



# STATE OF INDIANA

ERIC J. HOLCOMB, GOVERNOR

## Indiana Department of Insurance

Stephen W. Robertson, Commissioner  
311 W. Washington Street, Suite 103  
Indianapolis, Indiana 46204-2787  
Telephone: 317-232-2385  
Fax: 317-234-2103  
Website: [in.gov/idoi](http://in.gov/idoi)

Dear Complainant,

Pursuant to your recent request, the Indiana Department of Insurance (IDOI) is enclosing a **Complaint Form** for your use to submit a formal complaint against any insurance carrier. Please be specific as to dates, names and events when completing this form. Include the full name of the insurance company and/or the name and address of the third party administrator. Also, include copies of any pertinent documents that support your complaint along with a copy of the insurance card, if available. Do not include the originals of important documents, as all materials received remain with your case file and cannot be returned. Please take care to type the form or write neatly and legibly.

The Department handles many types of insurance-related issues, including coverage concerns, claims disputes and premium issues. For a list of other issues and how the Department can help, visit [in.gov/idoi/2547.htm#2](http://in.gov/idoi/2547.htm#2).

It is important for you to understand that the authority of the Indiana Department of Insurance is limited to reviewing complaints for violations of the insurance laws and policy terms and conditions. The Department does not have the authority to compel payment of, or to determine the monetary value of a claim.

After receipt of your Complaint Form, the Department will keep you informed of the status and disposition of this matter.

### Complaint Process

- Your complaint is processed within 72 hours of receipt by the Department.
- You will receive a confirmation letter from the Consumer Services Division at the IDOI acknowledging the receipt of your complaint. The confirmation letter will have a problem report number listed, along with the name of the Consumer Consultant handling your file.
  - Please refer to the problem report number listed in your letter for any further correspondence to the Consumer Services Division regarding your complaint.
- Your complaint, along with a letter from the Department, is mailed to the insurance company you are filing a complaint against. By Indiana law, the insurance company has 20 business days to respond in writing back to IDOI.
- After receipt of the insurance company's response, the IDOI will send you a copy of it along with the Department's response or recommendation.

**PLEASE NOTE:** If your complaint involves the Healthy Indiana Plan (HIP), please do NOT fill out the Indiana Department of Insurance Complaint Form. This Department does NOT handle any complaints involving HIP as it is a federally administered plan and the Department has no jurisdiction in the matter even if your HIP plan is administered by an insurance company. To file a complaint regarding HIP, contact: FSSA/Communications, Attn: Lana Schneider, 402 W. Washington Street, W461, Indianapolis, IN 46204

Sincerely,

Indiana Department of Insurance  
Consumer Services Division

ACCREDITED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

AGENCY SERVICES 317-232-2389    COMPANY COMPLIANCE 317-232-3495    CONSUMER SERVICES 317-232-2395/1-800-622-4461    FINANCIAL SERVICES 317-232-2390    MEDICAL MALPRACTICE 317-232-2402    COMPANY RECORDS 317-232-5692    STATE HEALTH INSURANCE PROGRAM 1-800-452-4800



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. **Please do not include any Social Security Numbers.**

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 : (\_\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

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

<input type="checkbox"/> Automobile	<input type="checkbox"/> Homeowners	<input type="checkbox"/> Fire	<input type="checkbox"/> Life	<input type="checkbox"/> ACA
<input type="checkbox"/> Health	<input type="checkbox"/> Medicare Supplement	<input type="checkbox"/> Business	<input type="checkbox"/> Other	<input type="checkbox"/> Navigator

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy  
 A through 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. If Navigator is involved, please give name. \_\_\_\_\_

6. Policy Number: \_\_\_\_\_  
 Claim Number (If known): \_\_\_\_\_

7. Named Insured: \_\_\_\_\_

8. If group insurance, please give the name of the employer.  
 Name: \_\_\_\_\_

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

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

Location: \_\_\_\_\_

City

State

Zip Code

10. Briefly describe your problem. If more space is needed, please attach additional sheets. **Please do not include Social Security Numbers.**

Multiple horizontal lines for writing the description of the problem.

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: \_\_\_\_\_