

INSTRUCTIONS:

DNS: To prevent delay, please be sure to complete both sides of this form in full. Please print clearly or type. Do not include your Social Security Number on this form or in any accompanying documents. Please note: If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Section 1: Your Information				
Salutation	Street Address			
🗌 Mr. 🔄 Mrs. 🗌 Ms. 📄 Dr. 📄 Miss 📄 Rev.				
Full Name or Organization/Agency	City	State	Zip Code	
5 5 Y				
If an Organization/Agency provide a Primary Contact Name	County	Daytime Phone		
	county	Dayano i none		
	Email Address			
May we contact you by email? If yes, we				
Are you or your spouse active military?			L No	
Section 2: Who is the Complaint Against?				
Individual/Business	Name of Individual/Representative you dealt with			
	nume of marrieda, representative y			
Street Address	City	State	Zip Code	
	City	Oldie		
County Douting Dhone				
County Daytime Phone	Email Address			
Section 3: Transaction/Incident Details				
3-A: Date of Transaction/Incident 3-B: If a Transaction, what was	s the Transaction for?			
	My family/household My farm	Non-Pr	ofit/Church	
3-C: Where did the Transaction/Incident occur? (check box where applicable)				
My home By Internet/Email				
At the location of the business	— •			
Away from the location of the business (work, convention, etc.)	By Social Media			
By Mail				
3-D: What was the very first contact between you and the Individual/Business?				
☐ I telephoned the individual/business ☐ I received information in the mail ☐ I responded to a printed advertisement ☐ I responded to a TV/radio ad ☐ I went to the location of the business ☐ Other, describe below:				
A person came to my home I received a phone call from the business				
□ I received information by email □ I responded to an offer on the internet				
3 E. How did you Pay?				
3-E: How did you Pay?		ofor		
Cash Credit Card/Pre-Pay Medicaid	☐ Pay-Pal	nsfer		
Cash Credit Card/Pre-Pay Medicaid Check Installment Loan Medicare	Private Insurance Other	nsfer		
Cash Credit Card/Pre-Pay Medicaid		isfer		
Cash Credit Card/Pre-Pay Medicaid Check Installment Loan Medicare 3-F: What, if any, is the Dollar amount associated with your loss?	Private Insurance Other	isfer		
Cash Credit Card/Pre-Pay Medicaid Check Installment Loan Medicare 3-F: What, if any, is the Dollar amount associated with your loss? Section 4 Actions Taken by Consumer	Private Insurance Other			
Cash Credit Card/Pre-Pay Medicaid Check Installment Loan Medicare 3-F: What, if any, is the Dollar amount associated with your loss? Section 4 Actions Taken by Consumer Yes No 4-A: Did you sign a written agreement or contract?	Private Insurance Other			
Cash Credit Card/Pre-Pay Medicaid Check Installment Loan Medicare 3-F: What, if any, is the Dollar amount associated with your loss? Section 4 Actions Taken by Consumer	Private Insurance Other Private Insurance Other If yes, please attach a copy of the do			

Section 4 Actions Taken by Consumer - <i>continued</i>		
Yes No 4-E: Have you complained to the Individual/Business?		
Yes No 4-F: Have you filed a complaint with any other agency? If yes, list other	er agency:	
Section 5 Transaction/Incident Details – <i>attach additional pages if necessary</i>		
Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statem check, correspondence etc). Please print clearly or type. Do Not Include your Social Security Number .	nent, invoice, contract or written agreement, advertisement, cancelled	
If you answered "Yes" to 4-E or 4-F above, please include those details also with your description of the Transaction/Incident.		
Section 6 How would you like your Complaint resolved?		
	Castion 9 Mail Completed Forms to	
Section 7 WHAT HAPPENS NEXT?	Section 8 Mail Completed Forms to:	
The Consumer Protection Division will send a copy of your complaint to the	Office of the Indiana Attorney General Consumer Protection Division	
respondent individual/business or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a	Government Center South, 5th Floor	
disciplinary action against the licensed professional. This office represents the State of	302 W. Washington Street	
Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may	Indianapolis, IN 46204 317-232-6330 (phone) • 317-233-4393 (fax)	
want to consider contacting a private attorney or your local small claims court.	www.IndianaConsumer.com	
Section 9 Consent and Verification		
Yes No The nature of the com	nplaint and the individual/business name	
Do you consent to disclosing the following information to the public? → ☐ Yes ☐ No Your name		
☐ Yes ☐ No Your phone number		
I affirm, under penalties for perjury, that the foregoing representations are true. I consent to th	ne Consumer Protection Division obtaining or releasing	
any information in furtherance of the disposition of this complaint. I consent to the release o	f information included in this complaint to other public	
agencies attempting to discover ongoing fraudulent patterns or practices and for the purpor		
include my Social Security Number in any information submitted to the Consumer Protection Division. If I do provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5(2).		