Connecticut Insurance Department
Fraud Reporting

Insurance Fraud Report

Confidential Information
(Version 00-003)

Send completed Form to:	**Direct questions to:**	**To be completed by DOI**
Fraud Unit State of Connecticut Department of Insurance P.O. Box 816 Hartford, CT 06142-0816	Telephone: 860-297-3933 Fax: 860-297-3872 E-mail: CID.FRAUD@CT.GOV	DOI File # _____ Date Received _____ Assigned to_____

Reporting Information

Reported by		Date	SIU File #
Company (if applicable)		Contact	Phone #
Street		Reason for Reporting (check one) • Information Only ☐ • Request DOI Assistance ☐ • **(Provide Detail on Page 2)**	
City			
State	Zip		

Insurance Information

Insurer		Insured/Policyholder	
Policy #	Line of Business	Effective Date	Expiration Date
Member (Group Ins. Only)		Certificate # (Group Ins. Only)	
Claimant		Claim #	Date of Loss

Suspect Information*

Name		Social Security #	Tax ID #
Street		Driver's License #	Professional License #
City		License Plate #	Telephone #
State	ZIP	Vehicle Identification #	

Insured: ____ Claimant: ____ Agent/Employee: _____Medical provider: ____ Legal Provider: ____

Other: _____ ***Use page 2 for additional suspects.**

Suspected Fraudulent Activity

Brief description of facts (who, what, when, why and how).

Referrals to Authorities

List law enforcement and /or other agencies that have been advised of this suspected fraudulent activity (if applicable).

Additional Suspect Information (if applicable)			
Name		Social Security #	Tax ID #
Street		Driver's License #	Professional License #
City		License Plate #	Telephone #
State	ZIP	Vehicle Identification #	

Insured: ____ Claimant: ____ Agent/Employee: _____Medical provider: ____ Legal Provider: ____

Other: _____

Additional Suspected Fraudulent Activity (if applicable)

Brief description of facts (who, what, when, why and how).

Additional Suspect Information (if applicable)			
Name		Social Security #	Tax ID #
Street		Driver's License #	Professional License #
City		License Plate #	Telephone #
State	ZIP	Vehicle Identification #	

Insured: ____ Claimant: ____ Agent/Employee: _____Medical provider: ____ Legal Provider: ____

Other: _____

Additional Suspected Fraudulent Activity (if applicable)

Brief description of facts (who, what, when, why and how).

Action Requested (if applicable)

Brief summary of assistance requested (specific actions that you wish DOI to take). Note: Provide documentation Supporting Allegations.