(f) All information included in an insurer's plan submitted to the DAFC pursuant to this subchapter or any other information including training programs submitted to DAFC pursuant to this subchapter shall be confidential and not subject to public disclosure or inspection.

11:16-6.10 Penalties

Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as prescribed by law.

11:16-6.11 Transition

No later than August 5, 2000, all insurers shall file with the Department of a new fraud prevention and detection plan and manual in conformance with these rules.

11:16–6.12 Confidential records and information

(a) All information and materials in the possession of the Office of Insurance Fraud Prosecutor concerning the possibility of the existence or occurrence of insurance fraud or related criminal activities are confidential and privileged against disclosure, and shall not be deemed public records, so as to protect the public interest in the prosecution of insurance fraud, including protecting witness security, the State's relationship with informants and witnesses, the privacy interests of persons investigated by OIFP where no fraud has been proven and other confidential relationships.

(b) The confidentiality which extends to information and materials possessed by the Office of Insurance Fraud Prosecutor with respect to the existence or occurrence of insurance fraud or related criminal activities extends to all papers, documents, reports, evidence and databases, such as investigative reports, referrals, reports or notifications of suspicious claims or applications or suspected insurance fraud, computer maintained databases of such investigative information, and such other materials and information as the Insurance Fraud Prosecutor, on the basis of his experience and exercise of judgment, believes must be kept confidential in order to ensure the orderly investigation and prosecution of insurance fraud.

(c) Confidentiality of the information and materials in the possession of OIFP shall not preclude OIFP from fulfilling its statutory obligations of working with other law enforcement agencies, the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police and such local government units as may be necessary or practicable and of coordinating and providing information to and among referring entities on pending cases of suspected insurance fraud, where such action would serve the public interest in facilitating the investigation or prosecution of insurance fraud.

APPENDIX

	For OIFP use only:
FP-1A (01/01)	OIFP Case #/
OF THE STATE STATE STATE STATE STATE STATE	Intake #
Office of Insurance Fraud Prosecutor P.O. Box 094 Trenton, NJ 08625	Investigator
INSURANCE CO.	
ADDRESS	
TELEDHONE	
TELEPHONE CONTACT PERSON	
E-MAIL ADDRESS	
	– <i>STATUS</i> (Check appropriate box)
TYPE OF COVERAGE (Check appropriate box) LIFE W.C. AUTO HOME COMM OTHER	PENDING PAID - IN FULL DENIED PAID - IN PART AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR IN PAR THE DOLLAR AMOUNT OF THE PENDING OR DENIE CLAIM: \$
INSURED/SUBJECT	
LAST FIRST	MIDDLE
LAST FIRST FIRST CITY	STATE-ZIP
LAST FIRST FIRST CITY	STATE-ZIP Z PH D.O.B
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES NO	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES NO IF YES, LIST OTHER RELATED CLAIM NUM	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES NO IF YES, LIST OTHER RELATED CLAIM NUM	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES NO IF YES, LIST OTHER RELATED CLAIM NUM	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES □ NO □ IF YES, LIST OTHER RELATED CLAIM NUM ATTACH COPIES OF OTHER REFERRALS, IF AI 	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES NO IF YES, LIST OTHER RELATED CLAIM NUM	STATE-ZIP
LAST FIRST STREET CITY HOME PH WORK S.S. # D.L. # DOES THIS CLAIM FORM PART OF A PATTERN OF PC YES □ NO □ IF YES, LIST OTHER RELATED CLAIM NUM ATTACH COPIES OF OTHER REFERRALS, IF AI 	STATE-ZIP

PART II

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX OR BOXES)

- **a(1) presents false information**: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)
- □ **a(2)** makes a false statement: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)
- □ **a(3) conceals relevant information:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)
- **b** conspires with another: ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).
- □ c knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED______).
- □ **d involvement of hospital:** AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- **e** using or being a runner: A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:
 - ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
 - ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
 - ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

<u>NOTE:</u> IF THE INSURANCE COMPANY PAID MONEY FOR THE CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS REFERRAL FORM.

I. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THAT CLAIMANT DID AN FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOV (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT ISINOT ACCEPTABLE WITHOUT SPECIFIC DESIGNAT OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*	FI	RAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOV (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS <u>NO</u> T ACCEPTABLE WITHOUT SPECIFIC DESIGNAT OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)* LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATIC DITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE
 OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURAR RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)* 3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCE INDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATION MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION' NOT MERELY A MISTAKE).* 4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAY KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER: 		MITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURA
 OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURAR RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)* 3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCE INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCE (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEME OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATION MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION 'N NOT MERELY A MISTAKE).* 4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAY KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER: 		MITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURA
 INDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEM OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATION MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION 'N NOT MERELY A MISTAKE).* 4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAY KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER: 		
 INDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEM OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATION MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION 'N NOT MERELY A MISTAKE).* 4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAY KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER: 		
KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER:		NDICATED IN PARAGRAPH 1. ABOVE: (FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEM OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATI MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION
KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN HIS EMPLOYER:		
	K	NOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AN

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please completed the attached Certification of Custodian of Records.

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

Dated:

-

<u>COMPLETE THE FC</u>	LLOWING ONLY IF THERE ARE ADDITION	NAL SUBJECTS OF THE INVESTIGATION
IN	FORMATION REGARDING ANY ADDITIO	NAL INSUREDS:
LAST	FIRST	MIDDLE
STREET	СІТҮ	STATE/ZIP
HOME PH.	WORK PH	S.S. #
D.L. #		
CLAIMANT #1 (IF OTH	ER THAN INSURED/SUBJECT)	
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН.	WORK PH	S.S. #
D.L. #		
CLAIMANT #2		
	FIRST	
	CITY	
	WORK PH	S.S. #
D.L. #		
CLAIMANT #3		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
HOME PH.	WORK PH	S.S. #
D.L. #		

1

c

PART V COMPLETE THE FOLLOWING ONLY IF LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION

PROFESSIONAL SERVICE PROVI SHOP / OTHER OTHERWISE SPECIFY TYPE OF SER	(CIRCLE APPLICABLE				
LAST	FIRST		MIDDLE		LIC #
EMPLOYER			PHONE #		
ADDRESS	5		TAX ID #		
ADDRESS (CONT.)	D.C).В		_ S.S. # _	
PROFESSIONAL SERVICE PROVI SHOP / OTHER OTHERWISE SPECIFY TYPE OF SER LAST	(CIRCLE APPLICABLE VICE PROVIDER)	PROFI	ESSIONAL LICEN	ISE OR O	CCUPATION TYPE OR
EMPLOYER					
ADDRESS			TAX ID #		
ADDRESS (CONT.)					
PROFESSIONAL SERVICE PROVISIONAL SERVICE PROVISIONAL SERVICE PROVIDENT OTHER	(CIRCLE APPLICABLE VICE PROVIDER) FIRST	PROFI	MIDDLE	ise or o	CCUPATION TYPE OR
ADDRESS			TAX ID #		
ADDRESS (CONT.)	D.C).B		S.S. #	
PROFESSIONAL SERVICE PROVI SHOP / OTHER OTHERWISE SPECIFY TYPE OF SER LAST EMPLOYER ADDRESS	(CIRCLE APPLICABLE VICE PROVIDER) FIRST	PROF	MIDDLE PHONE # TAX ID #	ISE OR O	CCUPATION TYPE OR
ADDRESS (CONT.)	D.C).B		S.S. #	i

For OIFP use only:

APPLICAT	TION FRAUD REFERRAL	FORM
OIFP-1B	(01/01)	

	State of New Jersey Office of Insurance Fraud Prose P.O. Box 094 Trenton, NJ 08625	ecutor	Intake #	//
RT I				
INSURANCE CO.		DAT	E REPORTED	
<u>TYPE OF COVERAG</u>	<u>E</u> (Check appropriate box)		cate as appropriate)	
LIFE I W. AUTO I HO COMM. I OT	C. DME THER	AMO APP NOI	MIUM ADJUSTED DUNT \$ LICATION DECLINE N-RENEWAL	D
INSURED/SUBJECT:		CAN	ICELED	
	······································	FIRST		MIDDLE
	1			
<u>PRODUCER :</u> AC	GENCY NAME			
	: LAST			
				STATE/ZIP
WORK PH.	LICEN	NSE #		
PART II PROVISION (CHECK A)	N(S) OF N.J.S.A. 17:331-4 RELAT PPROPRIATE BOX)	ING TO APPLICATIO	NS THAT MAY HAV	E BEEN VIOLATED:
□ a(4 AN)(a) - rate evader: PREPARES OR MA NY INSURANCE COMPANY OR P	AKES ANY WRITTEN C RODUCER FOR THE PU	OR ORAL STATEMENT	', INTENDED TO BE PRESENTE

- POLICY, THAT THE PERSON TO BE INSURED MAINTAINS A PRINCIPLE RESIDENCE IN THIS STATE, WHEN IN FACT, THAT PERSON PRINCIPALLY RESIDES IN A STATE OTHER THAN THIS STATE. N.J.S.A. 17:33A-4A(4)(A)
- □ a(4)(b) makes a false statement: PREPARES FOR MAKES ANY WRITTEN OR ORAL STATEMENT, INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THE PURPOSE OF OBTAINING AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT FOR THING MATERIAL TO AN INSURANCE APPLICATION FOR CONTRACT. N.J.S.A. 1733A-4A(4)(B)

January 2001

- a(5) conceals relevant evidence of application fraud: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE ANY EVIDENCE, WHICH MAY BE RELEVANT TO A FINDING THAT A VIOLATION OF N.J.S.A. 17:33A-4A(4) HAS OCCURRED. N.J.S.A. 17:33A-4A(5)
 - □ a(5)(b)-conspires with another: KNOWINGLY ASSISTS, CONSPIRES WITH, OR URGES A PERSON TO VIOLATE ANY PROVISION OF THIS ACT. N.J.S.A. 17:33A-4B. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE APPLICANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE. (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENTS IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH DOCUMENTS EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, THE APPLICATION AND ANY DOCUMENT SUBMITTED IN SUPPORT OF THE APPLICATION)^{*}

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED INSURANCE PRODUCER (AGENT) OR INSURANCE AGENCY EMPLOYEE KNOWINGLY PARTICIPATED IN THE APPLICATION FRAUD, PROVIDE THE NAME AND ADDRESS OF THIS PERSON.*

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

16-17

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

Dated:

SUSPICIOUS CLAIM/APPLICATION NOTIFICATION FORM

FP-2 (01/01)		For OIFP use only:
State of New Jersey Office of Insurance Fraud Prose P.O. Box 094 Trenton, NJ 08625	ecutor	OIFP Case #///////_
RT I		
INSURANCE CO.		NAIC #
ADDRESS		D.O.L.
		CLAIM #
TELEPHONE		POLICY #
CONTACT PERSON		
E-MAIL ADDRESS		
TYPE OF COVERAGE (Check appropriate box) LIFE W.C. AUTO HOME COMM OTHER		STATUS (Check appropriate box) PENDING PAID - IN FULL DENIED PAID - IN PART AMOUNT PD \$ DATE/RANGE IF PENDING OR DENIED, EITHER IN FULL OR IN PART THE DOLLAR AMOUNT OF THE PENDING OR DENIED CLAIM: \$
INSURED/SUBJECT		
LAST	FIRST	MIDDLE
STREET	CITY	STATE-ZIP
НОМЕРН	WORK PH.	D.O.B.
SS #	D.L. #	

PART III

INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE APPLICANT/CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE:

(MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

INDICATE ALL STATEMENTS MADE WHICH YOU SUSPECT TO BE FALSE AND IDENTIFY ANY RELEVANT INFORMATION OMITTED. IDENTIFY ANY DOCUMENTS WHICH INCLUDE THE FALSE INFORMATION OR WHICH OMITTED RELEVANT INFORMATION:*

INDICATE ANY FACTS AND CIRCUMSTANCES WHICH PROVIDE ANY BASIS TO SUSPECT THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:*

NOTE: IF THE INSURANCE COMPANY PAID MONEY FOR A CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS NOTIFICATION FORM.

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

PART II

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX OR BOXES)

- □ a(1) presents false information: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)
- □ **a(2)** makes a false statement: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)
- □ **a(3)** conceals relevant information: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)
- **b** conspires with another: ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).
- c knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).
- □ **d involvement of hospital**: AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- **e** using or being a runner: A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:
 - ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
 - ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
 - ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.
- □ **a(4)(a) rate evader:** PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT, INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THE PURPOSE OF OBTAINING A MOTOR VEHICLE INSURANCE POLICY, THAT THE PERSON TO BE INSURED MAINTAINS A PRINCIPAL RESIDENCE IN THIS STATE, WHEN IN FACT, THAT PERSON'S PRINCIPAL RESIDENCE IS IN A STATE OTHER THAN THIS STATE. N.J.S.A. 17:33A-4A(4)(A)
- □ a(4)(b) makes a false statement (application): PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT, INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THE PURPOSE OF OBTAINING AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO AN INSURANCE APPLICATION OR CONTRACT. N.J.S.A. 17:33A-4A(4)(B)
- □ **a(5) conceals relevant evidence of application fraud:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE ANY EVIDENCE, WHICH MAY BE RELEVANT TO A FINDING THAT A VIOLATION OF N.J.S.A. 17:33A-4A(4) HAS OCCURRED. N.J.S.A. 17:33A-4A(5).

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

Dated:

V <u>COMPLETE THE</u>	FOLLOWING ONLY IF THERE ARE ADDITION	NAL SUBJECTS OF THE INVESTIGATION
	INFORMATION REGARDING ANY ADDITIO	NAL INSUREDS:
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH	S.S. #
D.L. #		
CLAIMANT #1 (IF O	THER THAN INSURED/SUBJECT)	
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH.	S.S. #
D.L. #		
CLAIMANT #2		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
HOME PH	WORK PH	S.S. #
D.L. #		
CLAIMANT #3		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
HOME PH.	WORK PH	S.S. #
D.L. #		

_

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LAST	FIRST		MIDDLE	LIC #
EMPLOYER				
ADDRESS				
ADDRESS (CONT.)				
PROFESSIONAL SERVICE SHOP / OTHER OTHERWISE SPECIFY TYPE O	(CIRCL		,	
LAST	FIRST		MIDDLE	LIC #
EMPLOYER			_ PHONE #	
ADDRESS				
ADDRESS (CONT.) PROFESSIONAL SERVICE SHOP / OTHER OTHERWISE SPECIFY TYPE (PROVIDER TYPE: ATTO (Circl	DRNEY / PRODUCE	r / medical s	SERVICE PROVIDER
PROFESSIONAL SERVICE SHOP / OTHER OTHERWISE SPECIFY TYPE (LAST	PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST	DRNEY / PRODUCE E APPLICABLE PROF	R / MEDICAL S Essional lice MIDDLE	SERVICE PROVIDER NSE OR OCCUPATIC
PROFESSIONAL SERVICE SHOP / OTHER OTHERWISE SPECIFY TYPE (LAST EMPLOYER	PROVIDER TYPE: ATTO (CIRCL) OF SERVICE PROVIDER) FIRST	DRNEY / PRODUCE E APPLICABLE PROF	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE #	SERVICE PROVIDER NSE OR OCCUPATIC LIC #
PROFESSIONAL SERVICE SHOP / OTHER	PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST	DRNEY / PRODUCE .e Applicable prof	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE # TAX ID #	SERVICE PROVIDER NSE OR OCCUPATIC LIC #
PROFESSIONAL SERVICE SHOP / OTHER OTHERWISE SPECIFY TYPE O LAST EMPLOYER ADDRESS	PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST FIRST PROVIDER TYPE: ATTO (CIRCL	DRNEY / PRODUCE LE APPLICABLE PROF	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE # TAX ID # R / MEDICAL S	SERVICE PROVIDER NSE OR OCCUPATIC LIC #
PROFESSIONAL SERVICE I SHOP / OTHER OTHERWISE SPECIFY TYPE (LAST EMPLOYER ADDRESS ADDRESS (CONT.) PROFESSIONAL SERVICE I SHOP / OTHER	PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER)	DRNEY / PRODUCE E APPLICABLE PROF D.O.B DRNEY / PRODUCE E APPLICABLE PROF	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE # TAX ID # R / MEDICAL S ESSIONAL LICE	SERVICE PROVIDER NSE OR OCCUPATIC LIC # S.S. # GERVICE PROVIDER NSE OR OCCUPATIC
PROFESSIONAL SERVICE I SHOP / OTHER OTHERWISE SPECIFY TYPE (LAST EMPLOYER ADDRESS ADDRESS (CONT.) PROFESSIONAL SERVICE I SHOP / OTHER OTHERWISE SPECIFY TYPE (PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST	DRNEY / PRODUCE E APPLICABLE PROF D.O.B DRNEY / PRODUCE E APPLICABLE PROF	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE # TAX ID # R / MEDICAL S ESSIONAL LICE	SERVICE PROVIDER NSE OR OCCUPATIC LIC # S.S. # SERVICE PROVIDER NSE OR OCCUPATIC LIC #
PROFESSIONAL SERVICE I SHOP / OTHER OTHERWISE SPECIFY TYPE (LAST	PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST PROVIDER TYPE: ATTO (CIRCL OF SERVICE PROVIDER) FIRST	DRNEY / PRODUCE E APPLICABLE PROF D.O.B DRNEY / PRODUCE E APPLICABLE PROF	R / MEDICAL S ESSIONAL LICE MIDDLE PHONE # TAX ID # R / MEDICAL S ESSIONAL LICE MIDDLE PHONE #	SERVICE PROVIDER NSE OR OCCUPATIC LIC # S.S. # SERVICE PROVIDER NSE OR OCCUPATIC LIC #

HEALTH CLAIM FRAUD REFERRAL FORM

of THE STATE State of New Jersey	-	For Old	FP use only:
Office of Insurance E	raud Prosecutor	OIFP Case #/	/
P.O. Box 094 Trenton, NJ 08625		Intake #	
		Investigator	
ART I	-		
INSURANCE CO		DATE REPORTED	
ADDRESS		NAIC COMPANY #	
		D.O.S	
TELEPHONE			
CONTACT PERSON			
E-MAIL ADDRESS			
TYPE OF COVERAGE (Check appropria HEALTH (INDEMNITY) HEALTH (INDEMNITY) HEALTH (INDEMNITY) DEN OTHER	LTH (MEDICAID) 🗆 TAL 🗆	OTHER AMOUNT PD \$ IF PENDING OR DE THE DOLLAR AMO	PAID - IN FULL PAID - IN FULL PAID - IN PART DATE/RANGE PD ENIED, EITHER IN FULL OR IN PART, PUNT OF THE PENDING OR DENIED
<u>INSURED/SUBJECT/PROVIDER</u> (CIRC	CLE)		
LAST	FIRST		MIDDLE
STREET	CITY		STATE-ZIP
НОМЕ РН	WORK PH.		D.O.B
S.S./T.I.N #	D.L. #		
LICENSE #	STATE		
BUSINESS NAME		TIN #	

<u>TYPE OF PROVIDER</u> (Check appropriate box)

MD DO D PHD DDS DDMD HOSPITAL OUTPATIENT FACILITY PHYSICAL THERAPY MD/CHIRO PRACTICE DME SUPPLIER HOME HEALTH PHARMACIST SURGI-CENTER MSW OTHER

TAX ID #s USED:

SPECIALTY

ALLERGIST
ANESTHESIOLOGY
CARDIOLOGY
CHIROPRACTIC
DERMATOLOGY
EMERGENCY MEDICINE
ENDROCRINOLOGY
ENDODONTIST
ENT
EPIDEMIOLOGY
FAMILY MEDICINE
GASTROINTEROLOGY
GENERAL PRACTICE
IMMUNOLOGY
INFECTIOUS DISEASE
INTERNAL MEDICINE
NEONATOLOGY
NEUROLOGY
OBSTETRICS/GYNECOLOGY
ONCOLOGY
OPHTHALMOLOGY
OPTOMETRY
ORAL SURGEON
ORTHODONTIST
ORTHOPEDICS
OTOLARYNGOLOGY
PEDIATRICS
PODIATRY
PERIODONTIST
PLASTIC SURGERY
OTHER
OTHER

January 2001

11:16-6 App.

<u>PROVIDER</u>	FIRST:	MID	DI F.
	TICE NAME:		
	CITY:		
TELEPHONE #:	DOB:		
STATE LICENSE #:			
YES D NO IF YES, LIST OTHER F ATTACH COPIES OF O	T OF A PATTERN OF POSSIBLE VIC RELATED CLAIM NUMBERS, INDI THER REFERRALS, IF APPLICABLE:	CATE STATUS OF OTHER	RELATED CLAIMS, AND
YES D NO IF YOU CHECKED "YES", PLEA	□ SE COMPLETE THE FOLLOWING:		
NAME OF OTHER COMPANY		VESTIGATOR	CONTACT NUMBER
PART II			

PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX OR BOXES)

- a(1) presents false information: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)
- □ a(2) makes a false statement: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)
- □ **a(3) conceals relevant information**: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)
- □ **b** conspires with another: ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- □ c knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).

- **d** involvement of hospital: AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- **e using or being a runner:** A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:
 - ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
 - ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
 - ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

<u>NOTE:</u> IF THE INSURANCE COMPANY PAID MONEY FOR THE CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS REFERRAL FORM.

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE: (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS <u>NO</u>T ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, ACORD FORM, AFFIDAVIT OF VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:

(FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT'S REPORT, OTHER APPARENT MISREPRESENTATIONS MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE).*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:

(FOR EXAMPLE, POLICE OFFICER, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER).*

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

1

Dated:

- -

.....

V <u>COMPLETE THI</u>	E FOLLOWING ONLY IF THERE ARE ADDITION	NAL SUBJECTS OF THE INVESTIGATION
	INFORMATION REGARDING ANY ADDITIO	NAL INSUREDS:
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH	S.S. #
D.L. #		
CLAIMANT #1 (IF C	OTHER THAN INSURED/SUBJECT)	
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН.	WORK PH	S.S. #
D.L. #		
CLAIMANT #2		MIDDLE
	FIRST	
	CITY	
D.L. #	WORK PH	5.3. #
CLAIMANT #3		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH	S.S. #
D.L. #		

PART V COMPLETE THE FOLLOWING ONLY IF LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ______ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST	FIRST		MIDDLE	<u> </u>	LIC #	
EMPLOYER			PHONE #_			_
ADDRESS	******		TAX ID # _			
ADDRESS (CONT.)		D.O.B		S.S. #		

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ______ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST	FIRST		MIDDLE		LIC #
EMPLOYER			PHONE #		
ADDRESS			TAX ID #		
ADDRESS (CONT.)		D.O.B.		S.S. #	

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ______ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST	FIRST	MIDDLE		LIC #
EMPLOYER		PHONE #		
ADDRESS		TAX ID #		
ADDRESS (CONT.)	D.O.B.		S.S. #	

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER ______ (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST	FIRST	MIDDLE	LIC #
EMPLOYER		PHONE #	
ADDRESS		TAX ID #	
ADDRESS (CONT.)	D.O.B	S.S. #	

HEALTH APPLICATION FRAUD REFERRAL FORM OIFP-3B (01/01)

THE ST.		F	or OIFP use only:
	y Jersey urance Fraud Prosecutor	OIFP Case #	
P.O. Box 09		Intake #	
Trenton, NJ	08625	Investigator	
PART I			
INSURANCE CO.	I	DATE REPORTED	
ADDRESS			
			N
	I	POL	ICY#
TELEPHONE	-		
CONTACT PERSON			
E-MAIL ADDRESS			
<u>TYPE OF COVERAGE</u> (Check appro	opriate box) <u>STATUS</u> ((Indicate as appropriate)	
	EALTH (MEDICAID)	REMIUM ADJUSTED	
HEALTH (HMO) DENTAL OTHER		T \$APPLICATION DECLIN	NED
	1	NON-RENEWAL	
			<u> </u>
<u>INSURED/SUBJECT/PROVIDER</u> (O LAST			MIDDLE
			STATE-ZIP
			D.O.B
	D.L.#		
	AGENCY NAME		
PRODUCER NAME: LAST_			MI
			ፍፐ ለ ፕፑ /ፖ ፒ
ADDRESS: STREET			
ADDRESS: STREET	CITY LICENSE #		
ADDRESS: STREET WORK PH			
ADDRESS: STREET WORK PH PART II	LICENSE #A. 17:331-4 RELATING TO APPLICA		
ADDRESS: STREET WORK PH PART II PROVISION(S) OF N.J.S. (CHECK APPROPRIATE a(5)-conceals rele	LICENSE # A. 17:331-4 RELATING TO APPLICA BOX) vant evidence of application fraud: CONC	TIONS THAT MAY HA	
ADDRESS: STREET WORK PH PART II PROVISION(S) OF N.J.S. (CHECK APPROPRIATE a(5)-conceals rele WHICH MAY BE 17:33A-4A(5) a(5)(b)-conspires	LICENSE # A. 17:331-4 RELATING TO APPLICA BOX) vant evidence of application fraud: CONC RELEVANT TO A FINDING THAT A with another: KNOWINGLY ASSISTS,	TIONS THAT MAY HA EALS OR KNOWINGLY VIOLATION OF N.J.S.A CONSPIRES WITH, OR	AVE BEEN VIOLATED: FAILS TO DISCLOSE ANY EVIDENCE,

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE APPLICANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED, AS CHECKED ABOVE. (MERELY STATING "SEE ATTACHED" FILE OR DOCUMENTS IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH DOCUMENTS EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, THE APPLICATION AND ANY DOCUMENT SUBMITTED IN SUPPORT OF THE APPLICATION)* 3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:* 4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED INSURANCE PRODUCER (AGENT) OR INSURANCE AGENCY EMPLOYEE KNOWINGLY PARTICIPATED IN THE APPLICATION FRAUD. PROVIDE THE NAME AND ADDRESS OF THIS PERSON.*

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

Dated:

SUSPICIOUS HEALTH CLAIM/APPLICATION NOTIFICATION FORM

ADDRESS D.O.L.	Office of Insurance Fraud Prosecutor P.O. Box 094 Trenton, NJ 08625	Intake #
P.O. Box 094 Trenton, NJ 08625 Intake #	P.O. Box 094 Trenton, NJ 08625 RT I INSURANCE CO. ADDRESS TELEPHONE CONTACT PERSON E-MAIL ADDRESS TYPE OF COVERAGE (Check appropriate box) HEALTH (INDEMNITY) □ HEALTH (MEDICAID) □ HEALTH (HMO) □ DENTAL □ OTHER INSURED/SUBJECT/PROVIDER (CIRCLE) LAST FIRST	Investigator
Trenton, NJ 08625 Investigator	Trenton, NJ 08625 RT I INSURANCE CO. ADDRESS	Investigator
INSURANCE CO NAIC # ADDRESS D.O.L TELEPHONE POLICY # CONTACT PERSON E-MAIL ADDRESS E-MAIL ADDRESS INDERSIDE OF COVERAGE (Check appropriate box) PENDING © PAID - IN FULL © DENIED © PAID - IN FULL © AMOUNT PD \$ PAID - IN PART © AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR II THE DOLLAR AMOUNT OF THE PENDING OR I CLAIM: \$ INSUREDISUBIECT/PROVIDER (CIRCLE) LAST NIDDLE INSURESS NAME D.L. # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES NO IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER	INSURANCE COADDRESS	D.O.L
INSURANCE CO NAIC # ADDRESS D.O.L TELEPHONE POLICY # CONTACT PERSON E-MAIL ADDRESS E-MAIL ADDRESS IF PENDING OR DENIED, EITHER IN FULL OR II THE DOLLAR AMOUNT OF THE PENDING OR I CLAIM: \$ INSUREDSUBJECT/PROVIDER (CIRCLE) LAST NIDDLE INSURESS NAME D.L. # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES NO IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER	INSURANCE COADDRESSADDRESSADDRESS TELEPHONE CONTACT PERSON E-MAIL ADDRESS E-MAIL ADDRESS TYPE OF COVERAGE (Check appropriate box) HEALTH (INDEMNITY) □ HEALTH (MEDICAID) □ HEALTH (INDEMNITY) □ DENTAL □ OTHER INSURED/SUBJECT/PROVIDER (CIRCLE) LAST FIRST	D.O.L
ADDRESS D.O.L CLAIM # TELEPHONE POLICY # CONTACT PERSON E-MAIL ADDRESS E-MAIL ADDRESS TYPE OF COVERAGE (Check appropriate box) PENDING □ PAID - IN FULL □ HEALTH (INDEMNITY) □ HEALTH (MEDICAID) □ DENIED □ PAID - IN PART □ HEALTH (IMO) □ DENTAL □ OTHER □ OTHER □ AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR II THE DOLLAR AMOUNT OF THE PENDING OR I CLAIM: \$ INSURED/SUBJECT/PROVIDER (CIRCLE) LAST FIRST MIDDLE STREET CITY STATE-ZIP HOME PH D.L. # LICENSE # D.L. # BUSINESS NAME TIN # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES □ NO □	ADDRESS	D.O.L
	TELEPHONE	CLAIM # POLICY # PENDING
TELEPHONE POLICY #	TELEPHONE	POLICY # STATUS (Check appropriate box) PENDING PAID - IN FULL DENIED PAID - IN FULL DENIED PAID - IN PART OTHER AMOUNT PD \$ IF PENDING OR DENIED, EITHER IN FULL OR IN PART THE DOLLAR AMOUNT OF THE PENDING OR DENIE
CONTACT PERSON	CONTACT PERSON	STATUS (Check appropriate box) PENDING PAID - IN FULL D DENIED PAID - IN PART D OTHER AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR IN PAR THE DOLLAR AMOUNT OF THE PENDING OR DENIE
E-MAIL ADDRESS	E-MAIL ADDRESS	PENDING PAID - IN FULL DENIED PAID - IN PART OTHER AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR IN PART THE DOLLAR AMOUNT OF THE PENDING OR DENIE
STATUS (Check appropriate box) PAID - IN FULL □ HEALTH (INDEMNITY) □ HEALTH (MEDICAID) □ DENIED □ PAID - IN FULL □ HEALTH (INDEMNITY) □ HEALTH (MEDICAID) □ DENIED □ PAID - IN PART □ OTHER	TYPE OF COVERAGE (Check appropriate box) HEALTH (INDEMNITY) HEALTH (MEDICAID) HEALTH (HMO) DENTAL OTHER DENTAL INSURED/SUBJECT/PROVIDER (CIRCLE) LAST FIRST	PENDING PAID - IN FULL DENIED PAID - IN PART OTHER AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR IN PART THE DOLLAR AMOUNT OF THE PENDING OR DENIE
TYPE OF COVERAGE (Check appropriate box) PENDING PAID - IN FULL HEALTH (INDEMNITY) HEALTH (MEDICAID) DENIED PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) DENIED PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) DENIED PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) DENIED PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) DENIED PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) OTHER PAID - IN PART HEALTH (INDEMNITY) DENTAL OTHER PAID - IN PART HEALTH (INDEMNITY) HEALTH (MEDICAID) OTHER DATE/RANGE PD_ OTHER IF PENDING OR DENIED, EITHER IN FULL OR IN INFULL OR IN IF PENDING OR DENIED, EITHER IN FULL OR IN INFULL OR IN INFUL OR IN INSURED/SUBJECT/PROVIDER (CIRCLE) INTHE DOLLAR AMOUNT OF THE PENDING OR IN LAST FIRST MIDDLE STATE-ZIP STREET OIL. # D.O.B. D.O.B. S.S./T.I.N # STATE STATE BUSINESS NAME TIN # STATE IS THIS	HEALTH (INDEMNITY) HEALTH (MEDICAID) HEALTH (HMO) HEALTH (HMO) HEALTH (HMO) HEALTH (HMO) HEALTH (MEDICAID) HEALTH (HMO) HE	PENDING PAID - IN FULL DENIED PAID - IN PART OTHER AMOUNT PD \$ DATE/RANGE PD IF PENDING OR DENIED, EITHER IN FULL OR IN PART THE DOLLAR AMOUNT OF THE PENDING OR DENIE
INSURED/SUBJECT/PROVIDER (CIRCLE) LAST	LAST FIRST	
STREET CITY STATE-ZIP HOME PH. D.O.B. D.O.B. S.S./T.I.N # D.L. # D.I. # LICENSE # STATE STATE BUSINESS NAME TIN # DISTHIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES NO I IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER		MIDDLE
HOME PH. D.O.B. S.S./T.I.N # D.L. # LICENSE # STATE BUSINESS NAME TIN # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES NO IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER	STREET CITY	
S.S./T.I.N #D.L. # LICENSE #STATE BUSINESS NAMETIN # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES D NO D IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER		
LICENSE #STATE BUSINESS NAMETIN # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES D NO D IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER		
BUSINESS NAME TIN # IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES D NO D IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER		
IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. I YES D NO D IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER		
IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFER	S.S./T.I.N #D.L. #D.L. #D.L. #D.L. #STATEBUSINESS NAMEIS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF	TIN #
	IF YES, LIST OTHER RELATED MATTERS, INDICATI	E STATUS, AND ATTACH COPIES OF OTHER REFERRALS

January 2001

PART II	
	PROVISIONS OF N.J.S.A. 17:33A-4 RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED:
	(CHECK APPROPRIATE BOX OR BOXES)

- □ **a(1) presents false information**: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(1)
- □ **a(2) makes a false statement**: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)
- □ a(3) conceals relevant information: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)
- **b** conspires with another: ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).
- □ c knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER, KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED ______).
- □ d involvement of hospital: AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED _____).
- e using or being a runner: A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:
 - ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
 - ANY PERSON TO BRING CAUSES OF ACTION TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
 - ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.
- □ **a(4)(b)** makes a false statement (application): PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT, INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THE PURPOSE OF OBTAINING AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO AN INSURANCE APPLICATION OR CONTRACT. N.J.S.A. 17:33A-4A(4)(B)
- □ a(5) conceals relevant evidence of application fraud: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE ANY EVIDENCE, WHICH MAY BE RELEVANT TO A FINDING THAT A VIOLATION OF N.J.S.A. 17:33A-4A(4) HAS OCCURRED. N.J.S.A. 17:33A-4A(5).

PART III

1. INDICATE THE PARTICULAR FACTS AND CIRCUMSTANCES, INCLUDING WHAT THE APPLICANT/CLAIMANT DID AND FRAUD INDICATORS, WHICH LED YOU TO SUSPECT THAT THE ACT WAS VIOLATED. AS CHECKED ABOVE:

(MERELY STATING "SEE ATTACHED" FILE OR DOCUMENT IS NOT ACCEPTABLE WITHOUT SPECIFIC DESIGNATION OF PAGE AND LINE REFERENCED, BUT EXTRA SHEETS MAY BE USED TO MORE COMPLETELY EXPLAIN.)*

2. INDICATE ALL STATEMENT'S MADE WHICH YOU SUSPECT TO BE FALSE AND IDENTIFY ANY RELEVANT INFORMATION OMITTED. IDENTIFY ANY DOCUMENTS WHICH INCLUDE THE FALSE INFORMATION OR WHICH OMITTED RELEVANT INFORMATION:*

3. INDICATE ANY FACTS AND CIRCUMSTANCES WHICH PROVIDE ANY BASIS TO SUSPECT THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:*

<u>NOTE:</u> IF THE INSURANCE COMPANY PAID MONEY FOR A CLAIM(S), OBTAIN ALL CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER SUBMISSION OF THIS NOTIFICATION FORM.

* For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.

CERTIFICATION OF CUSTODIAN OF RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place. If additional records later become known or available, I shall promptly provide them to the Office of Insurance Fraud Prosecutor. I certify that the foregoing statements by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

(List each document in this space or reference a separate attached listing)

Custodian of Records (Full Name and Title)

Dated:

V <u>COMPLETE THE</u>	FOLLOWING ONLY IF THERE ARE ADDITIO	NAL SUBJECTS OF THE INVESTIGATION
	INFORMATION REGARDING ANY ADDITIO	NAL INSUREDS:
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH	S.S. #
D.L. #		
CLAIMANT #1 (IF O	THER THAN INSURED/SUBJECT)	
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
HOME PH	WORK PH.	S.S. #
D.L. #		
CLAIMANT #2		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH.	S.S. #
D.L. #		
CLAIMANT #3		
LAST	FIRST	MIDDLE
STREET	CITY	STATE/ZIP
НОМЕ РН	WORK PH.	S.S. #
D.L. #		

COMPLETE THE FOLLOWING ONLY IF LICENSED PROFESSIONALS ARE SUBJECTS OF THE INVESTIGATION PART V PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR (CIRCLE' APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR SHOP / OTHER OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER) _____ FIRST _____ MIDDLE ____ LIC # _____ LAST EMPLOYER _____ PHONE #_____ ADDRESS ______ TAX ID # _____ ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____ PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / RÉPAIR (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR SHOP / OTHER OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER) LAST FIRST MIDDLE LIC # EMPLOYER ______ PHONE #_____ ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____ PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER) LAST ______ FIRST ______ MIDDLE _____ LIC # _____ EMPLOYER _____ PHONE #_____ ADDRESS ______ TAX ID # _____ ADDRESS (CONT.) _____ D.O.B. _____ S.S. # _____ PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER (CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER) LAST_____FIRST_____MIDDLE LIC # EMPLOYER _____ PHONE #_____ ADDRESS ______ TAX ID # _____ ADDRESS (CONT.) _____ D.O.B. ____ S.S. # _____

		rsey Department of Ban Faud Prevention and Det Annual	ection Plan
ompany Name:	<u></u>		First Name:
ddress 1:			Last Name:
ddress 2:			Title:
Dity:	State:	Zip:	NAIC Co. #
1. The number of NJ claims	processed fo	or the preceding calendar year	:

2. The number of NJ claims referred to SIU:

3. The number of NJ policy applications processed for the preceding calendar year:

4. The number of NJ applications referred to SIU for the preceding calendar year:

5. The number of NJ claims denied for fraud based on an SIU investigation:

6. The dollar amount spent implementing a fraud prevention and detection plan in NJ:

7. The dollar amount of NJ claims denied for fraud:

8. The dollar amount of restitution obtained as the result of fraud investigations:

9. In health policies, the number of insured lives covered:

9a. Comprehensive benefits:

NAIC Grp. #

11:16-6 App.

Form: DAFC #1

MI:

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Repeal and New Rule, R.2001 d.76, effective March 5, 2001. See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Company Name: Address 1: Address 2:

City: