Indiana Department of Insurance
Consumer Services Division

311 West Washington Street, Suite 300
Indianapolis, IN 46204
Phone: (317) 232-2395 or 800-622-4461
Fax: (317) 234-2103
www.in.gov/idoi

INSURANCE AGENT 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 dark ink.**

Name: _____

Address: _____ **Email:** _____

City: _____ **State**: _____ **Zip**: _____

Daytime Telephone (_____) _____ - _____ (Home, Work, Cell, Other)
Circle One

Alternate Telephone (_____) _____ - _____ (Home, Work, Cell, Other)
Circle One

1. **Type of Insurance (Please check one)**

☐ Automobile ☐ Business ☐ Medicare Supplement ☐ Health

☐ Homeowners ☐ Life ☐ Fire ☐ Other _____

2. **Insurance Agent your complaint is against:**

Name/Office: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

3. **Policy Number:** _____
4. **Claim Number:** _____
5. **Name of Insured:** _____
6. **Name of Employer, if group insured:** _____
7. **Date of loss:** (mm/dd/yyyy) _____
8. **Location of loss:**
   Address: _____
   City: _____ State: _____ Zip: _____
9. **Briefly describe your complaint. If more space is needed, please attach additional sheets.**

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

Date: (mm/dd/yyyy) _____ **Signature:** _____