STATE OF HAWAII
Insurance Fraud Investigation Branch

Suspected Fradulent Claim (SFC) Referral

Please mail to:
Insurance Fraud Investigation Branch
PO Box 3614
Honolulu, Hawaii 96811-3614

REPORTING REQUIREMENTS: Hawaii Revised Statutes 431:2-I requires companies licensed to write insurance in Hawaii to submit this form or provide to the State of Hawaii Insurance Fraud Investigation Branch information **within 60 days** after determining a claim appears fraudulent.

FRAUD TYPE: ☐ Automobile ☐ Life ☐ Homeowners ☐ Health ☐ Other _____

SECTION I. REPORTING PARTY INFORMATION

Check one: ☐ New Referral ☐ Amended Referral

Reporting Party: _____ (Company Name)

Address: _____ (Street Address) _____ (City) _____ (State) _____ (ZIP Code)

Email Address: _____ Phone: _____

SECTION II. LOSS/INJURY INFORMATION

Alleged Victim: _____

Address: _____ City: _____ State: _____ ZIP: _____

Claim #: _____ Policy #: _____ Date of Loss / Injury: _____

Address or Location where Loss / Injury occurred: _____

Address: _____ City: _____ State: _____ ZIP: _____

Premium Loss: _____ Potential Loss: _____ Actual Paid to Date: _____ Suspected Fraudulent Loss to Date: _____

SECTION III. SUSPECTED FRAUDULENT CLAIM ACTIVITY

SYNOPSIS: State the facts (who, what, when, where, how, why) that support your suspicion of fraudulent claim activity including any material misrepresentation(s). Provide details regarding any prior history of fraudulent insurance claim activity by any of the parties. If known, include relevant claim numbers. (Attach additional summary sheets if needed.)

☐ YES ☐ NO Has the SUSPECT been notified of this case referral?

☐ YES ☐ NO Has the SUSPECT been made aware of the initiation of a fraud investigation by your company?

SECTION IV. REPORTS TO OTHER AGENCIES

☐ Other Law Enforcement Agency (Name) _____

☐ Prosecutor / Attorney General (Name) _____

☐ NICB ☐ Index System ☐ Other _____

SECTION V. CONTACT INFORMATION

Contact (name/title) _____ Phone: _____

File Handler (if different) _____ Phone: _____ Date Form Completed: _____

Completed By (if different) _____ Phone: _____

SECTION VI. INSURED INFORMATION

PARTY A.

Name: _____ Home Phone: _____

Address: _____ Other Phone: _____

DOB/Age: _____ SSN: _____ Tax ID Number: _____

Driver's License Number: _____ State: _____

Vehicle: _____ License Plate: _____ VIN: _____

Date of Loss / Injury: _____ Location of Loss / Injury: _____

aka's / dba's _____

SECTION VII. OTHER PARTIES TO THE LOSS / INJURY

PARTY B.

Name: _____ Home Phone: _____

Address: _____ Other Phone: _____

DOB/Age: _____ SSN: _____ Tax ID Number: _____

Driver's License Number: _____ State: _____

Vehicle: _____ License Plate: _____ VIN: _____

aka's / dba's _____

PARTY C.

Name: _____ Home Phone: _____

Address: _____ Other Phone: _____

DOB/Age: _____ SSN: _____ Tax ID Number: _____

Driver's License Number: _____ State: _____

Vehicle: _____ License Plate: _____ VIN: _____

aka's / dba's _____

PARTY D.

Name: _____ Home Phone: _____

Address: _____ Other Phone: _____

DOB/Age: _____ SSN: _____ Tax ID Number: _____

Driver's License Number: _____ State: _____

Vehicle: _____ License Plate: _____ VIN: _____

aka's / dba's _____

PARTY E.

Name: _____ Home Phone: _____

Address: _____ Other Phone: _____

DOB/Age: _____ SSN: _____ Tax ID Number: _____

Driver's License Number: _____ State: _____

Vehicle: _____ License Plate: _____ VIN: _____

aka's / dba's _____