Insurance Fraud Complaint Form

Your Name

Name of Your Organization (if applicable)

Your Address

Street Address

Address Line 2

City, State

Zip

Your Email Address

Your Telephone Number

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What is the false statement / misrepresentation / potential fraud you believe was committed and by whom? (Please attach copies of any supporting documentation to this complaint).

How do you know it is a false statement / misrepresentation / potential fraud and what evidence supports your conclusion?

Why does the false statement / misrepresentation / potential fraud matter?

Did a licensed professional participate?

Yes ☐

No ☐

If representing a business / organization, what was the amount claimed?

If representing a business / organization, what was the amount paid?

Date of Loss

MM - DD - YYYY

Date of Claim

MM - DD - YYYY

Individuals Involved - Suspects

If available, please include names, addresses, and telephone numbers of any parties you believe are involved in the false statement / misrepresentation / potential fraud.

Individuals Involved - Witnesses

If available, please include names, addresses, and telephone numbers of any parties you believe may have witnessed the false statement / misrepresentation / potential fraud.

Other Agencies or Invidviduals Contacted About This Matter

Please mail this form to our office, with all supporting documentation to:

Insurance Fraud Division
Office of the Attorney General
P. O. Box 11549
Columbia, SC 29211-1549