COMMONWEALTH OF PENNSYLVANIA

INSURANCE COMPLAINT FORM

(PLEASE TYPE OR PRINT)

In order for the Insurance Department to review your complaint, we ask you to complete this form and return it to the nearest regional office listed on the following page. It is our goal to assist you in resolving your complaint as quickly as possible. The more information and documentation you provide with this complaint form the better we will be able to assist you in a timely manner. You will receive an acknowledgement within a few days of our receipt of your complaint advising you of the name and telephone number of the investigator assigned to assist you and the file number of your case. In general, you can expect the investigator to contact you within thirty (30) days to advise you of our findings.

DAYTIME TELEPHONE

HOME: (_____) _____

WORK: (_____) _____ - _____

NAME: _____

ADDRESS: _____

_____

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

INSURANCE CARD ID NUMBER: _____

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

2. Type of Insurance:
   - ☐ Auto
   - ☐ Homeowners
   - ☐ Renters/Condo
   - ☐ Commercial
   - ☐ Flood
   - ☐ Title
   - ☐ Individual Life
   - ☐ Group Life
   - ☐ Annuity
   - ☐ Viatical
   - ☐ Individual Health
   - ☐ Group Health
   - ☐ HMO
   - ☐ Medicaid
   - ☐ Medicare
   - ☐ Medicare Advantage
   - ☐ Medicare Supplement
   - ☐ Long Term Care

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

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. If you feel that copies of your policy, correspondence or other supporting documentation will assist us in understanding or evaluating the issues, please send copies to us. 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)

OPTIONAL- (IF YOUR COMPLAINT INVOLVES A MEDICAL ISSUE 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/CREDIT INFORMATION** WHICH 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: 1-877-881-6388

Please feel free to submit your question or complaint on-line at:

Website: www.insurance.pa.gov