Rules of
Department of Insurance
Division 100—Division of Consumer Affairs
Chapter 3—Fraudulent Practices

Title 20—DEPARTMENT OF INSURANCE
Division 100—Division of Consumer Affairs
Chapter 3—Fraudulent Practices

20 CSR 100-3.100 Fraud Investigation Reports

PURPOSE: This rule sets forth the forms to be used in reporting fraudulent insurance acts to the Missouri Department of Insurance under sections 375.991—375.994, RSMo.

(1) The Fraud Investigation Report (Insurer) form set forth as Exhibit 1 of this rule shall be used by any insurer reporting an allegation of a fraudulent insurance claim to the department. This form also may be used by an insurer seeking the department's assistance in the investigation and prosecution alleged fraudulent insurance claims and other types of fraudulent insurance acts.

(2) The Fraud Investigation Report (Consumer) form set forth as Exhibit 2 of this rule shall be used by any noninsurer for reporting a fraudulent insurance act to the department.

Auth: sections 374.045, RSMo (1986) and 375.991, 375.992, 375.993 and 375.994, RSMo (Cum. Supp. 1990). Original rule filed Sept. 15, 1992, effective June 7, 1993.*

**Original authority: 374.045, RSMo (1967) and 375.991—375.994, RSMo (1990).*

Exhibit 1

STATE OF MISSOURI
DEPARTMENT OF INSURANCE

FRAUD INVESTIGATION REPORT (INSURER)

CONFIDENTIAL
This report and the attached documents are confidential to the extent provided under Section 375.993 of the Revised Statutes of Missouri.

INSURER REPORTING REQUIREMENTS

☐ Claim Reporting Only: Insurers who seek *only* to report a suspected fraudulent insurance claim in order to satisfy section 375.992, RSMo, should check the adjacent box and provide the information required on SIDE 1 of this Fraud Investigation Report.

☐ Assistance Requested, Claim: Insurers who seek to report a suspected fraudulent insurance claim in order to satisfy section 375.992, RSMo, and who *also* seek the Department's assistance in investigating and prosecuting the suspected fraudulent insurance claim should check the adjacent box, provide the information required on SIDE 1 of this Report and follow the instructions which appear on SIDE 2 of this Report.

☐ Assistance Requested, *Non*-Claim: Insurers requesting the Department's assistance in investigating and prosecuting a suspected fraudulent insurance act *other than* a fraudulent insurance claim should check the adjacent box, provide the information required on SIDE 1 of this Report and follow the instructions which appear on the SIDE 2 of this Report.

Send this form, along with any attachments to:

Consumer Fraud Unit
Department of Insurance
P.O. Box 690
Jefferson City, Missouri 65102-0690

PLEASE PRINT, TYPE OR WRITE CLEARLY

1. NAME OF COMPANY				TELEPHONE NUMBER ( )
MAILING ADDRESS	(STREET)	(CITY)	(STATE)	(ZIP CODE)
2. NAME OF INSURED				
2a. EMPLOYER NAME (IF GROUP POLICY)				
MAILING ADDRESS	(STREET)	(CITY)	(STATE)	(ZIP CODE)
3. WHO IS COMPLAINT AGAINST? (NAME OF CONSUMER, BROKER, AGENCY, ETC.)				
ADDRESS, IF KNOWN	(STREET)	(CITY)	(STATE)	(ZIP CODE)

4. GROUP OR CERTIFICATE NUMBER	POLICY OR I.D. NUMBER	EFFECTIVE DATE
5. CLAIM NUMBER	AGENT NAME (IF APPLICABLE)	DATE OF LOSS

6. NATURE OF COMPLAINT

☐ LIFE ☐ GROUP HEALTH ☐ INDIVIDUAL HEALTH ☐ AUTO ☐ FIRE HOMEOWNERS ☐ WORKERS COMPENSATION ☐ OTHER (SPECIFY) ▶

DETAILS OF COMPLAINT (ATTACH ADDITIONAL SHEETS IF NECESSARY)

SIGNATURE OF COMPANY REPRESENTATIVE ▶	DATE	POSITION

MO 375-1785 (2-93) THIS FORM MAY BE COPIED IF NECESSARY (SIDE 1) CA

A. A cover letter on company stationery must accompany each case submitted for investigation, in addition to this Consumer Fraud Report.

B. The request for investigation should contain the following information:

1. Full name, date of birth, address and social security number, occupation and employer of the insured.
2. Full name, date of birth, address and social security number, occupation and employer of claimant.
3. Date and location of accident, loss or theft.
4. Brief summary of facts relating to the claim. If settled, show amount of settlement.
5. If injury involved, list name and address of each doctor consulted, records of treatments and charges submitted by each doctor.
6. If claimant treated in hospital, list name of hospital, date of admission, and itemized charges.
7. Name and office address of each attorney, date retained, and copies of all demand letters.
8. Narrative statement of reasons why claim is suspected to be fraudulent with documentation.

C. Attachments

1. Copy of Proof of Loss to your company. If property involved, submit complete description.
2. Copy of Index Bureau Report, if applicable.
3. Copy of the official accident report.
4. Copy of any additional documents that may indicate fraud, such as photographs.
5. Copy of all statements taken. Recorded statements must be transcribed.
6. Copy of coverage analysis.

Please retain all original documents, along with the postmarked envelopes in which they were received, in your claim file.

In some cases it may be necessary for an investigator from the Consumer Fraud Unit to have access to the entire file. In these instances, an official request in writing will be made by this Department to the company's claims manager for the entire file to be forwarded.

Section 375.993.2 RSMo Supp 1991 provides:

> 2. No insurer, employees or agents of any insurer or any other person acting without malice, shall be subject to civil liability for libel or otherwise by virtue of the filing of reports or furnishing other information requested by this section or required by the Department of Insurance as a result of the authority granted in this section.

MO 375-1785 (2-93) THIS FORM MAY BE COPIED IF NECESSARY (SIDE 2) CA

STATE OF MISSOURI
DEPARTMENT OF INSURANCE

Exhibit 2

FRAUD INVESTIGATION REPORT (CONSUMER)

CONFIDENTIAL
This report and the attached documents are confidential to the extent provided under section 375.993 of the Revised Statutes of Missouri.

INSTRUCTIONS

Please complete all items below and enclose copies of any correspondence or other papers which you feel would help the investigation of your complaint. Sign and date at the bottom.

Send completed form along with any attachments to:

Consumer Fraud Unit
Department of Insurance
P.O. Box 690
Jefferson City, Missouri 65102-0690
Telephone: (314) 751-2640
Telecommunications Device for the Deaf (TDD) Number: (314) 526-4536

PLEASE PRINT, TYPE OR WRITE CLEARLY

1. NAME OF COMPANY			TELEPHONE NUMBER ( )	
MAILING ADDRESS (STREET)	(CITY)		(STATE)	(ZIP CODE)
2. NAME OF INSURED				
2a. EMPLOYER NAME (IF GROUP POLICY)				
MAILING ADDRESS (STREET)	(CITY)		(STATE)	(ZIP CODE)
3. WHO IS COMPLAINT AGAINST? (NAME OF CONSUMER, BROKER, AGENCY, ETC.)				
ADDRESS, IF KNOWN (STREET)	(CITY)		(STATE)	(ZIP CODE)
4. GROUP OR CERTIFICATE NUMBER	POLICY OR I.D. NUMBER		EFFECTIVE DATE	
5. CLAIM NUMBER	AGENT NAME (IF APPLICABLE)		DATE OF LOSS	

6. NATURE OF COMPLAINT

☐ LIFE ☐ GROUP HEALTH ☐ INDIVIDUAL HEALTH ☐ AUTO ☐ FIRE HOMEOWNERS ☐ WORKERS COMPENSATION ☐ OTHER (SPECIFY) ▶

DETAILS OF COMPLAINT (USE BACK IF NECESSARY)

SIGNATURE OF CONSUMER ▶	DATE

MO 375-0055 (2-93) THIS FORM MAY BE COPIED IF NECESSARY CA