STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243

DON SUNDQUIST
GOVERNOR

DOUGLAS M. SIZEMORE
COMMISSIONER

BULLETIN

Attention: All Insurers writing Workers' Compensation Insurance, Self Insured Plans and Self-Insured Groups

Subject: Workers' compensation Anti-fraud Plans and Summaries

Date: September 20, 1996

Tennessee has enacted new workers' compensation legislation. The new law amends and repeals portions of Tennessee Code Annotated relative to workers safety, injuries and workers' compensation.

The new law mandates that all insurers writing workers' compensation, including self-insured employers and self-insured groups implement an anti-fraud plan to be filed with the Department of Commerce and Insurance by January 1, 1997.

There are certain sections in the new law relating to the anti-fraud plan, which are of importance to employers. This Bulletin will inform you of the requirements of this new law.

ANTI-FRAUD PLAN

The law requires every insurer including self-insured employers and groups, to prepare, implement, maintain and submit to the Department of Commerce and Insurance a workers' compensation anti-fraud plan. This includes self-insured employers and groups.

Each insurer's anti-fraud plan shall outline specific procedures to:

1) Prevent, detect and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents, fraud resulting from misrepresentations in the application, renewal or rating of insurance policies; claims fraud; and security of the insurer's data processing system;

2) Educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

3) Provide for the hiring of, or contracting for, fraud investigators;

4) Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud;

5) Pursue restitution for financial loss caused by insurance fraud, where appropriate.

To make compliance with the new law easier, we have developed an anti-fraud plan guideline and forms for your use. The model plan guidelines may be ordered, if you desire, in hard copy or diskette form (WordPerfect format on a 3.5 inch disk). An order form is included with this bulletin. You must customize the plan to meet the requirements of your company and to include the specific procedures described in numbers 1 to 5 above. A fraud plan that your company already has in place that complies with the new law may be submitted.

All companies should promptly notify all their Tennessee agents and employees of the provisions of this plan. At any time the plan is modified, a copy of the modified plan is to be refiled with the Department of Commerce and Insurance.

FRAUD REPORTING

A copy of standard reporting forms for workers' compensation fraud are attached. These forms must be submitted when reporting potential fraudulent activity. All fraud relating to employer/insurer fraud must be reported to the Tennessee Department of Commerce and Insurance at:

Lewis F. Elrod
Director, Fraud & Special Investigations
Department of Commerce and Insurance
500 James Robertson Parkway, 4th Floor
Nashville, TN 37243-0574

Phone: 615-532-5341 (800)-792-7573
FAX: 615-532-7389

All employee related fraud must be reported to the Tennessee Department of Labor at:

Dina Tobin, Director of Workers Compensation
Department of Labor
710 James Robertson Parkway, 2nd Floor
Nashville, TN 37243-0655

Phone: 615-741-2395

The above referenced form can be used for both types of reporting.

ANNUAL SUMMARY REPORT

Each insurer must file an annual summary on actions taken under its anti-fraud plan to prevent and combat insurance fraud. This summary shall include details regarding fraudulent activity and any recoveries identified during the reporting period with emphasis being placed on criminal activities of an organized nature. The report should include claim costs for discovered fraud from claims activity and also any and all internal activities taken to detect fraud in the workers' compensation system.

A copy of a report form that outlines the information that should be part of your summary report is attached to this document. The law provides privacy protection for these reports. Both the anti-fraud plans and the summary of anti-fraud activities and results are not public record and are exempt from the provisions of the public records act and shall be proprietary and not subject to public examination.

MANDATED FRAUD NOTICE

On or before January 1, 1997 all printed applications for Insurance, and all printed claim forms provided and required by an insuror or self-insured are required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

> It is a crime to knowingly provide false, incomplete a misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

PENALTIES

Failure to file the plan subjects an insurer to a penalty of five hundred dollars ($500) per day, not to exceed twenty-five thousand dollars ($25,000).

All other filings and inquiries regarding these requirements should be directed to:

Lewis F. Elrod
Director, Fraud & Special Investigations
Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243-0574

Phone: 615-532-5341
FAX: 615-532-7389

Thank you for your cooperation with the new Workers' Compensation Law.

VICTIM INFORMATION

Name of Company_____
Address_____
_____ Telephone #_____
Contact Person_____ Telephone#_____
Name of Individual_____Telephone #_____
Address_____
Date of Birth_____ SS#_____ Race_____ Sex____

OTHERS INVOLVED

IDENTIFY ALL PRINCIPALS AND THEIR ROLES USING THE FOLLOWING:
ADJ- Adjuster; AGT- Agent; APP- Appraiser; ATT- Attorney; CHIRO- Chiropractor; CLMT- Claimant; INSD- Insured; MEDOC- Medical Doctor; PASS- Passenger; PHYS- Physical Therapist; WIT- Witness.

Name_____ Telephone #_____
Address_____
_____ Role_____

Name_____ Telephone #_____
Address_____
_____ Role_____

Name_____ Telephone #_____
Address_____
_____ Role_____

Name_____ Telephone #_____
Address_____
_____ Role_____

Name_____ Telephone #_____
Address_____
_____ Role_____

MAIL COMPLETED FORMS AND SUPPORTING DOCUMENTATION AS DIRECTED BELOW:

EMPLOYEE FRAUD
TN. DEPT. OF LABOR
ATTN: DIRECTOR DINA TOBIN
GATEWAY PLAZA, 2ND FLOOR
710 JAMES ROBERTSON PKWY.
NASHVILLE, TN 37243-0661

ALL OTHER FRAUD
TN. DEPT. OF COMMERCE & INSURANCE
ATTN: DIRECTOR LEWIS ELROD
FRAUD & SPECIAL INVESTIGATIONS-4th FLOOR
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TN 37243-0574

WORKERS' COMPENSATION FRAUD REFERRAL FORM

PLEASE TYPE OR PRINT INFORMATION (COMPLETE ALL APPLICABLE SECTIONS)

Date of Referral_____

Referral By: Insurance Co._____Other_____

ReferringPerson:_____Telephone#_____

Referred to Law Enforcement Agency: No___ Yes___ Who_____

REASON FOR REFERRAL (PLEASE ATTACH RELEVANT DOCUMENTS)

_____

_____

_____

CONTACT INFORMATION

Contact Person_____ Telephone #_____

Address_____

Company Name_____Telephone #_____

Company Address_____

Type of Workers' Comp Fraud: (Please mark applicable category)

_____ Claimant/Benefits Fraud(i.e, false application, staged accident, etc.)

_____ Premium Avoidance Fraud(i.e, payroll and/or employee misclassification, etc.)

_____ Agent Theft

_____ Other_____

LOSS INFORMATION

Date of Accident/Loss_____ Location of Accident/Loss_____

Description of Accident/Loss:_____

_____

_____

Insurance Claim #_____ Police Report #_____

Other Insurance Company Involved_____

Address_____

Contact Person_____ Telephone #_____

Claim #_____ Policy #_____

Value of Claim: $_____ Amount of Demand_____

SUSPECT INFORMATION

Name_____Telephone #_____

Address_____

Date of Birth_____ SS#_____ Race_____ Sex_____ Height_____

Weight____ Hair____ Eyes____ Scars/Marks/Tattoos_____

Vehicle: Year_____ Make_____ Model _____ Color_____

Tag #_____ State____ VIN #_____ Driver's License #_____ State___

ORDER FORM

MODEL WORKERS COMPENSATION ANTI-FRAUD PLAN

To: DEPARTMENT OF COMMERCE AND INSURANCE
Fraud & Special Investigations - 4th Floor
500 James Robertson Parkway
Nashville, Tennessee 37243-0574

From:

Name:_____

Company:_____

Mailing Address:_____

City:_____ State_____ Zip_____

Item	Cost	Quantity
Hard copy of the Tennessee Model Workers' Compensation Anti-Fraud Plan, printed on 8.5 by 11 inch paper	$10.00	_____
Tennessee Model Workers' Compensation Anti-Fraud Plan on 3.5 inch diskette in WordPerfect format	$10.00	_____

Amount Enclosed $_____

PLEASE DO NOT SEND CASH!

Make checks payable to: Tennessee Department of Commerce and Insurance. And enclose with a copy of this completed form. Items will be mailed in the order received and in the shortest possible time.

SUMMARY REPORT FORM FOR
WORKERS' COMPENSATION ANTI-FRAUD PLAN

Company Name:_____

Report prepared by:_____

Firm:_____

Address:_____City_____ST_____Zip_____

Reporting Period:_____

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1. Describe the resources committed to the combating of fraud in this reporting period (number of employee, investigations performed by contracted investigators, costs of the resources used, etc.)

2. List the number of instances and amount of fraud discovered in this reporting period.

3. List the number and amount of recovery during this reporting period.

4. Describe, in as much detail as possible, any and all discovered criminal activities of an organized nature.

5. List the claim costs for discovered fraud from claims activity.

6. Describe the internal activities taken to detect fraud among company employees.

THIS FORM MUST BE SIGNED AND DATED

_____ _____

REGISTRATION FORM FOR
WORKERS COMPENSATION ANTI-FRAUD PLAN*

Mark one box: ☐ Original Filing
☐ Refiling of Modified Plan

Company Name: _____

Contact Person: _____

Position Title: _____

Phone: _____

Location Address: _____

City: _____ ST: _____ ZIP _____

Mailing Address: _____

City: _____ ST: _____ ZIP _____

Mark one box: ☐ Insurance Company
☐ Self-insured Employer
☐ Self-insured Group

If Self-insured Employer or Group, are you using a TPA to manage your plan? ☐ Yes ☐ No

TPA Name: _____

Address: _____

City: _____ ST: _____ ZIP _____

Contact Person: _____

Phone: _____

Signed at: _____ By: _____

Date: _____ Title: _____

* This form or the information required by this form must be a cover to your anti-fraud plan.