



INDIANA DEPARTMENT OF INSURANCE
 CONSUMER SERVICES DIVISION
 311 West Washington Street
 Indianapolis, Indiana 46204-2787
 (317)232-2395 or (800) 622-4461
 FAX (317)234-2103

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address. **Please do not include any Social Security Numbers.**

COMPLETE BOTH SIDES OF THIS FORM.
 TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name: _____

Your Address: _____

City _____ State _____ Zip Code _____

County: _____

Daytime Telephone Number : (____) _____ E-mail _____

1. (A) Type of Insurance (Please Check One):

<input type="checkbox"/> Automobile	<input type="checkbox"/> Homeowners	<input type="checkbox"/> Fire	<input type="checkbox"/> Life	<input type="checkbox"/> ACA
<input type="checkbox"/> Health	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Business	<input type="checkbox"/> Other	<input type="checkbox"/> Navigator

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy
 A through J _____

2. My complaint is against:
 Name of Insurance Company _____

3. What State was your policy issued/purchased in: _____

4. If an agent is involved, please give the agent's name and address.
 Name: _____
 Address: _____

5. If Navigator is involved, please give name. _____

6. Policy Number: _____
 Claim Number (If known): _____

7. Named Insured: _____

8. If group insurance, please give the name of the employer.
 Name: _____

9. If a loss or an accident is involved, please give the location and/or date of the loss:

Date: ____ / ____ / ____

Location: _____

City

State

Zip Code

10. Briefly describe your problem. If more space is needed, please attach additional sheets. **Please do not include Social Security Numbers.**

Multiple horizontal lines for writing the description of the problem.

I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records WILL NOT be public records at any time.

Date: ____ / ____ / ____ Signature: _____