45 NJR 9(2)
September 16, 2013
Filed September 4, 2013

PROPOSAL SECTION

INSURANCE

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

Notice of Administrative Correction and Extension of Public Comment Period

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 Appendix

Take notice that the Office of Administrative Law discovered errors in the above-referenced notice of proposal as published in the September 3, 2013 New Jersey Register at 45 N.J.R. 1989(a). Due to errors in the printing of that Register issue, portions of proposed new rule N.J.A.C. 11:16 Appendix were omitted from the published notice of proposal. The omitted text included the last 16 lines of Health Claim Fraud Referral/Notification Form OIFP/BFD-3 (04/13), the MCEAFC Automobile Insurance Anti-Fraud Experience Report 20110801, and the MCEAFC Health Insurance Anti-Fraud Experience Report 20110801. The omitted text should have appeared at 45 N.J.R. 2011, 2017, and 2020, respectively, which pages appear without proposal text in the Published Register issue. This notice, published pursuant to N.J.A.C. 1:30-2.7, corrects the errors in the published notice of proposal by setting forth the complete text of proposed new rule N.J.A.C. 11:16 Appendix.

Take further notice that, due to the errors in the published notice of proposal, the Department of Banking and Insurance is extending the public comment period on the notice of proposal from November 2, 2013, to November 15, 2013. Submit comments by November 15, 2013 to:

Robert J. Melillo, Chief

Legislative and Regulatory Affairs

Department of Banking and Insurance

20 West State Street

P.O. Box 325

Trenton, NJ 08625-0325

Fax: (609) 292-0896

Email: legsregs@dobi.state.nj.us

Full text of corrected proposed new rule N.J.A.C. 11:16 Appendix follows:

APPENDIX

CLAIM FRAUD REFERRAL / NOTIFICATION FORM

OIFP/BFD-1 (04/13)

State of New Jersey

Insurance Fraud Referral/Notification

P.O. Box 094

Trenton, NJ, 08625-0094

BFD Case # _____/____/_____

OIFP #____________________

Investigator _________________

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)

State of New Jersey

Insurance Fraud Referral/Notification

P.O. Box 094

Trenton NJ, 08625-0094

BFD Case #_________________

OIFP______________________

Investigator_________________

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
Insurance Fraud Referral/Notification
P.O. Box 094
Trenton NJ, 08625-0094

BFD Case #__________________
OIFP#______________________
Investigator__________________

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 ENDROCRINOLOGY ENDODONTIST ENT EPIDEMIOLOGY

FAMILY MEDICINE GASTROINTEROLOGY GENERAL PRACTICE IMMUNOLOGY

INFECTIOUS DISEASE INTERNAL MEDICINE NEONATOLOGY NEUROLOGY

OBSTETRICS/GYNECOLOGY ONCOLOGY OPHTHALMOLOGY OPTOMETRY ORAL

SURGEON ORTHODONTIST ORTHOPEDICS OTOLARYNGOLOGY PEDIATRICS

PODIATRY PERIODONTIST PLASTIC SURGERY PROSTIDONTIST PSYCHIATRY

RADIOLOGY SURGERY UROLOGY WEIGHT LOSS OTHER

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. 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 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

Insurance Fraud Referral/Notification

P.O. Box 094

Trenton, NJ 08625-0094

BFD Case#____________________

OIFP________________________

Investigator___________________

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)

HEALTH (INDEMNITY) HEALTH (MEDICAID)

HEALTH (HMO) DENTAL

OTHER

STATUS (Indicate as appropriate)

PREMIUM ADJUSTED

AMOUNT $

APPLICATION DECLINED

NON-RENEWAL

CANCELED

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST FIRST MIDDLE

STREET CITY STATE-ZIP

HOME PH WORK PH D.O.B.

S.S./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

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1. 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:

Submit by Email

Print Form

MCEAFC Health Insurance Anti-fraud Experience Report 20110801

Instructions and Definitions

1. 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.

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NEW JERSEY DEPARTMENT OF BANKING AND INSURANCE

MCEAFC HEALTH INSURANCE ANTI-FRAUD EXPERIENCE REPORT 20110801

I. Identification

Calendar Year Ending

Company Name

Group Name

Street Address

City

Respondent:

Phone number:

Date form completed:

NAIC Company Code . . . .

NAIC Group Code . . . .

Address 2

State:

Zip

Title

e-mail:

II. Coverages

Total lives insured

Comprehensive coverages

Limited benefits

Reported data includes the following (check all that applies)

- ☐ Comprehensive
- ☐ Limited coverages
- ☐ Accident only
- ☐ Credit only
- ☐ Dental only
- ☐ Disability
- ☐ Long term care
- ☐ Medicare supplement
- ☐ Non coordinated benefits
- ☐ Other hospital indemnity benefits
- ☐ Vision only
- ☐ 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:

Submit by Email

Print Form

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