(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

CLAIM FRAUD REFERRAL FORM
OIFP-1A (01/01)

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

PART I

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

CONTACT PERSON _____

E-MAIL ADDRESS _____

DATE REPORTED _____

NAIC COMPANY # _____

D.O.L. _____

CLAIM # _____

POLICY # _____

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 PD_____
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 _____

HOME PH. _____ WORK PH. _____ D.O.B. _____

S.S. # _____ D.L. #_____

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?
YES ☐ NO ☐
IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

_____
_____
_____
_____
_____
_____
_____

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.

NOTE: 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 THAT 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. 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 OR 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 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:

4

PART IV *COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION*

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #1 (IF OTHER 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 _____

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. # _____

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 __________ 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. # ______________

APPLICATION FRAUD REFERRAL FORM
OIFP-1B (01/01)

For OIFP use only:

OIFP Case # _____/_____/_____

Intake # _____

Investigator _____

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

PART I

INSURANCE CO. _____
ADDRESS _____
_____
_____
TELEPHONE _____
E-MAIL ADDRESS _____

DATE REPORTED _____
NAIC COMPANY # _____
DATE OF APPLICATION _____
POLICY # _____
CONTACT PERSON _____

TYPE OF COVERAGE (Check appropriate box)

LIFE ☐ W.C. ☐
AUTO ☐ HOME ☐
COMM. ☐ OTHER _____

STATUS (Indicate as appropriate)

PREMIUM ADJUSTED _____
AMOUNT $_____
APPLICATION DECLINED _____
NON-RENEWAL _____
CANCELED _____

INSURED/SUBJECT:

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE-ZIP _____
HOME PH. _____ WORK PH. _____ D.O.B. _____
S.S. # _____ D.L.#_____

PRODUCER: AGENCY NAME_____
PRODUCER NAME: LAST_____ FIRST_____ MI_____
STREET_____ CITY_____ STATE/ZIP_____
WORK PH. _____ LICENSE #_____

PART II

PROVISION(S) OF **N.J.S.A. 17:331-4** RELATING TO APPLICATIONS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX)

☐ **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 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. 17:33A-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.**

2

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

OIFP-2 (01/01)

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

PART 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 PD_____
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 _____

HOME PH. _____ WORK PH. _____ D.O.B. _____

S.S. # _____ D.L. #_____

IS THIS A CLAIM OR APPLICATION WHICH FORMS PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?
YES ☐ NO ☐
IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

_____

_____

_____

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:

PART IV *COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION*

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #1 (IF OTHER 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 _____

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. # _____

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 __________ 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 CLAIM FRAUD REFERRAL FORM
OIFP-3A (01/01)

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

PART I

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

CONTACT PERSON _____

E-MAIL ADDRESS _____

DATE REPORTED _____

NAIC COMPANY # _____

D.O.S. _____

CLAIM # _____

POLICY # _____

TYPE OF COVERAGE (Check appropriate box)
HEALTH (INDEMNITY) ☐ HEALTH (MEDICAID) ☐
HEALTH (HMO) ☐ DENTAL ☐
OTHER _____

STATUS (Check appropriate box)
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 DENIED CLAIM: $_____

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE-ZIP _____

HOME PH. _____ WORK PH. _____ D.O.B. _____

S.S./T.I.N # _____ D.L. #_____

LICENSE # _____ STATE _____

BUSINESS NAME _____ TIN # _____

TYPE OF PROVIDER (Check appropriate box)
MD ☐ DO ☐ PHD ☐ DDS ☐ DMD ☐ 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 ☐ PROSTIDONTIST ☐ PSYCHIATRY ☐ RADIOLOGY ☐ SURGERY ☐ UROLOGY ☐ WEIGHT LOSS ☐ OTHER ☐

_____

January 2001

PROVIDER

LAST: _____ FIRST: _____ MIDDLE: _____

DBA, LLC, PA OR GROUP PRACTICE NAME: _____

STREET: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE #: _____ DOB: _____ SS #: _____

STATE LICENSE #: _____

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?

YES ☐ NO ☐

IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

_____

_____

_____

_____

_____

_____

ARE YOU AWARE OF ANY OTHER COMPANIES PURSUING RECOVERIES AGAINST THIS SUBJECT?

YES ☐ NO ☐

IF YOU CHECKED "YES", PLEASE COMPLETE THE FOLLOWING:

NAME OF OTHER COMPANY	INVESTIGATOR	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.

NOTE: 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 NOT 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)

Dated:

5

PART IV *COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION*

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE/ZIP _____
HOME PH. _____ WORK PH. _____ S.S. # _____
D.L. # _____

CLAIMANT #1 (IF OTHER 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 _____
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. # _____

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 __________ 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)

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

For OIFP use only:

OIFP Case # ____/_____/____
Intake # _____
Investigator _____

PART I

INSURANCE CO. _____
ADDRESS _____
_____
_____

DATE REPORTED _____
NAIC COMPANY # _____
DATE OF APPLICATION _____
P O L I C Y #
_____

TELEPHONE _____
CONTACT PERSON _____
E-MAIL ADDRESS _____

TYPE OF COVERAGE (Check appropriate box)

HEALTH (INDEMNITY) ☐ HEALTH (MEDICAID) ☐
HEALTH (HMO) ☐ DENTAL ☐
OTHER _____

STATUS (Indicate as appropriate)

PREMIUM ADJUSTED _____
AMOUNT $ _____
APPLICATION DECLINED _____
NON-RENEWAL _____
CANCELED _____

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST _____ FIRST _____ MIDDLE _____
STREET _____ CITY _____ STATE-ZIP _____
HOME PH. _____ WORK PH. _____ D.O.B. _____
S.S. # _____ D.L.# _____
BUSINESS NAME _____ TIN # _____

PRODUCER (IF APPLICABLE): AGENCY NAME _____
PRODUCER NAME: LAST _____ FIRST _____ MI _____
ADDRESS: STREET _____ CITY _____ STATE/ZIP _____
WORK PH. _____ LICENSE # _____

PART II

PROVISION(S) OF **N.J.S.A. 17:331-4** RELATING TO APPLICATIONS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX)

☐ **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 _____).

January 2001

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

OIFP-4 (01/01)

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

State of New Jersey
Office of Insurance Fraud Prosecutor
P.O. Box 094
Trenton, NJ 08625

PART I

INSURANCE CO. _____ NAIC # _____

ADDRESS _____ D.O.L. _____

_____ CLAIM # _____

TELEPHONE _____ POLICY # _____

CONTACT PERSON _____

E-MAIL ADDRESS _____

TYPE OF COVERAGE (Check appropriate box)
HEALTH (INDEMNITY) ☐ HEALTH (MEDICAID) ☐
HEALTH (HMO) ☐ DENTAL ☐
OTHER _____

STATUS (Check appropriate box)
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 DENIED CLAIM: $_____

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE-ZIP _____

HOME PH. _____ WORK 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. 17:33A-4?
YES ☐ NO ☐
IF YES, LIST OTHER RELATED MATTERS, INDICATE STATUS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

_____
_____
_____
_____
_____
_____

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 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:*

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:*

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.**

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:

PART IV *COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION*

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE/ZIP _____

HOME PH. _____ WORK PH. _____ S.S. # _____

D.L. # _____

CLAIMANT #1 (IF OTHER 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 _____

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. # _____

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 __________ 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. # ______________

Form: DAFC #1

New Jersey Department of Banking & Insurance
Fraud Prevention and Detection Plan
_____ Annual Report
year

Company Name:			First Name:		MI:
Address 1:			Last Name:		
Address 2:			Title:		
City:	State:	Zip:	NAIC Co. #	NAIC Grp. #	

1. The number of NJ claims processed for 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:	
9b. Limited benefits:	

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).

Next Page is 16-23