

# Fraud Prevention

This guide is derived from NAIC Model Regulations, Acts, and/or Bulletins. Because states independently determine whether to adopt NAIC Models—and may do so in whole, in part, or with state-specific modifications—requirements can vary by jurisdiction. CEFLI Oversight Guides provide checklists of potential oversight elements to help support regulatory compliance. The guides and any referenced resources are not legal advice. CEFLI Member Companies should ensure their oversight programs reflect their specific product portfolios, distribution strategies, risk tolerances, internal controls and prior market conduct examination findings. Member Companies should carefully evaluate and incorporate unique state regulatory requirements, including any deviations from NAIC Models, in the states where they conduct business.

## Helpful Resources

- [NAIC Market Regulation Handbook 2025, Volume 1-IV](#)
- [NAIC Insurance Fraud Prevention Act Model Regulation \(#680\)](#)
- [NAIC Insurance Fraud Prevention Act Model Regulation \(#680\) Adoption Chart](#)
- [NAIC Insurance Fraud Prevention Laws State Compendium Summary \(by State\)](#) This is a comprehensive NAIC resource that summarizes key fraud prevention-related requirements by state.
- [NAIC Antifraud Plan Guideline \(#GL-1690-1\)](#) While the NAIC adoption chart (see link below) indicates only one state has *formally* adopted the guidelines, individual states may still apply the guidelines or have similar requirements in place.)
- [NAIC Antifraud Plan Guideline \(#GL-1690-1\) Adoption Chart](#)
- [NAIC Uniform Suspected Insurance Fraud Reporting Form](#)
- [NAIC Instructions for Uniform Suspected Insurance Fraud Reporting Form](#)
- [NAIC Uniform Case Update Form](#)
- [NAIC's Online Fraud Reporting System \(OFRS\)](#)

## Scope of the Regulation (Model 680)

- The NAIC Insurance Fraud Prevention Act Model Regulation and the NAIC Antifraud Plan Guideline document do not specify the type of insurance that is in scope or the type of insurance that may be excluded. For this reason, insurers may wish to apply the requirements broadly or rely on individual state rules and regulations.

## Insurance Fraud Prevention Act (Model Regulation 680)

- Committing Fraud or Interfering with Investigations.** A person shall not commit a fraudulent insurance act and shall not knowingly or intentionally interfere with fraud enforcement provisions or investigations of suspected or actual violations. Refer to sections 3.A. and 3.B.
- Past Felony Convictions Involving a Breach of Trust or Dishonesty.** A person convicted of a felony involving dishonesty or breach of trust may not participate in the business of insurance. Further, a person in the business of insurance shall not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance. Refer to section 3.C.
- Required Fraud Warning.** Claim forms and applications for insurance, regardless of the form of transmission, must contain the following or a substantially similar statement:  
*“Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”*  
This requirement does not pertain to reinsurance claim forms or reinsurance applications. Refer to section 4.A.



- Unauthorized Insurers.** Policies issued by unauthorized insurers must contain a statement disclosing the status of the insurer to do business in the state where the policy is delivered or issued for delivery or the state where coverage is in force. This requirement does not pertain to reinsurance claim forms or reinsurance applications. Refer to section 4.C.
- Mandatory Reporting.** A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be or has been committed must provide to the commissioner the information required in a manner prescribed by the commissioner. Others (i.e., someone not in the business of insurance) may do the same. Refer to sections 6.A. and 6.B.
- Insurer Antifraud Initiatives.** Insurers must have antifraud initiatives reasonably designed to detect, prosecute and prevent insurance fraud. Initiatives may include fraud investigators (employees or contractors) and/or may include an antifraud plan submitted to the commissioner. Refer to sections 11.A. and 11.B.

## Antifraud Plan Guideline (#GL-1690-1) – Plan Creation and Submission

- Antifraud Plan Creation.** An insurer must have a written antifraud plan that documents the insurer’s antifraud efforts. Refer to section 3.A.
- Antifraud Plan Submission.** An insurer must submit their antifraud plan in accordance with all state laws, regulations and requirements. Refer to section 3.B.
- Antifraud Plan Updates.** If an insurer makes material or substantive changes in the manner in which it detects, investigates and/or reports suspected insurance fraud, or if there is a change in the person(s) responsible for the insurer’s antifraud efforts, the insurer must timely amend its antifraud plan. Refer to section 3.E.

## Antifraud Plan Guideline (#GL-1690-1) – Plan Content Requirements

The antifraud plan is an overview of an insurer’s efforts to prevent, detect, investigate and report all aspects of suspected insurance fraud related to the different types of insurance offered by the insurer. One antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities. The following information should be included in the submitted antifraud plan:

- Name and NAIC Codes.** The insurer’s name and NAIC individual and group code numbers. Refer to section 4.C.1.
- Lines of Authority.** A description of the insurer’s approved lines of authority. Refer to section 4.C.2.
- Criteria Acknowledgement.** An acknowledgment that the insurer has established criteria that will be used for the investigation of internal fraud and suspected fraud related to the different types of insurance offered. Refer to section 4.C.3.
- Fraud Awareness Outreach.** A statement as to whether the insurer has implemented an internal and/or external fraud awareness and/or outreach program to educate employees, applicants, policy holders and/or members of the general public about insurance fraud. Refer to section 4.C.4.
- External Outreach Efforts.** A description of the insurer’s external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public. Refer to section 4.C.5.
- Internal Training Efforts.** A description of the insurer’s internal awareness/antifraud education and training initiatives of any personnel involved in antifraud related efforts. The description shall include:
  - An overview of the antifraud training provided to new employees.



- The internal positions (e.g., underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.) the insurer offers regular education and training to.
- A description of training topics covered with employees.
- The method(s) in which training is provided.
- The frequency and minimum number of training hours provided.
- The method(s) in which employees, policyholders and members of the general public can report suspected fraud.

Refer to section 4.C.6.

**Corporate Policies.** A description of the insurer's corporate policies for preventing, detecting and investigating suspected internal fraud committed by company employees, consultants or others (e.g., underwriters, claims representatives, appointed agents, etc.). The following information should be included:

- A description of the insurer's internal fraud reporting policy.
- The person and/or position within the organization who is ultimately responsible for the investigation of internal fraud.
- A description of the insurer's standard operating procedures (SOP) for investigating internal fraud.
- A description of the reporting procedures the insurer will follow upon a criminal and/or insurance law violation being identified as the result of an internal investigation conducted (i.e. agent misconduct, referral to Fraud Unit or law enforcement, etc.).

Refer to section 4.C.7.

**Fraud Prevention Policies.** A description of the insurer's corporate policies for preventing fraudulent insurance acts committed by first- or third-party claimants, medical or service providers, attorneys, or any other party associated with a claim. The content should include:

- A description of the technology and/or detection procedures the insurer has put in place to identify suspected fraud.
- The criteria used to report suspicious claims of insurance fraud for investigation to an insurer's SIU.

Refer to section 4.C.8.

**Establishment of an SIU.** A statement regarding whether the insurer has established an internal SIU to investigate suspected insurance fraud. The statement should include:

- A description regarding whether the unit is part of any other department within the organization.
- A description or chart outlining the organizational arrangement of all internal SIU positions/ job titles.
- A general overview of each SIU position is required. (In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the DOI.)
- General contact information for the company's SIU as well as contact information for the person/position(s) responsible for overseeing the insurer's antifraud efforts.
- A description of the insurer's SOPs for investigating suspected insurance fraud.

Refer to section 4.C.9.

**Use of External/Third Party Resources for SIUs.** A statement regarding whether the insurer utilizes an external/third party as their SIU or in conjunction with their internal SIU. Additionally:

- If an external/third party is used to substantially perform the insurer's SIU function, the insurer shall provide the name of the company(ies) used and contact information for the company(ies).
- The insurer shall specify the internal persons or position responsible for maintaining contact with the external company(ies) which will serve as the insurer's SIU. The insurer shall provide a description of how they will monitor and/or gauge the external/third party's compliance with insurer antifraud mandates.

Refer to section 4.C.10.

**Documenting Referrals and Conducting Investigations.** A description of the method(s) used to document SIU referrals received and investigations conducted. The description should include:



- An overview of any case management system and/or computer program used to memorialize SIU referrals received and investigations conducted.
- How the insurer tracks SIU/investigative information for compliance purposes (i.e., the number of SIU referrals received, the number of investigations opened, the outcome of investigations conducted, etc.). Refer to section 4.C.11.

- Fraud Reporting.** A description of the procedures the insurer has established to ensure that suspected insurance fraud reported to regulators timely. Refer to section 4.C.12.
- Parties Responsible for Reporting Fraud.** A statement regarding the individual(s) or group, within the organization responsible for reporting suspected fraud on the insurer’s behalf.
  - The statement may cite specific position descriptions in lieu of employee names.
  - The statement must include a description of the insurer’s criteria or threshold for reporting fraud to the commissioner.
  - The statement must include a description of insurer’s process for the submission of suspected fraud reports to the commissioner (e.g. Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system, or other).
 Refer to section 4.C.13.
- Timely Regulatory Responses.** An antifraud plan must include the steps the insurer will take to ensure all information they, or a contracted party, possess about a specific claim or incident of suspected insurance fraud is provided in a timely and complete manner when a formal written request is received from a regulator. The timely release of information means by the deadline provided by the DOI. Unless an insurer can cite legal grounds for withholding information, they must not redact or withhold any information that has been requested by the DOI. If an insurer has a reasonable belief that information cannot legally be provided to the DOI, the insurer will be required to provide, in writing, a description of any information being withheld, and cite the legal grounds for withholding such information. Refer to section 4.C.14.