MISSOURI DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL REGISTRATION
CONSUMER AFFAIRS DIVISION

CONSUMER COMPLAINT REPORT

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COMPLAINT AGAINST (ONE OR MORE)
☐ INSURANCE COMPANY ☐ AGENT/PRODUCER
☐ PUBLIC ADJUSTER ☐ BAIL BOND AGENT

INSTRUCTIONS

PLEASE COMPLETE ALL ITEMS BELOW AND ENCLOSE COPIES OF ANY CORRESPONDENCE OR OTHER PAPERS WHICH YOU FEEL WOULD HELP THE INVESTIGATION OF YOUR COMPLAINT. SIGN AND DATE AT THE BOTTOM. **A COPY OF THIS FORM AND ANY OR ALL OF THE ENCLOSED INFORMATION MAY BE SENT TO THE PARTY COMPLAINED AGAINST.** SEND COMPLETED FORM ALONG WITH ANY ATTACHMENTS TO (MUST CHECK ONE OF THE FOLLOWING):

MISSOURI DEPARTMENT OF INSURANCE
FINANCIAL INSTITUTIONS AND
PROFESSIONAL REGISTRATION
P.O. BOX 690
JEFFERSON CITY, MISSOURI 65102-0690
(573) 751-2640
(800) 726-7390
(573) 526-4536 TDD

☐ I do **not** authorize release of my complaint form and any or all of my file information, other than to party complained against.
☐ I authorize release of my name and address only to outside parties as requested.
☐ I authorize release of my complaint form only to outside parties as requested.
☐ I authorize release of my file information, including medical records, to outside parties as requested.

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK

1. NAME OF COMPLAINANT (LAST) (FIRST) (MI)
☐ MR ☐ MS

AGE OF INSURED
☐ 1 - 24 ☐ 25 - 49 ☐ 50 - 64 ☐ 65+

MAILING ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

TELEPHONE NUMBER (HOME) (WORK) (E-MAIL)

2. NAME OF INSURED (PERSON WITH INSURANCE PROBLEM)

2A EMPLOYER NAME (IF GROUP POLICY) AND POLICY HOLDER

MAILING ADDRESS (STREET) (CITY) (STATE) (ZIP CODE)

3. WHO IS COMPLAINT AGAINST? (NAME OF COMPANY, BROKER, AGENT, PRODUCER, AGENCY, PUBLIC ADJUSTER OR BAIL BOND AGENT)

ADDRESS, IF KNOWN (STREET) (CITY) (STATE) (ZIP CODE)

4. GROUP NUMBER (OR)	POLICY NUMBER	DATE OF ISSUE
ID NUMBER	CERTIFICATE NUMBER	DATE OF ISSUE
CLAIM NUMBER	AGENT NAME (IF APPLICABLE)	DATE OF LOSS

5. TYPE OF POLICY (CHECK ONE)

☐ BOND ☐ TITLE ☐ LONG TERM CARE ☐ RENTERS ☐ DISABILITY
☐ INDIVIDUAL LIFE ☐ INDIVIDUAL HEALTH ☐ PRIVATE AUTO ☐ HOMEOWNERS ☐ WORKERS COMPENSATION
☐ GROUP LIFE ☐ GROUP HEALTH ☐ COMMERCIAL AUTO ☐ MOBILE HOMEOWNERS ☐ WARRANTY
☐ ANNUITY ☐ MED SUPPLEMENT - SPECIFY PLAN A THRU L _____ ☐ OTHER (SPECIFY)

6. REASON FOR COMPLAINT (CHECK ONE)

☐ CLAIM PROBLEM ☐ NONRENEW/ CANCELLATION ☐ SALES PROBLEM ☐ PREMIUM PROBLEM ☐ POLICY PROBLEM ☐ OTHER (SPECIFY) ▸

DETAILS OF COMPLAINT (USE A SEPARATE SHEET AND ATTACH IF NECESSARY)

WHAT SPECIFIC RESULTS DO YOU DESIRE?

I GIVE PERMISSION FOR THE DEPARTMENT OF INSURANCE TO RELEASE MY MEDICAL RECORDS TO THE INSURANCE COMPANY.

SIGNATURE OF COMPLAINANT	DATE ▸