Fraud Division

Case #: County Code: SFC #:	Suspected Fraudulent Claim (SFC)	CDI USE ONLY					
URBAN AUTO FRAUD PROGRAM OTHER HEALTHCARE	Referral Form (FD-1)	Case #: County Code: SFC #:					
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' Compessions claims to BOTTI the CDI Fraud Divisions and the local Distinct Attorney's Office WITHIN 60 DAYS. SECTION IL REPORTING PARTY WINDOWNATION CODE							
Compensation claims to BOTH the CDI Fraud Division and the local District Altomey's Office WITHIN 60 DANS SECTION I. REPORTING PARTY INFORMATION CODE CILCK ONE NEW REPERRAL AMENDED REPERRAL REPORTING PARTY Company Name Centificate of Authority (CA) Soft-Beased PAN	REPORTING REQUIREMENTS: Please print legibly or type. California Insurance Code (CIC) § 1872.4 requires companies licensed to write insurance in California						
SECTION I. REPORTING PARTY INFORMATION CODE REPORTING PARTY: Cengany Name Centificate of Authority (CA) # Self-Encard-TAV ADDRESS CITY: STATE: ZIP: EMAIL ADDRESS (IF APPLICABLE): SECTION II. LOSS/INJURY INFORMATION ALLEGED VICTIM: Company Name Centificate of Authority (CA) # Self-Encard-TAV ADDRESS CITY: STATE: ZIP: DATE OF LOSS/INJURY INFORMATION ALLEGED VICTIM: Company Name Company Nam	to submit this form WITHIN 60 DAYS after determining that a c	claim appears to be fraudulent. CIC § 1877.3 further requires reporting of suspected fraudulent Workers'					
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ALLEGED VICTIM: Company Name	E-MAIL ADDRESS (IF APPLICABLE):						
ADDRESS: CITY: STATE: ZIP: CLAIM #: POLICY #: DATE OF LOSS/INJURY: / / ADDRESS OR LOCATION WHERE LOSS / INJURY OCCURRED: ADDRESS: CITY: STATE: ZIP: PREMIUM POTENTIAL ACTUAL PAID 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 V. REPORTS TO OTHER AGENCIES OTHER LAW ENFORCEMENT AGENCY (specify name): DISTRICT ATTORNEY'S OFFICE (specify name): DATE FORM CONTACT (name*title): PHONE: DATE FORM COMPLETED:	SEC	TION II. LOSS/INJURY INFORMATION					
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□ DISTRICT ATTORNEY'S OFFICE (specify name): □ NICB □ OTHER: □ OTHER: <td></td> <td></td>							
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FILE HANDLER (if different): PHONE: () COMPLETED:	CONTACT (name/title):	PHONE: ()					
		DATE FORM					

Mail completed forms to: CDI Fraud Division Intake Unit 9342 Tech Center Drive, Suite 100, Sacramento, CA 95826

FD-1 (rev.01/08) Page 1 of 3

Fraud Division

Suspected Fraudulent Claim (SFC)	CDIU	JSE ONLY		
Referral Form (FD-1)	Case #: County C	ode: SFC #:		
		COMPENSATION SPECIAL OPS		
Parties to the Loss/Injury	URBAN AUTO FRAUD PROGRA			
Claim #:	Policy #:	Date of Loss/Injury: / /		
	INSURED/EMPLOYER INFORMATION (Par	ty A)		
PARTY A. INSURED	☐ EMPLOYER (CHECK ONE/If Workers' Com	nnensation must show employer here)		
		Phone #:(
	First Name MI	State: 7in:		
Address: DOB/Age:		State: Zip: Tax ID #:		
DL #: State: Lice				
DBAs/Multiple Numbers/AKA's:				
	ER PARTIES TO THE LOSS/INJURY (Additio			
PARTY B. (Enter party code in box)	•	•		
		Diama H.		
Name: Last Name	First Name MI	Phone #: ()		
Address:				
DOB/Age:	SSN:			
DL#: State: Lice		VIN #:		
DBAs/Multiple Numbers/AKA's: Party Claiming Injury: \(\text{Yes} \) No				
PARTY C. (Enter party code in box)				
Name:		Phone #:()		
Last Name	First Name MI			
Address: DOB/Age:	City: SSN:			
		Tux ID II.		
DL #: State: Lice		VIN #:		
DBAs/Multiple Numbers/AKA's:	ense Plate #: State:	VIN #:		
DBAs/Multiple Numbers/AKA's:	ense Plate #: State:	VIN #:		
	ense Plate #: State:	VIN #: Party Claiming Injury: Yes No		
DBAs/Multiple Numbers/AKA's:	ense Plate #: State:	VIN #:		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name:	ense Plate #: State:	VIN #: Party Claiming Injury: Yes No Phone #: ()		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name: Address: DOB/Age:	First Name MI City: SSN:	VIN #: Party Claiming Injury: Yes No Phone #: ()		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name: Address: DOB/Age: DL #: State: Lice	First Name MI City: SSN: ense Plate #: State:	VIN #: Party Claiming Injury: Yes No Phone #: () State: Zip: Tax ID #: VIN #:		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name: Address: DOB/Age:	First Name MI City: SSN: ense Plate #: State:	VIN #: Party Claiming Injury: Yes No Phone #: () State: Zip: Tax ID #:		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name: Last Name Address: DOB/Age: DL #: State: Lice DBAs/Multiple Numbers/AKA's:	First Name MI City: SSN: ense Plate #: State:	VIN #: Party Claiming Injury: Yes No Phone #: () State: Zip: Tax ID #: VIN #:		
DBAs/Multiple Numbers/AKA's: PARTY D. (Enter party code in box) Name: Last Name Address: DOB/Age: DL #: State: Lice DBAs/Multiple Numbers/AKA's: PARTY E. (Enter party code in box)	First Name MI City: SSN: ense Plate #: State:	VIN #: Party Claiming Injury: Yes No Phone #:		
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FD-1 (rev.01/08) Page 2 of 3

Suspected Fraudulent Claim (SFC)	CDI USE ONLY			
Referral Form (FD-1)	Case #:	County (Code: SFC #:	
	☐ AUTOMOBII	LE WORKERS	COMPENSATION SPECIAL OPS	
Parties to the Loss/Injury (continued)		O FRAUD PROGR	AM OTHER HEALTHCARE	
Claim #:	Policy #:		Date of Loss/Injury:/ /	
SECTION VII. OTHE	R PARTIES TO THE L	OSS/INJURY (Addition	onal Parties)	
PARTY . (Enter party code in box)				
Name: Last Name			Phone #:()	
A 11		MI		
DOB/Age:				
DL #: State: Licer				
DBAs/Multiple Numbers/AKA's:				
PARTY . (Enter party code in box)				
Name:	First Name	MI	Phone #: ()	
Address:	City:		State: Zip:	
DOB/Age:	SSN:		Tax ID #:	
DL #: State: Licer	nse Plate #:	State:	VIN #:	
DBAs/Multiple Numbers/AKA's:			Party Claiming Injury: Yes No	
PARTY . (Enter party code in box)				
			Phone #: ()	
Last Name		MI		
Address:			State: Zip:	
DOB/Age:		Ct-t-	Tax ID #:	
DL #: State: Licer DBAs/Multiple Numbers/AKA's:			VIN #: Party Claiming Injury: ☐ Yes ☐ No	
		·	Tany claiming many. — The — The	
PARTY . (Enter party code in box)				
Name:			Phone #: ()	
Last Name Address:	First Name City:	MI	State: Zip:	
DOB/Age:			Tax ID #:	
DL#: State: Licer	·		VIN #:	
DBAs/Multiple Numbers/AKA's:			Party Claiming Injury: Yes No	
PARTY . (Enter party code in box)				
Name:	First Name	MI	Phone #: ()	
Address:		WII	State: Zip:	
DOB/Age:			Tax ID #:	
DL #: State: Licer	·		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.

FD-1 (rev.01/08)