit's other educational goals, improve prevention and deterrence of fraudulent crimes, and promote public awareness about insurance crimes in Texas.

Recommendations

Add a provision to Texas Insurance Code, Chapter 701 authorizing the TDI Fraud Unit to seek grants. The new provision would prohibit receiving grants from a regulated entity.

Fraud Attorneys and Investigations

Background

Section 701.102 of the Texas Insurance Code gives TDI broad authority to investigate insurance fraud in Texas and aid in enforcing laws related to fraudulent insurance acts or an offense under Section 35.02(a) of the Texas Penal Code.

TDI's investigators and fraud attorneys help enforce insurance fraud laws by investigating complaints and providing assistance to governmental agencies prosecuting laws under the Penal Code; however, the Insurance Code only grants enforcement authority for acts investigated and prosecuted under Section 35.02(a) of the Penal Code and many times offenses are investigated and prosecuted under other sections.

Moreover, the Insurance Code has not been updated to keep up with the changes to Subsection 35.02, or reflect the increasingly sophisticated and complex fraudulent insurance activity. While TDI does not need the Penal Code reference to investigate fraudulent insurance acts, the reference to Subsection 35.02(a) creates an inconsistency between the Insurance Code and the Penal Code.

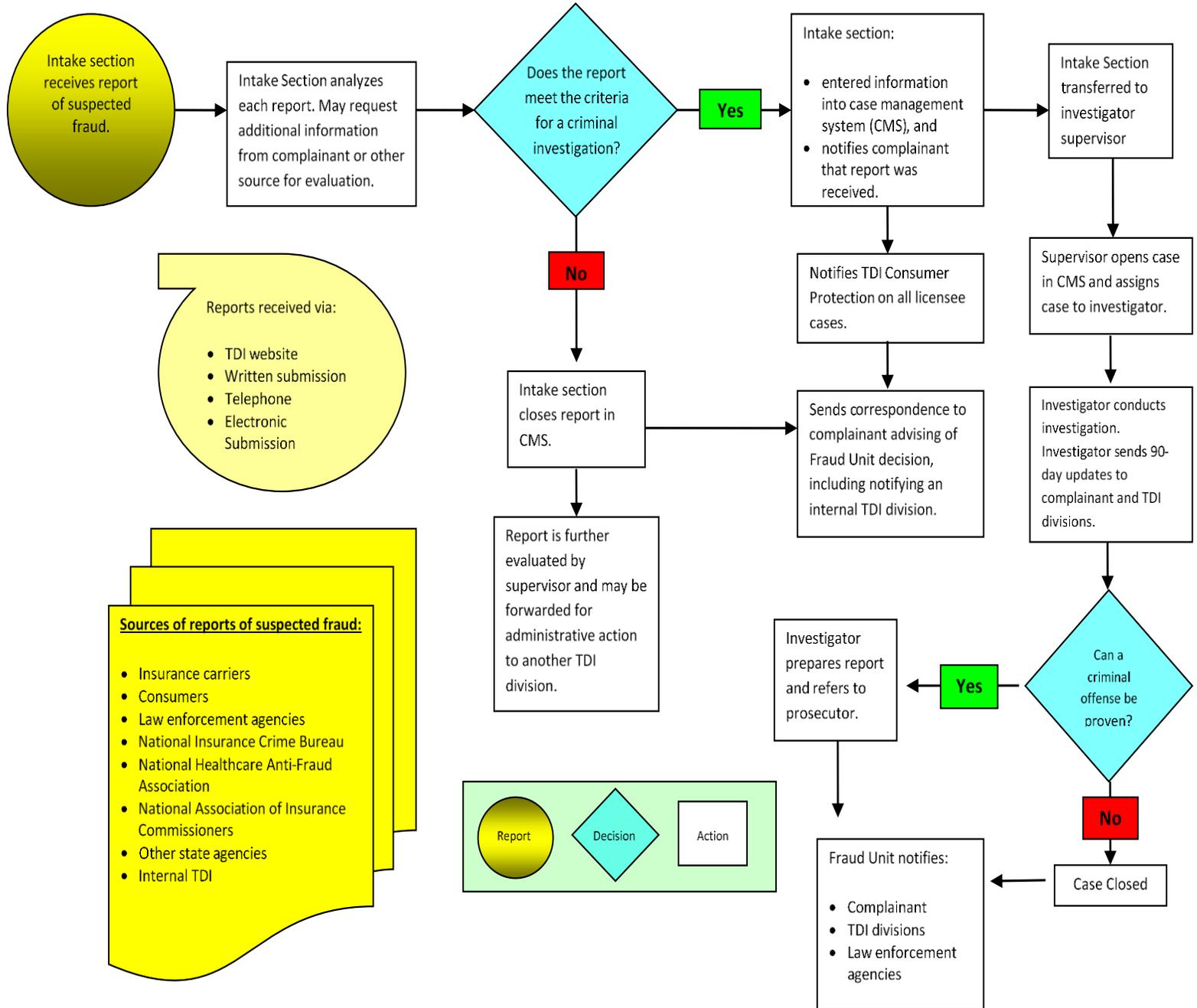
Issues

Section 701.102 of the Insurance Code allows TDI to investigate and aid in enforcing laws for all fraudulent insurance acts. Accordingly, the reference to the outdated Penal Code provision in the section is not necessary and the statute can be cleaned up by removing the outdated reference to Section 35.02 of the Penal Code. Additionally, due to the specialized nature of insurance fraud investigation and criminal prosecution, Section 701.102 needs to be cleaned up to reflect the technical and legal assistance provided throughout the investigative and prosecutorial processes.

Recommendations

Amend Insurance Code, Section 701.102 to remove the reference to Penal Code Section 35.02, and amend Subparagraph (b) to accurately reflect the commissioner's duty to aid in fraud law enforcement, including providing technical or litigation assistance to governmental agencies, under the Penal Code.

PROCESS CHART



ORGANIZATIONAL CHART

