

MARYLAND INSURANCE ADMINISTRATION
200 ST. PAUL PLACE, SUITE 2700
BALTIMORE, MD 21202
410-468- 3905 OR 1-800-846-4069
FAX 410-347-5350

PLEASE TYPE OR PRINT INFORMATION (COMPLETE ALL APPLICABLE SECTIONS)

REASON FOR REFERRAL:

Attach relevant documents: **Claim form copies. ATTACH INVESTIGATIVE NARRATIVE**

Did an IFD Investigator request this referral ? YES NO IFD Investigator: _____

Date Referred: _____

Referred to Other Law Enforcement ? YES NO Who ? _____

CONTACT INFORMATION

REFERRING PERSON: _____ **TELEPHONE #:** _____

CONTACT PERSON: _____ **TELEPHONE #:** _____

ADDRESS: _____

COMPANY NAME: _____ **TELEPHONE #:** _____

ADDRESS: _____

TYPE OF INSURANCE: AUTO WC COMMERCIAL

HEALTH PROPERTY OTHER

TYPE OF FRAUD: ADJUSTER / EMPLOYEE THEFT AGENT / BROKER FALSE APPLICATION

HEALTHCARE / PROVIDER HEALTH INSURANCE INSURER

LIFE INSURANCE OTHER PERSONAL INJURY / AUTO

PERSONAL INJURY / OTHER PROPERTY CLAIM / OTHER RESIDENCY / ELIGIBILITY

WORKMEN COMPENSATION

LOSS INFORMATION

DESCRIPTION OF LOSS: _____

DATE OF LOSS: _____ **LOCATION OF INCIDENT:** _____

CLAIM #: _____ **POLICE REPORT #:** _____

OTHER INSURANCE COMPANY INVOLVED: _____

ADDRESS: _____

CONTACT PERSON: _____ **TELEPHONE #:** _____

CLAIM #: _____ **POLICY #:** _____

\$ VALUE OF CLAIM: _____ **AMOUNT OF DEMAND:** _____

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VICTIM INFORMATION

NAME OF COMPANY: _____
ADDRESS: _____

CONTACT PERSON: _____ **TELEPHONE #:** _____
NAME OF INDIVIDUAL: _____
ADDRESS: _____

DATE OF BIRTH: _____ **SS#:** _____ **TELEPHONE#:** _____

SUSPECT INFORMATION

NAME OF INDIVIDUAL: _____
ADDRESS: _____

DATE OF BIRTH: _____ **SS#:** _____ **TELEPHONE#:** _____
HEIGHT: _____ **WEIGHT:** _____ **RACE:** _____ **IDENTIFYING MARKS:** _____
VEHICLE MAKE: _____ **MODEL:** _____ **YEAR:** _____ **VIN:** _____
COLOR: _____ **TAG #:** _____

OTHERS INVOLVED

IDENTIFY ALL PRINCIPALS AND THEIR ROLES:

- | | | |
|--------------------------|--------------------------------|-------------------|
| ADJ – ADJUSTER | AGENT - AGENT | APP- APPRAISER |
| ATTOR – ATTORNEY | CHIRO – CHIROPRACTOR | CLMT – CLAIMANT |
| INSD – INSURED | MEDOC – MEDICAL DOCTOR | PASSN – PASSENGER |
| PHYS – PHYSICAL THERPIST | RPAIR – BODY SHOP/ CONTRACTORS | WIT - WITNESS |

NAME OF INDIVIDUAL: _____ **TELEPHONE #:** _____
ADDRESS: _____

ROLE: _____

NAME OF INDIVIDUAL: _____ **TELEPHONE #:** _____
ADDRESS: _____

ROLE: _____

NAME OF INDIVIDUAL: _____ **TELEPHONE #:** _____
ADDRESS: _____

ROLE: _____

NAME OF INDIVIDUAL: _____ **TELEPHONE #:** _____
ADDRESS: _____

ROLE: _____