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: Donald Bryan, Acting Commissioner, Department of Banking and Insurance

Authority: 17:1-8.1, 17:1-15e, 17:23-8 et seq. and 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 2006-65

Submit comments by May 5, 2006 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

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66 (1978) 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 was scheduled to expire on January 31, 2006 however, based upon the timely filing of this notice, the expiration date of the chapter is extended until July 30, 2006, pursuant to N.J.S.A. 52:14B-5.1e.

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). 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;

The rules in this chapter were promulgated to implement the statutory requirements in Title 17 of the New Jersey Statutes. 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 Fraud Prevention and Detection in insurance. 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 and secondly they provide guidance to the insurance industry in the methodology of establishing and the implementation of: fraud detection plans, special investigations units, training programs and manuals, records retention, reporting and approval of the plan by the Department. In addition, this chapter includes provisions and formats for: Claim Fraud Referral Forms and instructions for the Office of the Insurance Fraud Prosecutor (OIFP); Application Fraud Referral Forms to the OIFP; Suspicious Claim/Application Notification Form to the OIFP; Health Claim Fraud Referral Form to the OIFP; Health Application Fraud Referral Form to the OIFP; Suspicious

Health Claim/Application Notification Form to the OIFP and Company Fraud Prevention and Detection Plan/Annual Reporting forms and instructions-Exhibits 1 to 3.

The rules proposed for readoption with amendments contains only changes to references of the newly titled reporting forms suggested by the insurance industry to enhance the efficiency of reporting fraud data. These replacement forms have been reviewed and authorized by the Department of Law and Public Safety (DLPS). The original adoption of these rules was the product of a joint proposal of the DLPS and the Department of Banking and Insurance. Any future substantive amendments will be accomplished via Joint Proposals. Because no substantive amendments are being proposed to Chapter 16, and the amendments involve merely the repeal of the Subchapter 6 Appendix and proposed new subchapter Appendix, containing amended forms as discussed below, in an effort to enhance the efficiency of reporting data, and because the new forms were designed through an advisory committee of insurance industry participants and work experts from DLPS and DOBI, the Department believes that additional confirmation of the agreement of the Attorney General's office to this proposal is not necessary. The replacement or deletion of certain original fraud reporting forms, within the subchapter Appendix, will refine the fraud reporting process and result in reporting efficiency and cost containment or possible cost reductions for both insurance companies, DLPS and DOBI. In May of 2005, DLPS and DOBI amended NJAC 11:16-6 to create separate automobile and health reporting forms and to eliminate the reference on the forms to the DOBI Anti-fraud Unit, which was merged into the DOBI market conduct unit. The Department now seeks to amend the forms, subsequent to the active participation of the OIFP in the formulation of the proposed revisions, merely to include the seal of the Office of the Insurance Fraud Prosecutor, which reports to the Attorney General, on the forms, instead of the Great Seal of the State of New Jersey and to delete redundant forms.

Based upon the foregoing, the Department is proposing to repeal Subchapter 6 Appendix and replace it with a new subchapter appendix, primarily for technical reasons, as discussed above, and to rename certain forms as discussed below. The Department is proposing the following new forms:

1. Claim Fraud Referral/Notification Form OIFP-1 (06/06) to replace the Claim Fraud Referral From OIFP-1A (01/01);
2. Application Fraud Referral/Notification Form OIFP-2 (01/06) to replace the Application Fraud Referral Form OIFP-1B (01/01);
3. Health Claim Fraud Referral/Notification Form OIFP-3 (01/06) to replace the Health Claim Fraud Referral Form OIFP-3A (01/01);
4. Health Application Fraud Referral/Notification Form OIFP-4 (01/06) to replace the Health Application Fraud Referral Form OIFP-3A;
5. Automobile Insurance MCEAFC Form #1A, which allows insurers to file annual statistical data for Automobile Insurance Fraud and Prevention plans to DOBI and eliminates the reference to the Department's Anti-Fraud Unit which was merged into the Market Conduct Unit, to replace Exhibit 1, MCEAFC Form #1;
6. Health Insurance MCEAFC Form #2A, which allows insurers to file annual statistical data for Health Insurance Fraud and Prevention plans to DOBI and eliminates the reference to the Department's Anti-Fraud Unit which was merged into the Market Conduct Unit, to replace Exhibit 2, Form #1A; and
7. Two instruction/definition forms. Form #1B (used to complete Form #1A) and Form #2B (used to complete Form #2A), which replace Exhibit 3, Instructions and Definitions MCEAFC forms #1 and 11A.

The following two forms are proposed for repeal and are not being replaced with new forms, as the forms use is redundant. Suspicious Claim/Application Notification Form OIFP-2 (01/01) and Suspicious Health Claim/Application Notification Form OIFP-4 (01/01).

As a result of the proposed repeal and new rules, amendments are proposed to update references to these forms in N.J.A.C. 11:16-6.6(b) and (c) and 6.7(a).

Finally, the Department proposes to amend the language of N.J.A.C. 11:16-6.8(b) to update the reference to the propose MCEAFC replacement forms cited above and to delete an obsolete reference to MS-DOS formatted disks, while retaining the requirement that companies submit data by hard copy or by e-mail.

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 laws and other applicable laws of this State, 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

As noted above, the rules proposed for readoption with amendments, repeals and new rule address several areas of concern to consumers and protect them from potential unfair trade practices concerning insurance and its solicitation. For example, the rules concerning agent and broker avoidance of debt help ensure that consumers are protected from certain bad faith practices on the part of insurance agents. The rules concerning disability discrimination establish a designated coordinator whose duties include assuring that the Department complies with and carries out its responsibilities under the Americans with Disabilities Act. The rules concerning cancellation and non-renewal of commercial insurance policies protect insureds from invalid non-renewals and cancellations, while providing insurers with the flexibility to cancel and non-renew policies due to conditions that warrant such actions. The rules governing public adjusters establish procedures for the examination, licensing and conduct of persons acting as public adjusters in this State. Finally, the rules governing notice of consumer insurance rate increases help ensure that the policyholders are informed of pending action by an insurer that may impact their rates.

The industry also relies on the presence and effectiveness of these rules in its operations. Insurers are provided with guidance in various regulated actions. For example: the filing of rates, manual rules, rating plans, policy forms and endorsements; admission procedures, requirements and standards governing the application of a foreign or alien insurer to do property/casualty business in this State; and the procedures for the formation of a domestic property/casualty insurer or a reciprocal exchange.

The rules in this chapter enable the Department to fulfill its regulatory duties under law. Failure to readopt these rules would impair the Department’s regulatory powers and would 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 a sound and effective regulatory policy.

The proposed amendments, new rules and repeals 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 as a result of a consensus that was reached among the OIFP, the Department and certain major insurers and were 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, repeals and new rule will enable the Department to make better use of the information obtained.

Economic Impact

The failure to readopt this subchapter would require the insurance industry to perform many significant statutory functions without guidance from the Department. This would impose significant 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.

Insurers and other regulated entities will be required to incur any costs associated with continued compliance with the requirements set forth in this subchapter. The rules proposed for readoption with amendments, repeal and new rule impose costs on insurers who must file for rate and form approval pursuant to Department guidelines. Foreign and alien insurers will also continue to incur costs in seeking admission to do business in this State. In addition, costs will be incurred in the application for a certificate of authority as a domestic insurer in this State. None of these costs are new; they merely restate the existing requirements. The proposed amendments are technical in nature and impose no new requirements.

These rules also have a beneficial impact on consumers. The rules concerning bad faith actions on the part of brokers and agents help ensure that a consumer is not treated unfairly. In addition, rules concerning nonrenewal and cancellation provide requirements for notice to insureds of such actions and require acceptable reasons for cancellation and non-renewal, thereby providing a reasonable degree of assurance for an insured that coverage will be maintained and potential economic losses avoided. The rules governing rate and rule filings enable the Department to ensure that insurers comply with statutory prohibitions against using rates that are excessive, inadequate or unfairly discriminatory.

Readoption of the current rules 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 favorably affect insurers and other regulated entities who, based upon statutory law, are assessed to fund its insurance operations. The avoidance of unnecessary increases in the administrative costs of insurers also has the effect of exerting downward pressure on rates, since such costs are a factor that is considered when rates are determined.

Throughout the years, the Department has carefully monitored, and continues to monitor, the impact of the rules in this chapter through communication with the insurance industry and the public. The Department is unaware of any provision of these rules that imposes undue or unnecessarily onerous financial burdens on consumers or the insurance industry. The readoption of this chapter with amendments, repeals and new rules will not impose any additional economic impact on insurers, other regulated entities or consumers in that the readoption will continue long-standing requirements.

To the extent that the amendments and repeals enable 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.

Federal Standards Statement

A Federal standards analysis is not required because the rules proposed for readoption with amendments, repeal and new rules 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, repeal and new rules 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, repeal and new rules.

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. Several rules (for example, those which address conduct constituting violations by brokers and agents, and those providing for the regulation of public adjusters) relate to the conduct of insurance producers and public adjusters, most of whom are "small businesses." Many subchapters specifically address insurers that are not located in this State and thus are not "small businesses," such as those addressing admission requirements and those relating to surplus lines insurers.

Numerous recordkeeping, reporting and compliance requirements will continue to be imposed by this chapter. These include the requirements concerning rate and form filings, loss reserve opinions and medical malpractice reporting requirements. The Department has determined that all such compliance, recordkeeping and reporting requirements continue to be reasonable and necessary for the purpose for which they were originally adopted. 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, including the protection of

consumers of insurance products that 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, repeal and new rule will impose no new recordkeeping, reporting or other compliance requirements, but merely continue those requirements that have been in existence 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 costs savings, as explained in the Summary and Economic Impact above. The Department does not anticipate the good professional services to achieve compliant with these rules.

Smart Growth Impact

The rules proposed for readoption with amendments, repeals and new rules will not have an impact on the achievement of smart growth or the implementation of the State Development and Redevelopment Plan.

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 proposed 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 follow (additions indicated boldface **thus**; deletions indicated in brackets [thus]):

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 OIFP, for further OIFP investigation or other appropriate action, on the prescribed Referral Form ([OIFP-1A for Claim Fraud Referral, OIFP-1B for Application Fraud Referral, OIFP-2 for Suspicious Claim/Application Notification, OIFP-3A for Health Claim Fraud Referral, OIFP-3B for Health Application Fraud Referral, and OIFP-4 for Suspicious Health Claim/Application notification] **(OIFP-1 for Claim Fraud Referral or Notification, OIFP-2 for Application Fraud Referral or Notification, OIFP-3 for Health Claim Fraud Referral or Notification, and OIFP-4 for Health Application Fraud Referral or Notification incorporated herein by reference in the subchapter Appendix)**, with all other information required by the form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16-6.7.

2. - 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 OIFP on [Notification Form OIFP-2 and for Health Insurance Notification on OIFP-4] **OIFP Form 1, OIFP Form 2, OIFP Form 3 or OIFP Form 4, indicating "NOTIFICATION" [(]** incorporated herein by reference in the subchapter Appendix**[)]**, unless this form is superseded by an electronic reporting form, of instances in which a violation of N.J.S.A. 17:33A-4 is suspected on the basis of fraud factors or indicators, but where sufficient evidence to support a case referral pursuant to N.J.A.C. 11:16-6.7 has not been developed.

(d) - (f) (No change.)

11:16-6.7 Referrals to OIFP

(a) The plan shall provide that upon completion of its investigation, as described in (d) below, an SIU shall refer cases, on form [OIFP-1A, OIFP-1B, OIFP-3A or OIFP-3B] **OIFP 1, OIFP 2, OIFP 3, OIFP 4, indicating "REFERRAL"** which meet the following standard to OIFP.

1.- 2. (No change.)

(b)- (d) (No change.)

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 MCEAFC [#1 or] **Form #1A and/or #2A**, pursuant to instructions and definitions provided in MCEAFC Form #1B **(for the completion of #1A) and Form #2B (for the completion of #2A),** incorporated herein by reference in the subchapter Appendix. Individual insurers that comprise a group shall submit separate reports. Reports shall be submitted in hard copy [and either on an MS-DOS formatted disk] or by email to:

New Jersey Department of Banking and Insurance

Market Conduct Examinations and Anti-Fraud Compliance Unit

20 West State Street

PO Box 329

Trenton, NJ 08625-0329

Email: mceafc@dobi.state.nj.us

1. (No change.)

Full text of the proposed new rule follows:

(Agency Note: Proposed new N.J.A.C. 11:16-6 Appendix is published below without the standard boldfacing used for proposed new text. Boldface text appearing within the Appendix is a permanent feature of the document.

APPENDIX

CLAIM FRAUD REFERRAL / NOTIFICATION FORM

OIFP-1 (01/06)

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

OIFP Case # _____/_____/

Intake #_____

Investigator_____

☐ REFERRAL ☐ NOTIFICATION

PART 1

INSURANCE CO._____ DATE REPORTED._____

ADDRESS_____ NAIC COMPANY #_____

_____ D.O.L..._____

TELEPHONE_____ POLICY #_____

CONTACT PERSON_____

E-MAIL ADDRESS_____

TYPE OF COVERAGE (Check appropriate box)

LIFE ☐ W.C. ☐

AUTO ☐ HOME ☐

COMM ☐

OTHER _____

STATUS (Indicate as appropriate)

PENDING ☐ PAID - IN FULL ☐

DENIED ☐ PAID - IN PART ☐

AMOUNT PD $_____ DATE/RANGE PD

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

INSURED/SUBJECT:

LAST _____ FIRST_____ MIDDLE

STREET_____ CITY_____ STATE-ZIP_____

HOME PH._____ WORK PH

D.O.B_____ S.S. #_____ D.L.#

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?

YES ☐ NO ☐

IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

January 2006
PART 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 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 HE OCCURRENCE OF AN EVENT WHICH AFFECTS ANY PERSON'S INITIAL OR CONTINUED RIGHT TO ENTITLEMENT TO PAYMENT OF A CLAIM. N.J.S.A. 17:33A-4A(3)

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

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

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

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

- ☐ ANY PERSON OR PRACTITIONER TO ENGAGE , EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
- ☐ ANY PERSON TO BRING CAUSES OF ACTION RO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
- ☐ ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

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

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE:
(FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:
(FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT REPORT, OTHER APPARENT MISREPRESENTATIONS MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE).*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER:
(FOR EXAMPLE, POLICE OFFICER, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER).*

***For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.**

PART IV

CERTIFICATION OF CUSTODIAN RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place.

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

Custodian of Records
(Full Name and Title)

Dated:

PART V

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

INFORMATION REGARDING ANY ADDITIONAL INSUREDS:

LAST_____ FIRST_____ MIDDLE

STREET_____ CITY_____ STATE/ZIP

HOME PH._____ WORK PH_____ S.S.

D.L.#

CLAIMANT #1 (IF OTHER THAN INSURED/SUBJECT)

LAST_____ FIRST_____ MIDDLE

STREET_____ CITY_____ STATE/ZIP

HOME PH._____ WORK PH_____ S.S.

D.L.#

CLAIMANT #2

LAST _____ FIRST_____ MIDDLE

STREET_____ CITY_____ STATE/ZIP

HOME PH._____ WORK PH_____ S.S.

D.L.#

CLAIMANT #3

LAST_____ FIRST_____ MIDDLE

STREET _____ CITY_____ STATE/ZIP

HOME PH._____ WORK PH_____ S.S.

D.L.#

PART VI

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

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER
(CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST______________________________ FIRST___________________________ MIDDLE
LIC#
EMPLOYER____ PHONE #
ADDRESS____ TAX ID#
ADDRESS (cont.)___________________________ D.O.B. _____________________ S.S.#

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER
(CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST______________________________ FIRST___________________________ MIDDLE
LIC#
EMPLOYER____ PHONE #
ADDRESS____ TAX ID#
ADDRESS (cont.)___________________________ D.O.B. _____________________ S.S.#

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER
(CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST______________________________ FIRST___________________________ MIDDLE
LIC#
EMPLOYER____ PHONE #
ADDRESS____ TAX ID#
ADDRESS (cont.)___________________________ D.O.B. _____________________ S.S.#

PROFESSIONAL SERVICE PROVIDER TYPE: ATTORNEY / PRODUCER / MEDICAL SERVICE PROVIDER / REPAIR SHOP / OTHER

(CIRCLE APPLICABLE PROFESSIONAL LICENSE OR OCCUPATION TYPE OR OTHERWISE SPECIFY TYPE OF SERVICE PROVIDER)

LAST_____ FIRST_____ MIDDLE

LIC#

EMPLOYER_____ PHONE #

ADDRESS_____ TAX ID#

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

APPLICATION FRAUD REFERRAL/NOTIFICATION FORM

OIFP-2 (01/06)

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

OIFP Case #_____/_____/
Intake #

Investigator

☐ REFERRAL ☐ NOTIFICATION

PART 1

INSURANCE CO._____ DATE REPORTED

ADDRESS_____ NAIC COMPANY #

_____ DATE OF APPLICATION

_____ POLICY #

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#

January, 2006 OIFP 2

PART II

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

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

☐ **a(5)(b) - conspires with another:** KNOWINGLY ASSISTS, CONSPIRES WITH, OR URGES A PERSON TO VIOLATE ANY PROVISION OF THIS ACT. N.J.S.A. 17:33A-4B. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED .

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO THE INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH DOCUMENTS EACH STATEMENT OR OMISSION IS MADE: (FOR EXAMPLE, THE APPLICATION AND ANY DOCUMENT SUBMITTED IN SUPPORT OF THE APPLICATION)*****

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:*****

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED INSURANCE PRODUCER (AGENT) OR INSURANCE AGENCY EMPLOYEE KNOWINGLY PARTICIPATED IN THE APPLICATION FRAUD. PROVIDE THE NAME AND ADDRESS OF THIS PERSON.*****

*** For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.**

PART IV **CERTIFICATION OF CUSTODIAN OF RECORDS**

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place.

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

DATED:

Custodian of Records
(Full Name and Title)

HEALTH CLAIM/FRAUD REFERRAL/ NOTIFICATION FORM
OIFP-3 (01/06)

OIFP Case # / /
Intake #
Investigator

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

☐ REFERRAL ☐ NOTIFICATION

PART 1

INSURANCE CO._____DATE REPORTED_____

ADDRESS_____ NAIC COMPANY _____

_____ D.O.L _____

TELEPHONE_____POLICY #_____

CONTACT PERSON_____

E-MAIL ADDRESS_____

TYPE OF COVERAGE (Check appropriate box)
Health (Indemnity) ☐ Health Medicaid ☐
Health HMO ☐ Dental ☐
OTHER _____

STATUS (Indicate as appropriate)
PENDING ☐ PAID - IN FULL ☐
DENIED ☐ PAID - IN PART ☐
AMOUNT PD $_____ DATE/RANGE PD
IF PENDING OR DENIED, EITHER IN FULL OR IN PART, THE DOLLAR AMOUNT OF THE PENDING OR DENIED CLAIM: $

INSURED/SUBJECT/PROVIDER (CIRCLE)

LAST_____ FIRST_____ MIDDLE_____

STREET_____ CITY_____ STATE-ZIP_____

HOME PH_____ WORK PH_____ D.O.B._____

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

LICENSE #_____ STATE_____

BUSINESS NAME_____ TIN #_____

TYPE OF PROVIDER (Check appropriate box)

MD ☐ DO ☐ PHD ☐ DDS ☐ DMD ☐ HOSPITAL ☐ OUTPATIENT FACILITY ☐ PHYSICAL THERAPY ☐

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

MSW ☐

OTHER

TAX ID #S USED

January 2006

SPECIALTY

ALLERGIST ☐ ANESTHESIOLOGY ☐ CARDIOLOGY ☐ CHIROPRACTIC ☐ DERMATOLOGY ☐ EMERGENCY MEDICINE ☐ 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

DBA, LLC, PA OR GROUP PRACTICE NAME

STREET:_____ CITY:_____ STATE_____ ZIP _____

TELEPHONE #:_____ DOB:_____ SS#:_____

STATE LICENSE #:

DOES THIS CLAIM FORM PART OF A PATTERN OF POSSIBLE VIOLATIONS OF N.J.S.A. 17:33A-4?

YES ☐ NO ☐

IF YES, LIST OTHER RELATED CLAIM NUMBERS, INDICATE STATUS OF OTHER RELATED CLAIMS, AND ATTACH COPIES OF OTHER REFERRALS, IF APPLICABLE:

ARE YOU AWARE OF ANY OTHER COMPANIES PURSUING RECOVERIES AGAINST THIS SUBJECT?

YES ☐ NO ☐

IF YOU CHECKED "YES", PLEASE COMPLETE THE FOLLOWING:

NAME OF OTHER COMPANY	INVESTIGATOR	CONTACT NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

PART II

PROVISIONS OF **N.J.S.A. 17:33A-4** RELATING TO FALSE CLAIMS THAT MAY HAVE BEEN VIOLATED:
(CHECK APPROPRIATE BOX OR BOXES)

☐ a**(1) - presents false information**: KNOWINGLY PRESENTS OR CAUSES TO BE PRESENTED ANY WRITTEN OF ORAL STATEMENT CONTAINING ANY FALSE MISLEADING INFORMATION CONCERNING ANY FACT OR THING MATERIAL TO THE CLAIM. N.J.S.A. 17:33A- 4A(1)

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

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

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

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

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

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

- ☐ ANY PERSON OR PRACTITIONER TO ENGAGE , EMPLOY OR RETAIN A PERSON TO MANAGE, ADJUST OR PROSECUTE, ANY CLAIM OR CAUSE OF ACTION FOR DAMAGES.
- ☐ ANY PERSON TO BRING CAUSES OF ACTION RO RECOVER DAMAGES FOR PERSONAL INJURIES/DEATH.
- ☐ ANY PERSON TO MAKE A CLAIM FOR PERSONAL INJURY PROTECTION BENEFITS. N.J.S.A. 17:33A-4E.

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

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE:
(FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:
(FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT REPORT, OTHER APPARENT MISREPRESENTATIONS MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE).*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS EMPLOYER: (FOR EXAMPLE, POLICE OFFICER, MEDICAL SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER).*

***For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.**

PART IV

CERTIFICATION OF CUSTODIAN RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place.

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

Custodian of Records
(Full Name and Title)

Dated:

HEALTH APPLICATION FRAUD REFERRAL/ NOTIFICATION FORM

OIFP-4 (01/06)

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

OIFP Case #_____/_____/
Intake #

Investigator

☐ REFERRAL ☐ NOTIFICATION

PART 1

INSURANCE CO._____ DATE REPORTED_____

ADDRESS_____ NAIC COMPANY #_____

_____ DATE OF APPLICATION_____

_____ POLICY #_____

TELEPHONE_____

CONTACT PERSON_____

E-MAIL ADDRESS

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.#

LICENSE #_____ STATE

BUSINESS NAME TIN #

PRODUCER (IF APPLICABLE): AGENCY NAME

PRODUCER NAME: LAST_____ FIRST_____ MI

ADDRESS: STREET_____ CITY_____ STATE/ZIP

WORK PH._____ LICENSE

January 2006

PART 11

PROVISION(S) OF **N.J.S.A. 17:331-4** RELATING TO APPLICATIONS THAT MAY HAVE BEEN VIOLATED:
(CHECK APPROPRIATE BOX)

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

☐ **a(5)(b) - conspires with another:** KNOWINGLY ASSISTS, CONSPIRES WITH, OR URGES A PERSON TO VIOLATE ANY PROVISION OF THIS ACT. N.J.S.A. 17:33A-4B. (SPECIFY WHICH PROVISION(S) OF THE ACT WERE VIOLATED_____).

PART III

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

2. LIST ALL FALSE OR MISLEADING STATEMENTS MADE TO INSURANCE CARRIER, OR INFORMATION OMITTED, AND INDICATE ON WHICH CLAIM DOCUMENT EACH STATEMENT OR OMISSION IS MADE:
(FOR EXAMPLE, ACORD FORM, AFFIDAVIT OR VEHICLE THEFT, APPRAISAL, AFFIDAVIT OF NO INSURANCE, RECORDED STATEMENT, POLICE ACCIDENT REPORT, RECEIPT, ETC.)*

3. INDICATE THE EVIDENCE WHICH CORROBORATES THE SUSPICIOUS FACTS AND CIRCUMSTANCES INDICATED IN PARAGRAPH 1. ABOVE:
(FOR EXAMPLE, WITNESS STATEMENT, DOCUMENTARY EVIDENCE WHICH DIRECTLY CONTRADICTS A STATEMENT OR OMISSION MADE IN THE CLAIM PROCESS, AN EXPERT REPORT, OTHER APPARENT MISREPRESENTATIONS MADE TO SUPPORT THE CLAIM WHICH TEND TO INDICATE THAT THE MISREPRESENTATION OR OMISSION WAS NOT MERELY A MISTAKE).*

4. SPECIFY ANY EVIDENCE WHICH WOULD TEND TO INDICATE THAT A LICENSED PROFESSIONAL MAY HAVE KNOWINGLY PARTICIPATED EMPLOYER:
(FOR EXAMPLE, POLICE OFFICER, MEDICAL IN VIOLATING THE ACT, AND LIST THE INDIVIDUAL(S), HIS PROFESSION AND HIS SERVICE PROVIDER, ATTORNEY, INSURANCE PRODUCER/AGENT, INSURANCE CARRIER EMPLOYEE, AUTO REPAIR FACILITY EMPLOYEE, APPRAISER, OR CLAIMS ADJUSTER).*

***For each document listed in support of the allegation of fraud, please attach an exact copy or the original. In addition, as to all documents attached to this form, please complete the attached Certification of Custodian of Records.**

PART IV

CERTIFICATION OF CUSTODIAN RECORDS

I certify that the records identified herein are originals or exact copies of the records made by a person with actual knowledge in the regular course of business at the time the activity took place.

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

Custodian of Records
(Full Name and Title)

DATED:

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

Group Company Name _____ NAIC Group Number _____

Company/ Affiliate Name _____ NAIC Company Number _____

Address 1 _____ Address 2 _____

City _____ State _____ Zip _____

Respondent First and Last Name _____ Phone Number (___) _____

Respondent Title _____ Calendar Year of Report _____

SIU Established? YES _____ NO _____

1 Claims Data

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

b. Total dollars saved by denial and compromise during Calendar Year due to investigation[i] _____

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

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

[1] Includes claims investigations conducted by SIU where SIU is required based upon number of exposures; as well as investigations conducted by non-SIU personnel where SIU is not required due minimal exposures.

ll. Underwriting Data

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

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

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

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

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

_____

[2] Includes policy and application investigations conducted by SIU where SIU is required based upon number of exposures, as well as investigations conducted by non-SIU personnel where SIU is not required due to minimal exposures.

lll. Total SIU Expenditures*

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

NJ SIU Salaries [3] _____ Direct Expenses [4] _____ Other/Indirect Expenses[5] _____

[3] . Gross compensation exclusive of benefits including investigators, support staff, etc.
[4] . Includes benefits excluded in item 3, as well as expenses incurred directly by SIU such as phones, equipment, cars etc.
[5] . includes indirect expenses incurred by SIU including rent, space, utilities. May also include non-SIU expenses From other work units such as legal department, claim/underwriting department follow-up, etc.
* Insurers that have not established an SIU should include salary, direct and other/indirect expenses on a pro-rata,

Estimated basis, for all costs associated with fraud investigations.

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

I. Instructions

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

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

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

Contact Person for Questions:	Virgil Dowtin 609-341-2513 ext 50402 vdowtin@dobi.state.nj.us
Report may be emailed to:	mceafc@dobi.state.nj.us
Report may be mailed to:	New Jersey Department of Banking and Insurance Office of Consumer Protection Services Market Conduct and Anti-Fraud Compliance 20 West State Street P.O.Box 329 Trenton, N.J. 08625
Scope:	This report includes automobile fraud prevention and detection statistics.

II. Definitions

Calendar Year means the period January 1 to December 31.

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

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

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

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

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

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

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

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

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

Group Company Name _____ NAIC Group Number _____

Company/ Affiliate Name _____ NAIC Company Number _____

Address 1 _____ Address 2 _____

City _____ State _____ Zip _____

Respondent First and Last Name _____ Phone Number (___) _____

Respondent Title _____ Calendar Year of Report _____

SIU Established? YES _____ NO _____ Company also writes self-insured business and reported pro-rata data on Non-self-insured business Yes_____: NO_____(See Scope/Definitions)

1 Claims Data

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

b. Total dollars saved by denial and compromise during Calendar Year due to investigation[ii] _____

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

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

[1] Includes claims investigations conducted by SIU where SIU is required based upon number of exposures; as well as investigations conducted by non-SIU personnel where SIU is not required due minimal exposures.

ll. Underwriting Data

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

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

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

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

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

_____

[2] Includes policy and application investigations conducted by SIU where SIU is required based upon number of exposures, as well as investigations conducted by non-SIU personnel where SIU is not required due to minimal exposures.

lll. Total SIU Expenditures*

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

NJ SIU Salaries [3] _____ Direct Expenses [4] _____ Other/Indirect Expenses[5] _____

[3] . Gross compensation exclusive of benefits including investigators, support staff, etc.
[4] . Includes benefits excluded in item 3, as well as expenses incurred directly by SIU such as phones, equipment, cars etc.
[5] . includes indirect expenses incurred by SIU including rent, space, utilities. May also include non-SIU expenses

From other work units such as legal department, claim/underwriting department follow-up, etc.

* Insurers that have not established an SIU should include salary, direct and other/indirect expenses on a pro-rata, Estimated basis, for all costs associated with fraud investigations.

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

I. Instructions

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

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

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

Contact Person for Questions:	Virgil Dowtin 609-341-2513 ext 50402 vdowtin@dobi.state.nj.us
Report may be emailed to:	mceafc@dobi.state.nj.us
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Scope:	This report includes automobile fraud prevention and detection statistics.

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

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

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

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. . .

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