STATE OF INDIANA

MIKE BRAUN, GOVERNOR

Indiana Department of Insurance
Holly W. Lambert, Commissioner
311 W. Washington Street, Suite 103
Indianapolis, Indiana 46204-2787
Telephone: 317-232-3520
Fax: 317-232-5251
Website: in.gov/idoi

Dear Complainant:

Pursuant to your recent request, we are enclosing a Complaint Form you may use in submitting 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. The Complaint Form can be used to address these and other issues. For a list of other issues and how the Department can help, visit in.gov/idoi/2547.htm#2.

Please Note: If your complaint involves the Healthy Indiana Plan (HIP 2.0), please do NOT fill out the Indiana Department of Insurance Complaint Form. This Department does NOT handle any complaints involving HIP 2.0 as it is a federally administered plan and the Department has no jurisdiction in the matter even if your HIP 2.0 plan is administered by an insurance company.

To file a complaint regarding HIP 2.0, contact:

FSSA/Communications
Attn: Lana Schneider
402 W. Washington Street, W461
Indianapolis, IN 46204

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

The Department will keep you informed of the status and disposition of your complaint. The complaint process is as follows:

- Your complaint is processed within 72 hours of receipt.
- You will receive a confirmation letter from the Consumer Services Division acknowledging the receipt of your complaint. On the confirmation letter, your Problem Report number is listed along with the name of the Consumer Consultant assigned to your file. Please refer to this Problem Report number on any correspondence regarding your complaint.
- Your complaint and a letter from the Department is mailed to the insurance company. By Indiana law, the insurance company has 20 business days to respond in writing to the IDOI.
- After receipt of the response, the IDOI will send you a copy of the company's response and our response or recommendation.

Sincerely,

Indiana Department of Insurance
Consumer Services Division
Consumer Protection Unit

ACCREDITED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

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 AND PRINT CLEARLY.

Name:		
Address:		County:
City:	State:	Zip Code:
Phone #:		Email:

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

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life ☐ ACA

☐ Health ☐ Medicare ☐ Business ☐ Navigator ☐ Other_____

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.

Agent Name:

Address:		
City:	State:	Zip Code:

5. If Navigator was 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:

Employer Name:		
Address:		
City:	State:	Zip Code:

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.**

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.

Signature: _____ Date:____/____/____

Print Name: _____

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