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. However, there are times when our investigation may take longer.

NAME: _____

ADDRESS: _____

_____

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

INSURANCE CARD ID NUMBER: _____

HOME: ( ) _____

WORK: ( ) _____

EMAIL: _____

AUTHORIZED REPRESENTATIVE (Optional)

You may give a trusted person permission to talk about this complaint with us, see your information, and act for you on matters related to this complaint, including getting information about your complaint and signing your complaint on your behalf. This person is called an "authorized representative." The person you identify will need to agree to be your representative before we will communicate with them about your complaint. They can agree to be your representative by signing the optional form at the end.

If you ever need to change or remove your authorized representative, contact the Pennsylvania Insurance Department.

By signing your name below, you allow _____ to get official information about this complaint, and act for you on all future matters related to this complaint. You also allow us, the Department, to communicate with the authorized representative using any information we receive related to this complaint, even if it is confidential information such as medical and financial information.

Signature _____ Date: _____

COMPLAINT DETAILS

1. Does this complaint involve an individual that is Medicare eligible ☐ (Y/N) or a Veteran ☐ (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	☐ Disability
☐ Commercial	☐ Viatical	☐ Medicaid	☐ Other _____
☐ Flood		☐ Medicare	_____
☐ Title		☐ Medicare Advantage	

3. Type of Problem: Cancellation/Nonrenewal ☐ Claim Handling ☐ Billing/Premium Disput
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. 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)

(Please circle either Medical, Credit or both if your complaint involves a medical issue and/or credit info)

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

(Signature) (Date)

A person named as an Authorized Representative may indicate their agreement to serve by signing and dating this statement:

I, _____ am the person designated by the consumer filing this complaint, _____, as their authorized representative. I acknowledge that I will act in accord with their reasonable expectations to the extent actually known by me and, otherwise, in good faith and in their best interest, and in good faith.

_____ _____
Authorized Representative 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

Are you a veteran of the United States Army, Navy, Air Force, Marine Corps or Coast Guard?
If yes, you are eligible for the Pennsylvania Veteran's Registry which connects Pennsylvania veterans to state and federal benefits and programs to which you are eligible. You may register as a Pennsylvania Veteran by going to the following website https://register.dmva.pa.gov/ or call us at 1-877-881-6388 to request a copy of the PA Veterans Registry Form. When completing the registry form, please indicate that Insurance Department referred you to the Registry.