



**INFORMATIONAL MEMORANDUM ISSUED  
September 15, 2006  
by  
Department of Financial Services  
Division of Insurance Fraud**

**Implementation of Chapter 69D-2.001-005, F.A.C.  
Insurer Anti-Fraud Investigative Units and Anti-Fraud Plans  
Implementing the provisions of Section 626.9891, Florida Statutes**

***TO: All Property & Casualty Insurers, Life & Health Insurers and Health Maintenance Organizations Authorized To Conduct Business In Florida***

**RE: The Purpose And Scope Of Rule Chapters 69D-2.001-005, Florida Administrative Code (FAC), Entitled "Insurer Anti-Fraud Investigative Units (SIU) and Insurer Anti-Fraud Plans" and An Announcement of the Development of an Electronic Interface for Submitting Referrals to the Division of Insurance Fraud, and the Development of an Online Case-Status Query Tool.**

The purpose of this memorandum is to provide notice of Rule Chapter 69D-2, FAC which will implement the provisions of Section 626.9891, Florida Statutes. This Rule requires a higher level of detail and accountability for Insurer Anti-Fraud Special Investigative Unit (SIU) Description filings and Insurer Anti-Fraud Plan filings.

All property & casualty insurers, life & health insurers and health maintenance

organizations (HMO) licensed to do business in Florida shall file with the Division of Insurance Fraud a description of the Insurer Anti-fraud Investigative Unit (SIU) or an Insurer Anti-fraud Plan pursuant to Section 626.9891, F.S. and Rule Chapter 69D-2.001-005, FAC (attached).

The type of filing will be differentiated by the insurer's volume of Florida annual direct written premium for calendar year 2006. Those insurers that write \$10 million or more in annual direct written premium in Florida are subject to Section 626.9891(1), F.S. and 69D-2.003, F.A.C; and those that write less than \$10 million annual direct written premium in Florida are subject to Section 626.9891(2), F.S. and 69D-2.004, F.A.C.

Insurers that write in excess of \$10 million annual direct written premium in Florida will be required to file the following information pursuant to Section 69D-2.003:

1. The names of all personnel assigned to the SIU and a description of each person's work responsibilities;
2. An acknowledgment that the SIU has established criteria for detecting suspicious or fraudulent activity relating to different types of insurance offered by the insurer;
3. An acknowledgement that the SIU has established criteria for the investigation of acts of suspected insurance fraud relating to different types of insurance offered by the insurer;
4. An acknowledgement that the insurer or SIU shall report all suspected fraudulent acts directly to the Division of Insurance Fraud electronically using form DFS-L1-1691 (Effective 9/15/06) entitled the "Suspected Fraud Referral Form" or via an electronic reporting interface that is linked to such form as provided on the division's website at [www.fldfs.com/fraud](http://www.fldfs.com/fraud);
5. An acknowledgement that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity;
6. An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the division;
7. An acknowledgement that the insurer or SIU shall provide training relating to the detection and investigation of fraudulent insurance acts for all personnel involved in anti-fraud related efforts;
8. An acknowledgement that the insurer or SIU shall provide on-going training during the reporting period;
9. The contact information including names, email addresses and telephone numbers for personnel designated by the insurer or SIU who are responsible for achieving and maintaining compliance with Section 626.9891 (1), F.S. and

this rule chapter;

10. The insurer's NAIC individual and group code numbers, and

An insurer or SIU subject to Section 626.9891(1), F.S., and this rule chapter, shall submit this SIU description electronically via the Division of Insurance Fraud's website at [www.fldfs.com/fraud](http://www.fldfs.com/fraud). The SIU description shall be submitted electronically on Form DFS-L1-1689 (Effective 9/15/06) entitled the "SIU Description Form" as provided on the Division of Insurance Fraud's website at [www.fldfs.com/fraud](http://www.fldfs.com/fraud). The insurer's filing of the information required by Chapter 69D-2.001-003, F.A.C., summarized above, shall constitute an adequately detailed description of its SIU as required by Section 626.9891(1), F.S.

Insurers that write less than \$10 million annual direct written premium in Florida will be required to file the following information pursuant to Section 69D-2.004, F.A.C.:

1. A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts;
2. A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts. The description shall include an acknowledgement that the insurer has established criteria that will be used to detect suspicious or fraudulent activity during investigations relating to the different types of insurance offered by that insurer. The description shall also include an acknowledgement that the insurer has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer;
3. A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Insurance Fraud pursuant to Section 626.989(6), F.S. The description shall include an explanation of the insurer's method for reporting all suspected fraudulent insurance acts directly to the Division of Insurance Fraud electronically on Form DFS-L1-1691 as provided for in Rule 69D-2.003(1)(d), F.A.C. The description will also include an acknowledgement that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity. The description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Insurance Fraud will also include an acknowledgement that the insurer shall record the date that suspected fraudulent activity is detected, and shall record the date that such reports of such suspected insurance fraud are sent directly to the Division of Insurance Fraud;
4. A description of the insurer's plan for anti-fraud education and training of its claims adjusters and any other personnel involved in anti-fraud related efforts. This description shall include a plan that involves training relative to the detection and investigation of fraudulent insurance acts for all employees involved in anti-fraud related efforts. The description will also include a plan

that involves on-going training during the reporting period;

5. The contact information, including names, email addresses and telephone numbers for personnel designated by this rule chapter who are responsible for achieving and maintaining compliance with Section 626.9891(2), F.S. and this rule chapter;

6. The NAIC individual and group code numbers, and

An insurer subject to Section 626.9891(2) F.S., and this rule chapter, shall submit this anti-fraud plan electronically via the division's website at [www.fldfs.com/fraud](http://www.fldfs.com/fraud). The anti-fraud plan shall be submitted electronically on Form DFS-L1-1690 (Effective 9/15/06) "Anti-Fraud Plan Form" as provided on the division's website at [www.fldfs.com/fraud](http://www.fldfs.com/fraud). The insurer's filing of the information required by 69D-2.004-005,

F.A.C., summarized above, shall constitute an adequately detailed description of its SIU as required by Section 626.9891(2) F.S.

The filing of information required herein in either of these forms is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality, or any proprietary interest in its anti-fraud plan or its anti-fraud related policies and procedures.

All insurers and HMO's subject to Section 626.9891, F.S. and this rule chapter shall file their SIU description filing or anti-fraud plan filing to the Florida Department of Financial Services, Division of Insurance Fraud website (<http://www.fldfs.com/fraud>). The Division of Insurance Fraud has developed an on-line database known as the INSURANCE FRAUD PLAN REPORT system (IFPR) for filing either the required SIU description or the anti-fraud plan. Forms have been created to file these descriptions and plans. Form DFS-L1-1689 (SIU descriptions) and Form DFS-L1-1690 (Anti-fraud plans) are attached and can be found at the above referenced website. Insurers and HMO's will access the website for the required forms. The insurer or HMO user will have two options to download whichever form is required based on their Florida premium volume. The user will access the website, then select "SIU DESCRIPTIONS AND ANTI-FRAUD PLAN REPORT FILING PURSUANT TO RULE 69D-2, FAC AND SECTION 626.9891, F.S. INSURANCE FRAUD PLAN REPORT SYSTEM." The insurer or HMO user will then select Form DFS-L1-1689 to submit an SIU description filing (for insurers collecting \$10 million or more in annual Florida premium) or Form DFS-L1-1690 to submit an anti-fraud plan filing (for insurers collecting less than \$10 million in annual Florida premium). The website provides either a Microsoft Word file document or an Adobe PDF file document. Once the user has selected the proper form, the file document form can be saved to your local computer. The form, once completed, must be saved as a new document and saved to your local computer or network server. You should save the completed form with a new document name or it will automatically save using the filename of the original form-filing document. The provided forms are in a "question and answer" format. The compliance requirements of the rule are posed as "questions" and the insurers' responses for the required compliance information would be placed in the "answer" portion of the forms. When the filing form is completed and saved, it will then be "uploaded" to the IFPR system by the user.

Once the SIU description or anti-fraud plan form is completed and saved, the insurer or HMO user will return to the Division of Insurance Fraud website (<http://www.fldfs.com/fraud>) and select INSURANCE FRAUD PLAN REPORT system (IFPR) to make the filing. The insurer or HMO user will be required to “Activate a New Account” as allowed on the menu options. This screen requests basic identifying information of the insurer, HMO or their contracted party making the filing. The user must supply a valid email address and a password in order to access the IFPR filing system. Once the identifying information has been submitted, a link to the IFPR system will automatically be emailed to the insurer or HMO user. After the insurer or HMO user has selected the link for the IFPR system, the user will enter their password. The insurer or HMO user will then “Start a New Filing” from the menu options. From this point, the user will select insurer names, HMO names, NAIC individual, or NAIC group codes for which the filing is being made. It is at this point that the IFPR system provides an upload feature, which will attach the user’s SIU description, or anti-fraud plan Microsoft Word document filing, or Adobe PDF document filing that has been completed and saved. The upload feature allows the user to select the saved document from their local computer. The saved document filing may then be uploaded to the database. The user must use either Form DFS-L1-1689 (SIU Description Form) or DFS-L1-1690 (Anti-Fraud Plan Form) depending on the premium volume size as described above. No other type of form, document, filing or communication will be accepted. The IFPR system’s Frequently Asked Questions (FAQ’s) will provide more detailed instructions for making the filings. Insurers and HMOs can also submit questions to [IFPRRPT@fldfs.com](mailto:IFPRRPT@fldfs.com). This email account will be reviewed and responses will be provided to the user/writer by Division of Insurance Fraud staff.

Insurers and HMO’s may periodically need to amend their SIU descriptions or anti-fraud plans that have been filed with the Division of Insurance Fraud via the IFPR system. If an insurer or HMO needs to modify the names or personnel assigned to the SIU pursuant to 69D-2.003(1)(a), F.A.C., or contact information pursuant to 69D.2.003(1)(i), F.A.C., the user can submit this information via an email memorandum to [IFPRRPT@fldfs.com](mailto:IFPRRPT@fldfs.com). The same procedure is applicable for anti-fraud plan filings pursuant to 69D- 2.004(1)(a)and(e), F.A.C. The user must clearly identify to which insurer or HMO the change in personnel would apply. However, if an insurer or HMO needs to update or modify any substance of the filing, they will need to submit a new SIU description or anti-fraud plan filing using the IFPR system. The IFPR system will be designed so that an updated or modified SIU description or anti-fraud plan filing can be made using the same instructions as described above. The previously filed SIU description or anti-fraud plan will be considered obsolete and will be replaced with the updated filing.

Rule 69D-2.005, F.A.C., entitled the Compliance and Enforcement section, provides for the division to review the filings and the Office of Insurance Regulation to conduct audits pursuant to Section 624.3161, F.S. These reviews and audits will determine compliance with Section 626.9891, F.S.

The SIU descriptions and anti-fraud plan forms filed with the Division of Insurance Fraud allow for “acknowledgements” that criteria have been established for many components of the rule chapter. Office of Insurance Regulation auditors, in the course of their audits relative to these rules, may review the written detailed criteria that have been established for the insurer’s special investigative unit or anti-fraud operations. If an insurer or HMO user fails to timely file a SIU description or an anti-fraud plan, fails to implement or follow the provisions of their SIU

description or anti-fraud plan, or in any other way fails to comply with the requirements of Section 626.9891, F.S. and Rule 69D- 2, F.A.C., the Office of Insurance Regulation shall take appropriate administrative action as provided in Section 626.9891(7), F.S. and Section 624.4211, F.S. A copy of Rule 69D-2.001-005, F.A.C. is attached. If you have any questions, you may contact Charles Gowland, Senior Attorney, Division of Insurance Fraud (DIF) at 850 413-4066 or Denise E. Prather, Senior Management Analyst, (DIF) at 850 413-4036.

**Electronic Interface with the National Insurance Crime Bureau for Submitting Referrals to the Division of Insurance Fraud and the Development of an Online Case-Status Query Tool:**

The Division of Insurance Fraud allows referrals submitted electronically through the National Insurance Crime Bureau (NICB) to satisfy the stated requirements for fraud referrals to the Division of Insurance Fraud. The National Insurance Crime Bureau, with the cooperation of the Division of Insurance Fraud, developed an electronic interface that allows NICB referrals related to suspected fraud in a Florida claim to route directly to the Division of Insurance Fraud's case management system. This interface allows 65,000 characters in its text field and will accelerate the review and assignment of fraud referrals received from the NICB and its members.

The Division of Insurance Fraud has also created an on-line system to check the status of referrals (tips) and cases. The on-line query search will serve as a mechanism for customers to check the current status of tips and cases. Users can access this new query system via the Division's website, [www.fldfs.com/fraud](http://www.fldfs.com/fraud). The user will click "Look Up Your Tip or Case Status" under CONSUMER/SIU INFORMATION. The user will enter the tip number (example: T06-000) or a case number (example: 06-000).

Tip numbers are electronically provided to a user after the user has entered and submitted tip referral information to the Division of Insurance Fraud's eFile referral site as long as the user provides a valid email address. The user receives an automated acknowledgement that provides basic information including the tip number and field office contact identifiers. By entering the tip number, the user can retrieve tip and case status information gleaned from the Division's electronic case tracking and management system. A tip number search will provide the tip status description and the field office that is currently assigned to the tip. If a criminal case has been initiated, the query tool will provide a case number. A case number search will provide the case status description and identify the Division of Insurance Fraud field office that is currently assigned the tip for review. It will also indicate conviction information if the case has been disposed of by a court of competent jurisdiction.

This notice is not intended to be a comprehensive analysis of the adopted rule(s). You are responsible for reading the adopted rule(s) and taking any necessary steps to ensure compliance. If you have any questions about the changes, please contact Eric Miller, Director, Division of Insurance Fraud at (850) 413-4000.

69-D-2 Info Memo

Title 37. Insurance (Chs. 624-651)  
Chapter 626. Insurance Field Representatives and Operations  
Part IX. Unfair Insurance Trade Practices

Fla. Stat. § 626.9891 (2006)

§ 626.9891. Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance

(1) Every insurer admitted to do business in this state who in the previous calendar year, at any time during that year, had \$ 10 million or more in direct premiums written shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or

(b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds.

An insurer subject to this subsection shall file with the Division of Insurance Fraud of the department on or before July 1, 1996, a detailed description of the unit or division established pursuant to paragraph (a) or a copy of the contract and related documents required by paragraph (b).

(2) Every insurer admitted to do business in this state, which in the previous calendar year had less than \$ 10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department on or before July 1, 1996. An insurer may, in lieu of adopting and filing an anti-fraud plan, comply with the provisions of subsection (1).

(3) Each insurers anti-fraud plans shall include:

(a) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;

(b) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Insurance Fraud of the department;

(c) A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel; and

(d) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

(4) Any insurer who obtains a certificate of authority after July 1, 1995, shall have 18 months in which to comply with the requirements of this section.

(5) For purposes of this section, the term "unit or division" includes the assignment of fraud

investigation to employees whose principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.

(6) Each insurer writing workers' compensation insurance shall report to the department, on or before August 1 of each year, on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include, at a minimum:

(a) The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.

(b) The number of referrals to the Bureau of Workers' Compensation Fraud for the prior year.

(c) A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.

(d) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.

(e) The inservice education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.

(f) A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it.

(7) If an insurer fails to timely submit a final acceptable anti-fraud plan or anti-fraud investigative unit description, fails to implement the provisions of a plan or an anti-fraud investigative unit description, or otherwise refuses to comply with the provisions of this section, the department, office, or commission may:

(a) Impose an administrative fine of not more than \$ 2,000 per day for such failure by an insurer to submit an acceptable anti-fraud plan or anti-fraud investigative unit description, until the department, office, or commission deems the insurer to be in compliance;

(b) Impose an administrative fine for failure by an insurer to implement or follow the provisions of an anti-fraud plan or anti-fraud investigative unit description; or

(c) Impose the provisions of both paragraphs (a) and (b).

(8) The department may adopt rules to administer this section.