

CHAPTER 16

FRAUD PREVENTION AND DETECTION

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., and 47:1A-2.

Source and Effective Date

R.2006 d.308, effective July 30, 2006.
See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 16, Fraud Prevention and Detection, expires on January 26, 2014. See: 45 N.J.R. 1989(a).

Chapter Historical Note

Chapter 16, General Requirements, and Subchapter 1, Verification and Claim Form Statements, were adopted as R.1986 d.13, effective February 3, 1986, operative June 3, 1986. See: 17 N.J.R. 47(a), 18 N.J.R. 281(a).

Subchapter 2, Reports to the National Automobile Theft Bureau, was adopted as R.1989 d.583, effective November 20, 1989. See: 21 N.J.R. 2901(a), 21 N.J.R. 3668(b).

Pursuant to Executive Order No. 66(1978), Chapter 16, General Requirements, 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, was adopted as new rules by R.1995 d.368, effective July 3, 1995. 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 Chapter 16, Fraud Prevention and Detection, by R.1996 d.117, effective January 31, 1996. See: 27 N.J.R. 4492(a), 28 N.J.R. 1389(a).

Subchapter 4, Fraud and Theft Prevention/Detection Plans, and Subchapter 5, Health Fraud Prevention/Detection Plans, were repealed by R.2000 d.58, and Subchapter 6, Fraud Prevention and Detection Plans, was adopted as R.2000 d.58, effective February 7, 2000. See: 31 N.J.R. 3196(a), 32 N.J.R. 478(a).

Pursuant to Executive Order No. 66(1978), Chapter 16, Fraud Prevention and Detection, was readopted as R.2001 d.76, effective January 31, 2001. See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Chapter 16, Fraud Prevention and Detection, was readopted as R.2006 d.308, effective July 30, 2006. See: Source and Effective Date. See, also, section annotations.

Pursuant to the transfer of authority under P.L. 2010, c. 32, and by notice of administrative change, Subchapter 1 of Chapter 88 of Title 13, Administrative Procedures and Penalties, was recodified as Subchapter 7 of Chapter 16 of Title 11, effective June 2, 2011. See: 43 N.J.R. 1536(a).

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 16, Fraud Prevention and Detection, was scheduled to expire on July 30, 2013. See: 43 N.J.R. 1203(a).

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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 Banking and Insurance.

“Insurer” means any person, corporation, association, partnership, company, fraternal benefit society, eligible unauthorised 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).
Amended by R.2001 d.76, effective March 5, 2001.
See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

11:16-1.2 Statement of liability for fraud on claim and application 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) Pursuant to N.J.S.A. 17:33A-6, all applications for insurance shall prominently and clearly contain the following statement:

“Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.”

(c) In lieu of the statement in (a) and (b) 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 Anti Fraud Compliance
New Jersey Department of Banking and 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).

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Added a new (b) and recodified former (b) as (c).

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”) or its successor, in implementation of N.J.S.A. 17:23-19. 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.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Inserted “or its successor” following “(‘NICB’)” and substituted an N.J.S.A. reference for “P.L. 1989, c.65”.

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.

National Insurance Crime Bureau (“NICB”) means that corporate entity, or its successor in interest, that is referred to in N.J.S.A. 17:23-19 that operates and maintains a data base for the data referred to N.J.A.C. 11:16-2.4.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Inserted “National Insurance Crime Bureau (“NICB”)”.

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.

 SUBCHAPTERS 3 THROUGH 5. (RESERVED)

 SUBCHAPTER 6. FRAUD PREVENTION AND
DETECTION PLANS
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 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.

“Department” means the New Jersey Department of Banking and Insurance.

“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.

“Insurer” pursuant to N.J.S.A. 17:33A-3 (health insurance) also means:

1. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd’s insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or 17B:17-1 et seq.)
2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.
3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;
4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;
5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

6. Any dental plan organization operating pursuant to N.J.S.A. 17:48D-1 et seq.

“MCEAFC” means the Market Conduct Examinations and Anti-Fraud Compliance Unit in the Department of Banking and Insurance, Office of Consumer Protection Services.

“OIFP” means the Office of the Insurance Fraud Prosecutor in the Division of Criminal Justice in the Department of Law and Public Safety.

“Special Investigations Unit” or “SIU” means the functional group established by an insurer to carry out the duties set forth in N.J.A.C. 11:16-6.4.

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

Amended by R.2005 d.159, effective May 16, 2005.
 See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
 Deleted “DAFC”; added “MCEAFC”.
 Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).
 See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).
 In definition “Application”, deleted “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” following “that”; and deleted definition “Eligible person”.

11:16-6.3 General requirements and filing format

(a) All insurers shall file for approval a fraud prevention and detection plan (“plan”) in accordance with N.J.S.A. 17:33A-15 and this subchapter. No insurer shall use or implement any plan that is not filed and approved.

(b) Insurers shall submit their plan on 8 ½ by 11-inch paper. The first page shall show the filer’s company name, the filer’s identifying number for this filing, National Association of Insurance Commissioners (“NAIC”) company number(s), and NAIC group number.

(c) Insurers shall file their plan with the Department at the following address:

Fraud Prevention and Detection Plans
 New Jersey Department of Banking and Insurance
 Market Conduct Examinations and Anti Fraud
 Compliance Unit
 PO Box 329
 Trenton, NJ 08625-0329

Amended by R.2005 d.159, effective May 16, 2005.
 See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
 In (c), amended the address.

11:16-6.4 Special Investigations Unit (SIU)—duties, qualifications, and composition

(a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile policies, and health insurers that insure fewer than 10,000 lives, the plan filed in accordance with N.J.A.C. 11:16-6.3 shall establish a full-time Special Investigations Unit (“SIU”).

(b) The SIU shall be responsible for the following:

1. Conducting investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;

2. Providing liaison with OIFP, other law enforcement personnel and the MCEAFC;

3. Providing in-service training to claims personnel, underwriting personnel, and adjusters in accordance with the provisions of N.J.A.C. 11:16-6.5;

4. Maintaining a database of fraudulent claims and application fraud which shall contain, at a minimum, the names, addresses and other identifying information regarding all parties to the investigation referred to in (b)1 above;

5. Informing insurance underwriters of ineligible risks by reason of prior fraudulent activities from the database in (b)4 above;

6. Identifying persons and organizations that are involved in suspicious claim activity and application fraud, as described in (b)1 above;

7. Referring matters to OIFP in accordance with N.J.A.C. 11:16-6.6(b) and 6.7 and providing notice of suspicious claims in accordance with N.J.A.C. 11:16-6.6(c); and

8. Ensuring that all evidence on matters referred to the SIU including, but not limited to, checks issued in payment of claims, taped statements, original receipts, and original documents submitted by a person or entity in support of or in opposition to a claim applicant, are identified, collected and preserved in order to be turned over to OIFP at the request of OIFP in connection with the referral of cases to OIFP.

(c) The SIU shall have the following composition:

1. SIU investigators and SIU specialists shall be a separate unit from the claims or underwriting unit. For purposes of this paragraph, it shall not violate this provision if the SIU issues a check paying a claim or denies payment of a claim so long as:

i. The SIU personnel are a separate and distinct unit; and

ii. When closing the file at the completion of the investigation, the SIU records its findings in writing together with its recommendation to pay or deny the claim with the reasons.

2. Automobile insurers shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for each 30,000 New Jersey automobile policies serviced.

3. Health insurers offering comprehensive benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 60,000 insured lives.

4. Health insurers offering limited benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long-term care; Medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any other supplemental hospital indemnity benefits.

(d) Qualifications of SIU investigators and specialists shall be as follows:

1. SIU investigators shall have at least one of the following:

- i. A Bachelor's degree;
- ii. An Associate's degree plus a minimum of two years experience with insurance related employment;
- iii. A minimum of four years of experience with insurance related employment; or
- iv. A minimum of five years of law enforcement experience.

2. When approved by the Department in the plan, an insurer shall be permitted to employ a limited number of SIU specialists who shall possess unique qualifications by way of training, technical skill, and/or experience to investigate and identify cases of fraud, but lack the specific educational requirements set forth in (d)1 above, to be SIU investigators.

(e) The plan may provide that the functions of the SIU may be assigned to an outside vendor or third party administrator. In such case, the plan shall provide that the outside vendor or third party administrator shall also be responsible, together with the insurer, for compliance with N.J.A.C. 11:16-6.

Amended by R.2005 d.159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).

In (b), substituted "MCEAFC" for "DAFC" in 2.

11:16-6.5 Training program and manual for the prevention and detection of fraud

(a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile policies and health insurers that insure fewer than 10,000 lives, the plan shall provide anti-fraud education for SIU investigators, SIU specialists, claims adjusters and underwriters that shall include a detailed and comprehensive program of insurance fraud awareness and education to prepare claims adjusting and underwriting personnel for insurance fraud prevention and detection.

1. The training program, which shall include Basic Entry Level Training and Continuing Education Training for all adjusters, claims processors, underwriters, SIU investigators and SIU specialists, shall be submitted to and approved by the Department by August 5, 2000. The instructions format may be classroom instruction, self-guided instruction, videotape, seminar, computer based or by any other means.

2. The training programs referred to in (a)1 above shall be provided as follows:

i. In the case of automobile insurers, training shall include, but not be limited to, the following areas as appropriate: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, bodily injury liability claim investigation, statutory requirements for fraud referrals, techniques for the identification of fraudulent applications for coverage, insurance rate making practices, tier rating plans used by the insurer, PIP medical expense benefits and medical treatment protocols and precertification plans, and current indicators of fraud.

ii. In the case of health insurers, training shall include, but not be limited to, the following areas as appropriate: overcharging and overpayment detection, claims processing guidelines, medical coding, duplicate bills, excessive charges, unnecessary services or supplies, over-utilization, services never rendered, miscoded or misleading claim information, hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement, abusive or fraudulent referrals, statutory requirements dealing with fraud referrals, techniques for the identification of fraudulent applications for coverage, the type, methods of service and operating procedures of various health insurers, and current indicators of fraud.

iii. The Basic Entry Level Training shall be no less than nine hours of classroom instruction. The Continuing Education Training shall be no less than nine hours of training per year for SIU personnel and four hours per year for claims and underwriting personnel. Basic Entry Level training shall be given to all employees within 180 days from the commencement of their employment at each of these positions: underwriters, adjusters, claims processors, SIU investigators, or SIU specialists. The four hour continuous education training provided to non-

SIU personnel shall emphasize the responsibility of all employees to identify and report indications of internal and external fraud to the proper authority. Persons currently employed in these positions as of February 7, 2000 shall be exempt from entry level training requirements.

(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 satisfies the insurer's acceptance criteria and that 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 Motor Vehicle Commission (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-1 for Claim Fraud Referral or Notification, OIFP-2 for Application Fraud Referral or Notification, OIFP-3 for Health Claim Fraud Referral or Notification, and OIFP-4 for Health Application Fraud Referral or Notification 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 OIFP Form 1, OIFP Form 2, OIFP Form 3 or OIFP Form 4, indicating "NOTIFICATION," 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.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

Rewrote (b)1 and (c).

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote (b)1 and (c).

Amended by R.2008 d.380, effective December 15, 2008 (operative January 1, 2009).

See: 40 N.J.R. 3572(a), 40 N.J.R. 6970(b).

In (a), substituted "satisfies the insurer's acceptance criteria" for "is an eligible person" and inserted "that" preceding "the policy", and substituted "New Jersey Motor Vehicle Commission" for "New Jersey Division of Motor Vehicle Services".

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 1, OIFP 2, OIFP 3, OIFP 4, indicating "REFERRAL," 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.

Amended by R.2001 d.76, effective March 5, 2001.

See: 32 N.J.R. 4197(a), 33 N.J.R. 804(a).

In (a), inserted "OIFP-3A or OIFP-3B" preceding "which meet".

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote introductory paragraph of (a).

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) Insurers shall submit to the Commissioner on or before March 31 of each year an annual report for the prior calendar year on MCEAFC Form #1A and/or #2A, pursuant to instructions and definitions provided in MCEAFC Form #1B (for the completion of #1A) and Form #2B (for the completion of #2A), incorporated herein by reference in the subchapter Appendix. Individual insurers that comprise a group shall submit separate reports. Reports shall be submitted in hard copy or by email to:

New Jersey Department of Banking and Insurance
Market Conduct Examinations and Anti-Fraud
Compliance Unit
20 West State Street
PO Box 329
Trenton, NJ 08625-0329
Email: mceafc@dobi.state.nj.us

1. The information shall be submitted in a spreadsheet format established by the Department. Insurers may acquire the required spreadsheet format from the Department:

- i. By directing an email request for the "Annual Filing Template" to mceafc@dobi.state.nj.us; or
- ii. By directing a written request, along with a blank 3.5 inch, 1.44 MB MS-DOS formatted disk, to the above address. The Department shall return the disk and a blank spreadsheet for completion by the insurer.

Amended by R.2005 d.159, effective May 16, 2005.

See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).

Rewrote (b).

Amended by R.2006 d.308, effective September 5, 2006.

See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

Rewrote introductory paragraph of (b).

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 MCEAFC 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 MCEAFC from conducting reviews of an insurer's compliance with its fraud prevention and detection plan at the office of the MCEAFC when determined to be necessary by the MCEAFC.

(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 MCEAFC pursuant to this subchapter including, but not limited to, training programs submitted to MCEAFC pursuant to this subchapter, shall be confidential and not subject to public disclosure or inspection.

Amended by R.2005 d.159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
Substituted "MCEAFC" for "DAFC" throughout.

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 Confidential records and information

(a) All information and materials in the possession of the OIFP 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 OIFP 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.

Recodified from N.J.A.C. 11:16-6.12 and amended by R.2005 d. 159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
Former N.J.A.C. 11:16-6.11, Transition, was repealed.

11:16-6.12 (Reserved)

Recodified to N.J.A.C. 11:16-6.11 by R.2005 d. 159, effective May 16, 2005.
See: 37 N.J.R. 199(a), 37 N.J.R. 1733(a).
Section was "Confidential records and information".

APPENDIX

CLAIM FRAUD REFERRAL / NOTIFICATION FORM
OIFP-1 (01/06)



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

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

REFERRAL

NOTIFICATION

PART I

INSURANCE CO. _____ DATE REPORTED _____
ADDRESS _____ NAIC COMPANY # _____
TELEPHONE _____ D.O.L. _____
CONTACT PERSON _____ POLICY # _____
E-MAIL ADDRESS _____ CLAIM # (IF AVAILABLE) _____
SIU # (IF AVAILABLE) _____

TYPE OF COVERAGE (Check appropriate box)

STATUS (Indicate as appropriate)

LIFE W.C.
AUTO HOME
COMM
OTHER _____

PENDING PAID - IN FULL
DENIED PAID - IN PART
AMOUNT PD \$ _____ DATE/RANGE PD _____

IF PENDING OR DENIED, EITHER IN FULL OR
IN PART, THE DOLLAR AMOUNT OF THE PENDING
OR DENIED CLAIM: \$ _____

INSURED:

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

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 2006

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 CAUSE 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 TO 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 RO 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 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 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.**

PART IV

CERTIFICATION OF CUSTODIAN 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.

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

Dated:

Custodian of Records
(Full Name and Title)

PART V

COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS OF THE INVESTIGATION

ADDITIONAL SUBJECTS

ADDITIONAL INSURED

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

ADDITIONAL SUBJECTS

ADDITIONAL INSURED

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

ADDITIONAL SUBJECTS

ADDITIONAL INSURED

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

ADDITIONAL SUBJECTS

ADDITIONAL INSURED

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

PART VI

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/NOTIFICATION FORM

OIFP-2 (01/06)



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

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

REFERRAL

NOTIFICATION

PART I

INSURANCE CO. _____
 ADDRESS _____

 TELEPHONE _____
 CONTACT PERSON _____
 E-MAIL ADDRESS _____

DATE REPORTED _____
 NAIC COMPANY # _____
 DATE OF APPLICATION _____
 POLICY # (if available) _____
 CLAIM # (if available) _____

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 _____
 ADDRESS:
 STREET _____ CITY _____ STATE/ZIP _____
 WORK PH. _____ LICENSE# _____

PART II

Provision(s) OF **N.J.S.A. 17:33A-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.

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.**

PART IV 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.

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

DATED:

Custodian of Records
(Full Name and Title)

HEALTH CLAIM/FRAUD REFERRAL/NOTIFICATION FORM

OIFP-3 (01/06)



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

OIFP Case #	/	/
Intake #		
Investigator		

REFERRAL

NOTIFICATION

PART I

INSURANCE CO. _____	DATE REPORTED _____
ADDRESS _____	NAIC COMPANY _____
TELEPHONE _____	D.O.L _____
CONTACT PERSON _____	POLICY # _____
E-MAIL ADDRESS _____	CLAIM # (if available) _____
	SIU # (if available) _____

TYPE OF COVERAGE (Check appropriate box)

Health (Indemnity) Health Medicaid
Health HMO Dental
OTHER _____

STATUS (Indicate as appropriate)

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/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 _____
January 2006

SPECIALTY

ALLERGIST ANESTHESIOLOGY CARDIOLOGY CHIROPRACTIC DERMATOLOGY
 EMERGENCY MEDICINE ENDOCRINOLOGY 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

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 TO 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 RO 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 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 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.**

PART IV

CERTIFICATION OF CUSTODIAN 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.

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

Custodian of Records
(Full Name and Title)

Dated:

HEALTH APPLICATION FRAUD REFERRAL/ NOTIFICATION FORM

OIFP-4 (01/06)



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

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

REFERRAL

NOTIFICATION

PART I

INSURANCE CO. _____

DATE REPORTED _____

ADDRESS _____

NAIC COMPANY # _____

DATE OF APPLICATION _____

TELEPHONE _____

POLICY # _____

CONTACT PERSON _____

CLAIM # (if available) _____

E-MAIL ADDRESS _____

SIU # (if available) _____

TYPE OF COVERAGE (Check appropriate box)

STATUS (Indicate as appropriate)

HEALTH (INDEMNITY) HEALTH (MEDICAID)

PREMIUM ADJUSTED

HEALTH (HMO) DENTAL

AMOUNT \$

OTHER _____

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

LICENSE # _____ STATE _____

BUSINESS NAME _____ TIN # _____

PRODUCER (IF APPLICABLE): AGENCY NAME _____

PRODUCER NAME: LAST _____ FIRST _____ MI _____

ADDRESS: STREET _____ CITY _____ STATE/ZIP _____

WORK PH. _____ LICENSE _____

January 2006

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(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 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 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 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 EMPLOYER:

(FOR EXAMPLE, POLICE OFFICER, MEDICAL IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS 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.**

PART IV

CERTIFICATION OF CUSTODIAN 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.

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

Custodian of Records
(Full Name and Title)

DATED:

NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
FRAUD PREVENTION AND DETECTION PLAN ANNUAL REPORT AS OF DECEMBER 31, _____
AUTOMOBILE INSURANCE
MCEAFC Form #1A

Group Company Name _____	NAIC Group Number _____
Company/ Affiliate Name _____	NAIC Company Number _____
Address 1 _____	Address 2 _____
City _____	State _____ Zip _____
Respondent First and Last Name _____	Phone Number (____) _____
Respondent Title _____	Calendar Year of Report _____
SIU Established? YES _____ NO _____	

I. Claims Data

- a. Number of NJ Claims Opened/Received During Calendar Year _____
- b. Total dollars saved by denial and compromise during Calendar Year due to investigation¹ _____
- c. Number of NJ Claims referred to SIU during Calendar Year _____
- d. Number of NJ Claims referred to OIFP during Calendar year _____

¹ Includes claims investigations conducted by SIU and non-SIU personnel.

II. Underwriting Data

- a. Number of NJ Policies in Force During Calendar Year (includes new and renewal business). _____
- b. Number of NJ Policies and Applications Declined for Fraud During Calendar Year (includes new applications and first 60-day cancellations).² _____
- c. Number of NJ Applications and Policies (new business, renewals, terminations) referred to SIU During calendar year. _____
- d. Number of NJ Applications and Policies (new business, renewals, terminations) referred to OIFP During calendar year. _____
- e. Total dollars saved by Declination, Policy Cancellation or nonrenewal during calendar year due to fraud investigation. ²

² Includes policy and application investigations conducted by SIU and non-SIU personnel.

III. Total SIU Expenditures*

- a. Dollar Amount Spent on NJ Claim and Underwriting Fraud Detection and Prevention (See Footnotes 3-5 below):

NJ SIU Salaries ³ _____ Direct Expenses ⁴ _____ Other/Indirect Expenses⁵ _____

³ . Gross compensation exclusive of benefits including investigators, support staff, etc.

⁴ . Includes benefits excluded in item 3, as well as expenses incurred directly by SIU such as phones, equipment, cars etc.

⁵ . includes indirect expenses incurred by SIU including rent, space, utilities. May also include non-SIU expenses From other work units such as legal department, claim/underwriting department follow-up, etc.

Fraud Detection and Prevention Annual Report
Instructions and Definitions
MCEAFC FORM #1B

I. Instructions

This report is due annually, on or before March 31 of each year.

The data evaluation date for this report is January 1 through December 31.

Data must be provided separately for each company that is part of a group.

Contact Person for Questions: Virgil Dowtin
609-341-2513 ext 50402
vdowtin@dobi.state.nj.us

Report may be emailed to: mceafc@dobi.state.nj.us

Report may be mailed to: New Jersey Department of Banking and Insurance
Office of Consumer Protection Services
Market Conduct and Anti-Fraud Compliance
20 West State Street
P.O. Box 329
Trenton, N.J.
08625

Scope: This report includes automobile fraud prevention and detection statistics.

II. Definitions

Calendar Year means the period January 1 to December 31.

Claim means a request for indemnity by an insured or claimant.

Claims Opened/Received means the total number of claims opened or received by SIU (or the company in the event that an insured is not required to establish an SIU, during the reporting period).

Dollar Amount Spent is based either on actual expenses for those insurers that track this information individually and by State, or the insurer's pro-rata share in the event that expenses are tracked on an aggregate, national level. Self-insured risk expenditures should be excluded, either on a direct dollar basis or by pro-rata share or other method that distinguishes self-insured and non-self-insured expenditures.

NJ Claim refers to a claim that was made in the State of New Jersey.

NJ Policies and Applications refer to coverages written or applied for in the State of New Jersey.

Non-SIU Investigation means all fraud-investigative activity conducted in the normal course of handling a claim and where an SIU has not been established.

SIU Investigation means all investigative activity that was performed exclusively by the Special Investigative Unit.

Total Dollars Saved applies to all funds that would have been fraudulently or improperly obtained by claimants, ordered or agreed to be returned through adjudication or judgment, as a result of a fraud investigation.

**NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE
 FRAUD PREVENTION AND DETECTION PLAN ANNUAL REPORT AS OF DECEMBER 31, _____
 HEALTH INSURANCE
 MCEAFC Form #2A**

Group Company Name _____	NAIC Group Number _____
Company/ Affiliate Name _____	NAIC Company Number _____
Address 1 _____	Address 2 _____
City _____	State _____ Zip _____
Respondent First and Last Name _____	Phone Number (____) _____
Respondent Title _____	Calendar Year of Report _____
SIU Established? YES _____ NO _____ Company also writes self-insured business and reported pro-rata data on Non-self-insured business Yes _____; NO _____ (See Scope/Definitions)	

I. Claims Data

a. Number of NJ Claims Opened/Received During Calendar Year _____

b. Total dollars saved by denial and compromise during Calendar Year due to investigationⁱⁱ _____

c. Number of NJ Claims referred to SIU during Calendar Year _____

d. Number of NJ Claims referred to OIFP during Calendar year _____

¹ Includes claims investigations conducted by SIU and non-SIU personnel.

II. Underwriting Data

a. Number of NJ Policies in Force During Calendar Year (includes new and renewal business). _____

b. Number of NJ Policies and Applications Declined for Fraud During Calendar Year (includes new applications and first 60-day cancellations).² _____

c. Number of NJ Applications and Policies (new business, renewals, terminations) referred to SIU During calendar year. _____

d. Number of NJ Applications and Policies (new business, renewals, terminations) referred to OIFP During calendar year. _____

e. Total dollars saved by Declination, Policy Cancellation or nonrenewal during calendar year due to fraud investigation. ² _____

² Includes policy and application investigations conducted by SIU and non-SIU personnel.

III. Total SIU Expenditures*

a. Dollar Amount Spent on NJ Claim and Underwriting Fraud Detection and Prevention (See Footnotes 3-5 below):

NJ SIU Salaries ³ _____ Direct Expenses ⁴ _____ Other/Indirect Expenses⁵ _____

³ . Gross compensation exclusive of benefits including investigators, support staff, etc.

⁴ . Includes benefits excluded in item 3, as well as expenses incurred directly by SIU such as phones, equipment, cars etc.

⁵ . includes indirect expenses incurred by SIU including rent, space, utilities. May also include non-SIU expenses From other work units such as legal department, claim/underwriting department follow-up, etc.

**Fraud Detection and Prevention Annual Report
Instructions and Definitions
MCEAFC FORM #2B**

I. Instructions

This report is due annually, on or before March 31 of each year.

The data evaluation date for this report is January 1 through December 31.

Data must be provided separately for each company that is part of a group.

Contact Person for Questions:

Virgil Dowtin
609-341-2513 ext 50402
vdowtin@dobi.state.nj.us

Report may be emailed to:

mceafc@dobi.state.nj.us

Report may be mailed to:

New Jersey Department of
Banking and Insurance
Office of Consumer
Protection Services
Market Conduct and Anti-
Fraud Compliance
20 West State Street
P.O. Box 329
Trenton, N.J. 08625

Scope:

This report includes
automobile
fraud prevention and
detection statistics.

II. Definitions

Calendar Year means the period January 1 to December 31.

Claim means a request for indemnity by an insured or claimant.

Claims Opened/Received means the total number of claims opened or received by SIU (or the company in the event that an insured is not required to establish an SIU, during the reporting period).

Dollar Amount Spent is based either on actual expenses for those insurers that track this information individually and by State, or the insurer's pro-rata share in the event that expenses are tracked on an aggregate, national level. Self-insured risk expenditures should be excluded, either on a direct dollar basis or by pro-rata share or other method that distinguishes self-insured and non-self-insured expenditures.

NJ Claim refers to a claim that was made in the State of New Jersey.

NJ Policies and Applications refer to coverages written or applied for in the State of New Jersey.

Non-SIU Investigation means all fraud-investigative activity conducted in the normal course of handling a claim and where an SIU has not been established.

SIU Investigation means all investigative activity that was performed exclusively by the Special Investigative Unit.

Total Dollars Saved applies to all funds that would have been fraudulently or improperly obtained by claimants, ordered or agreed to be returned through adjudication or judgment, as a result of a fraud investigation.

Repeal and New Rule, R.2006 d.308, effective September 5, 2006.
See: 38 N.J.R. 1276(a), 38 N.J.R. 3592(a).

SUBCHAPTER 7. ADMINISTRATIVE PROCEDURES AND PENALTIES

11:16-7.1 Purpose and scope

This subchapter sets forth the procedures that govern the conduct of administrative hearings for imposing civil and administrative penalties for violations of the New Jersey Insurance Fraud Prevention Act, as amended, N.J.S.A. 17:33A-1 et seq. These rules are intended to implement N.J.S.A. 17:33A-5 which allows for the imposition of civil and administrative penalties, costs of prosecution, including attorneys fees, and orders of restitution. These rules do not govern criminal or civil proceedings for violations of the New Jersey Insurance Fraud Prevention Act filed in the Superior Court.

11:16-7.2 Construction

(a) These rules shall be liberally construed to permit the Bureau of Fraud Deterrence to discharge its statutory function.

(b) Upon notice to all parties, these rules may be relaxed for good cause in a particular situation in order to effectuate the purposes of the New Jersey Insurance Fraud Prevention Act. Statutory time limits may not be relaxed.

11:16-7.3 Definitions

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

“Administrative complaint” means a pleading that provides the notice to a person required by N.J.S.A. 17:33A-5c that a civil and administrative penalty is being imposed on the person for a violation of N.J.S.A. 17:33A-1 et seq.

“Administrative consent order” means an offer of settlement in the form of an order in which the BFD and a person alleged to have violated N.J.S.A. 17:33A-1 et seq. mutually agree to resolve a case.

“BFD” means the Bureau of Fraud Deterrence in the Department of Banking and Insurance.

“Burden of proof” means the obligation of a party to meet the requirements of a rule of law that a fact be proved.

“Civil and administrative penalty” means a sanction authorized by any statute or administrative rule to be imposed on a person for any act or omission in violation of N.J.S.A.

17:33A-1 et seq., including any monetary penalty and any order to make restitution and to pay the reasonable costs of prosecution, including attorneys fees, of any matter.

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Final agency order” means any and all final orders issued or executed by the Commissioner.

“Hearing” means a proceeding held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, for the purpose of determining disputed issues of fact, law or disposition.

“Insurance company” or “Insurer” means any entity coming within the definition of insurance company set forth in N.J.S.A. 17:33A-3.

“Notice” means a written communication from the BFD to an alleged violator of the assessment of a civil and administrative penalty containing those elements set forth in N.J.A.C. 11:16-7.4.

“Person” means a person as defined in N.J.S.A. 17:33A-3.

“Petitioner” means the State of New Jersey, Bureau of Fraud Deterrence.

“Respondent” means an alleged violator named in a civil and administrative complaint.

Amended by R.2009 d.354, effective December 7, 2009.
See: 41 N.J.R. 2630(a), 41 N.J.R. 4454(a).

In definition “Civil and administrative penalty”, substituted “omission” for “mission”; and in definition “Notice”, updated the N.J.A.C. reference.

11:16-7.4 Notice of the intent to impose civil and administrative penalties

(a) Before a civil and administrative penalty is imposed, the BFD shall serve the respondent with a notice, in the nature of an administrative complaint, in the manner provided in N.J.A.C. 11:16-7.5. The notice shall include:

1. A reference to the statute, rule, order and/or prohibited conduct under the Insurance Fraud Prevention Act (N.J.S.A. 17:33A-1 et seq.) the respondent violated;

2. A concise statement of the facts providing the basis for the determination of a violation of N.J.S.A. 17:33A-1 et seq.;

3. A statement of the civil and administrative penalty or penalties to be imposed; and

4. A statement advising the respondent of the right to a hearing and the procedure for requesting a hearing.

(b) The administrative complaint may describe more than one violation and more than one specific penalty for each violation. A single form of notice may be used to notify several respondents, provided each person is named and properly served with a copy of the notice in accordance with N.J.A.C. 11:16-7.5.

(c) Prior to issuing an administrative complaint, the BFD may attempt a mutual resolution of the matter by offering the alleged violator the opportunity to resolve the matter by an administrative consent order. Under these circumstances, an offer of settlement by administrative consent order shall not be deemed to constitute notice of initiation of an action and shall not be available to be presented in evidence in a formal administrative action.

11:16-7.5 Service of notice

(a) If the respondent is an individual, service of the notice of administrative complaint described in N.J.A.C. 11:16-7.4 may be made by delivering a copy of the administrative complaint to the respondent, personally or by leaving a copy thereof at the respondent's dwelling place or usual place of abode with a competent household member of the age of 14 years or over then residing therein, or by delivering a copy thereof to a person authorized by appointment or by law to receive service of process on the respondent's behalf.

(b) In lieu of the manner of service set forth in (a) above, service on an individual may be made by mailing the administrative complaint by regular and certified mail, return receipt requested, to the respondent's last known business or residence mailing address in or outside of this State.

(c) If the respondent is a domestic or foreign corporation, partnership or other business entity, service may be made by delivering a copy of the administrative complaint to either an officer, director, trustee, partner or managing or general agent, or any person authorized by appointment or by law to receive service of process on behalf of the corporation, partnership or other business entity or the person at the registered office or the principal place of business of the corporation, partnership or other business entity in charge thereof. If service cannot be made upon any of the foregoing, then it may be made upon any agent, servant or employee of the corporation acting in the discharge of the duties of the corporation.

(d) In lieu of the manner of service set forth in (c) above, service may be made by mailing the administrative complaint by regular and certified mail, return receipt requested, to either an officer, director, trustee, partner or managing or general agent, or any person authorized by appointment or by law to receive service of process on behalf of the corporation,

partnership or other business entity or the person at the registered office or the principal place of business of the corporation, partnership or other business entity in charge thereof.

(e) Service of an administrative complaint may also be made upon a respondent in a manner provided in R. 4:4-4(a) of the Rules Governing the Courts of the State of New Jersey.

11:16-7.6 Failure to respond to notice

(a) If a respondent does not deliver to BFD a written request for a hearing in the form and manner required by N.J.A.C. 11:16-7.8, a final agency order shall be issued imposing the civil and administrative penalty or penalties described in the administrative complaint as well as costs of prosecution, including attorneys fees, and restitution, if awarded.

(b) BFD shall mail a copy of the final order to the respondent at the address where service was made or at a respondent's last known address.

11:16-7.7 Resolution of administrative complaints by administrative consent order

(a) In order for a matter set forth in an administrative complaint to be deemed concluded by consent of the respondent to the imposition of the civil and administrative penalty described in the notice, the BFD may require any or all of the following in an administrative consent order:

1. The payment of a monetary penalty;
2. The restitution of moneys owed to any person;
3. Costs of prosecution, including attorneys fees; and
4. Admissions of material facts, conclusions of law, and such other terms and conditions as the BFD may deem to be necessary and appropriate under the circumstances.

11:16-7.8 Request for a hearing

(a) A respondent shall have 20 calendar days from the date of service of an administrative complaint within which to deliver a written request for a hearing to the BFD.

(b) A request for a hearing shall include:

1. The name, address and daytime telephone number of the respondent;
2. The caption and agency number of the administrative complaint;
3. A statement requesting a hearing;
4. A specific admission, denial, or explanation of each fact alleged in the administrative complaint, or a statement that the respondent is without knowledge of the action(s) complained of. A respondent shall not generally deny all of the allegations but shall make denials as specific denials

that meet the substance of the designated allegations of the complaint; and

5. A concise statement of the facts or principles of law claimed to constitute a factual or legal defense.

(c) If a request for a hearing lacks any of the elements in (b) above, the BFD may deny the request or advise the requester in writing of the deficiencies and provide an additional 10 calendar days from the issuance of the deficiency letter to correct them. If no reply correcting the deficiencies is received by the BFD within 10 calendar days, the BFD may deny the request for a hearing and issue a final order without holding a hearing.

(d) Upon receipt of a properly completed request for a hearing, the Assistant Commissioner, BFD or such other BFD personnel as may be designated by the Commissioner, shall examine the request and may conduct or direct such further proceedings as may be appropriate, including, but not limited to, an interview with the respondent.

(e) Not later than 30 days after the receipt of a properly completed request for a hearing, the Assistant Commissioner, BFD, or such other BFD personnel as may be designated by the Commissioner, shall advise the respondent of the manner of disposition, which may be as follows:

1. Withdrawal of the administrative complaint with or without prejudice;

2. Resolution by administrative consent order, which may provide for a lesser or different civil and administrative penalty than that originally sought; or

3. A finding that the matter constitutes a contested case, pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. In such case, the BFD shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(f) Computation of time shall be in accordance with N.J.A.C. 1:1-1.4.

(g) The burden of proof in a contested case shall rest upon the petitioner and shall be met by a preponderance of the credible evidence.

11:16-7.9 Penalties, restitution and costs

(a) Civil and administrative penalties may be imposed of not more than \$5,000 for the first violation; \$10,000 for the second violation; and \$15,000 for each subsequent violation of any provision of N.J.S.A. 17:33A-1 et seq. and restitution may be ordered to any insurance company or other person who has suffered a loss as a result of a violation.

(b) For the purpose of applying N.J.S.A. 17:33A-5, each violation of a provision of N.J.S.A. 17:33A-4 in the course of a single claim or application for insurance constitutes a separate violation of the Fraud Act for which a separate civil and administrative penalty may be imposed in accordance with (a) above.

(c) After a hearing, if requested, as provided in N.J.A.C. 11:16-7.8 and upon finding that a violation has occurred, the Commissioner shall issue a final agency order assessing the costs of prosecution, including attorneys fees, in addition to the penalty referred to in (a) above.

(d) In any matter in which payment of a civil and administrative penalty is ordered, payment of the civil and administrative penalty shall be made not later than 10 days following service of the final agency order. Payment of an assessed civil and administrative penalty shall be by certified check or money order made payable to the Commissioner, New Jersey Department of Banking and Insurance by forwarding same to the BFD.

(e) In any matter in which payment of the costs of prosecution, including attorneys fees, are ordered, payment thereof shall be made not later than 10 days following service of the final agency order. Payment of the assessed costs of prosecution, including attorneys fees, shall be by certified check or money order made payable to the State of New Jersey, and forwarding same to the BFD.

(f) In any matter in which payment of restitution is ordered, payment thereof shall be made not later than 10 days following service of the final agency order. Payment of restitution shall be by certified check or money order made payable to the person named in the final agency order by forwarding same to the BFD.

(g) Any civil and administrative penalty imposed pursuant to N.J.A.C. 11:16-7.6, 7.7 or 7.9 may be collected with costs, including attorneys fees, in a summary proceeding pursuant to the penalty enforcement law, N.J.S.A. 2A:58-10 et seq. Any civil and administrative penalty collected pursuant to this subsection shall be applied in accordance with N.J.S.A. 17:33A-5e.

Amended by R.2009 d.354, effective December 7, 2009.

See: 41 N.J.R. 2630(a), 41 N.J.R. 4454(a).

Section was "Service of notice".

11:16-7.10 Severability

If any rule, sentence, paragraph or section of these rules, or the application thereof to any persons or circumstances, shall be adjudged by a court of competent jurisdiction to be invalid, or if by legislative action any rule shall lose its force and effect, such judgment or action shall not affect, impair or void the remainder of these rules.

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).