

# Complaint form

Please use this form to submit a complaint about an insurance company

We will do our best to advocate on your behalf. In the meantime, you should continue to pursue your rights under the terms of your insurance contract.

\* Indicates a required field

## I. Your contact information

\* Name: \_\_\_\_\_  
\* Address: \_\_\_\_\_  
\* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* Zip: \_\_\_\_\_  
\* Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

## Policyholder information (\* if different than above)

Name of policyholder: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home phone: ( ) \_\_\_\_\_ Work phone: ( ) \_\_\_\_\_  
Cell phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

## 2. Insurance information

\* Insurance company: \_\_\_\_\_  
Type of policy:     Group                       Individual                       Unknown  
Policy #: \_\_\_\_\_ Claim #: \_\_\_\_\_  
Date of loss: \_\_\_\_/\_\_\_\_/\_\_\_\_                      \* Type of insurance:     Annuity     Business property  
 Dental     Disability     Health     Home/Condo/Renters     Personal auto/Motorcycle/RV/Business auto  
 Life     Long Term Care     Medical Supplement     Warranty/Service contract     Discount plan  
 Credit life/disability     Other: \_\_\_\_\_  
Agent/Adjuster name: \_\_\_\_\_  
Company name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone number: ( ) \_\_\_\_\_



## 5. How did you hear about us?

Example: friends, family, phone book, internet, etc: \_\_\_\_\_  
\_\_\_\_\_

## 6. Declaration

By filling in my name and date below, I declare the information contained on this form is true and accurate.

\* Name: \_\_\_\_\_ \*Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 7. \*Release of medical information

I authorize any insurance company, health care service contractor, health maintenance organization, or Multiple Employer Welfare Arrangement that has any record of, or knowledge about, the insured named on this form, to provide that information to the Washington State Office of the Insurance Commissioner. The information shared may be copies of any records or any other information. This includes any medical records and claim files. A photographic copy of this authorization is as valid as the original.

**Insured or representative signature:** \_\_\_\_\_

**Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Nature of representation** (parent, guardian, power of attorney, etc.): \_\_\_\_\_

To read our confidentiality statement go to <http://www.insurance.wa.gov/consumers/complaint-help.shtml>

## 8. Submit documents

Once you have completed this form, please mail or fax it and all (if any) supporting documents to:

Washington State Office of the Insurance Commissioner

P.O. Box 40256

Olympia, WA 98504-0256

Phone: 1-800-562-6900 or (360) 725-7080 Fax: (360) 586-2018

Questions?

Call our Insurance Consumer Hotline at

**1-800-562-6900**

