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: _____

_____

_____

DAYTIME TELEPHONE

HOME: (_____)_____

WORK: (_____)_____

EMAIL: _____

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

_____

INSURANCE CARD ID NUMBER:

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

2. Type of Insurance:

☐ Auto	☐ Individual Life	☐ Individual Health	☐ Medicare Supplement
☐ Homeowners	☐ Group Life	☐ Group Health	☐ Long Term Care
☐ Renters/Condo	☐ Annuity	☐ HMO	
☐ Commercial	☐ Viatical	☐ Medicaid	
☐ Flood		☐ Medicare	
☐ Title		☐ 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

8. Are you represented by an attorney? ☐ Yes ☐ No If yes, please give name, address and telephone #:

Note: If you have proceeded with litigation against the company and/or agent we will not be able to assist you until the litigation has been completed and the court has found misconduct on the part of these parties.

9. Briefly describe your problem and state how you feel it should be resolved. Copies of your policy, correspondence or other supporting documentation will assist us in understanding or evaluating the issues, please include this documentation with your complaint form. If more space is needed to describe your problem, please attach additional sheets.

PLEASE READ, SIGN AND DATE THE STATEMENT BELOW:

I CERTIFY THAT THE INFORMATION THAT I HAVE GIVEN ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT A COPY OF THIS FORM AND ATTACHMENTS MAY BE FORWARDED TO THE INSURANCE COMPANY, AGENT OR BROKER INVOLVED.

(Signature) (Date)

(IF YOUR COMPLAINT INVOLVES A MEDICAL ISSUE AND/OR CREDIT INFORMATION)
Please circle either Medical Issue, Credit Information or Both.

I AUTHORIZE_____(Name of Insurance Company) TO RELEASE TO THE PENNSYLVANIA INSURANCE DEPARTMENT ANY **MEDICAL OR CREDIT INFORMATION** THAT MAY BE PERTINENT TO THE RESOLUTION OF MY COMPLAINT.

(Signature) (Date)

Mail or Fax Complaint Form to:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: (717) 787-8585

Toll Free Consumer Hotline: 1-877-881-6388

Please feel free to submit your question or complaint on-line at:
Website: www.insurance.pa.gov