THE TREASURER OF THE STATE OF FLORIDA
DEPARTMENT OF INSURANCE

SUSPECTED FRAUD REFERRAL FORM

CONFIDENTIAL

Company : ____________________
NAIC # ____________________
Contact Person : ____________________
Phone # ____________________
Address : ____________________
Insured Name : ____________________
Phone # ____________________
Address : ____________________
Claim # __________ **Policy #** __________ **Effective Date :** __________
Date of Loss : __________ **Time of Loss:** __________ **Date Reported :** __________
Location of Loss : ____________________
Has this claim been paid? __________ **Estimated Amount of Claim $** __________
Type of Fraud: ☐ **Agent** ☐ **Workers' Compensation** ☐ **Medical** ☐ **Claims** ☐ **Other, explain** ____

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Type of Insurance : ____________________
Names & phone numbers of individuals significant to loss; include doctors, lawyers, witnesses, etc.

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Person(s) Suspected of Committing Fraud: **(Use additional forms for each suspect)**
Name: ____________________
Address : ____________________
Phone # __________ **Driver License #** __________ **State :** ______
Date of Birth : __________ **Social Security #** __________
Place of Employment : ____________________
Occupation : ____________________

Referral To Any Other Entities; i.e., law enforcement agencies, professional boards, etc.:
Name of Entity : ____________________
Date of Referral : ____________________
Contact Person : ____________________
Phone # ____________________

Brief Description Of Facts: (where, when, why, what, how & who?) **(Use additional paper if necessary)** ______
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____
____

Is This Related To Any Other Fraudulent Activity? If yes, please explain (Use additional paper if necessary)
____
____

Signature: ____________________ **Date:** ____________________

Submit request to:
Division of Insurance Fraud
200 East Gaines Street
Tallahassee, FL 32399-0324
Facsimile # (850) 410-0406