CHAPTER 16

FRAUD PREVENTION AND DETECTION

Authority

N.J.S.A. 17:1–8.1, 17:1C–6(e), 17:23–8 et seq., 17:23–19, 17:33A–1 et seq., 17:33A–15 and 17:33B–46 et seq.

Source and Effective Date

R.1996 d.117, effective January 31, 1996.
See: 27 N.J.R. 4492(a), 28 N.J.R. 1389(a).

Executive Order No. 66(1978) Expiration Date

Chapter 16, Fraud Prevention and Detection, expires on January 31, 2001.

Chapter Historical Note

Chapter 16, General Requirements, became effective February 3, 1986 (operative June 3, 1986), as R.1986 d.13, with Subchapter 1, Verification and Claim Form Statements. See: 17 N.J.R. 47(a), 18 N.J.R. 281(a). Subchapter 2, Reports to the National Automobile Theft Bureau, became effective November 20, 1989 as R.1989 d.583. See: 21 N.J.R. 2901(a), 21 N.J.R. 3668(b). Pursuant to Executive Order No. 66(1978), Chapter 16 was readopted as R.1991 d.102, effective January 31, 1991. See: 22 N.J.R. 3688(b), 23 N.J.R. 702(a). Subchapter 4, Fraud and Theft Prevention/Detection Plans, was adopted as new rules by R.1992 d.190, effective April 20, 1992. See: 23 N.J.R. 3236(a), 24 N.J.R. 1505(a). Subchapter 5, Health Fraud Prevention/Detection Plans, became effective July 3, 1995 as R.1995 d.368. See: 26 N.J.R. 4882(a), 27 N.J.R. 2583(a). Pursuant to Executive Order No. 66(1978), Chapter 16, General Requirements, was readopted as Fraud Prevention and Detection by R.1996 d.117, effective January 31, 1996. See: Source and Effective Date. See, also, section annotations.

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SUBCHAPTER 1. CLAIM FORM STATEMENTS

11:16–1.1 Scope; definitions

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

(b) For the purpose of this subchapter:

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

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

Amended by R.1988 d.342, effective July 18, 1988.
See: 20 N.J.R. 1062(a), 20 N.J.R. 1720(b).
Amended by R.1996 d.117, effective March 4, 1996.
See: 27 N.J.R. 4492(a), 28 N.J.R. 1389(a).

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

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

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

(b) In lieu of the statement in (a) above, insurers may use a substantially similar statement with the prior approval of the Commissioner.

1. The Commissioner may approve the use of a statement substantially similar to that set forth above upon finding that the statement properly describes the prohibited conduct and references both criminal and civil penalties.

2. Requests for approval of substantially similar statements shall be directed to the Department at the following address:

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

Amended by R.1988 d.342, effective July 18, 1988.
See: 20 N.J.R. 1062(a), 20 N.J.R. 1720(b).
Recodified from 11:16–1.5. Repealed 11:16–1.2 (General requirements), 11:16–1.3 (Form and content of verification), 11:16–1.4 (Notification to claimant), Appendix A (Certification/Verification), and Appendix B (Consumer Notice—Verification Required with Bills To Be Reimbursed).
Administrative Correction.
See: 25 N.J.R. 5229(b).
Amended by R.1996 d.117, effective March 4, 1996.
See: 27 N.J.R. 4492(a), 28 N.J.R. 1389(a).

Case Notes

Insured's husband who provided chiropractic therapy had to verify treatment for which insured made claim. State Farm Mut. Auto. Ins. Co. v. Dalton, 234 N.J.Super. 128, 560 A.2d 683 (A.D.1989), certification denied 117 N.J. 664, 569 A.2d 1356, certiorari denied 110 S.Ct. 1131, 493 U.S. 1078, 107 L.Ed.2d 1037.

SUBCHAPTER 2. REPORTS TO THE NATIONAL INSURANCE CRIME BUREAU

11:16–2.1 Purpose and scope

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

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

11:16–2.2 Definitions

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

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

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

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

11:16–2.3 NICB membership or service company requirement

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

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

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

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

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

11:16–2.4 Insurer reporting requirements

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

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

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

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

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

11:16–2.5 Insurer cooperation with NICB

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

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

11:16–2.6 NICB cooperation with insurers

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

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

11:16–2.7 Deferred claim processing and payment

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

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

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

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

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

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

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

11:16–2.8 NICB record retention

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

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

11:16–2.9 Penalties

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

SUBCHAPTER 3. (RESERVED)

SUBCHAPTER 4. (RESERVED)

Subchapter Historical Note

Subchapter 4, Fraud and Theft Prevention/Detection Plans, was repealed by R.2000 d.58, effective February 7, 2000. See: 31 N.J.R. 3196(a), 32 N.J.R. 478(a).

SUBCHAPTER 5. (RESERVED)

Subchapter Historical Note

Subchapter 5, Health Fraud Prevention/Detection Plans, was repealed by R.2000 d.58, effective February 7, 2000. See: 31 N.J.R. 3196(a), 32 N.J.R. 478(a).

SUBCHAPTER 6. FRAUD PREVENTION AND DETECTION PLANS

Authority

N.J.S.A. 17:1–8.1, 17:1–15e, 17:23–8 et seq., 17:23–19, 17:23–20 et seq., 17:33A–1 et seq., 47:1A–2, Executive Reorganization Plan No. 7(1998) and Executive Order No. 9(Governor Richard J. Hughes, September 20, 1963).

Source and Effective Date

R.2000 d.58, effective February 7, 2000.
See: 31 N.J.R. 3196(a), 32 N.J.R. 478(a).

11:16–6.1 Purpose and scope

(a) This subchapter sets forth the standards for a plan for the prevention and detection of fraudulent insurance applications and claims filed for approval pursuant to N.J.S.A. 17:33A–15 by insurers which transact the business of private passenger automobile insurance or health insurance in this State. These provisions apply to all insurers that transact the business of private passenger automobile insurance in New Jersey, including both personal and commercial coverage; and to all insurers transacting the business of health insurance as set forth in N.J.S.A. 17:33A–3 and N.J.A.C. 11:16–6.2.

(b) The subchapter also sets forth the reporting standards and forms necessary to refer insurance fraud matters to the Office of Insurance Fraud Prosecutor ("OIFP"). These provisions apply to all insurers as defined by N.J.S.A. 17:33A–3 and N.J.A.C. 11:16–6.2 including those with PAIP and CAIP assignments.

11:16–6.2 Definitions

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

"Application" means any document that contains the minimum information necessary as set forth at N.J.A.C. 11:3–44.3(a) to determine whether an applicant is an eligible person or is used in any way by the insurer to rate or underwrite a policy, including the coverage selection form and renewal questionnaire as provided at N.J.A.C. 11:3–15.7 and 11:3–8 and, if requested, a copy of the applicant's driver's license, a copy of the motor vehicle registration of the principal vehicle to be insured and any additional proof of New Jersey residency.

The term "application" shall also mean those signed forms, data, reports, analysis and other documents supplied in support of an application when requested by an insurer or by any other person, and/or supplied by the insured/applicant, or other person(s), seeking coverage under a policy or plan of health insurance that is provided to or used by an insurer in assessing the risk, or premium, or which is relied upon by the insurer in agreeing to provide coverage under the policy or plan, including but not limited to that information submitted in accordance with N.J.A.C. 11:4–16.7, 11:20–4.1 and 11:21–6.1.

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

"DAFC" means the Division of Anti Fraud Compliance in the Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

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

"Fraud and misrepresentation" means the knowing misrepresentation of any material fact in a claim or application or the knowing failure to disclose any material fact in a claim or application which, if properly revealed or disclosed, could change the premium, or affect the placement or underwriting of the risk, or the assignment in the insurer's rating plan, or could affect the payment of a claim.

"Fraud prevention and detection plan" or "plan" means an insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

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

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

"Insurer" means any person or entity authorized to transact the business of private passenger automobile insurance in New Jersey, whether in accordance with a personal lines or commercial lines rating system, and includes a group of affiliated companies, and the Property Liability Insurance Guaranty Association established pursuant to N.J.S.A. 17:30A–1 et seq. when performing its statutory function.

(b) Except for insurers which insure fewer than 2,500 New Jersey automobile policies, or health insurers fewer than 10,000 lives, the plan shall provide a Fraud Prevention and Detection Procedures Manual and disseminate it to, or make it available to, as appropriate, all SIU, claims adjusters, and underwriting personnel. The Fraud Prevention and Detection Procedures Manual shall include, at a minimum, the following:

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

2. The process to be employed for reporting to OIFP when specific facts and circumstances are identified, in connection with a claim or application, which upon further SIU investigation leads to a reasonable conclusion that a violation of N.J.S.A. 17:33A–4 has occurred;

3. For automobile insurers, the "fraud indicators" used for automobile theft, automobile physical damage fraud, personal injury claims fraud, bodily injury claims fraud, and application fraud;

4. For health insurers, "fraud factors" or "indicators" for health fraud, application fraud, and claims fraud;

5. The duties and functions of the SIU;

6. The procedure for referral of a claim or application to the SIU;

7. The post-referral procedure for communication between the claims unit and/or the underwriting unit and the SIU; and

8. An update page indicating that the manual has been updated and kept current.

11:16–6.6 Fraud prevention and detection plan

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

(b) The following concern referral of applications and claims.

1. The plan shall provide that an application or claim shall be referred as a case to OIFP, for further OIFP investigation or other appropriate action, on the prescribed Referral Form (OIFP–1A for claims and OIFP–1B for applications, incorporated herein by reference in the subchapter Appendix), with all other information required by the form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16–6.7.

2. The plan shall provide that all applications and claims, which meet the standard for referral set forth in N.J.A.C. 11:16–6.7, shall be referred to OIFP by the SIU as soon as practicable, but in no case later than 30 days from when the investigation is complete.

3. The plan shall provide criteria and levels of economic impact for the referral of insurance claims and application fraud in accordance with the requirements of N.J.A.C. 11:16–6.7.

(c) The plan shall provide that after completion of an SIU investigation, or after identification by an SIU of a pattern of applications or claims, the insurer shall provide notice to OIFP on Notification Form OIFP–2 (incorporated herein by reference in the subchapter Appendix), unless this form is superseded by an electronic reporting form, of instances in which a violation of N.J.S.A. 17:33A–4 is suspected on the basis of fraud factors or indicators, but where sufficient evidence to support a case referral pursuant to N.J.A.C. 11:16–6.7 has not been developed.

(d) The plan shall provide that all referrals of application and claims fraud and notifications of suspected application or claims fraud by the insurer to OIFP shall be made by personnel in the insurer's SIU or other personnel designated in the plan so long as records are kept of all referrals and notifications and the appropriate form is used.

(e) Where an insurer contracts any of its SIU functions to an outside vendor or third party administrator in accordance with N.J.A.C. 11:16–6.4(e), the plan shall provide the name and address of the outside vendor or third party administrator used by the insurer to conduct investigations or perform SIU functions together with a copy of the contract between the insurer and the outside vendor or third party administrator.

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

11:16–6.7 Referrals to OIFP

(a) The plan shall provide that upon completion of its investigation, as described in (d) below, an SIU shall refer cases, on form OIFP–1A or OIFP–1B, which meet the following standard to OIFP:

1. Any application or claim where the facts and circumstances create a reasonable suspicion that a person or entity has violated N.J.S.A. 17:33A–4; and

2. There is sufficient independent evidence corroborating the reasonable suspicion described in (a)1 above, from which a person could reasonably conclude that the person or entity has violated N.J.S.A. 17:33A–4.

(b) The facts and circumstances referred to in (a)1 above can include, but are not limited to, "fraud indicators" contained in an insurer's approved plan, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of N.J.S.A. 17:33A–4 has occurred.

(c) As referred to in (a)2 above, independent evidence corroborating the reasonable suspicion that a person has violated N.J.S.A. 17:33A–4 includes, but is not limited to:

1. A statement from a witness;

2. Documentary evidence that directly negates a material element of the claim or directly establishes the falsity of a material element of an insurance application;

3. A report of an expert; or

4. Additional apparent misrepresentations tending to negate a possibility that the misrepresentation was merely an error.

(d) An investigation shall be complete for purposes of referral to OIFP when reasonable and appropriate investigative leads and opportunities have been exhausted. When an investigation has identified a pattern of possible violations of N.J.S.A. 17:33A–4, the investigation will be deemed complete for purposes of referral as a case to OIFP when one or more violations included in the identified pattern have been sufficiently investigated and corroborated, in accordance with (a) above for referral to OIFP.

11:16–6.8 Record retention

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

(b) As of January 1 of each year, insurers shall submit an annual report for the prior calendar year to the Commissioner on DAFC Form #1, incorporated herein by reference in the subchapter Appendix.

1. The report referred to in (b) above shall be filed with the Department on or before February 1 of each year and sent to the following address:

New Jersey Department of Banking and Insurance
Division of Anti Fraud Compliance
PO Box 324
Trenton, NJ 08625–0324

2. Insurers shall submit the report referred to in (b) above in written copy and on an MS–DOS formatted disk. The disk shall be a 3.5 inch 1.44 MB disk. The information shall be provided in an Access Database provided by DAFC. Insurers may submit a disk, together with a self-addressed stamped diskette mailer to the DAFC. The DAFC will properly format the disk and return to the insurer to facilitate compliance.

3. As an alternative to the filings described in (1) and (2) above, insurers may submit this annual informational filing to the Department at the following e-mail address: dafc@dobi.state.nj.us. Insurers can acquire the required Access Database format from the Department by directing a request for the "annual filing template" to the DAFC e-mail address referenced here.

11:16–6.9 Approval and filing of fraud prevention and detection plans

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

(b) The Commissioner may request such amendments to the plan as he or she deems necessary.

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

(d) The insurer shall permit the DAFC access to its offices upon reasonable notice and at reasonable hours to conduct an audit of the insurer's compliance with its fraud prevention plan. Nothing in this section shall be construed as to preclude the DAFC from conducting reviews of an insurer's compliance with its fraud prevention and detection plan at the office of the DAFC when determined to be necessary by the DAFC.

(e) In those instances in which an insurer uses an outside agent, third party administrator or contractor to perform SIU functions or claims investigations, the Plan and contract with the outside vendor or third party administrator shall provide that the Department shall be permitted to audit the records, books, and documents maintained by the outside contractor or third party administrator in the same manner and fashion as it would be able to examine the books and records in accordance with N.J.S.A. 17:33A–15 and N.J.S.A. 17:23–22.

(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

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

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

PART I

INSURANCE CO. _____

ADDRESS _____

_____

TELEPHONE _____

NAIC COMPANY # _____

NAIC GROUP # _____

D.O.L. _____

CLAIM # _____

POLICY # _____

CONTACT PERSON _____

TYPE OF COVERAGE (Check appropriate box)

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

STATUS (Check appropriate box)

PENDING ☐ DENIED ☐ PAID ☐
AMOUNT PD $_____ DATE PD _____
IF PENDING OR DENIED, THE DOLLAR AMOUNT OF THE PENDING OR DENIED CLAIM: $_____
INDICATE TYPE OF CLAIM: _____
(e.g. PIP, BI, WC Injury, property, theft)

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 2000

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 AND 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).

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 / AGENT / 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 / AGENT / 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 / AGENT / 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 / AGENT / 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. # ________

5

APPLICATION FRAUD REFERRAL FORM
OIFP-1B

For OIFP use only:

OIFP Case # ____/_____/____

Intake # _____

Investigator _____

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

PART I

INSURANCE CO. _____ NAIC COMPANY # _____

ADDRESS _____ NAIC GROUP # _____

_____ CONTACT PERSON _____

_____ DATE OF APPLICATION _____

TELEPHONE _____ PREMIUM DIFFERENCE $ _____

TYPE OF COVERAGE (Check appropriate box)

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

STATUS (Indicate as appropriate)

POLICY # _____
PREMIUM ADJUSTED _____
AMOUNT $ _____
APPLICATION DECLINED _____
NON-RENEWAL _____

INSURED/SUBJECT:

LAST _____ FIRST _____ MIDDLE _____

STREET _____ CITY _____ STATE-ZIP _____

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

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

AGENT: AGENCY NAME _____

AGENT 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(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 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)

January 2000

☐ **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)

☐ **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.

_____
_____
_____
_____

SUSPICIOUS CLAIM/APPLICATION NOTIFICATION FORM
OIFP-2

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

For OIFP use only:

OIFP Case # _____/_____/_____

Intake # _____

Investigator _____

PART I

INSURANCE CO. _____ NAIC # _____

ADDRESS _____ D.O.L. _____

_____ CLAIM # _____

TELEPHONE _____ POLICY # _____

TYPE OF COVERAGE (Check appropriate box)

LIFE ☐ HEALTH ☐ W.C. ☐
AUTO ☐ HOME ☐
COMM. ☐ DENTAL ☐

OTHER _____

STATUS OF CLAIM(Check appropriate box)

PENDING ☐ DENIED ☐ PAID ☐
AMOUNT PD $_____ DATE PD _____
IF PENDING OR DENIED, THE DOLLAR AMOUNT OF THE PENDING OR DENIED CLAIM: $_____
TYPE OF CLAIM: _____
(Indicate, e.g. PIP, BI, WC Injury, property, theft)

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 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)

January 2000

☐ **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).

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.

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 / AGENT / 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 / AGENT / 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 / AGENT / 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 / AGENT / 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:	

APPENDIX A

(RESERVED)

Repeal and New Rule, R.1997 d.87, effective February 18, 1997.
See: 28 N.J.R. 4341(a), 29 N.J.R. 563(a).

Repealed by R.2000 d.58, effective February 7, 2000.
See: 31 N.J.R. 3196(a), 32 N.J.R. 478(a).