



DIFP

Department of Insurance,
Financial Institutions &
Professional Registration

Consumer Complaint Report

MAIL TO

Missouri DIFP
PO Box 690
Jefferson City, MO 65102
800-726-7390
573-751-2640
TDD: 573-526-4536

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 (Person with insurance problem)

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

LAST NAME FIRST

ADDRESS

Leave STREET

blank if same as claimant CITY STATE ZIP CODE

EMPLOYER NAME

(if group health policy)

POLICY-HOLDER NAME

3 INFO ON COMPANY/PERSON THAT COMPLAINT IS ABOUT

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 _____ |

6 REASON FOR COMPLAINT (Check one)

- Claim problem Nonrenew/Cancellation Sales problem Premium problem Policy problem Other

7 DETAILS OF COMPLAINT (Attach separate sheet if needed)

7 SIGNATURE

I declare the information I have provided is true and accurate. I hereby authorize the insurer or persons or entities complained against to release all claim and policy information and documents, including medical records, to the Missouri Department of Insurance on request.

Signature of complainant  _____ DATE _____