CHAPTER 16

GENERAL REQUIREMENTS

Authority

N.J.S.A. 17:1C–6(e), 17:33A–1 et seq., 17:23–8 et seq.

Source and Effective Date

R.1991 d.102, effective January 31, 1991.
See: 22 N.J.R. 3688(b), 23 N.J.R. 702(a).

Executive Order No. 66(1978) Expiration Date

Chapter 16, General Requirements, expires on January 31, 1996.

Chapter Historical Note

Chapter 16, General Requirements, became effective February 3, 1986 (operative June 3, 1986), as R.1986 d.13, with Subchapter 1, Verification and Claim Form Statements. See: 17 N.J.R. 47(a), 18 N.J.R. 281(a). Subchapter 2, Reports to the National Automobile Theft Bureau, became effective November 20, 1989 as R.1989 d.583. See: 21 N.J.R. 2901(a), 21 N.J.R. 3668(b). Subchapter 5, Health Fraud Prevention/Detection Plans, became effective July 3, 1995 as R.1995 d.368. See: 26 N.J.R. 4882(a), 27 N.J.R. 2583(a).

Pursuant to Executive Order No. 66(1978), Chapter 16 was readopted as R.1991 d.102. See: Source and Effective Date.

See section annotations for specific rulemaking activity.

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SUBCHAPTER 1. CLAIM FORM STATEMENTS

11:16–1.1 Scope; definitions

(a) This subchapter applies to all insurers in the State of New Jersey.

(b) For the purpose of this subchapter, "insurer" means any person, corporation, association, partnership, company, fraternal benefit society, eligible unauthorized surplus lines insurer and other legal entity engaged as an indemnitor or contractor in the business of insurance or any hospital service corporation as defined at N.J.S.A. 17:48–1, medical service corporation as defined at N.J.S.A. 17:48A–1, health service corporation defined at section 1 of P.L. 1985, chap. 236, dental service corporation as defined at N.J.S.A. 17:48C–2 and dental plan organization as defined at N.J.S.A. 17:48D–2. "Insurer" shall also include any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

Amended by R.1988 d.342, effective July 18, 1988.
See: 20 N.J.R. 1062(a), 20 N.J.R. 1720(b).

11:16–1.2 Statement of liability for fraud on claim forms

Insurers shall either place on or attach to all claim forms the following warning:

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Amended by R.1988 d.342, effective July 18, 1988.
See: 20 N.J.R. 1062(a), 20 N.J.R. 1720(b).
Recodified from 11:16–1.5. Repealed 11:16–1.2 (General requirements), 11:16–1.3 (Form and content of verification), 11:16–1.4 (Notification to claimant), Appendix A (Certification/Verification), and Appendix B (Consumer Notice—Verification Required with Bills To Be Reimbursed).
Administrative Correction.
See: 25 N.J.R. 5229(b).

Case Notes

Insured's husband who provided chiropractic therapy had to verify treatment for which insured made claim. State Farm Mut. Auto. Ins. Co. v. Dalton, 234 N.J.Super. 128, 560 A.2d 683 (A.D.1989), certifica-

tion denied 117 N.J. 664, 569 A.2d 1356, certiorari denied 110 S.Ct. 1131, 493 U.S. 1078, 107 L.Ed.2d 1037.

SUBCHAPTER 2. REPORTS TO THE NATIONAL INSURANCE CRIME BUREAU

11:16–2.1 Purpose and scope

This subchapter governs the reporting of motor vehicle theft or salvage and related transactions between insurers and the National Insurance Crime Bureau ("NICB"), in implementation of P.L.1989, c.65. This subchapter applies to all insurers transacting motor vehicle insurance in New Jersey.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Insurer" means any corporation, company, partnership, association, society, order, individual or combination of individuals transacting automobile insurance in New Jersey.

"Major component part" means the engine, transmission, front end assembly, hood, doors, trunk lid, rear clip or any other part of a motor vehicle on which a unique vehicle identifying number has been placed.

"Motor vehicle" means all vehicles propelled other than by muscular power, excepting such vehicles as are run only upon rails or tracks.

11:16–2.3 NICB membership or service company requirement

(a) By December 20, 1989, every insurer transacting motor vehicle insurance in New Jersey that is not already a member or a service company of the NICB, shall make application to become either a member or a service company of the NICB. An insurer shall pay all assessments for membership or service company status as may be required by the NICB in the manner prescribed by the NICB.

(b) An insurer shall become and remain either a member or a service company of the NICB as a condition of maintaining its authorization to conduct the business of motor vehicle insurance in New Jersey.

(c) Applications for membership and service company status and related information can be secured from:

NICB
10330 South Roberts Road—3A
Palos Hills, Illinois 60465–1998

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.4 Insurer reporting requirements

(a) Insurers shall report to the NICB all motor vehicles involved in losses as follows:

1. All thefts of a motor vehicle, or any of its major component parts, shall be reported within two working days from the receipt of sufficient information from the insured. The NICB shall acknowledge the receipt of each theft report received from an insurer within 10 working days. If the insurer has not received any acknowledgment or communication from the NICB within 10 working days following its submission to the NICB of the report, the insurer shall immediately communicate with the NICB to determine the status of its report.

2. All losses involving motor vehicle salvage, however sustained, including salvage retained by either an insured or a third party claimant, shall be reported to the NICB within five working days after the sale of salvage; or, if the insured is permitted to retain salvage, within five working days after the date of loss payment.

3. All insurers required to submit reports to the NICB in compliance with this subchapter shall be bound by all of the reporting requirements of the NICB.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.5 Insurer cooperation with NICB

Insurers shall cooperate with the NICB and shall release information in their possession to the NICB upon its reasonable request.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.6 NICB cooperation with insurers

The NICB shall cooperate with insurers in the resolution of errors and the investigation of claims suspected to be fraudulent.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.7 Deferred claim processing and payment

(a) Notwithstanding any provision of Title 11 of the New Jersey Administrative Code to the contrary, an insurer shall defer the processing and payment of a claim filed under comprehensive or other coverage in accordance with the following:

1. No insurer shall pay a claim filed by an insured under comprehensive or other coverage for the theft of a motor vehicle or its major component parts unless said claim has first been reported to and acknowledged by the NICB.

2. An insurer shall defer the payment of a claim for five calendar days following receipt of the acknowledgment from the NICB of the insurer's report. If no further communication is received from the NICB during this five-day period indicating unresolved questionable circumstances, the insurer shall continue with the processing of the claim in accordance with the provisions of this section and other provisions of Title 11 of the New Jersey Administrative Code.

3. If the NICB indicates in its response to the insurer that coverage is in effect by more than one insurer for the same motor vehicle or that the motor vehicle has been previously reported as stolen and unrecovered, or that previous claims on the vehicle have been reported, the insurer shall promptly investigate and resolve such discrepancy.

4. If the NICB discovers an erroneous vehicle identification number (VIN) and the NICB is unable to clear up such discrepancy internally, the NICB shall send a questionnaire to the insurer. This questionnaire shall be returned within five working days of receipt by the insurer. If the NICB and insurer are unsuccessful, after due diligence, in resolving the VIN error after a 30–day period from the date of the receipt by the insurer of sufficient information from the insured, the insurer shall proceed with the processing of the loss claim.

5. If the NICB indicates in its response to the insurer or the insurer finds that it has reasonable cause to believe that the loss may have been caused by the criminal or fraudulent act of any person, the insurer shall suspend the processing of the claim and promptly begin an investigation. The insurer shall promptly provide such information to the NICB and shall cooperate fully with the NICB in its investigation of criminal or fraudulent acts.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.8 NICB record retention

Such reports as may be required to be filed with the NICB by an insurer pursuant to P.L. 1989, c.65, this subchapter and the operating procedures of the NICB, shall be maintained by the NICB for at least a period of five years from the date of entry into the NICB system, except that in the case of motor vehicle salvage, such reports shall be maintained for a period of at least two years from such entry.

Amended by R.1993 d.48, effective January 19, 1993.
See: 24 N.J.R. 3606(a), 25 N.J.R. 311(a).
National Automobile Theft Bureau changed to National Insurance Crime Bureau.

11:16–2.9 Penalties

Failure of an insurer to abide by the requirements of this subchapter may lead to the imposition of sanctions or penalties as provided by law.

SUBCHAPTER 3. (RESERVED)

SUBCHAPTER 4. FRAUD AND THEFT PREVENTION/DETECTION PLANS

Authority

N.J.S.A. 17:33B–46 and 17:1C–6(e).

Source and Effective Date

R.1992 d.190, effective April 20, 1992.
See: 23 N.J.R. 3236(a), 24 N.J.R. 1505(a).

11:16–4.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the standards for a fraud and theft prevention/detection plan to be filed for approval pursuant to N.J.S.A. 17:33B–46, by insurers which transact business of private passenger automobile insurance in this State.

(b) These rules apply to all insurers that transact the business of private passenger automobile insurance in New Jersey, including both personal lines and commercial lines of insurance.

11:16–4.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Eligible person" means an individual that meets the qualifications set forth in N.J.A.C. 11:3–34.

"Fraud and theft prevention/detection plan" or "plan" means the insurer's plan for the prevention of fraudulent

insurance applications and claims and for the prevention of automobile theft.

"IFP" means the New Jersey Division of Insurance Fraud Prevention established by N.J.S.A. 17:33A–8.

"Insurer" means any person authorized to transact the business of private passenger automobile insurance in New Jersey, whether in accordance with a personal lines or commercial lines rating system, and includes a group of affiliated companies.

"Special investigations unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in N.J.A.C. 11:16–4.4(a).

11:16–4.3 General requirements and filing format

(a) All insurers which transact the business of private passenger automobile insurance in New Jersey shall file for approval a fraud and theft prevention/detection plan in accordance with N.J.S.A. 17:33B–46 and this subchapter. No insurer shall use or implement any plan not filed and approved as set forth herein.

(b) Insurers shall submit their Plan on 8½ by 11 inch paper using one side of the page. The first page shall show the filer's company name, the filer's identifying number for this filing, National Association of Insurance Commissioners (NAIC) company number(s), and NAIC group number.

(c) Insurers shall file their Plan with the Department of Insurance at the following address:

Anti–Fraud/Anti–Theft Plans
New Jersey Department of Insurance
Division of Insurance Fraud Prevention
CN–324
Trenton, NJ 08625–0324

11:16–4.4 Elements of fraud and theft prevention/detection plan

(a) Except for insurers which insure less than 1,000 New Jersey automobiles, the plan filed in accordance with this subchapter shall establish a full-time special investigations unit.

1. The SIU shall conduct investigations on claims referred by the claim personnel whenever the adjuster or processor suspects fraud.

i. SIU investigators shall be a separate unit from the claims adjusting function.

ii. Insurers shall employ at least one SIU investigator for each 30,000 New Jersey Automobile policies serviced.

2. In addition to actually performing investigations, the duties of an SIU investigator shall include, but not be limited to, the following:

i. Providing liaison with the IFD and law enforcement personnel;

ii. Providing in-service training to claims personnel;

iii. Maintaining a data base on fraudulent claims;

iv. Informing insurance underwriters of ineligible risks by reason of prior fraudulent activities;

v. Identifying persons and organizations that are involved in suspicious claim activity; and

vi. Initiating civil or criminal actions based on their investigations as authorized by the insurer.

3. An SIU investigator shall be qualified by education and/or experience, which shall include either a college degree and one to three years of insurance claim investigation experience or five years of law enforcement investigation experience involving economic crimes.

(b) Except for insurers which insure less than 1,000 New Jersey automobiles, the plan shall provide fraud education for claims personnel which shall contain a detailed and comprehensive program of insurance fraud awareness and education to prepare claims personnel for fraud detection.

1. The program shall consist of formal, specialized training for adjustors, claims processors and investigators.

2. Training shall be provided in the following specialties: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, and bodily injury liability claim investigation.

(c) Except for insurers which insure less than 1,000 New Jersey automobiles, the Plan shall provide a Fraud Detection Procedures Manual and disseminate it to all claims personnel for the handling of suspicious automobile insurance claims. The Fraud Detection and Procedures Manual shall include, at a minimum, the following:

1. Information for claims personnel and SIU investigators regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Fraud Prevention Act;

2. The process to be employed when a suspicious claim is identified;

3. The "fraud profiles" or indicators for automobile theft, automobile physical damage and bodily injury claims fraud;

4. The duties and functions of the SIU;

5. The procedure for referral of a claim to the SIU; and

6. The post-referral procedure for communication between the claims unit and the SIU.

(d) The plan shall provide for underwriting investigations to verify that the insured is an eligible person and is properly rated within 60 days of receipt of the application. These underwriting investigations shall verify the insured's residency provided by the insured on his or her application for insurance. The plan may provide that these investigations are generally done "in-house" by telephone and by using information from the New Jersey Division of Motor Vehicle Services (or similar agencies in other states) and prior insurers.

1. The Plan shall provide that the insurer shall notify the IFD of an ineligible insured based on residency pursuant to N.J.S.A. 17:33A–9a of the Fraud Prevention Act.

(e) The plan shall provide that all suspicious claims be referred to the IFD as soon as practical on the prescribed reporting form (as set forth in Appendix A, incorporated herein by reference), and thereafter cooperate with the IFD investigation. The IFD will assist insurers by providing necessary information, such as fraud profiles or indicators.

(f) The insurer shall permit the IFD access to its offices upon reasonable notice and at reasonable hours to conduct on site review of the insurer's compliance with its fraud prevention plan.

(g) The plan may include such other items as the insurer may wish to provide.

11:16–4.5 Record retention

(a) Insurers shall maintain up-to-date and accurate records on their fraud and theft prevention/detection plan, which shall at minimum include those necessary to prepare the report required in (b) below.

(b) By April 1, insurers shall file their annual report for the prior calendar year with the Commissioner beginning January 1, 1993. For the 1991 calendar year insurers are permitted to submit their reports by June 1, 1992. Such report shall include:

1. The number of claims processed for the preceding calendar year;

2. The number of suspected fraudulent claims referred to the SIU unit;

3. The number of claims denied for fraud (based on a SIU investigation);

4. The dollar amount spent implementing a fraud prevention plan;

5. The dollar amount of claims denied for fraud (based on a SIU investigation); and

6. The dollar amount of restitution obtained as the result of successful fraud investigations.

(c) The report required by (b) above shall be sent to the following address:

New Jersey Department of Insurance
Division of Fraud Prevention
CN–324
Trenton, NJ 08625–0324

11:16–4.6 Approval and filing of fraud and theft prevention/detection plans

(a) An insurer's fraud and theft prevention/detection plan shall be deemed approved by the Commissioner if not affirmatively approved or disapproved by the Commissioner within 90 days of the date of filing.

(b) During the 90 day approval period, the Commissioner may request such amendments to the Plan as he or she deems necessary.

(c) An insurer may submit amendments to its plan. Any amendments to a plan filed with the Commissioner shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing.

11:16–4.7 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as provided by N.J.S.A. 17:33B–46c.

SUBCHAPTER 5. HEALTH FRAUD PREVENTION/DETECTION PLANS

Authority

N.J.S.A. 17:33A–15 and 17:1C–6(e).

Source and Effective Date

R.1995 d.368, effective July 3, 1995.
See: 26 N.J.R. 4882(a) and 27 N.J.R. 2583(a).

11:16–5.1 Purpose and scope

(a) The purpose of this subchapter is to set forth standards and approval procedures whereby insurers shall file health fraud prevention/detection plans with the Commissioner pursuant to N.J.S.A. 17:33A–15.

(b) This subchapter shall apply to all insurers as defined at N.J.A.C. 11:16–5.2 transacting the business of health insurance in this State.

11:16–5.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Contract" means any plan, policy or other agreement for health insurance benefits delivered or issued for delivery in this State.

"Department" means the New Jersey Department of Insurance.

"Health fraud prevention detection plan" or "plan" means the health insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include administrative services only (ASO) contracts, workers' compensation coverage, or stop-loss coverage.

"IFD" means the New Jersey Division of Insurance Fraud Prevention established by N.J.S.A. 17:33A–8.

"Insured lives" means the actual number of New Jersey residents entitled to receive benefits under a contract delivered or issued for delivery in this State.

"Insurer" means any person or entity authorized to transact the business of health insurance in this State, including insurance companies operating pursuant to N.J.S.A. 17:17–1 et seq. and 17B:17–1 et seq.; medical service corporations operating pursuant to N.J.S.A. 17:48A–1 et seq.; hospital service corporations operating pursuant to N.J.S.A. 17:48–1 et seq., health service corporations operating pursuant to N.J.S.A. 17:48E–1 et seq.; dental service corporations operating pursuant to N.J.S.A. 17:48C–1 et seq., and dental plan organizations operating pursuant to N.J.S.A. 17:48D–1 et seq.

"Special investigation unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in this subchapter.

"Stop–loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified per person retention limits and/or aggregate retention limits, wherein neither the employees nor other individuals are third party beneficiaries under the policy, contract or plan.

11:16–5.3 General requirements

All insurers transacting the business of health insurance in this State shall file for approval with the Commissioner a health fraud prevention/detection plan pursuant to N.J.S.A. 17:33A–15 and this subchapter. No insurer shall use or implement any plan not filed and approved as set forth in this subchapter.

11:16–5.4 Standards for approval of health fraud prevention/detection plans

(a) For purposes of obtaining the Commissioner's approval, an insurer's health fraud prevention/detection plan filed with the Department pursuant to this subchapter shall meet the criteria set forth in this section.

(b) Except for insurers which insure less than 10,000 lives, the plan shall establish a full-time special investigations unit (SIU).

1. The SIU shall be a separate unit from the insurer's claims adjusting function.

2. Insurers shall employ the following number of SIU investigators:

i. Insurers offering comprehensive benefits contracts shall employ at least one SIU investigator for every 60,000 insured lives.

ii. Insurers offering limited benefits contracts shall employ at least one SIU investigator for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long–term care; medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any supplemental hospital indemnity benefits.

3. An SIU investigator shall be qualified by education and/or experience, which shall include a bachelor's degree or either four years of claims investigation experience or five years of professional investigation experience involving economic or insurance related matters.

i. An individual currently employed by an insurer as an investigator in an SIU which has been established as a separate unit from the insurer's claims adjusting function as of July 3, 1995, may continue to be employed in that capacity without meeting the criteria set forth in (b)3 above.

4. The SIU shall conduct investigations on claims referred by the insurer's claim personnel whenever fraud is suspected.

5. In addition to actually performing investigations, the duties of an SIU investigator shall include, but not be limited to, the following:

i. Providing liaison with the IFD and law enforcement personnel;

ii. Providing in-service training to claims personnel;

iii. Maintaining a data base on fraudulent claims;

iv. Identifying persons and organizations that are involved in suspicious claim activity; and

v. Initiating civil or criminal actions based on their investigations as authorized by the insurer.

(c) Except for insurers which insure less than 10,000 lives, the plan shall provide health fraud education for claims personnel which shall contain a detailed and comprehensive program of health insurance fraud awareness and training to prepare claims personnel for health fraud detection in the area(s) of health insurance benefits provided by the insurer.

1. The program shall consist of formal, specialized training for adjusters, claims processors and investigators.

2. Comprehensive training shall be provided in all areas of health insurance fraud, which may include, but not be limited to the following areas as appropriate: overcharging and overpayment detection; claims processing guidelines; medical coding; duplicate bills; excessive charges; unnecessary services or supplies; overutilization; services never rendered; miscoded or misleading claim information; hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement; abusive or fraudulent referrals; statutory requirements dealing with fraud referrals.

(d) Except for insurers which insure less than 10,000 lives, the plan shall provide a Health Fraud Detection Procedures Manual and disseminate it to, or make it available to, as appropriate, all claims personnel for the handling of suspicious health insurance claims. The Health Fraud Detection Procedures Manual shall include the following:

1. Information for claims personnel and SIU investigators regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Insurance Fraud Prevention Act;

2. The process to be employed when a suspicious claim is identified;

3. The "fraud profiles" or indicators for health fraud;

4. The duties and functions of the SIU;

5. The procedure for referral of a claim to the SIU; and

6. The post-referral procedure for communication between the claims unit and the SIU.

(e) The plan shall provide that all suspicious claims be referred to the IFD as soon as practical on the prescribed reporting form (as set forth in N.J.A.C. 11:16–4 Appendix A), and that the SIU thereafter cooperate with the IFD investigation. The IFD will assist insurers by providing necessary information, such as fraud profiles or indicators.

(f) The insurer shall permit the IFD access to its offices upon reasonable notice and at reasonable hours to conduct on site review of the insurer's compliance with its fraud prevention/detection health plan.

(g) The plan may include such other items the insurer determines to be reasonable and appropriate.

(h) All information included in an in surer's plan submitted to the IFD pursuant to this subchapter shall be confidential and not subject to public disclosure or inspection.

11:16–5.5 Filing and approval procedures for health fraud prevention/detection plans

(a) For purposes of utilizing or implementing a health fraud detection/prevention plan, insurers shall submit their plan for approval by the Commissioner to the following address:

Health Anti–Fraud Plans
New Jersey Department of Insurance
Division of Insurance Fraud Prevention
CN 324
Trenton, NJ 08625–0324

1. Insurers currently transacting the business of health insurance in this State shall file their plan with the Commissioner no later than October 31, 1995.

2. Insurers transacting the business of health insurance in this State subsequent to July 3, 1995 shall file their plan with the Commissioner no later than 120 days after the date the insurer commences business in this State.

(b) Insurers shall submit a proposed plan on 8½ by 11 inch paper using one side of the page. The first page shall include the insurer's company name, identifying number for this filing, National Association of Insurance Commissioners (NAIC) company number(s), and NAIC group number.

(c) An insurer's proposed plan submitted pursuant to this section shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing with the Department.

(d) During the 90–day approval period, the Commissioner may request in writing from the insurer such amendments to the proposed plan as are deemed necessary.

(e) Any amendments to a plan submitted by an insurer to the Commissioner pursuant to (d) above shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing with the Department.

11:16–5.6 Record retention and reporting

(a) Insurers shall maintain up-to-date and accurate records of their health fraud prevention/detection plan which shall at a minimum include the information necessary to complete the annual plan report described in (b) below.

(b) Insurers shall annually file a plan report for the prior calendar year with the Commissioner on or before April 1 of each year, beginning 1997 for the calendar year 1996. The report shall include the following:

1. The number of claims for the preceding calendar year;

2. The number of suspected fraudulent claims referred to the SIU;

3. The number of claims denied for fraud (based on an SIU investigation);

4. The dollar amount of the claims denied for fraud (based on an SIU investigation);

5. The dollar amount expended in implementing a health fraud prevention detection plan; and

6. The dollar amount of restitution obtained as the result of successful fraud investigations.

(c) The report described in (b) above shall be submitted by the insurer to the Commissioner at the following address:

New Jersey Department of Insurance
Division of Fraud Prevention
CN 324
Trenton, NJ 08625–0324

11:16–5.7 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as provided by N.J.S.A. 17:33A–15.

APPENDIX A

IFD Case #_____

State of New Jersey
Insurance Fraud Division
CN 324
Trenton, New Jersey 08625

SIU Yes_____No_____

JUA Yes_____No_____

Date Reported:_____ Company:_____ NAIC #_____

Contact Person:_____ Address:_____

Phone #:_____ City/State/Zip:_____

Claim #_____ D/L_____ Amount or Reserve_____ STATUS Pend Denied Paid Date:

AUTO TYPE: | AUTO THEFT PROP. DAMAGE | PIP COLL. | COMP. MISC.

TYPE OF CLAIM:_____

HOMEOWNERS TYPE: | COMMERCIAL TYPE: | LIFE & HEALTH TYPE: | OTHER TYPE:

Location of Incident: Loc. of 1st Notification: i.e. Claims Office Agt.

Name of Insured(s) Address City/State Phone

Subject Name Relationship to Insured(s) i.e., doctor, lawyer, claimant, etc. Phone

Address DOB Employer

City/State/Zip D/L #-State SS #

Name Phone

Address DOB Employer

City/State/Zip D/L #-State SS #

Reasons for Suspicions/Describe Facts identify violations of NJ Insurance Fraud Prevention Act (MUST BE COMPLETED)

Vehicle Year Make Model Color Reg. # State Vin. #

(1)_____

(2)_____

Referral to any other agency i.e. law enforcement, NATB, Professional Boards, etc.

Name Date of Referral Phone #

REMARKS: