

State of Connecticut Insurance Fraud Report Instructions

The purpose of these instructions is to provide information for completion of the State of Connecticut Insurance Annual Fraud Report. The instructions are segmented into five sections as follows:

I. Company Information

A separate report must be prepared for each licensed company. Insurance groups with multiple insurance companies must provide a separate report for each company. Report only information that pertains to policies written (application fraud) or claims paid (claim fraud) in the State of Connecticut. The report must be submitted to this Department no later than March 31 for the previous year's totals.

II. Reporting Criteria

The body of the Report requires quantitative input. Each data input is identified with a specific reporting Line Number on the Report.

III. Line of Business Information

The body of the Report has been designed to segment quantitative data by line of business for each report item. A separate column has been provided for each line of business required.

IV. Notations/Explanations

A section on the Report has been provided for the insurer to provide notations or explanations regarding the data provided. Explanations should be included for any lines of business shown as "other" in Column E or as "other" cases referred to authorities by type of perpetrator in line 06f. If monetary savings or recoveries for lines 04 and 05 are not tracked that policy should be so noted.

V. Preparation/Certification

Insurers are required to report who prepared the report and who certified the report. Certification must be by the SIU Director or comparable manager.

Company Information

The header of the Report has two lines to be completed. **A separate report is required for each Company/NAIC Number.** Complete each line as follows:

NAIC Number - Indicate the NAIC Number of the Company.

Company FEIN Number – Indicate the FEIN (Tax Identification) Number for the Company.

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Fraud Reporting Criteria

Please note: When entering data in the report, all fields must be completed. You may click the button at the top left of the report to fill in zeros in all fields, and then delete the zeros in the fields where data is being entered. Each Line number is defined as follows:

- **Line 01** – Report the number of policies in force (excluding group plans) as of the end of the reporting period (12/31). Generally this includes individual property & casualty, life, and health policies. Do not include group insurance policyholders on this line.
- **Line 01a** – Report the number of plan members (group plans only) as of the end of the reporting period (12/31). Generally this will include the number of members enrolled in group medical, dental, life insurance, and disability plans sponsored by an employer or other plan sponsor.
- **Line 02** – Report the number of individual claims (excluding group plans) received during the reporting period. Generally these will be claims that have been assigned an individual unique claim number identifier. Do not include claims paid on group insurance plans.
- **Line 02a** – Report the number of claims (group plans only) received during the reporting period. Generally, except for medical and dental claims, these will be claims that have been assigned an individual unique claim number identifier. However, in the case of medical and dental claims, insurers may track or define a claim differently, generally by a transaction number. In these cases the insurer should count a claim in a manner consistent with the insurers' internal reporting requirements. Only include claims paid on group insurance plans.
- **Line 03** – Report the total number of suspected cases accepted by the Special Investigations Unit (SIU) or comparable investigative unit. Lines 03a through 03c provide a further breakdown of cases accepted by type. Line 03 should equal the total of Lines 03a through 03c.
- **Line 03a** – Report the total number of cases accepted by the SIU for suspected application fraud. Generally these will be cases where the insured has provided false, incomplete or misleading information to the insurer when applying for an insurance policy.
- **Line 03b** – Report the total number of cases accepted by the SIU for claim fraud. Generally these will be cases where the insured, claimant or provider has provided false, incomplete or misleading information to an insurer regarding a claim payment under an insurance policy.

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- **Line 03c** – Report the total number of cases accepted by the SIU for other than application or claim fraud. Generally these will be cases of internal financial fraud committed by agents, employees or others associated with the insurer.
- **Line 04** – Report amount of money not paid on fraudulent cases. This amount represents actual money saved as a result of not paying specific claims based on a determination of insurance fraud from investigation.
- **Line 05** – Report amount of money recovered on fraudulent cases. This amount represents actual money or property returned and money or property recovered based on a determination of insurance fraud from investigation.
- **Line 06** – Report the number of cases of suspected fraud referred to authorities by the Special Investigations Unit (SIU) or comparable investigative unit. Authorities include Federal, State and Local law enforcement agencies, the Department of Insurance Fraud Unit and organizations such as NICB. Lines 06a through 06f provide a further breakdown of cases referred by type of perpetrator. Line 06 should equal the total of Lines 06a through 06f. Report each case once, regardless of the number of authorities case was referred to. In addition, in those cases where there were multiple types of perpetrators involved in the same case (i.e. Insured and Medical Provider), select the primary perpetrator and report as one case on Line 6 and as one case under the appropriate type on Lines 06a through 06f.
- **Line 06a** – Report the total number of cases referred to authorities where the suspected perpetrator is an insured or policyholder.
- **Line 06b** – Report the total number of cases referred to authorities where the suspected perpetrator is a claimant or member (group plans only).
- **Line 06c** – Report the total number of cases referred to authorities where the suspected perpetrator is an employee or an agent.
- **Line 06d** – Report the total number of cases referred to authorities where the suspected perpetrator is a medical provider.
- **Line 06e** – Report the total number of cases referred to authorities where the suspected perpetrator is a legal provider.
- **Line 06f** – Report the total number of cases referred to authorities where the suspected perpetrator is other than reported in Lines 06a through 06e.

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Line of Business Information

A separate column has been provided for each line of business required. Each Line item must be completed for each Column. *Enter a "0" in those situations where there is no information to report.* Each line of business Column is defined as follows:

- **Column A** – For each reporting criteria, report the number or amount that pertains to **Automobile** insurance. This includes all automobile lines, including automobile liability and automobile physical damage, both personal and commercial.
- **Column B** – For each reporting criteria, report the number or amount that pertains to **Workers Compensation** insurance.
- **Column C** – For each reporting criteria, report the number or amount that pertains to **Life** insurance. This includes all types of life insurance and annuities, including participating, non-participating and variable products. This includes group plans.
- **Column D** – For each reporting criteria, report the number or amount that pertains to **Accident and Health** insurance. This includes all medical and dental plans, including HMOs. Also include accident and disability products. This includes group plans, including those self-insured plans for which the insurer is the third party administrator.
- **Column E** – For each reporting criteria, report the number or amount that pertains to **Other** insurance lines not already reported in Columns A through D (i.e. property and surety).

Notations/Explanations

This section of the report provides the insurer the opportunity to disclose any information that the insurer deems necessary to clarify the data reported. This section most often will be used to explain why a Line item was not completed, but can be also used to provide an explanation for what appears to be an unusual entry. This is a freeform section, however, to facilitate completion and review please reference each notation/explanation to the corresponding Line Number and Column Letter. Completion of this section is optional. The following is an example of a possible entry to this section:

“04A – Amount of money not paid is not tracked for Automobile Line”

“Column E. – Surety and medical malpractice cases shown as other”

“Line 06f 0 a case where the perpetrator was a third party administrator was shown as other”

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Preparation/Certification Information

The footer of the report has two blocks to be completed. Complete each block as follows:

Preparation Information/Certification Information – Indicate the name and title of the person preparing and/or certifying the accuracy of the Insurance Fraud Report. Note: Typing the name/title is equivalent to signing the online form.

Questions about the process may also be sent to this e-mail address: cid.fraud@ct.gov