INDIANA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
311 West Washington Street
Indianapolis, Indiana 46204-2787
(317) 232-2395 or (800) 622-4461
FAX (317)234-2103

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address.

COMPLETE BOTH SIDES OF THIS FORM.
TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name: ______________________________

Your Address: ______________________________

____
City State Zip Code

County: ______________

Daytime Telephone Number :(_____) ________________

1. (A) Type of Insurance (Please Check One):

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life

☐ Health ☐ Medicare Supplement ☐ Business ☐ Other__________________

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy A though J ________________

2. My complaint is against:
   Name of Insurance Company ______________________________

3. What State was your policy issued/purchased in: ________________________

4. If an agent is involved, please give the agent's name and address.
   Name: ______________________________
   Address: ______________________________

5. Policy Number: ________________________________
   Claim Number (If known): ______________________________

6. Named Insured: ______________________________

7. If group insurance, please give the name of the employer.
   Name: ______________________________

8. If a loss or an accident is involved, please give the location and/or date of the loss:
   Date: ____/____/____

Location: ____

City State Zip Code

9. Briefly describe your problem. If more space is needed, please attach additional sheets.

I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records WILL NOT be public records at any time.

Date: ____/____/____ Signature: ____

 IF YOU HAVE ANY QUESTIONS, PLEASE CALL US AT 317/232-2395