

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Fraud Prevention and Detection

Proposed Readoption with Amendments: N.J.A.C. 11:16

Proposed Repeal and New Rule: N.J.A.C. 11:16-6 Appendix

Authorized By: Kenneth E. Kobylowski, Commissioner, Department of Banking and Insurance, with the approval of Ronald Chillemi, Acting Insurance Fraud Prosecutor, as to N.J.A.C. 11:16-6.7 and 11:16-6 Appendix.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17:23-8 et seq., 17:23-19, 17:23-20 et seq., 17:33A-1 et seq., and 47:1A-2.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Proposal Number: PRN 2013-123.

Submit comments by November 2, 2013 to:

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The agency proposal follows:

Summary

Pursuant to N.J.S.A. 17:33A-1 et seq., P.L. 2010, c. 32 and N.J.S.A. 52:14B-5.1, the Commissioner of Banking and Insurance (Commissioner) proposes to readopt N.J.A.C. 11:16, Fraud Prevention and Detection. This chapter includes rules related to different areas of insurance, including life/health and property/casualty, and the organization of the Department of Banking and Insurance (Department). N.J.A.C. 11:16 is scheduled to expire on July 30, 2013, in accordance with N.J.S.A. 52:14B-5.1b. In accordance with N.J.S.A. 52:14B-5.1.c(2), the submission of this notice to the Office of Administrative Law extended the expiration date 180 days to January 26, 2014.

Rules concerning the following subjects are codified in this chapter, listed by subchapter:

1. Claim Form Statements;
2. Reports to the National Insurance Crime Bureau;
3. – 5. Reserved;
6. Fraud Prevention and Detection Plans; and
7. Administrative Procedures and Penalties.

The rules in this chapter were promulgated to implement the statutory requirements in Title 17 of the New Jersey Statutes that relate to insurance fraud prevention and detection. In consultation with the Office of the Insurance Fraud Prosecutor (OIFP), the Department has undertaken a review of these rules at several levels to determine their current effectiveness and viability. These rules continue to provide the insurance industry and consumers with vital information and useful standards concerning many aspects of the prevention and detection of insurance fraud. The Department believes that the original purpose for each rule, as stated in the rule itself, continues to exist.

The rules in this chapter primarily serve two general purposes in the implementation of statutory law. First, they define and establish the purpose of detecting and reporting insurance

fraud. Secondly they provide guidance to the insurance industry in the methodology of establishing and the implementation of fraud detection plans, special investigations units (SIUs), training programs and manuals, records retention, reporting, and approval of fraud detection plans by the Department. In addition, this chapter includes provisions, formats and instructions for the submission to the Bureau of Fraud Deterrence (“BFD” or “the Bureau”) and the OIFP of the Claim Fraud Referral/Notification Form; Application Fraud Referral/Notification Form; the Health Claim Fraud Referral/Notification Form; and the Health Application Fraud Referral/Notification Form. This chapter also provides Company Fraud Prevention and Detection Plan/Annual Reporting forms and instructions in the Appendix Exhibits labeled MEAFC form numbers 1A and 1B and 2A and 2B.

The rules proposed for reoption with amendments codify P.L. 2010, c. 32, which amended N.J.S.A. 17:33A-1 et seq., to reflect the establishment of the Bureau of Fraud Deterrence in the Department and to authorize the Commissioner to conduct investigations of and impose civil and administrative penalties upon the perpetrators of civil insurance fraud. See N.J.S.A. 17:33A-8 as amended. In accordance with the amended law, rules relating to administrative penalties and procedures set forth in former N.J.A.C. 13:88-1, Office of Insurance Fraud Prosecutor, have, through a notice of administrative correction, been recodified at N.J.A.C. 11:16-7, Administrative Procedures and Penalties, (see 43 N.J.R. 1536(a)) in order to achieve efficiencies in the civil investigation of insurance fraud.

The rules proposed for reoption with amendments modify and supplement certain references to the OIFP in the rules and on the amended Fraud Referral Forms and instructions in the subchapter Appendix and, where appropriate, add references to the Bureau. Also proposed is the replacement of the forms used by insurers for the Annual Report of Fraud Data for Automobile and Health Fraud Prevention and Detection with updated versions that will refine the fraud data reporting process and result in increased efficiency and cost containment, and

possible cost reductions, for insurance companies, the OIFP, and the Department. Amendments are also proposed to the Market Conduct Fraud Detection Insurer Manual and reporting procedures.

The Department is proposing to add the following definitions to N.J.A.C. 11:16-6.2: anti-fraud prevention and detection plan, anti-fraud prevention and detection protocol, anti-fraud prevention and detection training program, anti-fraud prevention and detection procedure manual, Attorney General, automobile, automobile insurance, Bureau or BFD, CAIP, commercial lines insurance coverage, commercial motor vehicle, eligible person, Exportable List, health insurance comprehensive benefits, hospital, insurance company, limited health care services, PAIP, pattern, person, practitioner, principal residence, private passenger automobile insurance, producer, and statement. The eligible person definition is added to the rule pursuant to N.J.A.C. 11:3-34, Eligible Persons Qualifications and Automobile Insurance Eligibility Points Schedule.

N.J.A.C. 11:16-6.3, General requirements and filing format, currently requires insurers to submit their fraud detection and prevention plans on 8 ½ by 11 paper with the first page showing the filer's company name, filer's identification number, National Association of Insurance Commissioners (NAIC) company, and group numbers. The Department proposes to amend subsection (b), which specifies the required format, to include in the plan page numbering, a table of contents, and the insurer's anti-fraud protection and detection training program, protocol, and procedure manual. Requirements for the format of subsequent amendments are also specified. Proposed new paragraph (b)1 requires the inclusion of a brief description of the insurer's business model or company profile in its anti-fraud protection and prevention protocol.

N.J.A.C. 11:16-6.5, Training program and manual for the prevention and detection of fraud, currently describes the content of the anti-fraud training program and manual to be provided by insurers to their personnel and maintained within their records for review by the

Department. The Department proposes to add text specifying that the requirements applicable to the training program are set forth in subsection (a) and the requirements applicable to the manual for the prevention and detection of fraud are set forth in subsection (b). The training program requirements for non-SIU personnel contained in subparagraph (a)2iii are being amended from no less than nine hours to no less than four and one-half hours of classroom instruction for Basic Entry Level Training, and from four hours to not less than two hours for continuing education training. Amended paragraph (b)8 and new paragraphs 9, 10, and 11 are also proposed to specify new requirements applicable to the fraud prevention and detection manual regarding page numbers, a table of contents, the inclusion of Internet-based home pages and hyperlinks, and a description and effective date on all update pages. New subsection (c) clarifies the meaning of “unfair claims practices,” “New Jersey Insurance Fraud Prevention Act,” and “information disclosure” as used in subsection (b). New subsection (d) provides a Department web address at which specimen formats of the anti-fraud prevention and detection protocol, anti-fraud prevention and detection training program, and anti-fraud prevention and detection procedure manual may be viewed.

Under N.J.S.A. 17:33A-9, as amended by P.L. 2010, c. 32, fraud referrals shall be made on a form and in a manner jointly prescribed by the Commissioner and the Insurance Fraud Prosecutor. N.J.A.C. 11:16-6.6, Fraud prevention and detection plan, currently refers to the OIFP on the forms described therein. The Department and the OIFP are amending the rule text and including in the new forms and instructions references to the Bureau.

N.J.A.C. 11:16-6.7 currently provides for the submission of referrals to the OIFP. This section is being amended to also reference the Bureau as well as the OIFP.

N.J.A.C. 11:16-6.8, Record retention, currently describes the requirements for the annual submission to the Department of a report on, and the retention by insurers of records on, their fraud prevention and detection plans on Market Conduct Examinations and Anti-Fraud

Compliance (MCEAFC) forms concerning automobile and health insurance. Since the Department is proposing the refinement of these forms and reducing their number from four to two, references in the text will now refer to the MCEAFC Automobile Insurance Anti-fraud Experience Report 20110801 in accordance with the instructions and definitions provided, and the MCEAFC Health Insurance Anti-fraud Experience Report Form 20110801 in accordance with the instructions provided.

The Appendix to N.J.A.C. 11:16-6 currently names the OIFP in the forms and descriptions. Based upon N.J.S.A. 17:33A-9 as amended, the Department and the OIFP are proposing to repeal the current forms and adopt the following OIFP/BFD Claim Fraud Referral/Notification Forms, to which references to the Bureau have been added: Claim Fraud Referral/Notification Forms and instructions; Application Fraud Referral/Notification Forms; Health Claim Fraud Referral Notification Form; and Health Application Fraud Referral Notification Form. Additional spaces are provided on all of the proposed forms for the entry of the Bureau Case Number as well as additional spaces for categories and certifications which enhance fraud fact gathering.

The current subchapter Appendix includes four exhibits containing Company Fraud Prevention and Detection Plan/Annual Reporting forms for automobile and health insurance including instructions. The Department is proposing to improve the format of these forms by placing the instructions within the forms, thereby reducing the number of forms from four to two.

The Department believes that through readoption, these rules will continue to provide the regulatory framework by which the Department may effectively ensure that insurers and other regulated entities continue to comply with the insurance and other laws of this State applicable to insurance fraud prevention, deterrence, and detection, and provide for consistent evaluation and treatment by the Department of these entities. Moreover, through readoption, these rules will

continue to provide insurers and other regulated entities with guidance and specific standards for compliance with New Jersey laws, thereby avoiding confusion regarding such requirements. This will benefit insurers, other regulated entities, policyholders, the market and the public generally.

A 60-day comment period is provided for this notice of proposal, and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, the proposal is not subject to the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

The rules in this chapter enable the Department to fulfill its duties under law to aggressively combat insurance fraud. Failure to readopt these rules would impair the Department's regulatory powers and disrupt established relations between insurers and the general public and between these two groups and the Department. The protections that these rules afford the consumer and the operational guidance that they afford the insurance industry mandate their continued existence, both to implement statutory provisions and to foster and promote an effective anti-fraud policy.

The rules proposed for readoption and proposed amendments will have a positive impact on insurers because they will facilitate insurers' filing auto and health-specific fraud prevention and detection information with the Commissioner in a more efficient manner. The revised distinct forms were developed based on a consensus reached among the OIFP, the Department, and several major insurers and are intended to reflect the manner in which insurers currently capture data for internal purposes and for reporting to other states' insurance regulators. Moreover, the proposed amendments will enable the Department to make better use of the information obtained, all of which will have a positive social impact.

Economic Impact

The failure to readopt this chapter with amendments would require the insurance industry to perform many significant statutory functions without guidance from the Department. This would impose substantial costs on the industry since current compliance requirements would not be readily available to the industry. The industry has invested a great amount of time and resources to implement practices that enable insurers and other regulated entities to operate in compliance with the Department's current procedures. This results in benefits for both the insurer and the general public.

Readoption of the current rules with amendments will enable the Department to continue to effectively monitor and regulate insurance matters consistent with its current fiscal resources and capabilities. The Department's continued use of procedures that have proven effective over time provides administrative economies, which will favorably affect insurers and other regulated entities who, based upon statutory law, are assessed to fund its insurance operations. Insurance fraud is a significant contributor to insurance company costs and rates paid by New Jersey consumers. These rules have proven to be effective in limiting the level of insurance fraud perpetrated in the State.

These rules do not impose any undue or excessively onerous financial burdens on consumers or the insurance industry. The readoption of this chapter with amendments will not impose any additional economic impact on insurers, other regulated entities, or consumers in that the readoption will continue longstanding requirements. To the extent that the readoption with amendments enables insurers to fulfill the information reporting requirements imposed by the rules in a more efficient manner, their administrative costs will be reduced. Such a reduction in administrative costs will exert downward pressure on insurance rates, from which the public will benefit economically. Any additional costs insurers incur to adjust existing systems to implement the use of the revised reporting forms will be minimal and an isolated, rather than a recurring, expense.

The proposed readoption of Subchapter 7 will impose costs on those who violate the law. Civil and administrative penalties may be imposed of not more than \$5,000 for the first violation; \$10,000 for the second violation and up to \$15,000 for each subsequent violation of the Fraud Act. Restitution also may be awarded to any insurance company or other person who has suffered a loss as a result of a violation of the Fraud Act. The costs of the OIFP's prosecution, including attorney's fees, can be recovered upon successful prosecution of the case as provided in N.J.S.A. 17:33A-5. A surcharge may be imposed upon the violator by the Department of Banking and Insurance as provided by N.J.S.A. 17:33A-5.1. 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. Any civil and administrative penalty imposed may be collected with costs, including attorney fees, in a summary proceeding pursuant to the Penalty Enforcement Law, N.J.S.A. 2A:58-10 et seq.

Based upon the savings realized by the Department, insurers and consumers from the deterrence of insurance fraud in the State through the application of these rules, the benefits that will result from their readoption with the amendments proposed clearly outweigh the costs of compliance.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for readoption with amendments relate to the business of insurance and are not subject to any Federal requirements or standards.

Jobs Impact

The Department does not believe that these rules proposed for readoption with amendments will cause any jobs to be generated or lost. The Department invites interested

parties to submit any data or studies concerning the jobs impact of the proposed readoption together with their written comments on other aspects of the proposal.

Agriculture Industry Impact

The Department does not expect any impact on the agriculture industry on these rules proposed for readoption with amendments.

Regulatory Flexibility Analysis

Few, if any, insurers regulated by the rules in this chapter are "small businesses" as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The Department has determined that all compliance, recordkeeping, and reporting requirements continue to be reasonable and necessary for the purposes for which they were originally adopted. These requirements include those concerning rate and form filings, loss reserve opinions, and medical malpractice reporting requirements. The electronic reporting forms and enhanced hard copy forms as proposed will be more efficient and cost beneficial to companies and consumers, as well as time saving for all entities regardless of size as they comply and report fraud. "Small businesses" should not be required to hire outside consultants or other advisory services as a result of these rules proposed for readoption with amendments. These rules continue to apply to all insurers, insurance producers, or public adjusters, as the case may be, without regard to size, since they implement statutory provisions and/or regulatory policies intended to protect insurers and consumers of insurance products from fraud which allow for no such exceptions. The Department is unaware of any provisions of these rules that are excessively onerous to "small businesses" or unnecessary. The Department notes, however, that the readoption of these rules with amendments will impose new reporting requirements as discussed in the Summary above. Future annual costs of compliance with these rules are not expected to differ from current annual costs and may result in cost savings, as explained in the Summary and Economic Impact above.

Housing Affordability Impact Analysis

The rules proposed for readoption with amendments will not have an impact on housing affordability because the rules proposed readoption with amendments address insurance company reporting data.

Smart Growth Development Impact Analysis

The Department believes that there is an extreme unlikelihood that the rules proposed for readoption with amendments would evoke a change in the housing production in Planning Areas 1 and 2 or within the designated centers under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments address insurance company reporting fraud data.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:16.

Full text of the rule proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 11:16-6 Appendix.

Full text of the proposed amendments and new rule follows (additions indicated boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 6. FRAUD PREVENTION AND DETECTION PLANS

11:16-6.1 Purpose and scope

(a) (No change.)

(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.

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.

“Anti-fraud prevention and detection plan” means the creation and maintenance of an anti-fraud protection and detection protocol, an anti-fraud prevention and detection training program, and an anti-fraud prevention and detection procedure manual.

“Anti-fraud prevention and detection procedure manual” is the collection of New Jersey statutes, New Jersey administrative rules, Federal laws, and company guidelines, policies, and procedures that are distributed to and/or made available to personnel of the insurer in the Special Investigation Unit, and the underwriting and claims, or other applicable processing units of the insurer who are responsible for anti-fraud prevention and detection.

“Anti-fraud prevention and detection protocol” means the document that defines the insurer’s compliance with the activities set forth in N.J.A.C. 11:16-6.3, 6.4, 6.6, and 6.7.

“Anti-fraud prevention and detection training program” means the document which defines the insurer’s compliance with the requirements set forth in N.J.A.C. 11:16-6.5(a).

...

“Attorney General” means the Attorney General of New Jersey or his or her designated representatives.

“Automobile” means a private passenger automobile of a private passenger or station wagon type that is owned or hired and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or a camper-type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession, or business of the insured other than farming or ranching. An automobile owned by a farm family co-partnership or corporation, which is principally garaged on a farm or ranch and otherwise meets the definitions contained in this section, shall be considered a private passenger automobile owned by two or more relatives resident in the same household.

“Automobile insurance” means direct insurance against injury or damage including the legal liability therefor, arising out of the ownership, operation, maintenance, or use of automobiles, including, but not limited to, personal injury protection insurance, bodily injury liability insurance, property damage liability insurance, physical damage insurance, and uninsured and underinsured motorist insurance.

“Bureau” or “BFD” means the Bureau of Fraud Deterrence established by section 8 of P.L. 2010, c. 32 (N.J.S.A. 17:33A-8).

“CAIP” means the Commercial Automobile Insurance Plan as set forth in N.J.A.C. 11:3.

“Commercial lines insurance coverage” means property and liability insurance coverage for commercial motor vehicles as defined in this section.

“Commercial motor vehicle” includes every type of motor-driven vehicle used for commercial purposes on the highways, such as the transportation of goods, wares, and merchandise, excepting such vehicles as are run only upon rails or tracks and vehicles of the passenger car type used for touring purposes or the carrying of farm precuts and milk, as the case may be.

...

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

“Exportable List” means the list of certain classes of insurance coverages or risks promulgated by the Commissioner at N.J.A.C. 11:1-34 pursuant to N.J.S.A. 17:22-6.43.

...

“Health insurance comprehensive benefits” means preventive care, emergency care, inpatient and outpatient provider care, diagnostic laboratory and diagnostic and therapeutic radiological services, and other services as set forth in N.J.A.C. 11:24-5.

“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.

...

“Insurance company” 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 Title 17 of the Revised Statutes (N.J.S.A. 17:17-1 et seq.), or of Title 17B of the New Jersey Statutes (N.J.S.A. 17B:17-1 et seq.);**
- 2. Any medical service corporation operating pursuant to P.L. 1940, c. 74 (N.J.S.A. 17:48A-1 et seq.);**
- 3. Any hospital service corporation operating pursuant to P.L. 1938, c. 366 (N.J.S.A. 17:48-1 et seq.);**
- 4. Any health service corporation operating pursuant to P.L. 1985, c. 236 (N.J.S.A. 17:48E-1 et seq.);**
- 5. Any dental service corporation operating pursuant to P.L. 1968, c. 305 (N.J.S.A. 17:48C-1 et seq.);**
- 6. Any dental plan organization operating pursuant to P.L. 1979, c. 478 (N.J.S.A. 17:48D-1 et seq.);**
- 7. Any insurance plan operating pursuant to P.L. 1970, c. 215 (N.J.S.A. 17:29D-1 et seq.);**
- 8. The New Jersey Insurance Underwriting Association operating pursuant to P.L. 1968, c. 129 (N.J.S.A. 17:37A-1 et seq.); and**

9. Any risk retention group or purchasing group operating pursuant to the Liability Risk Retention Act of 1986, 15 U.S.C. §§ 3901 et seq.

...

“Limited health care services” means limited benefits policies or contracts such as accident only; accidental death and dismemberment, credit life and disability; long-term care; medicare supplement; dental only; vision only; supplemental liability; and any other supplemental hospital indemnity benefits.

...

“PAIP” means the New Jersey Personal Automobile Insurance Plan as set forth in N.J.A.C. 11:3-2.

“Pattern” means five or more related violations of P.L. 1983, c. 320 (N.J.S.A. 17:33A-1 et seq.).

“Person” means a person as defined in N.J.S.A. 1:1-2, and shall include, unless the context otherwise requires, a practitioner.

“Practitioner” means a licensee of this State authorized to practice medicine, surgery, psychology, chiropractic, or law or any other licensee of this State whose services are compensated, directly or indirectly, by insurance proceeds or a licensee similarly licensed in other states or nations or the practitioner of any non-medial treatment rendered in accordance with a recognized religious method of healing.

“Principal residence” means that residence at which a person spends the majority of his or her time. Principal residence may be an abode separate and distinct from a person’s domicile. Mere seasonal or weekend residence within this State does not constitute principal residence within this State.

“Private passenger automobile insurance” means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles that are owned individually or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

“Producer” means an insurance producer as defined in section 3 of P.L. 2001, c. 210 (N.J.S.A. 17:22A-28), licensed to transact the business of insurance in this State pursuant to the provisions of the New Jersey Insurance Producer Licensing Act of 2001, N.J.S.A. 17:22A-26 et seq.

...

“Statement” includes, but is not limited to, any application, writing, notice, expression, statement, proof of loss, bill of lading, receipt, invoice, account, estimate of property damage, bill for services, diagnosis, prescription, hospital or physician record, X-ray, test result, or other evidence of loss, injury, or expense.

...

(a) (No change.)

(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 **name and number. The plan shall include page numbering, a table of contents, and the insurer's anti-fraud prevention and detection training program, protocol, and procedure manual. Subsequent amendments to the plan shall include the effective date, page number, location, and explanation of the amendments.**

1. Insurers shall include a brief description of their business model or company profile in the front of the anti-fraud prevention and detection protocol for analysis by the Department in determining compliance with fraud prevention and detection.

(c) (No change.)

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

(a) **The requirements with respect to fraud prevention and detection training programs are set forth in this subsection.** 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, **and** shall be submitted to and approved by the Department [by August 5, 2000]. The **Continuing Education Training**

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. – ii. (No change)

iii. [The] **Each company shall submit for approval the** Basic Entry Level Training, **which** shall be no less than nine hours of classroom instruction **for SIU personnel and no less than four and one-half hours of classroom instruction for non-SIU personnel.** [The] Continuing Education Training shall be no less than nine hours of training per year for SIU personnel and [four] **no less than two** hours per year for claims and underwriting personnel. Basic Entry Level [training] **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] **no less than two hours of continuing** 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) **The requirements with respect to fraud prevention and detection procedures manuals are set forth in this subsection.** 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] **fraud prevention and detection procedure 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] **fraud prevention and detection procedure manual** shall include, at a minimum, the following:

- 1.– 6. (No change.)
7. The post-referral procedure for communication between the claims unit and/or the underwriting unit and the SIU **regarding claim resolution and file closure**; [and]
8. [An] **All update pages [indicating that the manual has been updated and kept current.] for the protocol, training program, and procedure manual shall include a description of the content being updated, the page number, and its effective date;**
9. **Hard copy procedure manuals shall include version/filing numbers in footers along with page numbering and a table of contents;**
10. **Internet-based procedure manuals shall provide home pages displaying hyperlinks or other navigation to the required content; and**
11. **Updates shall be referenced in hard copy and Internet manuals.**

(c) As used in (b) above:

1. **“Unfair claims practices” is understood to include copies of or valid hyperlinks to both:**
 - i. **N.J.S.A. 17B:30-13 and N.J.A.C. 11:2-17, Unfair Claim Settlement Practices, (health insurers); and**
 - ii. **N.J.S.A. 17:29B-4(9) and N.J.A.C. 11:2-17, Unfair Claim Settlement Practices, (property/casualty);**
2. **“New Jersey Insurance Fraud Prevention Act” is understood to include copies of or valid hyperlinks to both:**
 - i. **N.J.S.A. 17:33A-1 et seq., New Jersey Insurance Fraud Prevention Act; and**
 - ii. **N.J.A.C. 11:16-6, Fraud Prevention and Detection; and**
3. **“Information disclosure” is understood to include copies of or valid hyperlinks**

to:

- i. **P.L. 106-102, Gramm-Leach-Bliley;**
- ii. **P.L. 104-191, Health Insurance Portability and Accountability Act of 1996;**
- iii. **N.J.S.A. 56:11-44 et seq., Identity Theft Prevention Act;**
- iv. **N.J.S.A. 17:23A-13, Disclosure limitations and conditions; and**
- v. **N.J.A.C. 13:45F, Identity Theft.**

(d) **Specimen formats of the anti-fraud prevention and detection protocol, anti-fraud prevention and detection training program, and anti-fraud prevention and detection procedure manual are available for viewing on-line at http://www.state.nj.us/dobi/division_consumers/insurance/mceu.html.**

11:16-6.6 Fraud prevention and detection plan

- (a) (No change.)
- (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 **the Bureau and OIFP**, for further [OIFP] investigation or other appropriate action. [, on the prescribed] **The referral shall be made either using electronic referral forms that may be established by the Commissioner and the Insurance Fraud Prosecutor, or using the applicable hard-copy Referral Form [(OIFP-1) OIFP/BFD-1 for Claim Fraud [Referral or Notification], [OIFP-2) OIFP/BFD-2 for Application Fraud [Referral or Notification], [OIFP-3) OIFP/BFD-3 for Health Claim Fraud [Referral or Notification], and [OIFP-4) OIFP/BFD-4 for Health Application Fraud [Referral or Notification incorporated herein by reference in the subchapter Appendix), with all other information required by the form,] indicating “REFERRAL.” The hard-copy referral forms are reproduced in the subchapter Appendix, incorporated herein by reference. The plan shall provide that**

the referral shall include all information required by the electronic referral form or the hard-copy referral form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16-6.7.

2. - 3. (No change.)

(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 **the Bureau and the OIFP** [on] **using OIFP/BFD Form 1, OIFP/BFD Form 2, OIFP/BFD Form 3, or OIFP/BFD Form 4**, indicating “NOTIFICATION,” [incorporated herein by reference in the subchapter Appendix,] unless [this] **these forms** [is] **are** superseded by an electronic reporting form **established by the Commissioner and the Insurance Fraud Prosecutor**, 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) - (f) (No change.)

11:16-6.7 Referrals to **the Bureau and the 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] standards [to OIFP] **in (a)1 and 2 below. The SIU shall submit one copy of the appropriate referral form and one copy of any attachments to the address indicated on the form. Submission of one copy of the referral form and attachments shall constitute a referral to both the Bureau and OIFP.**

1.- 2. (No change.)

(b) - (c) (No change.)

(d) An investigation shall be complete for purposes of referral to **the Bureau and 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 **the Bureau and 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 **the Bureau and OIFP**.

11:16-6.8 Record retention

(a) (No change.)

(b) Insurers shall submit to the Commissioner on or before March 31 of each year an annual report for the prior calendar year on **the MCEAFC [Form #1A and/or #2A, pursuant to] Automobile Insurance Anti-fraud Experience Report 20110801 in accordance with the instructions and definitions provided [in] and the MCEAFC [Form #1B (for the completion of #1A) and Form #2B (for the completion of #2A),] Health Insurance Anti-fraud Experience Report 20110801 in accordance with the instructions provided and** 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] **e-mail** 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] **on a form** established by the Department. Insurers may acquire the required [spreadsheet format] **form** from the Department[:] **website at**

http://www.state.nj.us/dobi/division_consumers/insurance/mceu.html or

[i. By] **by** directing an [email] **e-mail** 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].

(Agency Note: The text of proposed new N.J.A.C. 11:16-6 Appendix below does not appear in boldface as new text due to the appearance of boldface text as part of the format of the forms in the Appendix.)

APPENDIX

CLAIM FRAUD REFERRAL / NOTIFICATION FORM

OIFP/BFD-1 (04/13)

State of New Jersey

BFD Case # ____/____/____

Insurance Fraud Referral/Notification

OIFP # _____

P.O. Box 094

Investigator _____

Trenton, NJ, 08625-0094

REFERRAL NOTIFICATION

PART 1

INSURANCE CO. DATE REPORTED. _____

CLAIM# _____

ADDRESS NAIC COMPANY # _____

SIU# _____

D.O.L.. _____

TELEPHONE POLICY #

CONTACT PERSON

E-MAIL ADDRESS _____

TYPE OF COVERAGE (Check appropriate box) STATUS (Indicate as appropriate)

LIFE W.C. PENDING PAID - IN FULL

AUTO HOME DENIED PAID - IN PART

COMM

CLAIM AMOUNT \$

AMOUNT PD \$ DATE/RANGE PD

FRAUD AMOUNT \$

OTHER

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.#

IS THIS MATTER UNDER INVESTIGATION BY ANY OTHER GOVERNMENT AGENCY OR HAS THIS

MATTER BEEN REFERRED TO ANY OTHER GOVERNMENT AGENCY? YES NO

IF YES, PROVIDE: AGENCY NAME AND ADDRESS, CONTACT NAME, PHONE# AND EMAIL; CASE#

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:

PART 11

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

ANY PERSON OR PRACTITIONER TO ENGAGE, EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.

ANY PERSON TO BRING CAUSES OF ACTION **TO** RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.

ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

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

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO 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)

I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

DATED: _____

SIGNATURE of CUSTODIAN

PRINT FULL NAME AND TITLE

PART V

COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS, CLAIMANTS OR INSUREDS OF THE INVESTIGATION:

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB 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# _____ STATE _____

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# _____ STATE _____

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# _____ STATE _____

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# _____ STATE _____

EMPLOYER PHONE #

ADDRESS TAX ID#

ADDRESS (cont.) D.O.B. S.S.#

APPLICATION FRAUD REFERRAL/NOTIFICATION FORM

OIFP/BFD-2 (04/13)

Insurance Fraud Referral/Notification

OIFP _____

P.O. Box 094

Investigator _____

Trenton NJ, 08625-0094

REFERRAL NOTIFICATION

PART 1

INSURANCE CO. DATE REPORTED

ADDRESS NAIC COMPANY #

DATE OF APPLICATION

CLAIM# _____

POLICY #

SIU# _____

TELEPHONE

CONTACT PERSON

E-MAIL ADDRESS

TYPE OF COVERAGE (Check appropriate box) STATUS (Indicate as appropriate)

LIFE W.C. PREMIUM ADJUSTED

AUTO HOME AMOUNT \$

COMM. OTHER 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#

VEHICLE INFORMATION

MAKE, MODEL, YEAR, VIN, REGISTRATION# AND REGISTRATION STATE

IS THIS MATTER UNDER INVESTIGATION BY ANY OTHER GOVERNMENT AGENCY OR HAS THIS MATTER BEEN REFERRED TO ANY OTHER GOVERNMENT AGENCY? YES NO

IF YES, PROVIDE: AGENCY NAME AND ADDRESS, CONTACT NAME, PHONE# AND EMAIL; CASE#

PART II

Provision(s) OF N.J.S.A. 17:33A-4 RELATING TO APPLICATIONS THAT MAY HAVE BEEN VIOLATED: (CHECK APPROPRIATE BOX)

- a. (3)[5] - conceals relevant evidence:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE AN EVENT AFFECTING ANY PERSON'S INITIAL RIGHT TO AN INSURANCE BENEFIT OR THE AMOUNT OF A BENEFIT. N.J.S.A. 17:33A-4a(3)
- a.(4)(A)Prepares or makes any written or oral statement:** Intended to be presented to any insurance company or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this State when, in fact, that person resides or is domiciled in a state other than this State N.J.S.A. 17:33A-4a(4)(a).
- a.(4)B Prepares or makes any written or oral statement:** Intended to be presented to any insurance company or producer for the purpose of obtaining an insurance policy, knowing that the statement contains any false or misleading information material to the application or contract. N.J.S.A. 17:33A-4a(4)(b).

- a.(5) - conceals relevant evidence of application fraud:** CONCEALS OR KNOWINGLY FAILS TO DISCLOSE ANY EVIDENCE, WHICH MAY BE RELEVANT TO A FINDING THAT A VIOLATION OF N.J.S.A. 17:33A-4A(4) HAS OCCURRED. N.J.S.A. 17:33A-4A(5)
- b.(5)- 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)

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

DATE: _____

SIGNATURE OF CUSTODIAN

PRINT FULL NAME AND TITLE

HEALTH CLAIM FRAUD REFERRAL/ NOTIFICATION FORM

OIFP/BFD-3 (04/13)

State of New Jersey

BFD Case # _____

Insurance Fraud Referral/Notification

OIFP# _____

P.O. Box 094

Investigator _____

Trenton NJ, 08625-0094

REFERRAL NOTIFICATION

PART 1

INSURANCE CO. _____ DATE REPORTED _____

ADDRESS NAIC COMPANY# _____

CONTACT PERSON

ADDRESS

PHONE

EMAIL

D.O.L _____ TELEPHONE _____

POLICY # _____ CLAIM# _____

CONTACT PERSON _____ SIU# _____

TYPE OF COVERAGE (Check appropriate box) **STATUS** (Indicate as appropriate)

Health (Indemnity) Health Medicaid PENDING PAID - IN FULL

Health (HMO) Dental DENIED PAID - IN PART

OTHER AMOUNT PD \$ DATE/RANGE PD

CLAIM: \$

FRAUD: \$

INSURED/SUBJECT/CLAIMANT (CIRCLE)

LAST FIRST MIDDLE _____

STREET CITY STATE-ZIP _____

HOME PH WORK PH D.O.B. _____

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

D.L. STATE _____

BUSINESS NAME ADDRESS TIN # _____

INSURED/SUBJECT/PROVIDER(CIRCLE)

LAST FIRST MIDDLE

DBA, LLC, PA OR GROUP PRACTICE NAME

STREET: CITY: STATE ZIP _____

TELEPHONE #: DOB: SS#: _____

PROFESSIONAL LICENSE #: _____ STATE _____

TYPE OF PROVIDER (Check appropriate box)

MD DO PHD DDS DMD HOSPITAL OUTPATIENT FACILITY PHYSICAL THERAPY

MD/CHIRO PRACTICE DME SUPPLIER HOME HEALTH PHARMACIST SURGI-CENTER

MSW

OTHER

TAX ID #S USED

SPECIALTY

ALLERGIST ANESTHESIOLOGY CARDIOLOGY CHIROPRACTIC DERMATOLOGY

EMERGENCY MEDICINE 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

DBS, LLC, PA OR GROUP PRACTICE NAME

STREET: CITY: STATE: ZIP _____

TELEPHONE#: DOB: SS# _____

PROFESSIONAL LICENSE #: _____ STATE _____

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 & EMAIL

IS ANY OTHER GOVERNMENT AGENCY INVESTIGATING THIS MATTER, OR HAS THIS MATTER BEEN REFERRED TO ANY OTHER GOVERNMENT AGENCY? YES NO.

IF YES, PROVIDE AGENCY NAME & ADDRESS. CONTACT NAME, PHONE# AND EMAIL. AGENCY CASE#.

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 OF ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A.

a(2) - makes a false statement: KNOWINGLY PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT CONTAINING ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A-4A(2)

a(3)-conceals relevant information: CONCEALS OR KNOWINGLY FAILS TO DISCLOSE THE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT OR ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)

b-conspires with another: KNOWINGLY ASSISTS, CONSPIRES WITH OR URGES ANY PERSON OR PRACTITIONER TO VIOLATE ANY PROVISION(S) OF THIS ACT. N.J.S.A. 17:33A-4B. (IF SO, SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED).

c-knowingly benefits from insurance fraud: DUE TO THE ASSISTANCE, CONSPIRACY OR URGING OF ANOTHER KNOWINGLY BENEFITS, DIRECTLY OR INDIRECTLY, FROM THE PROCEEDS DERIVED FROM A VIOLATION OF THIS ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED).

d-involvement of hospital: AN OWNER, ADMINISTRATOR OR EMPLOYEE OF ANY HOSPITAL WHO KNOWINGLY ALLOWS THE USE OF THE FACILITIES OF THE HOSPITAL BY ANY PERSON IN FURTHERANCE OF A SCHEME OR CONSPIRACY TO VIOLATE ANY OF THE PROVISION(S) OF THE ACT. N.J.S.A. 17:33A-4C. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED).

e-using or being a runner: A PERSON OR PRACTITIONER FOR PECUNIARY GAIN, DIRECTLY OR INDIRECTLY SOLICITS:

ANY PERSON OR PRACTITIONER TO ENGAGE , EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.

ANY PERSON TO BRING CAUSES OF ACTION **TO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.**

ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

NOTE: IF THE INSURANCE COMPANY PAID MONEY FOR THE CLAIM(S), OBTAIN ALL

CLAIMS CHECKS AND SUBMIT TO OIFP AS SOON AS PRACTICABLE AFTER
SUBMISSION OF THIS REFERRAL FORM.

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO 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)

I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

DATED: _____

SIGNATURE OF CUSTODIAN

PRINT FULL NAME AND TITLE

PART V

COMPLETE THE FOLLOWING ONLY IF THERE ARE ADDITIONAL SUBJECTS, CLAIMANTS OR INSUREDS OF THE INVESTIGATION:

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

SUBJECT CLAIMANT INSURED

LAST FIRST MIDDLE

STREET CITY STATE/ZIP

HOME PH. WORK PH DOB S.S.

D.L.#

PART VI

COMPLETE THE FOLLOWING ONLY IF ADDITIONAL LICENSED PROFESSIONALS ARE SUBJECTS OF THE

INVESTIGATION

LAST FIRST MIDDLE

DBA, LLC, PA OR GROUP PRACTICE NAME

STREET: CITY: STATE ZIP _____

TELEPHONE #: DOB: SS#: _____

PROFESSIONAL LICENSE #: STATE ? _____

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

LAST FIRST MIDDLE

DBA, LLC, PA OR GROUP PRACTICE NAME

STREET: CITY: STATE ZIP _____

TELEPHONE #: DOB: SS#: _____

PROFESSIONAL LICENSE #: STATE? _____

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

LAST FIRST MIDDLE

DBA, LLC, PA OR GROUP PRACTICE NAME

STREET: CITY: STATE ZIP _____

TELEPHONE #: DOB: SS#: _____

PROFESSIONAL LICENSE #: STATE : _____

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

HEALTH APPLICATION FRAUD REFERRAL/ NOTIFICATION FORM

OIFP/BFD-4 (04/13)

State of New Jersey

BFD Case# _____

Insurance Fraud Referral/Notification

OIFP _____

P.O. Box 094

Investigator _____

Trenton, NJ 08625-0094

REFERRAL NOTIFICATION

PART 1

INSURANCE CO. DATE REPORTED _____

NAIC COMPANY # _____

CONTACT PERSON

ADDRESS

TELEPHONE

E-MAIL ADDRESS

DATE OF APPLICATION _____

POLICY# _____ CLAIM# _____ SIU# _____

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.#

PROFESSIONAL LICENSE #

PROFESSIONAL LICENSE TYPE

STATE

BUSINESS NAME ,

T I N #

STREET

CITY

STATE ZIP

PRODUCER (IF APPLICABLE): AGENCY NAME

PRODUCER NAME: LAST FIRST MI

ADDRESS: STREET CITY STATE/ZIP

WORK PH. LICENSE#

PART 11

PROVISION(S) OF **N.J.S.A. 17:33A-4** RELATING TO APPLICATIONS THAT MAY HAVE BEEN

VIOLATED:

(CHECK APPROPRIATE BOX)

a(4)(b)-PREPARES OR MAKES ANY WRITTEN OR ORAL STATEMENT: INTENDED TO BE PRESENTED TO ANY INSURANCE COMPANY OR PRODUCER FOR THE PURPOSE OF OBTAINING AN INSURANCE POLICY, KNOWING THAT THE STATEMENT CONTAINS ANY FALSE OR MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO AN INSURANCE APPLICATION OR CONTRACT.

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) HAS OCCURRED.

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 APPLICANT 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 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 APPLICATION PROCESS, WHICH TENDS 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, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE .*)

*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)

I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE WILLFULLY FALSE, I AM SUBJECT TO PUNISHMENT.

DATED: _____

SIGNATURE OF CUSTODIAN _____

PRINT NAME _____ TITLE _____

MCEAFC Automobile Insurance Anti-fraud Experience Report 20110801

Instructions and Definitions

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.

Use the tab key to advance through form, shift tab to go back.

Mouse over fields for tips and additional information about that field.

Report may be printed using the “PRINT” button on the bottom of the form.

Report may be submitted using the “SUBMIT” button on the bottom of the form.

Comments may be e-mailed to: mceafc@dobi.state.nj.us

Report may be printed and 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 private passenger automobile and commercial coverage fraud prevention and detection statistics.

II. Definitions

Automobile as set forth in N.J.S.A. 39:6A-2 means a private passenger automobile of a private passenger or station wagon type that is owned or hired and is neither used as a public or livery conveyance for passengers nor rented to others with a driver; and a motor vehicle with a pickup body, a delivery sedan, a van, or a panel truck or a camper type vehicle used for recreational purposes owned by an individual or by husband and wife who are residents of the same household, not customarily used in the occupation, profession or business of the insured other than farming or ranching. An automobile owned by a farm family co partnership or corporation, which is principally garaged on a farm or ranch and otherwise meets the definitions contained in this section, shall be considered a private passenger automobile.

BFD means the Bureau of Fraud Deterrence, in the Division of Insurance, Department of Banking, and Insurance.

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 automobile policy claims (property damage, bodily injury, comprehensive and collision) received by the company in the reported calendar year.

Commercial coverage means insurance for private passenger type automobiles and light trucks for fleets not exceeding five vehicles owned by a corporation, partnership or any other entity except an individual or husband and wife and used for business purposes.

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.

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

Private passenger automobile means a policy of automobile insurance principally used to provide primary insurance on private passenger automobiles which are owned individually, or jointly by individuals who are residents of the same household, and used for personal, family, or household needs.

Private passenger type automobile means a vehicle that meets the definition in N.J.S.A. 39:6A-2a and is owned by a corporation, partnership or any other entity except an individual or husband and wife and used for business purposes.

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

MCEAFC AUTOMOBILE INSURANCE ANTI-FRAUD EXPERIENCE REPORT 20110801

I. Identification

Calendar Year Ending []

Company Name [] NAIC Company Code []
Group Name [] NAIC Group Code []
Street Address [] Address 2 []
City [] State: [] Zip []
Respondent: [] Title []
Phone number: [] e-mail: []
Date form completed: []

II. Reported data includes:

[] Private passenger automobile [] Special Investigation Unit established?
[] Commercial coverage

III. Claims data:

a. Number of NJ Claims Opened/Received During Calendar Year []
b. Number of NJ Claims referred to SIU during Calendar Year []
c. Number of NJ Claims referred to BFD and / or OIFP during Calendar year []
d. Total dollars saved by denial and compromise during Calendar Year due to investigation []

IV. Underwriting data:

a. Number of Policies In Force During Calendar Year []
b. Number of NJ Policies and Applications Declined for Fraud During Calendar Year []
c. Number of NJ Applications and Policies referred to SIU During Calendar Year []
d. Number of NJ Applications and Policies referred to BFD and / or OIFP During Calendar Year []
e. Total dollars saved by Declination, Policy Cancellation or nonrenewal during calendar year due to fraud []

V. Total SIU Expenditures:

Dollar Amount Spent on NJ Claim and Underwriting Fraud Detection and Prevention

a. New Jersey SIU Salaries []
b. New Jersey SIU Direct Expenses []
c. New Jersey SIU Other / Indirect Expenses []

Comments: []

MCEAFC Automobile Experience 2011801

Submit by Email

Print Form

3 of 3

MCEAFC Health Insurance Anti-fraud Experience Report 20110801

Instructions and Definitions

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.

Use the tab key to advance through form, shift tab to go back.

Mouse over fields for tips and additional information about that field.

Report may be printed using the "PRINT" button on the bottom of the form.

Report may be submitted using the "SUBMIT" button on the bottom of the form.

Comments may be e-mailed to: mceafc@dobi.state.nj.us

Report may be printed and 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 data regarding health insurance fraud prevention and detection statistics. Self-Insured data should not be included in this report.

II. Definitions

Calendar Year means the period January 1 to December 31.

Case refers to an SIU investigation or OIFP referral that may include several health care claims that were under investigation for fraud.

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

Comprehensive health care benefits means the following services: preventive care, emergency care, inpatient and outpatient hospital and provider care, diagnostic laboratory and diagnostic and therapeutic radiological services and other services set forth in N.J.A.C. 11:24-5, including all services listed at N.J.A.C. 11:24-5.2.

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

Health Insurer subject to this reporting requirement 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.

Limited Benefit Contracts include but are not limited to the following:

- Coverage only for accident (including accidental death and dismemberment)
- Disability income coverage
- Credit-only insurance (for example, mortgage insurance)
- Coverage for on-site medical clinics
- Limited-scope dental benefits
- Limited-scope vision benefits
- Long-term care benefits
- Coverage for only a specified disease or illness
- Hospital indemnity or other fixed indemnity insurance
- Medicare supplemental health insurance
- Insurance issued as a supplement to liability insurance
- Any other supplemental hospital indemnity benefits

NJ Cases refers to an SIU investigation or Office of the Insurance Fraud Prosecutor or the Bureau of Fraud Deterrence referral that may include several *claims* that were made in the State of New Jersey.

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

NJ Policies and Applications refer to coverage's 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.

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

MCEAFC HEALTH INSURANCE ANTI-FRAUD EXPERIENCE REPORT 20110801

I. Identification

Calendar Year Ending []

Company Name [] NAIC Company Code []
Group Name [] NAIC Group Code []
Street Address [] Address 2 []
City [] State: [] Zip []
Respondent: [] Title []
Phone number: [] e-mail: []
Date form completed: []

II. Coverages

Total lives insured [] Comprehensive coverages [] Limited benefits []

Reported data includes the following (check all that applies)

- Comprehensive [] Dental only [] Non coordinated benefits []
Limited coverages [] Disability [] Other hospital indemnity benefits []
Accident only [] Long term care [] Vision only []
Credit only [] Medicare supplement [] Supplement to liability insurance []

III. Claims data:

a. Number of NJ Claims Opened/Received During Calendar Year []
b. Number of NJ Claims referred to SIU during Calendar Year []
c. Number of NJ Claims referred to BFD and / or OIFP during Calendar year []
d. Total dollars saved by denial and compromise during Calendar Year due to investigation []

IV. Underwriting data:

a. Number of Policies In Force During Calendar Year []
b. Number of NJ Policies and Applications Declined for Fraud During Calendar Year []
c. Number of NJ Applications and Policies referred to SIU During Calendar Year []
d. Number of NJ Applications and Policies referred to BFD and / or OIFP During Calendar Year []
e. Total dollars saved by Declination, Policy Cancellation or nonrenewal during calendar year due to fraud []

V. Total SIU Expenditures:

Dollar Amount Spent on NJ Claim and Underwriting Fraud Detection and Prevention

a. New Jersey SIU Salaries []

b. New Jersey SIU Direct Expenses

c. Other / Indirect Expenses

Comments:

MCEAFC Health Experience Report 2011801-04062011

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