Solano County District Attorney's

WORKERS' COMPENSATION INSURANCE FRAUD REPORTING FORM

This form is designed to be used by members of the general public and their representatives. If you are employed in the insurance industry you must use Form FD-1 to make your report.

SECTION 1 – REPORTING PARTY

☐ Anonymous Date _____

Last Name _____ First Name _____

Email Address _____

Company Name _____ DBA _____

Street Address _____ City _____

State _____ Zip Code _____ Contact Phone # _____

SECTION 2 – INSURANCE FRAUD INFORMATION (Please Provide Known Information)

Insurance Company(s) _____

Policy # _____ Claim # _____

Date of Loss _____ Is Fraud Still On Going? ☐ Yes ☐ No

Location of loss: City _____ Zip Code _____

Person listed below is: ☐ Insured ☐ Claimant ☐ Suspect ☐ Other

Last Name _____ First Name _____

Street Address _____ City _____

State _____ Zip Code _____ Phone # _____

Company Name _____ DBA _____

Person listed below is: ☐ Insured ☐ Claimant ☐ Suspect ☐ Other

Last Name _____ First Name _____

Street Address _____ City _____

State _____ Zip Code _____ Phone # _____

Company Name _____ DBA _____

If you have additional names, enter them in the Summary Section on the next page.

SECTION 3 – This Information Has Also Been Referred To:

Has an insurance company been notified of this activity? If yes, listed company _____ ☐ Yes ☐ No

Has a law enforcement agency been notified of this activity? If yes, listed agency(s) _____ ☐ Yes ☐ No

Has a District Attorney's Office been notified of this activity? If yes, listed county _____ ☐ Yes ☐ No

Have other agency(s) been notified of this activity? If yes, listed agency(s) _____ ☐ Yes ☐ No

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SECTION 4 – SUMMARY

Please describe what fraud activity you wish to report and include answers to the following questions, if known:

Who are the persons committing the fraud?

When & where did the fraud occur?

What is the name of the insured if different than the suspect?

Include names of others who can corroborate this information.

Is anyone in the insurance industry aware of what is occurring?

If you wish to report something that was not covered by these questions, please include that information in your summary.

If you have additional information that does not fit on the space below, please include an additional pages.

Print form and mail to:
Attn: Workers' Compensation Insurance
Solano County District Attorney's Office
675 Texas Street, Suite 4500
Fairfield, CA 94533

Submit by Email

Or Email completed form to DAWorkersComp@solanocounty.com