State of California
SUSPECTED FRAUDULENT CLAIM (SFC) REFERRAL FORM
(FD-1) FD-1 (Rev. 6/2015)

Department of Insurance

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

CDI USE ONLY

Case #: _____ **County Code:** _____ **SFC #:** _____

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 1872.4 requires companies licensed to write insurance in California to submit this form **WITHIN 60 DAYS** after determining that a claim appears to be fraudulent. CIC § 1877.3 further requires reporting of suspected fraudulent Workers' Compensation claims to **BOTH** the CDI Fraud Division and the local District Attorney's Office **WITHIN 60 DAYS**.

SECTION I. REPORTING PARTY INFORMATION CODE

FRAUD TYPE CODE: _____ REPORTING PARTY CODE: _____ CHECK ONE: ☐ NEW REFERRAL ☐ AMENDED REFERRAL

REPORTING PARTY: _____ (Company Name) _____ (Certificate of Authority (CA) #) _____ (Self-Insured/TPA#)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

E-MAIL ADDRESS (IF APPLICABLE): _____

SECTION II. LOSS/INJURY INFORMATION

ALLEGED VICTIM: _____ (Company Name) _____ (Certificate of Authority (CA) #) _____ (Self-Insured/TPA#)

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.

You may include attachments documenting the suspected fraudulent activity. If a complete copy of the claim file has been submitted to the District Attorney's Office, please attach a complete copy to this Form FD-1. Otherwise, a complete copy of your claim file is not required.

DISASTER CLAIMS: If this suspicious activity is related to a major natural or non-natural disaster, check the box below that best describes the related event:

☐ EARTHQUAKE ☐ FLOOD ☐ FIRESTORM ☐ WIND ☐ OTHER NATURAL ☐ NON-NATURAL (MAN-MADE)

SECTION IV. REPORTS TO OTHER AGENCIES

☐ OTHER LAW ENFORCEMENT AGENCY (specify name): _____

☐ DISTRICT ATTORNEY'S OFFICE (specify name): _____

☐ NICB ☐ OTHER: _____

SECTION V. CONTACT INFORMATION

CONTACT (name/title): _____ PHONE: _____

FILE HANDLER (if different): _____ PHONE: _____ DATE FORM COMPLETED:

COMPLETED BY (if different): _____ PHONE: _____

Mail completed forms to: CDI, Fraud Division Intake Unit, 2400 Del Paso Road, Suite 250, Sacramento, CA 95834

State of California
SUSPECTED FRADULENT CLAIM (SFC) REFERRAL FORM (FD-1)
FD-1 (Rev. 6/2015)

Department of Insurance

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury

CDI USE ONLY

Case #: **County Code:** **SFC #:**

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

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

SECTION VI. INSURED/EMPLOYER INFORMATION (Party A)

PARTY A. ☐ INSURED ☐ EMPLOYER (CHECK ONE/If Workers' Compensation, must show employer here.)

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

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

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY B. ☐ **(Enter party code in box)**

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

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

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY C. ☐ **(Enter party code in box)**

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

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

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY D. ☐ **(Enter party code in box)**

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

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

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY E. ☐ **(Enter party code in box)**

Name: _____ Phone #: _____
Last Name First Name MI

Address: _____ City: _____ State: _____ Zip: _____

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

DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____

DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

Suspected Fraudulent Claim (SFC) Referral Form (FD-1)

Parties to the Loss/Injury (continued)

CDI USE ONLY

Case #: **County Code:** **SFC #:**

☐ AUTOMOBILE ☐ WORKERS' COMPENSATION ☐ SPECIAL OPS
☐ URBAN AUTO FRAUD PROGRAM ☐ OTHER ☐ HEALTHCARE

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

SECTION VII. OTHER PARTIES TO THE LOSS/INJURY (Additional Parties)

PARTY F. ☐ (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY G. ☐ (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY H. ☐ (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY I. ☐ (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

PARTY J. ☐ (Enter party code in box)

Name: _____ (Last Name / First Name / MI) Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
DOB/Age: _____ SSN: _____ Tax ID #: _____
DL #: _____ State: _____ License Plate #: _____ State: _____ VIN #: _____
DBAs/Multiple Numbers/AKA's: _____ Party Claiming Injury: ☐ Yes ☐ No

If you need to report more parties to the loss, please complete and attach additional copies of this page as needed.