

# Commonwealth of Virginia

## Department of State Police

### Bureau of Criminal Investigation Insurance Fraud Program

Mailing Address: P. O. Box 27472, Richmond, VA 23261-7472  
 Office Address: 7700 Midlothian Turnpike, Richmond, VA 23235  
 E-Mail: insurancefraud@vsp.virginia.gov Web site: www.stampoutfraud.com  
 Voice: (804) 674-2771 Fax: (804) 674-2933 Toll-Free Hotline 1-877-623-7283

IFP Use Only	
Notification #	<input type="checkbox"/> H/L <input type="checkbox"/> WWW <input type="checkbox"/> Other
Date Received	
Jurisdiction	Field Office
Case #	<input type="checkbox"/> UCF
Agent Assigned (Code #)	
Referred To	<input type="checkbox"/> Other VSP <input type="checkbox"/> Other Agency

#### 01 REPORTING INDIVIDUAL

Last Name	First Name	Middle Name	Office Phone	Fax phone
Address			City	State Zip Code
			E-Mail Address	
<input type="checkbox"/> SIU Member <input type="checkbox"/> Insurer <input type="checkbox"/> Insurance Professional <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Citizen <input type="checkbox"/> State/Federal Agency <input type="checkbox"/> Anonymous				

#### 02 POLICY INFORMATION

Policy Number				
Name of Insurance Carrier			Office Phone	Fax phone
Address			City	State Zip Code
			E-Mail Address	
Name of Insured				
Address			City	State Zip Code

#### 03 CLAIM INFORMATION

Claim Number		Date of Claim		
Name of Claimant (or person being reported if different from Insured)				
Address		City	State	Zip Code
Total Approximate Claim Amount		Have any payments been made on this claim?		
\$		<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If Yes Total Amount Paid: \$		
Amount of <u>Unpaid Claim</u> suspected to be fraudulent:		Amount of <u>Paid Claim</u> suspected to be fraudulent:		
\$		\$		
Is claim still active?				
<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If No Was Claim Denied? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Was claim withdrawn by claimant?				
<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If Yes explain briefly? _____				
Was a written claim filed?			Was the claim filed by telephone?	
<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If Yes Was it <input type="checkbox"/> Mailed <input type="checkbox"/> Submitted in Person			<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If Yes Was it recorded? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were any forms or payments on this claim sent through the mail (UPS, FedEx, etc.)?			Was a proof of Loss submitted?	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No ⇒ If Yes Was it notarized? <input type="checkbox"/> Yes <input type="checkbox"/> No	

#### 04 LINE OF BUSINESS / COVERAGE INFORMATION

<b>PROPERTY FRAUD</b>				(Check all that apply)
<input type="checkbox"/> Motor Vehicle / Auto	<input type="checkbox"/> Homeowners	<input type="checkbox"/> Commercial	<input type="checkbox"/> Other	
<input type="checkbox"/> Property Damage	<input type="checkbox"/> Property Damage	<input type="checkbox"/> Property Damage		
<input type="checkbox"/> Stolen Vehicle	<input type="checkbox"/> Theft/Loss	<input type="checkbox"/> Theft/Loss		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____		
<b>BODILY INJURY / CASUALTY</b>				
<input type="checkbox"/> Motor Vehicle / Auto	<input type="checkbox"/> Homeowners	<input type="checkbox"/> Commercial	<input type="checkbox"/> Workers Compensation	
<input type="checkbox"/> Medical Payments	<input type="checkbox"/> Personal Injury	<input type="checkbox"/> Personal Injury		
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other	

