



# DCI

Missouri Department of Commerce & Insurance

# Consumer Complaint Report

MAIL TO

Missouri DCI  
PO Box 690  
Jefferson City, MO 65102  
800-726-7390 / 573-751-2640  
Fax 573-526-4898  
RelayMO TTY Dial 711 or  
1-800-735-2966

My complaint is against (one or more):  Insurance company  Agent/producer  Bail bond agent  Public adjuster

Please complete all information and enclose copies of correspondence and other papers that will help us investigate your complaint. Sign and date on back side at bottom. Note: A copy of this form and any of the enclosed information will be sent to the party you are complaining about. Send form and attachments to the above address.

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

### 1 COMPLAINANT INFO

Mr.  Ms.

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ MI \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

COUNTY \_\_\_\_\_ EMAIL \_\_\_\_\_

PHONE ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HOME CELL WORK

RELATIONSHIP TO INSURED \_\_\_\_\_

### 2 INSURED INFO

AGE  1-24  25-49  50-64  65+

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET \_\_\_\_\_

Leave blank if same as claimant  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

EMPLOYER NAME (if group health policy) \_\_\_\_\_

POLICY-HOLDER NAME \_\_\_\_\_

### 3 INFO ON COMPANY

NAME OF COMPANY OR INDIVIDUAL YOU ARE COMPLAINING ABOUT \_\_\_\_\_

ADDRESS \_\_\_\_\_  
If known STREET \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

### 4 POLICY INFORMATION

GROUP or POLICY NUMBER \_\_\_\_\_ ISSUE DATE \_\_\_\_\_

ID or CERTIFICATE NUMBER \_\_\_\_\_ ISSUE DATE \_\_\_\_\_

CLAIM NUMBER \_\_\_\_\_ DATE OF LOSS \_\_\_\_\_

AGENT NAME, if applicable \_\_\_\_\_

### 5 TYPE OF POLICY (Check one)

- |  |  |   |                                   |   |
|--|--|---|-----------------------------------|---|
| <input type="checkbox"/> Homeowners        | <input type="checkbox"/> Commercial auto   | <input type="checkbox"/> Group life     | <input type="checkbox"/> Annuity  | <input type="checkbox"/> Medigap (Med Supplement) |
| <input type="checkbox"/> Renters           | <input type="checkbox"/> Individual health | <input type="checkbox"/> Workers' comp  | <input type="checkbox"/> Bond     | Specify plan A-L _____                            |
| <input type="checkbox"/> Mobile homeowners | <input type="checkbox"/> Group health      | <input type="checkbox"/> Disability     | <input type="checkbox"/> Title    | <input type="checkbox"/> Commercial/Business      |
| <input type="checkbox"/> Private auto      | <input type="checkbox"/> Individual life   | <input type="checkbox"/> Long-term care | <input type="checkbox"/> Warranty | <input type="checkbox"/> Other _____              |

