



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

COMPLAINT AGAINST (ONE OR MORE)

- INSURANCE COMPANY
 PUBLIC ADJUSTER

- AGENT/PRODUCER
 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:**

**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)		AGE OF INSURED	
<input type="checkbox"/> MR <input type="checkbox"/> MS		<input type="checkbox"/> 1 - 24 <input type="checkbox"/> 25 - 49 <input type="checkbox"/> 50 - 64 <input type="checkbox"/> 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	
CLAIM NUMBER		AGENT NAME (IF APPLICABLE) DATE OF LOSS	
5. TYPE OF POLICY (CHECK ONE)			
<input type="checkbox"/> BOND <input type="checkbox"/> TITLE <input type="checkbox"/> LONG TERM CARE <input type="checkbox"/> RENTERS <input type="checkbox"/> DISABILITY <input type="checkbox"/> INDIVIDUAL LIFE <input type="checkbox"/> INDIVIDUAL HEALTH <input type="checkbox"/> PRIVATE AUTO <input type="checkbox"/> HOMEOWNERS <input type="checkbox"/> WORKERS COMPENSATION <input type="checkbox"/> GROUP LIFE <input type="checkbox"/> GROUP HEALTH <input type="checkbox"/> COMMERCIAL AUTO <input type="checkbox"/> MOBILE HOMEOWNERS <input type="checkbox"/> WARRANTY <input type="checkbox"/> ANNUITY <input type="checkbox"/> MED SUPPLEMENT - SPECIFY PLAN A THRU L _____ <input type="checkbox"/> OTHER (SPECIFY)			
6. REASON FOR COMPLAINT (CHECK ONE)			
<input type="checkbox"/> CLAIM PROBLEM <input type="checkbox"/> NONRENEW/CANCELLATION <input type="checkbox"/> SALES PROBLEM <input type="checkbox"/> PREMIUM PROBLEM <input type="checkbox"/> POLICY PROBLEM <input type="checkbox"/> OTHER (SPECIFY) ▶			

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

WHAT SPECIFIC RESULTS DO YOU DESIRE?

I HEREBY AUTHORIZE THE INSURER TO RELEASE MY MEDICAL RECORDS TO THE DEPARTMENT OF INSURANCE IF RELEVANT.

SIGNATURE OF COMPLAINANT

DATE

