Illinois Workers' Compensation Act
§25.5: Penalties; Fraud

Section 25.5. Unlawful acts; penalties.

(a) It is unlawful for any person, company, corporation, insurance carrier, healthcare provider, or other entity to:
  (1) Intentionally present or cause to be presented any false or fraudulent claim for the payment of any workers' compensation benefit.
  (2) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining or denying any workers' compensation benefit.
  (3) Intentionally make or cause to be made any false or fraudulent statements with regard to entitlement to workers' compensation benefits with the intent to prevent an injured worker from making a legitimate claim for any workers' compensation benefits.
  (4) Intentionally prepare or provide an invalid, false, or counterfeit certificate of insurance as proof of workers' compensation insurance.
  (5) Intentionally make or cause to be made any false or fraudulent material statement or material representation for the purpose of obtaining workers' compensation insurance at less than the proper rate for that insurance.
  (6) Intentionally make or cause to be made any false or fraudulent material statement or material representation on an initial or renewal self-insurance application or accompanying financial statement for the purpose of obtaining self-insurance status or reducing the amount of security that may be required to be furnished pursuant to Section 4 of this Act.
  (7) Intentionally make or cause to be made any false or fraudulent material statement to the Division of Insurance's fraud and insurance non-compliance unit in the course of an investigation of fraud or insurance non-compliance.
  (8) Intentionally assist, abet, solicit, or conspire with any person, company, or other entity to commit any of the acts in paragraph (1), (2), (3), (4), (5), (6), or (7) of this subsection (a).

  For the purposes of paragraphs (2), (3), (5), (6), and (7), the term "statement" includes any writing, notice, proof of injury, bill for services, hospital or doctor records and reports, or X-ray and test results.

(b) Any person violating subsection (a) is guilty of a Class 4 felony. Any person or entity convicted of any violation of this Section shall be ordered to pay complete restitution to any person or entity so defrauded in addition to any fine or sentence imposed as a result of the conviction.

(c) The Division of Insurance of the Department of Financial and Professional Regulation shall establish a fraud and insurance non-compliance unit responsible for investigating incidences of fraud and insurance non-compliance pursuant to this Section. The size of the staff of the unit shall be subject to appropriation by the General Assembly. It shall be the duty of the fraud and insurance non-compliance unit to determine the identity of insurance carriers, employers, employees, or other persons or entities who have violated the fraud and insurance non-compliance provisions of this Section. The fraud and insurance non-compliance unit shall report violations of the fraud and insurance non-compliance provisions of this Section to the Attorney General or to the State's Attorney of the county in which the offense allegedly occurred, either of whom has the authority to prosecute violations under this Section.

  With respect to the subject of any investigation being conducted, the fraud and insurance non-compliance unit shall have the general power of subpoena of the Division of Insurance.

(d) Any person may report allegations of insurance non-compliance and fraud pursuant to this Section to the Division of Insurance's fraud and insurance non-compliance unit whose duty it shall be to investigate the report. The unit shall notify the Commission of reports of insurance non-compliance. Any person reporting an allegation of insurance non-compliance or fraud against either an employee

or employer under this Section must identify himself. Except as provided in this subsection and in subsection (e), all reports shall remain confidential except to refer an investigation to the Attorney General or State's Attorney for prosecution or if the fraud and insurance non-compliance unit's investigation reveals that the conduct reported may be in violation of other laws or regulations of the State of Illinois the unit may report such conduct to the appropriate governmental agency charged with administering such laws and regulations. Any person who intentionally makes a false report under this Section to the fraud and insurance non-compliance unit is guilty of a Class A misdemeanor.

(e) In order for the fraud and insurance non-compliance unit to investigate a report of fraud by an employee, (i) the employee must have filed with the Commission an Application for Adjustment of Claim and the employee must have either received or attempted to receive benefits under this Act that are related to the reported fraud or (ii) the employee must have made a written demand for the payment of benefits that are related to the reported fraud. Upon receipt of a report of fraud, the employee or employer shall receive immediate notice of the reported conduct, including the verified name and address of the complainant if that complainant is connected to the case and the nature of the reported conduct. The fraud and insurance non-compliance unit shall resolve all reports of fraud against employees or employers within 120 days of receipt of the report. There shall be no immunity, under this Act or otherwise, for any person who files a false report or who files a report without good and just cause. Confidentiality of medical information shall be strictly maintained. Investigations that are not referred for prosecution shall be immediately expunged and shall not be disclosed except that the employee or employer who was the subject of the report and the person making the report shall be notified that the investigation is being closed, at which time the name of any complainant not connected to the case shall be disclosed to the employee or the employer. It is unlawful for any employer, insurance carrier, or service adjustment company to file or threaten to file a report of fraud against an employee because of the exercise by the employee of the rights and remedies granted to the employee by this Act.

For purposes of this subsection (e), "employer" means any employer, insurance carrier, third party administrator, self-insured, or similar entity.

For purposes of this subsection (e), "complainant" refers to the person contacting the fraud and insurance non-compliance unit to initiate the complaint.

f) Any person convicted of fraud related to workers' compensation pursuant to this Section shall be subject to the penalties prescribed in the Criminal Code of 1961 and shall be ineligible to receive or retain any compensation, disability, or medical benefits as defined in this Act if the compensation, disability, or medical benefits were owed or received as a result of fraud for which the recipient of the compensation, disability, or medical benefit was convicted. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(g) Civil liability. Any person convicted of fraud who knowingly obtains, attempts to obtain, or causes to be obtained any benefits under this Act by the making of a false claim or who knowingly misrepresents any material fact shall be civilly liable to the payor of benefits or the insurer or the payor's or insurer's subrogee or assignee in an amount equal to 3 times the value of the benefits or insurance coverage wrongfully obtained or twice the value of the benefits or insurance coverage attempted to be obtained, plus reasonable attorney's fees and expenses incurred by the payor or the payor's subrogee or assignee who successfully brings a claim under this subsection. This subsection applies to accidental injuries or diseases that occur on or after the effective date of this amendatory Act of the 94th General Assembly.

(h) All proceedings under this Section shall be reported by the fraud and insurance non-compliance unit on an annual basis to the Workers' Compensation Advisory Board.

(Source: P.A. 94-277, eff. 7-20-05.)