

COMMONWEALTH OF PENNSYLVANIA

INSURANCE COMPLAINT FORM

(PLEASE TYPE OR PRINT)

It is our goal to assist you in resolving your complaint as quickly as possible. Therefore, we ask that you complete this form and return it to the office listed on the reverse side of this page. Please provide as much information and documentation as you can. Within a few days following our receipt of your complaint, you will receive a letter advising you of your file number, the name of the investigator assigned to assist you and information on how to contact our office if you have questions. In general, you can expect the investigator to contact you within thirty (30) days to advise you of our findings or the status of our review.

NAME:

ADDRESS:

INSURED'S NAME: (IF OTHER THAN THE ABOVE) :

INSURANCE CARD ID NUMBER:

DAYTIME TELEPHONE

HOME: (_____) _____

WORK: (_____) _____

EMAIL: _____

1. Does this complaint involve an individual that is Medicare eligible? (Y/N)

2. Type of Insurance:
- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Auto | <input type="checkbox"/> Individual Life | <input type="checkbox"/> Individual Health | <input type="checkbox"/> Medicare Supplement |
| <input type="checkbox"/> Homeowners | <input type="checkbox"/> Group Life | <input type="checkbox"/> Group Health | <input type="checkbox"/> Long Term Care |
| <input type="checkbox"/> Renters/Condo | <input type="checkbox"/> Annuity | <input type="checkbox"/> HMO | |
| <input type="checkbox"/> Commercial | <input type="checkbox"/> Viatical | <input type="checkbox"/> Medicaid | |
| <input type="checkbox"/> Flood | | <input type="checkbox"/> Medicare | |
| <input type="checkbox"/> Title | | <input type="checkbox"/> Medicare Advantage | |

3. Type of Problem: Cancellation/Nonrenewal Claim Handling Billing/Premium Dispute
 Sales Misrepresentation Other (specify) _____

4. (A) If your problem involves an insurance company, give the full name of the company:

(B) If your problem involves an agent or broker, give his/her full name, address and phone number.

5. Policy Number: _____ In what State was this policy sold? _____

6. Date & location of loss: _____ Claim #: _____

7. Have you previously reported this problem to our office or any other agency? Yes No

