SOUTH CAROLINA
INSURANCE FRAUD COMPLAINT FORM

Date: __________

Your Name/Organization: ____

Address: ____
____

Telephone: (home) ____
(work) ____
(fax) ____

What is the false statement/misrepresentation/crime you believe was committed and by whom? **(Include details such as names, addresses, and telephone numbers of witnesses to the events you describe. Use additional sheets, if necessary. Attach copies of any supporting documentation to this complaint.)**

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____
____

How do you know it is a false statement/misrepresentation/crime and what facts support your conclusion?
____
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____
____

Why does the false statement/misrepresentation matter?
____
____
____

Did a licensed professional participate?
____

Amount Involved: **(claimed)** **$**____________ **Date of Loss:** _____/_______/______
(paid) **$**____________ **Date of Claim:** _____/_______/______

Individuals Involved: **(If available, include names, addresses, and telephone numbers of any parties involved.)**

____
____
____

Other Agencies or Individuals Contacted About This Matter: ________________________
____
____

Mail completed form, and all relevant documentation to support your complaint, to:

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

Telephone: (803) 737-6424
Fax: (803) 734-6679