

Send To:

**Insurance Fraud Section
Office of Attorney General**

**Commonwealth of Pennsylvania
16th Floor, Strawberry Square
Harrisburg, PA 17120
ATTN: Referral Form
(717) 787-0272**

For State Use Only

541- _____

Region Assigned: _____

Revised 10/07

Referring Agency Information

Contact Person:

Agency Name:

Mailing Address:

City:

State:

Zip:

Phone No.:

Email Address:

Fax No.:

Subject Information**(If additional subjects are involved please include in Summary)**

Name (Include any known Alias):

Date of Birth:

SSN:

Street Address (include P.O. Box and apartment #'s):

Address Type:

Sex:

- Residential
 Business
 Other

- Male
 Female

City:

State:

Zip:

Phone No.:

Referral Status

Have you referred this matter to any other
law enforcement agency? Yes No

If Yes, identify: _____
Agency Contact Person

Reason why you are sending this matter to our office: Requesting an investigation For informational purposes only

Location (COUNTIES and/or STATES)

Incident Occurred In _____

Payment Made From _____

Claim Received In _____

Payment Sent To _____

False Statement Made _____

DO NOT PUT DATES IN THIS SECTION

Claim Information

(If additional Companies are involved please include in Summary)

Policy Number:

Claim Number:

Value of Policy:

Date of Loss:

Date Claim Filed:

Amount Claimed: \$

Amount Paid: \$

Type of Alleged Fraud:

- Auto Homeowners Commercial Health
 Workers Compensation Disability Rate Evasion
 Agent / Insurance Company Life
 Other _____

Status of Claim:

- Paid Denied
 Withdrawn Pending
 Settled Other _____

Fraud Allegation / Summary

This section **MUST** be completed – attach additional pages if necessary

Blank area for Fraud Allegation / Summary.