

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: \_\_\_\_\_ Date Form Completed:  
File Handler (if different) \_\_\_\_\_ Phone: \_\_\_\_\_  
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 \_\_\_\_\_