

**Ohio Department of Insurance**

Bob Taft – Governor  
 Ann Womer Benjamin – Director



**Fraud Complaint Form / Company**

Referring Person	_____	Insurance Company	_____
Contact Person	_____	Address	_____
Telephone	_____	City, State Zip	_____
Policy #	_____	Date of Loss	_____
Claim #	_____	Loss Location/ City, State	_____
Claim Value	_____	Was Claim Paid?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Law Enforcement	Involved Yes <input type="checkbox"/> No <input type="checkbox"/>	Agency	_____
Contact Person	_____	Telephone	_____
List Evidence	_____		

**INVOLVED PERSONS**

Name (First MI Last)	_____	Telephone	_____
Address	_____	Date of Birth	_____
City, State, Zip	_____	Social Security	_____
Claims History	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Involvement	Insured <input type="checkbox"/> 3 <sup>rd</sup> Party <input type="checkbox"/> Provider <input type="checkbox"/> Claimant <input type="checkbox"/> Witness <input type="checkbox"/> Suspect <input type="checkbox"/> Body Shop <input type="checkbox"/> Non-Suspect Attorney <input type="checkbox"/> Chiropractor <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other <input type="checkbox"/>		
Synopsis	_____		

Name (First MI Last)	_____	Telephone	_____
Address	_____	Date of Birth	_____
City, State, Zip	_____	Social Security	_____
Claims History?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Involvement	Insured <input type="checkbox"/> 3 <sup>rd</sup> Party <input type="checkbox"/> Provider <input type="checkbox"/> Claimant <input type="checkbox"/> Witness <input type="checkbox"/> Suspect <input type="checkbox"/> Body Shop <input type="checkbox"/> Non-Suspect Attorney <input type="checkbox"/> Chiropractor <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Law Enforcement <input type="checkbox"/> Other <input type="checkbox"/>		
Synopsis	_____		

Is this information for Referral  or Index Purposes  ?