Some Insurance Group.
NAIC Group #: 3098
Some Member Company **NAIC # 11111**
Another Member NAIC # 22222
Another Member NAIC # 33333

New Jersey Anti-fraud Prevention and Detection Procedure Manual

20XX

Contents

Update History

Effective Date	Page(s)	Description

This fraud prevention and detection procedure manual is disseminated it to, or otherwise made available to, as appropriate, all SIU, claims adjusters, and underwriting personnel.

General Investigative Guidelines:

Every claim file should be evaluated for potential fraud. The vast majority of claims are not fraudulent. Potentially fraudulent activity must be considered;

If there is an element of fraud appears, the file supervisor and SIU should be consulted. Then a determination will be made as to whether claim should be processed as an SIU file and if further investigation is needed. Special Investigation Unit files should be tracked and reported to the authorities as appropriate.

The primary responsibility for early detection of suspicious or fraudulent acts clearly rests with all integral anti-fraud personnel. “This Company” maintains its own dedicated SIU Unit within New Jersey which is responsible for coordinating the detection, referral and investigation of suspected fraudulent activity.

Mention any unique programs used to assist the integral anti-fraud staff in routinely detecting fraud such as access to a company intranet with investigative resources.

Include any company guidelines and policies for access to and utilizing various public databases, which can assist in providing information which may be pertinent to the claims.

This includes access to public records, national phone listings, aerial and satellite imaging, etc..

Claim adjusters

General investigative guidelines narrative for claim adjusters can include but not limited to the following example:

> Claim professionals are expected to promptly refer any issue of suspected fraud to their appropriate company SIU point of contact or following any of these early detection methods:
>
> - Calls from policyholders, subscribers, beneficiaries and other providers received on a toll free or local inquiry line;
> - Suspicions raised by claims or underwriting personnel;
> - Suspicions raised by field agents or brokers;
> - Suspicions raised by service providers;
> - Referrals from other policyholders;
> - Information obtained in conjunction with special surveys and studies conducted by the company;
> - Referrals from law enforcement, i.e. the Insurance Fraud Divisions, the F.B.I., State and local police departments, the Board of Physicians Quality Assurance, the Attorney General’s Office, Medicaid Fraud Control Unit, and U.S. Postal Inspectors, etc.

Underwriting personnel

General investigative guidelines narrative for underwriters can include but not limited to the following example:

Underwriters are expected to promptly refer any issue of suspected fraud to their appropriate company SIU point of contact or following any of these early detection methods:

- Calls from policyholders, subscribers, beneficiaries and other providers received on a toll free or local inquiry line;
- Suspicions raised by underwriting personnel;
- Suspicions raised by field agents or brokers;
- Suspicions raised by service providers;
- Referrals from other policyholders;
- Information obtained in conjunction with special surveys and studies conducted by the company;
- Referrals from law enforcement, i.e. the Insurance Fraud Divisions, the F.B.I., State and local police departments, the Board of Physicians Quality Assurance, the Attorney General's Office, Medicaid Fraud Control Unit, and U.S. Postal Inspectors, etc.

SIU investigators

General investigative guidelines narrative for example:

Upon receipt of the SIU referral, each activity/claim must be investigated by Special Investigation Unit personnel on its own merits, and the following general investigation must commence within 48 hours.

1. A SIU Investigator is assigned to the file;
2. Within 72 hours, an investigation is undertaken:
   This includes review of the referral, the facts and information in the claims file and/or regarding any activity. A full review of an analysis of electronic databases and insurance industry resources is undertaken and may include the following:
   a) ISO Index Bureau
   b) Property Insurance Loss Register
   c) Various state insurance departments and /or workers' compensation commissions
   d) Prosecuting Attorneys' Office
   e) Federal, State or local Law Enforcement Agency
3. A thorough plan of action is developed with consultation and input from the integral anti-fraud personnel and SIU;

SIU Specialists

Where Special Investigation Unit Specialists are employed - General investigative guidelines narrative as they differ from SIU Investigators guidelines

Conducting interviews

Good interviews are an important key to good investigations. Of as much importance as the questions asked are the interviewer's attitude, facial expressions, tone of voice and method of questioning, always keeping in mind good faith and fair dealing. Interviews

should not be treated as interrogations and should not be approached with conviction that fraud will be found.

Attitude

An attitude which is objective, cordial and polite, and projects interest, sincerity and understanding will be more successful in obtaining the information needed. Nobody likes giving information to somebody with an "attitude". Often if an accusatory attitude is projected the natural response is to give as little information as possible.

If the interview is in person, avoid such facial expressions as those of disbelief, shock, anger, humor, disgust, and skepticism, even if you feel such reactions are warranted. These will do nothing to obtain the information you are seeking. A better procedure would be to keep as neutral a demeanor as possible and simply ask the proper question.
For example if the answer to a question does not make sense, it is much more productive to make a simple statement to that effect. "Considering the fact that the alarm was set on your car and it was parked right outside your window, how was it that you heard nothing when it was stolen?", or "You said that your car was not damaged at all, how did you hurt your knee so badly?"

Tone of Voice

Do not use a skeptical tone of voice. Your voice should be of a conversational tone, not too loud or too soft.

Method of Questioning

Try to maintain good eye contact without staring. Never mention the word "fraud". Remember your objective is to obtain as much information as is needed, not to accuse the person you are questioning. Always remain polite and professional. Ask specific questions and WAIT for the answer, do not supply answers to your questions. (For example, "Wasn't your husband driving?")

Questions

Your questions should be specific.
What is a specific question? One which is not vague but uses specific wording.

Examples:

Vague	Specific
Where do you work?	What is the name and address of your employer?
Where is…?	What is the address of
How long were you there?	How much time did you spend with the medical provider

Vague questions sometimes illicit non-responsive answers and often prolong the interview.

For example, answers to the above vague questions could be:

(Where do you work?) I work for my brother-in-law in South Jersey.

(Where is...?) Next to the Doctor's office in Newark.

(How long were you there?) An hour. (This could mean 45 minutes in the waiting room and 15 minutes with the Medical provider.)

At best, when you ask vague questions, you have to ask additional questions. At worst you can come to the wrong conclusion if your questions are not specific.

A good technique when you are conducting an interview is to be prepared with as many facts as possible. Listen carefully to all the responses. Depending on the answer, additional questions may occur to you. This is why it is much better not to use a list of questions and go down the list.

If it helps, you can go over a list of questions when the interview is completed to make sure you did not miss anything. Remember not to lead the person and not to answer the questions for them.

Report Writing

Just as you should treat every interview and statement as if the file were going to be litigated so should you treat your reports. The aim of your written report is to be as concise and complete as you can. Here are some principles to help you achieve this ideal.

- The first paragraph should briefly outline who referred the matter and why it is being investigated, i.e. the “red flag” which prompted a referral, not a statement criticizing the claimant or insured.
- • Although you may be using a form for your report whose heading includes the name of the insured, policy number, claim number, etc. the first time you mention any of these in your report, identify them by name or number. This is also true of the policy address.
- • If it is an auto claim, describe the vehicle the first time it is mentioned. For example, instead of writing “Mr. Insured reported his car stolen on such a date,” it is better to write: Mr. John Insured reported to the Franklin Township Police that his l999 Jeep was stolen at 12:15 PM on January 2, 2000.” GIVE ALL DETAILS.
- • Be very careful using “he” or “she”. It is always best to mention the names of individuals in order to avoid confusion. For example, “Ms. Insured told me that her sister heard a noise and when she looked outside she was able to see an individual drive away in the car. She was able to identify the individual. ” The questions which are not clearly answered are: Who looked outside? Who saw the individual?, Was the individual male?, female?, alone?, and who was able to identify the individual?
- • It is much more professional to refer to yourself in a report as “this investigator” rather than “I” or “me”. • When referring to an employee of NJM do not assume everyone reading the report will know the person. Should the matter be referred to OIFP or another agency, not all parties are familiar with our employees. Write, for example, “Mary Smythe from NJM's Underwriting Dept. spoke to Mr. John Insured on April 24, 2000.”
- • If you refer to the NJM computer policy notes in the report, identify them specifically not simply “the policy notes”. Again, you can’t assume everyone reading the report will be as familiar with our system as you are.
- • If you refer to an individual you must either a) identify them by name and address, or b) state that they wish to be anonymous. Do not simply state in your report that you spoke to a neighbor of the insured or to the receptionist at the medical provider’s office.
- • If you mention an Examination Under Oath, do NOT include the opinions of our attorney. This is privileged work product.

- • DO NOT include your opinions in your reports. For example: “I think Mr. Insured is lying." Let the facts speak for themselves. For example: “Mr. Insured made several inconsistent statements ...” If you are asked for your opinion verbally, then this is permissible.
- • Underwriting investigation reports should include the amount of premium difference, if any, and a copy of the original application or renewal forms when appropriate.
- • Write the report as if the person reading it knows no facts. Do not assume that because you are sending the report to the person who referred the matter, that you do not have to include all facts, names, addresses, vehicle descriptions, etc.

KEEP IT SIMPLE AND FACTUAL.

Law enforcement relations

The very nature of the investigative function of the SIU requires a form of interrelationships with law enforcement offices and other public officials. The general policy of “This Company” with regard to such relationships is one of cooperation to the extent possible within the limits established by statutory enactment and court decisions.

We foster our relations with law enforcement through the attendance and participation in the NJSIA seminar and are guided by their needs to successfully prosecute individuals involved in fraudulent activities. We cooperate with all law enforcement agencies through our representative NICB to gather the materials necessary to assist them in their prosecution efforts. “This Company” provides all information requested by law enforcement agencies to assist them in their respective criminal proceedings. We readily identify and report all suspect criminal activity to the appropriate agency.

Investigators should not act under the direction of law enforcement or other public officials. It is not the function of “This Company” to foster or generate criminal prosecution. That is the responsibility of the local, state, and federal law enforcement agencies and public prosecutors.

Procedure for referring claims and applications to Office of the Insurance Fraud Prosecutor

As soon as possible after a matter has been investigated and the SIU investigator has made a determination that a reasonable suspicion of fraud exists, a final disposition report is to be written. This final disposition report, together with the completed OIFP approved referral form, will be submitted to the SIU Director and Counsel and to the Supervisors. After reviewing the final disposition report and the referral form, and making a determination of approval, the matter will be forwarded to the OIFP for any further consideration or whatever action is deemed appropriate. When appropriate, and with the approval of the OIFP, referral of the matter will also be made to additional agencies within the state as well as outside the state.

Fraud Indicators – Automobile Insurers

Automobile Bodily Injury Indicators

Automobile Physical Damage

Automobile Theft

General Claim Indicator

Personal Injury Claims Fraud,

Suspicious Claims Indicators

Underwriting / Application Indicators

Fraud Indicators –Health Insurers

General Indicators of Fraud

Disability Income Indicators

Healthcare Fraud Indicators

Application Fraud

Duties and Functions of Special Investigation Unit

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. 11:6-6.6(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,
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 Office of the Insurance Fraud Prosecutor

Procedure for referring a claim or application to the SIU

In General

As soon as a reasonably suspicious event arises, the individual who suspects that a fraud, abuse or other questionable circumstance has taken place will report that suspicion to his/her immediate supervisor for evaluation. If the evaluation of that immediate supervisor determines that further investigation is merited, an Special Investigation Unit referral shall be prepared. In the event the supervisor is undecided as to whether a situation warrants further investigation, the SIU Director and Counsel should be contacted for guidance.

The referral shall be made on a prescribed report form, adequate blank copies of which shall be maintained in each department. Representative copies of appropriate forms are incorporated into the Fraud Manual. The report shall include photocopies of all available relevant data so that the SIU shall be able to properly evaluate the potential abuse.

Timeliness of Referrals

The SIU should be contacted as soon as practical after the discovery of a suspicious event to discuss possible referral. Such contact should be made with the Director and Counsel of the SIU or in the event of his or her unavailability, to the appropriate SIU Supervisor. Time is of the essence to avoid assertions of bad faith and/or unfair practices.

In the event that non-SIU supervisory personnel are certain that a suspicious event merits submission of a referral to the SIU without the need for discussion of the said event with SIU personnel, the referral should be submitted to the SIU Director and Counsel in a timely manner.

Commencement of SIU Activity

Once the SIU has received a referral from an operational department of “the Company”, it shall send an acknowledgment on a prescribed form to the referring department. That acknowledgment shall be kept in the claim, underwriting or other operational file to alert personnel in the operational department to consult with SIU personnel before undertaking further action related to the operational file.

Upon receipt of a referral, the SIU shall immediately establish an appropriate SIU file and commence its Special Investigation Unit investigation within three business days of the receipt of the written referral, whenever possible.

The SIU investigation and other SIU activities shall be the responsibility of the Special Investigations Unit. Non-SIU personnel, however, shall render all reasonably necessary cooperation and assistance.

Unconfirmed - Unsupported SIU Referrals

The SIU investigation shall make every reasonable effort to determine as soon as practical whether there is a legitimate basis for continued SIU activity related to every referral.

As soon as it is determined by the SIU that there is no reasonable basis for continued SIU activity related to a referral, the SIU shall notify the referring department of its

decision on a prescribed form and thereafter close out the official SIU file with adequate record keeping in consideration for the purposes of preparing an annual Special Investigation Unit report.

Post Referral Procedures

The post-referral procedures for communication between the claims unit and/or the underwriting unit and the SIU are an essential anti-fraud aspect of our plan and procedures.

Throughout the SIU Investigation and referral process, updates and/or reports and electronic communication continue until the matter is fully resolved.

Upon resolution of the coordinated investigation, a formal decision will be made to:

1. Deny the claim;
2. Pay the claim;
3. Take the appropriate action if not a claim;
4. Bring appropriate civil action;
5. Bring appropriate criminal action;
6. Rescind coverage.

Please note: “The Company’s” claims, underwriting and SIU teams are to work collaboratively when modifications are required in the handling, referral and reporting of SIU related matters.

When necessary, final adjudication of the claim must be filed with the SIU for accurate (our procedures also require affiliate and TPA annual reporting when and if contracted). In addition, SIU's "reporting" function involves these additional claims/underwriting units and SIU:

1. Tracking items internally on a database or via manual entries, and;
2. As applicable, informing insurance underwriters of ineligible risks by reason of prior fraudulent activities from the database;
3. Communicating with the referring underwriter and or claims personnel and documenting the claims/underwriting file with a post-referral and closing report relative to the SIU action taken on the file and the results of the investigation and/or referral.

With respect to claim activity, whenever the handler (or SIU) has reasonable suspicions that a claim may be tainted then an appropriate flag or "resource code” can be added to a database or to a manual logging document. That data can then be retrieved later, either to comply with state required law reporting rules and regulations or, possibly, to identify patterns of fraudulent activity. The database and/or manual logs will contain at a minimum the names, addresses and other identifying information regarding all parties to the investigation.

We compile and report data on claims identified as having some actual or possible element of fraud. Using the claim database and other resources (e.g., the actual claim file), the Special Investigative Unit can and will comply with "notice" requirements.

Exhibit 1 Automobile Fraud Indicators

These indicators can help claims personnel to recognize fraud schemes. No indicator by itself is necessarily suspicious, and the presence of any indicator does not firmly establish that a fraud has been committed, but it should alert the claims representative that closer scrutiny of the claim is necessary.

Initial Referral Procedures

- ☐ All cases of suspected fraud should be reported to the Special Investigations Department.
- ☐ • The Special Investigations Supervisor will review the claim referral and assign to an investigator.

Bodily Injury Indicators

- ☐ No police report or on-scene police report.
- ☐ Several claimants and same vehicle; subjective injuries; similar reports; same doctors and the same attorneys.
- ☐ Food products liability with the foreign substance unavailable; extent or nature of treatment inconsistent with injury or illness.
- ☐ Bodily injuries appear excessive compared to the amount of physical damage to the auto.
- ☐ Accident is a rear end collision caused by a sudden unjustified stop by the claimant's car.
- ☐ Accident occurred shortly after one or more of the vehicles were purchased, registered or insured.
- ☐ Insured feel "set-up" by claimants.
- ☐ Claimant's work place telephone number connected to answering machine or registers to an answering service or mail drop.
- ☐ Slight impact; subjective injuries (soft tissue); substantial treatment and excessive demands.
- ☐ Questionable dates of treatment; evidence of alteration of dates and/or charges.
- ☐ Slip and fall with no actual witness; the witness is unusually observant.
- ☐ A company name on a lost wage statement cannot be located; there is no record of said employee at that company; the company is owned by a relative of the claimant.
- ☐ Claimed ailments persist far beyond normal recuperative time period.
- ☐ Insured takes out a new policy even though the insured vehicle was purchased long before coverage was sought.
- ☐ Doctor's mode of treatment, duration of treatment always the same even though injuries/accidents differ.
- ☐ Designated doctors and lawyers have known history of BI Claim involvement.
- ☐ Location of doctor/therapist inconvenient to claimant.
- ☐ Doctor making house calls beyond convenient distance.
- ☐ Wage documentation is lost; has no letterhead; is handwritten or photocopied; includes questionable earnings; is difficult to verify.
- ☐ Presence of damaged items (props) found (claimed) as damaged.

- ☐ Insured is eager to accept blame for the accident.
- ☐ Vehicle is a “beater” an old car with basic coverages.
- ☐ Vehicle damage, although generally minor, invariably “totals” the car.

Personal Injury

- **Injuries are subjective – soft tissues, sprains, headaches, psychological issues**
- **Psychological claims for Stress and Anxiety**
- **Claim is from previous injury**
- **Excessive recovery time**
- **Excessive Chiropractic treatment**
- **Excessive testing – MRI-NCV**
- **Excessive Therapeutic treatment – massages, acupuncture**
- **Subject shows no interest in getting better – doesn’t want tests**
- **Subject visit specific doctors immediately**
- **Subjects’ vitals are good –despite alleged long term inactivity**
- **Subject is over dramatic when describing injury**
- **Conflicting medical opinions**
- **Medical billings are billed on holidays and weekends**
- **Treatment includes prescriptions for controlled substances**
- **Variation in description of pain**

Indicators of Automobile Physical Damage Fraud

- Serious accident with expensive physical damage claim but only minor. subjectively diagnosed injuries. with little or no medical treatment.
- Despite expensive damage claims. the claimant vehicle remains drivable. Often, there are no towing charges for removing vehicle from the scene of the accident
- Claimant vehicle was struck by a rental vehicle soon after the rental had occurred
- Claimant vehicle is not to be repaired locally, but driven or shipped out of state for repair
- All vehicle.;; in a reported accident are taken to the same body shop
- Claimant vehicles are not readily available for independent appraisal.
- Reported accident occurred on private property near residence of those involved

Automobile Theft Indicators

INDICATORS OF FRAUD CONCERNING THE INSURED

- has lived at current address less than six months.
- has been with current employer less than six months
- address is a post office box or mail drop.
- does not have a telephone
- listed number is a mobile/cellular phone
- is difficult to contact
- frequently changes address and/or phone number.

- place of contact is a hotel, tavern, or other place which is neither his/her place of employment nor place of residence.
- handles all business in person, thus avoiding the use of the mail
- is unemployed .
- claims to be self-employed but is vague about the business and actual responsibilities.
- has recent or current marital and/or financial problems
- has a temporary, recently issued, or out-of-state driver's license
- driver's license has recently been suspended.
- recently called to confirm and/or increase coverage
- has an accumulation of parking tickets on vehicle.
- is unusually aggressive and pressures for quick settlement
- offers inducement for quick settlement
- is very knowledgeable of claims process and insurance terminology
- income is not compatible with value of insured vehicle
- claims expensive contents in vehicle at time of theft
- is employed with another insurance company.
- wants a friend or relative to pick up settlement check
- is behind in loan payments on vehicle and/or other financial obligations.
- avoids meetings with investigators and/or claim adjusters.
- cancels scheduled appointments with claim adjusters for statements and/or examination under oath.
- has a previous history of vehicle theft claims

INDICATORS OF FRAUD RELATED TO VEHICLE

- was purchased for cash with no bill of sale or proof of ownership.
- is a new or late model with no lien holder.
- was very recently purchased
- was not seen for an extended period of time prior to the reported theft
- was purchased out of state.
- has a history of mechanical problems.
- is a "gas guzzler."
- is customized, classic, and/or antique.
- displayed "for sale" signs prior to theft.
- was recovered clinically/carefully stripped
- is parked on street although garage is available.
- was recovered stripped, but insured wants to retain salvage, and repair appears to be impractical.
- is recovered by the insured or a friend
- purchase price was exceptionally high or low
- was recovered with old or recent damage and coverage was high deductible or no collision

coverage

- coverage is only on a binder
- has an incorrect VIN (e.g., not originally manufactured, inconsistent with model).
- VIN is different than VIN appearing on the title
- VIN provided to police is incorrect
- safety certification label is altered or missing.
- safety certification label displays different VIN than is displayed on vehicle
- has theft and/or salvage history
- is recovered with no ignition or steering lock damage
- is recovered with seized engine or blown transmission
- *was* previously involved in a major collision
- is late model with extremely high mileage, (exceptions: taxi, police, utility vehicles).
- is older model with exceptionally low mileage (i.e., odometer rollover/rollback)
- is older or inexpensive model and insured indicates it was equipped with expensive accessories which cannot be substantiated with receipts
- is recovered stripped, burned, or has severe collision damage within a short duration of time after loss allegedly occurred
- Leased vehicle with excessive mileage for which the insured would have been liable under the mileage limitation agreement

INDICATORS OF FRAUD RELATED TO COVERAGE

- Loss occurs within one month of issue or expiration of the policy
- Loss occurs after cancellation notice was sent to insured.
- Insurance premium was paid in cash
- Coverage obtained via walk-in business to agent
- Coverage obtained from an agent not located in close proximity to insured's residence or work place
- Coverage *is* for minimum liability with full comprehensive coverage on late model and/or expensive vehicle
- Coverage was recently increased

INDICATORS OF FRAUD RELATED TO REPORTING

- Police report has not been made by insured or has been delayed
- No report or claim is made to insurance carrier within one week after theft
- Neighbors, friends, and family are not aware of loss.
- License plate does not match vehicle and/or is not registered to insured
- Title is junk, salvage, out-of-state, photocopied, or duplicated
- Title history shows non-existent addresses
- Repair bills are consecutively numbered or dates show work accomplished on weekends or holidays.

- An individual, rather than a bank or financial institution, is named as the lien holder.

OTHER INDICATORS OF VEHICLE THEFT FRAUD

- Vehicle is towed to isolated yard at owner's request
- Salvage yard or repair garage takes unusual interest in claim
- Information concerning prior owner is unavailable
- Prior owner cannot be located
- Vehicle is recovered totally burned after theft.
- Fire damage is inconsistent with loss description.
- VINs were removed prior to fire

General Indicators of Fraud

- ☐ **Physical address is not disclosed**
- ☐ **Uses P.O. Box, attorney's office or relative**
- ☐ **Address provided is not valid**
- ☐ **Subject lives in transient housing**
- ☐ **Subject is moving around**
- ☐ **Subject uses other people's telephone numbers**
- ☐ **May call from payphone**
- ☐ **Subjects SS#, name or other pertinent info doesn't match up**
- ☐ **Receive tips or rumors from co-workers, neighbor or family**
- ☐ **Recent Claims in the family or co-workers**
- ☐ **Claim filed several days, weeks or months after alleged loss**
- ☐ **Recent increase in coverage**
- ☐ **Reduction of deductible**
- ☐ **High number or other recent claims**
- ☐ **Makes a social security disability claim as well**
- ☐ **Has multiple means of coverage for loss**

Suspicious Claims General Indicators

- ☐ • History of claims activity.
- ☐ • Familiar with insurance claims terms and procedures.
- ☐ • Refrains from using the mail, including fax; conducts business in person.
- ☐ • No police report or on-scene police report.
- ☐ • Aggressive demands for quick settlement, sometimes for less than full value.
- ☐ • Threatens to contact higher company authority to push demands.
- ☐ • Address is temporary: post office box or motel is used.
- ☐ • Recently issued policy; walk-in business.
- ☐ • Photocopies of supporting documentation.
- ☐ • Insured's employer's address is a P.O. Box.
- ☐ • Unreasonable delay in reporting loss.
- ☐ • Refuses to give recorded or written statement.
- ☐ • Self employed in vague occupation; reluctant to produce tax records.

- ☐ • First notice of claim and/or immediate representation by attorney.
- ☐ • Recent changes in coverage/inquiries with agent.
- ☐ • Loss occurs immediately before or after policy renewal/inception dates.
- ☐ • Claimant is experiencing declining financial conditions.
- ☐ • Discrepancies exist between official reports of incidents and statements made by insured/claimant.
- ☐ • Lifestyle inconsistent with observations and facts.
- ☐ • Insured/claimant wants a friend or relative to pick up check.
- ☐ • Over-documentation of loss.
- ☐ • Insured/claimant has no phone.
- ☐ • Claimant is transient or out-of-towner.

Underwriting Auto Applications

- ☐ Questions on the application left blank:
- ☐ Marital status
- ☐ Previous insurance information
- ☐ Questions about other residents in the household
- ☐ Usages:
- ☐ Difference in annual miles reported by driver versus vehicle odometer.
- ☐ Several vehicles in the household but everyone has pleasure use with no work miles indicated.
- ☐ No business use on pickups, vans, and trucks reported, insured is self-employed.
- ☐ Spouse listed as out of the household or out of the country.
- ☐ Address locations of work versus home and the usages indicate low mileage.
- ☐ PO BOX address given.
- ☐ Only operator in household with multiple vehicles.
- ☐ Possible other residents in the household.
- ☐ Vehicles could be garaged at other locations for other drivers.
- ☐ Photocopies of proof of registration or title that are obscured (drivers license placed over the name area of the title of a vehicle signature area of a lease folded out of the way prior to the photocopy being made).
- ☐ Single operator in household but the answering machine uses pronouns such as we or we're in the message ("We are not homer right now, but if you...") A male voice on a machine of a female applicant or vice versa.
- ☐ A check in payment for a binder listing two names but the application only lists one of the individuals.
- ☐ The applicant's answers to the driving history questions differ from the CLUE report and MVRs.
- ☐ Application is for a younger driver who indicates that they are the only resident/driver in the household; many times there are roommates or relatives in the household ; the address used on the application is parents' but no other drivers are listed in the household.
- ☐ Addition of youthful operator who has been licensed for extended period of time.
- ☐ Binder applications submitted with the same handwriting for different applicants (Possibility that someone is charging a broker fee who is not a licensed broker).

- ☐ Application indicated someone is not licensed but gives no further information as to why; license may be suspended.
- ☐ Applications for NJM insurance where the membership number for Business & Industry Association is provided but the person does not work for that company; applicant lists a member employer and indicates that they cannot be reached at work (the individual may not work there).
- ☐ When additional information is requested multiple times and the applicant sends everything but what was asked for (eg. asked for a photocopy of a lease agreement and the applicant only sends the registration card over and over again, or when requested to supply a driver's license number for a child in the household and someone else's number is sent).
- ☐ Applicant is licensed in another state and recently got a New Jersey Driver's License but cannot provide previous license number.
- ☐ Address not matching on driver's license and registration card.
- ☐ Binder applicants do not respond to binder call back or AI letters.
- ☐ After being quoted a premium amount a customer changes facts to be considered (reports son (or daughter) is away at school; reports they are now separated from spouse or he (she) moved out of the household).
- ☐ Multiple home phone numbers (possible children not listed on application).
- ☐ Phone numbers (home same as work, area code does not match address, exchange does not match area).
- ☐ Garage locations involving.
- ☐ Police officers or Firemen who are required to live in the city where they work.
- ☐ Students away at school "without vehicles" (CLUE may show claims with the location of occurrence close to the school).
- ☐ Multiple out-of-state claims with unidentified drivers/occupants.
- ☐ Dates, times and locations of accidents suggest under-reporting of one-way miles.

Suspicious Motor Vehicle Claims - Specific Indicators

- ☐ Cash purchase of late model or new vehicle
- ☐ Behind in payments to lien holder
- ☐ Out-of-state purchase
- ☐ Individual named as lien holder
- ☐ Insured has no bill of sale or the bill of sale is out of line with car’s value
- ☐ Insured purchased vehicle overseas
- ☐ Insured cannot produce documentation of compliance with American EPA standards for his import auto; gray market car
- ☐ Insured vehicle is a foreign make and the theft occurs within six months of being imported
- ☐ Vehicle is totally burned
- ☐ VIN (Vehicle Identification Number) of the damaged car does not match the VIN of the insured car or match the model shown in appraisal photographs
- ☐ VIN is inconsistent with NATB manual

- ☐ NATB cannot match VIN
- ☐ VIN plate is different than VIN on the title
- ☐ Vehicle was rebuilt
- ☐ Prior loss or salvage on vehicle
- ☐ Prior owner cannot be located
- ☐ All vehicles in accident taken to the same body shop
- ☐ Recently duplicated or assigned title
- ☐ Counterfeit title documentation
- ☐ Insured claim expensive equipment and items
- ☐ Vehicle has poor reputation (defects, recalls, performance, etc.)
- ☐ Neighbors, friends and relatives have no knowledge of vehicle
- ☐ Car has not been seen for some time prior to the theft
- ☐ Insured is unemployed
- ☐ Insured wants to retain title to salvage
- ☐ Where applicable, loss takes place between issuance of binder and state mandated pre-inspection
- ☐ Premium paid in cash
- ☐ Comprehensive coverage only
- ☐ Duplicate coverages
- ☐ Repair shop estimates include repairs that body shops is not equipped to make (painting, straightening)
- ☐ Body shop has history of high damage claims
- ☐ Appraiser/adjuster is threatened or offered a bribe for quick settlement
- ☐ There is heavy property damage to the vehicles indicating a major collision, but no bodily injuries are reported
- ☐ Salvage or repair shop takes active interest in the claim
- ☐ Repair or installation bill are numbered consecutively or dates show work done on Sundays or holidays
- ☐ Two vehicles are involved with heavy damage to struck vehicle and relatively light damage to striking vehicle
- ☐ The striking vehicle is a rented car
- ☐ Accounts of the accident by drivers, passengers and witnesses seem rehearsed or are conversely inconsistent
- ☐ Appraisal; photographs show only close-ups of the damage, but not enough of the car to identify make and model
- ☐ Vehicle is recovered and...
  - No ignition or steering column damage
  - Carefully stripped with lug bolts an washers put back
  - Extensive body damage and no towing charges; vehicle remains drivable
  - Car shows signs of previous damage
  - Damage doesn't match type of accident claim

Exhibit 2 Health Insurance Fraud Indicators

General Indicators of Fraud

- ☐ **Physical address is not disclosed**
- ☐ **Uses P.O. Box, attorney's office or relative**
- ☐ **Address provided is not valid**
- ☐ **Subject lives in transient housing**
- ☐ **Subject is moving around**
- ☐ **Subject uses other people's telephone numbers**
- ☐ **May call from payphone**
- ☐ **Subjects SS#, name or other pertinent info doesn't match up**
- ☐ **Receive tips or rumors from co-workers, neighbor or family**
- ☐ **Recent Claims in the family or co-workers**
- ☐ **Claim filed several days, weeks or months after alleged loss**
- ☐ **Recent increase in coverage**
- ☐ **Reduction of deductible**
- ☐ **High number or other recent claims**
- ☐ **Makes a social security disability claim as well**
- ☐ **Has multiple means of coverage for loss**

Agent & Application Fraud

- ☐ **Material Misrepresentation on application**
- ☐ **Clear inaccuracies on application**
- ☐ **Minimum premium paid on initiation of policy**
- ☐ **Insured paid cash**
- ☐ **Insured living with others not on application**
- ☐ **Insured denies having other or previous automobiles or can't remember**
- ☐ **Works in another state**
- ☐ **Garages vehicles out of state**
- ☐ **Out of state licenses**
- ☐ **Application not signed**
- ☐ **Blank answers**
- ☐ **Application completed by two or more different people**
- ☐ **Undisclosed risk issues**
- ☐ **Undisclosed commercial usage**
- ☐ **Poor driving record**
- ☐ **Vehicle not observed**
- ☐ **Some coverage, but not others**
- ☐ **Recent additions of coverage**
- ☐ **Lowering the deductible**
- ☐ **Full coverage on low value vehicle**
- ☐ **Any discrepancies of DL#, SS#, name, dob or address**
- ☐ **Walk in Clients**

Disability Income

- ☐ **Newly covered claimant**
- ☐ **Group policy without individual underwriting**
- ☐ **Claimant was self employed or had family business**
- ☐ **Verification of claimant's pre-event income not completed**

- ☐ **Declining income or indications it may have been likely to decline**
- ☐ **Recent increase in coverage**
- ☐ **Work related issues**
- ☐ **Eager for settlement**
- ☐ **Multiple disability income coverage**
- ☐ **Claimant traveling extensively**
- ☐ **Home or personal/family issues**

Healthcare Fraud

Red Flags of Possible Healthcare Fraud

- The medical treatment is inconsistent with injuries originally alleged by injured worker.
- The medical provider attempts to influence injured workers to seek treatment outside of Zenith's medical provider network panel.
- The injured worker undergoes excessive treatment for soft tissue injuries.
- The doctor's billing records are inconsistent with the treatment, as reported by the injured worker.
- The injured worker is unable to define the medical ailments listed on the claim form.
- The injured worker can not physically describe the treating physician or building.
- The medical billing does not coincide with medical records or reports.
- The injured worker reports seeing a doctor for very brief time, but billings indicate a lengthy visit.
- The injured worker's description of the treatment indicates that non-medical personnel rendered the medical treatment.
- The injured worker lives far from medical facility, yet receives frequent treatments.
- The medical provider prescribes TENS unit or similar DME (durable medical equipment) on the first or second visit.

Exhibit 3 N.J.A.C. 11:2-17 Unfair Claims Practices

TITLE 11 DEPARTMENT of BANKING and INSURANCE

CHAPTER 2 INSURANCE GROUP

SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES

(i) Current through May 2, 2005; 37 N.J. Reg. o. 9

11:2-17.1 Purpose

N.J.S.A. 17:29B-4(9) and 17B:30-13.1 prohibit insurers from engaging in unfair claims settlement practices. The purpose of this subchapter is to promote the fair and equitable treatment of claimants by defining certain minimum standards for the settlement of claims which, if violated with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices in the business of insurance.

<General Materials (GM) - References, Annotations, or Tables>

(ii) CASE NOTES

Immunity provided to New Jersey Full Insurance Underwriting Association servicing carriers for judgments arising from policy claims does not extend to acts outside scope of duties under contract that rise to level of bad faith. Miglicio v. HCM Claim Management Corp., 288 N.J.Super. 331, 672 A.2d 266 (L.1995).

NJ ADC 11:2-17.1

Should include 11:2-17.1 Purpose through 11:2-17.15 Penalties

Title 17B Insurance
N.J.S.A. 17B:30-13 Unfair Claims Settlement Practices Act

(Health Insurers include – Automobile Insurers exclude)

No person shall engage in unfair claim settlement practices in this State. Unfair claim settlement practices which shall be unfair practices as defined in N.J.S. 17B:30-2, shall include the following practices:

Committing or performing with such frequency as to indicate a general business practice any of the following:

a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

b. Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

d. Refusing to pay claims without conducting a reasonable investigation based upon all available information;

e. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

g. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds;

h. Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

i. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured;

j. Making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;

k. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

l. Delaying the investigation or payment of claims by requiring an insured, claimant or the physician of either to submit a preliminary claim report and then

requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

m. Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

L.1975, c. 101, s. 1.

Should include this entire section

(Automobile Insurers include – Health Insurers exclude)

Exhibit 5 - N.J.S.A. 17:29B Trade Practices Regulated

New Jersey Permanent Statutes

TITLE 17 CORPORATIONS AND INSTITUTIONS FOR FINANCE AND INSURANCE

17:29B Trade Practices Regulated

17:29B-1. Declaration of purpose

The purpose of this act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

L.1947, c. 379, p. 1200, s. 1.

17:29B-2. Definitions

(i) When used in this act:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers and adjusters.

(b) "Commissioner" shall mean the Commissioner of Banking and Insurance of this State.

L.1947, c. 379, p. 1200, s. 2.

Should include 17:29B-1 through 17:29B-19

N.J.S.A. 56:11-44 Identity Theft Protection

1.This act shall be known and may be cited as the "Identity Theft Prevention Act."
L.2005,c.226,s.1.

56:11-45 Findings, declarations relative to identity theft.

2. The Legislature finds and declares that:

a. The crime of identity theft has become one of the major law enforcement challenges of the new economy, as vast quantities of sensitive, personal information are now vulnerable to criminal interception and misuse; and

b .A number of indicators reveal that, despite increased public awareness of the crime, incidents of identity theft continue to rise; and

c .An integral part of many identity crimes involves the interception of personal financial data or the fraudulent acquisition of credit cards or other financial products in another person's name; and

d. Identity theft is an act that violates the privacy of our citizens and ruins their good names: victims can suffer restricted access to credit and diminished employment opportunities, and may spend years repairing damage to credit histories; and

e. Credit reporting agencies and issuers of credit should have uniform reporting requirements and effective fraud alerts to assist identity theft victims in repairing and protecting their credit; and

f. The Social Security number is the most frequently used record keeping number in the United States. Social Security numbers are used for employee files, medical records, health insurance accounts, credit and banking accounts, university ID cards and many other purposes; and

g. Social Security numbers are frequently used as identification numbers in many computer files, giving access to information an individual may want kept private and allowing an easy way of linking data bases. Therefore, it is wise to limit access to an individual's Social Security number whenever possible; and

h. It is therefore a valid public purpose for the New Jersey Legislature to ensure that the Social Security numbers of the citizens of the State of New Jersey are less accessible in order to detect and prevent identity theft and to enact certain other protections and remedies related thereto and thereby further the public safety.

Should include 56:11-45 a. through 56:11-46 m (3)

Exhibit 7 N.J.A.C. 13:45F Identity Theft

NEW JERSEY ADMINISTRATIVE CODE

*** This file includes all Regulations adopted and published through the ***

*** New Jersey Register, Vol. 46, No. 12, June 16, 2014 ***

TITLE 13. LAW AND PUBLIC SAFETY CHAPTER 45F. IDENTITY THEFT N.J.A.C. 13:45F (2014)

Title 13, Chapter 45F -- Chapter Notes

NOTES:

CHAPTER AUTHORITY:

N.J.S.A. 56:8-161 to 166 and 56:11-44 to 50.

CHAPTER SOURCE AND EFFECTIVE DATE:

R.2008 d.80, effective April 7, 2008.

See: 39 N.J.R. 1397(a), 40 N.J.R. 1898(a).

CHAPTER EXPIRATION DATE:

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 45F, Identity Theft, expires on April 7, 2015. See: 43 N.J.R. 1203(a).

CHAPTER HISTORICAL NOTE:

Chapter 45F, Identity Theft, was adopted as new rules by R.2008 d.80, effective April 7, 2008. See: Source and Effective Date.

N.J.A.C. 13:45F

§ 13:45F-1.1 Purpose

This chapter is promulgated by the Director under the Identity Theft Prevention Act (the ITPA), N.J.S.A. 56:11-44 et seq. The rules address the obligations of a consumer reporting agency to New Jersey consumers regarding placing, lifting or removing a security freeze on a consumer report under the ITPA at N.J.S.A. 56:11-46 et seq. Further, the rules address prohibited uses of Social Security numbers and the manner in which Social Security numbers may be given in a public setting under the ITPA at N.J.S.A. 56:8-164. Finally, the rules address the penalties for violations of the security freeze and breach of security provisions under the ITPA at N.J.S.A. 56:8-166 and 56:11-50.

§ 13:45F-1.2 Scope

This chapter applies to consumer reporting agencies that maintain consumer reports on New Jersey residents and any public or private entity or person who has access to the Social Security numbers of New Jersey residents.

§ 13:45F-1.3 Definitions

For the purposes of this chapter, the following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

"Communicate" means to send a written or other tangible record or to transmit a record by any means agreed upon by the persons sending and receiving the record.

"Consumer" means an individual.

"Consumer report" means any written, oral or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for:

1. Credit or insurance to be used primarily for personal, family or household purposes;

2. Employment purposes; or

3. Any other purpose authorized under the New Jersey Fair Credit Reporting Act, P.L. 1997, c. 172 § 4.

The term "consumer report" does not include:

1. Any report containing information solely on transactions or experiences between the consumer and the person making the report, communication of that information among persons related by common ownership or affiliated by corporate control, or communication of other information among persons related by common ownership or affiliated by corporate control, if it is clearly and conspicuously disclosed to the consumer that the information may be communicated among those persons and the consumer is given the opportunity, before the time that the information is initially communicated, to direct that the information not be communicated among those persons;

2. Any authorization or approval of a specific extension of credit directly or indirectly by the issuer of a credit card or similar device;

3. Any report in which a person, who has been requested by a third party to make a specific extension of credit directly or indirectly to a consumer, conveys his or her decision with respect to that request, if the third party advises the consumer of the name and address of the person to whom the request was made, and the person makes the disclosures to the consumer required under 15 U.S.C. § 1681m, incorporated herein by reference as may be amended and supplemented; or

4. Communication excluded from the definition of consumer report pursuant to subsection (o) of section 603 of the Fair Credit Reporting Act, 15 U.S.C. § 1681a, incorporated herein by reference, as may be amended and supplemented.

"Consumer reporting agency" means all consumer reporting agencies that compile or maintain flies on consumers on a nationwide basis, as defined by subsection (p) of section 603 of the Fair Credit Reporting Act, 15 U.S.C. § 1681a, incorporated herein by reference, as may be amended and supplemented.

Procedure Manual should include § 13:45F-1.1 Purpose through § 13:45F-5.2 Violations of breach of security provisions

Exhibit 8 - N.J.S.A. 17:23A-13 Disclosure Limitations and Conditions

Disclosure limitations and conditions. An insurance institution, agent or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure is:

a. With the written authorization of the individual, provided:

(1) If the authorization is submitted by another insurance institution, agent or insurance-support organization, the authorization meets the requirements of section 6 of this act, or

(2) If the authorization is submitted by a person other than an insurance institution, agent or insurance-support organization, the authorization is:

(a) Dated,

(b) Signed by the individual, and

(c) Obtained one year or less prior to the date a disclosure is sought pursuant to this subsection;

b. To a person other than an insurance institution, agent or insurance-support organization, provided the disclosure is reasonably necessary:

(1) To enable the person to perform a business, professional or insurance function for the disclosing insurance institution, agent or insurance-support organization, and the person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(a) Would otherwise be permitted by this section if made by an insurance institution, agent or insurance-support organization, or

(b) Is reasonably necessary for the person to perform its function for the disclosing insurance institution, agent or insurance-support organization; or

(2) To enable the person to provide information to the disclosing insurance institution, agent or insurance-support organization for the purpose of:

(a) Determining an individual's eligibility for an insurance benefit or payment, or

(b) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction;

c. To an insurance institution, agent, insurance-support organization or self-insurer, if the information disclosed is limited to that which is reasonably necessary:

(1) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions, or

(2) For either the disclosing or receiving insurance institution, agent or insurance-support organization to perform its functions in connection with an insurance transaction involving the individual;

Should include 17:23A-13 through 17:23A-13.1 h

Exhibit 9 - P.L. 106-102 Gramm-Leach Bliley Act

113 STAT. 1338 PUBLIC LAW 106–102—NOV. 12, 1999

Public Law 106–102

106th Congress

An Act

To enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, insurance companies, and other financial service providers, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Gramm-Leach-Bliley Act''.

(b) TABLE OF CONTENTS.—The table of contents for this Act is as follows:

Should include entire Public Law

Exhibit 10 - P.L. 104-191 Health Insurance Portability and Accountability Act of 1996

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

(i) Public Law 104-191

(ii) 104th Congress

(iii) An Act

(iv) To amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes.

(v) Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(vi) (a) SHORT TITLE.--This Act may be cited as the "Health Insurance Portability and Accountability Act of 1996".

(vii) (b) TABLE OF CONTENTS.--The table of contents of this Act is as follows:

(viii) Sec. 1. Short title; table of contents.

(ix) TITLE I--HEALTH CARE ACCESS, PORTABILITY, AND RENEWABILITY

(x) TITLE II--PREVENTING HEALTH CARE FRAUD AND ABUSE; ADMINISTRATIVE SIMPLIFICATION; MEDICAL LIABILITY REFORM

(xi) Subtitle F--Administrative Simplification

(xii) • Sec. 261. Purpose.

(xiii) • Sec. 262. Administrative simplification.

(xiv) "Part C--Administrative Simplification

(xv) • "Sec. 1171. Definitions.

Should include P.L. 104-191 in its entirety

Exhibit 11 N.J.S.A. 17:33A New Jersey Fraud Prevention Act

TITLE 17 CORPORATIONS AND INSTITUTIONS FOR FINANCE AND INSURANCE

17:33A-1. Short title

(i) This act shall be known and may be cited as the “New Jersey Insurance Fraud Prevention Act."

(ii) L.1983, c. 320, s. 1.

17:33A-2. Purpose of act

(i) The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.

(ii) L.1983, c. 320, s. 2.

17:33A-3. Definitions

(i) 3. As used in this act:

(ii) "Attorney General" means the Attorney General of New Jersey or his designated representatives.

(iii) "Commissioner" means the Commissioner of Banking and Insurance.

(iv) "Director" means the Director of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance.

(v) "Division" means the Division of Insurance Fraud Prevention established by this act.

(vi) "Hospital" means any general hospital, mental hospital, convalescent home, nursing home or any other institution, whether operated for profit or not, which maintains or operates facilities for health care.

Should include 17:33A-1 Short Title through 17:33A-30 Certification of amount allocable to office expenses.

Exhibit 12 N.J.A.C. 11:16-6 Fraud Prevention and Detection Plans

TITLE 11. INSURANCE
CHAPTER 16. FRAUD PREVENTION AND DETECTION
SUBCHAPTER 6. FRAUD PREVENTION AND DETECTION PLANS

N.J.A.C. 11:16-6, Appx. (2014)

§ 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 Bureau of Fraud Deterrence and the Office of Insurance Fraud Prosecutor (OIFP) in accordance with N.J.S.A. 17:33A-1 et seq., as amended by P.L. 2010, c. 32. 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.

HISTORY:

Amended by R.2014 d.035, effective February 18, 2014.

See: 45 N.J.R. 1989(a), 46 N.J.R. 358(a).

Rewrote (b).

Should include entire rule N.J.A.C. N.J.A.C. 11:16-6.1 Purpose and Scope through N.J.A.C. 11:16-6.12 (Reserved). There is an Appendix to N.J.A.C. 11:16-6 that should be referenced.