

Insurance Complaint Form



Michigan law, including PA 218 of 1956 as amended, authorizes the review of consumer complaints involving insurance and similar products. Completion of this form is voluntary and helps us review your claim.



My Name _____

Address _____

City _____ State _____ Zip _____

Home phone number () _____ Work phone number () _____

Name of Insurance COMPANY this complaint is about ▶ May also be an HMO, health carrier or other company.

Name of AGENT or AGENCY this complaint is about ▶ May not apply to every complaint. Leave blank if this does not apply.

Name of INSURED person ▶ Who is covered by the policy or plan?

Date of service or date of loss ▶ Could be the date of a fire, accident or other loss, or the date you received medical treatment

Policy or claim number _____

Type of insurance product my complaint is about:

<input type="checkbox"/> Auto	<input type="checkbox"/> Home or property	<input type="checkbox"/> Health insurance
<input type="checkbox"/> Life	<input type="checkbox"/> Annuity	<input type="checkbox"/> Medicare Supplement
<input type="checkbox"/> Long-term care	<input type="checkbox"/> Disability income	<input type="checkbox"/> Blue Cross/Blue Shield
<input type="checkbox"/> Other: _____	<input type="checkbox"/> HMO	

▶ **Is this an employer or group plan?**
 Yes No *If Yes, enter employer name, group name or group number below:*

Have you hired an attorney to represent you in this matter? Yes No Have you filed a lawsuit in this matter? Yes No

Please list events in the order they happened. Attach additional pages if needed. If possible, please use letter size paper (8 1/2 x 11") for all attachments.

Details of my complaint: _____

Reviewing documents often helps us understand important details of your complaint.

Please attach copies of letters or other documents that will help us review your complaint. This might include your insurance card, bills, receipts, a policy declaration sheet, claim documents or other items that relate to your complaint.

Arranging your documents in the order events took place helps us gain a quicker understanding of your complaint.

▶ Always send copies. Never send original documents.

Please suggest a fair resolution: _____

Please mail your complaint to:

OFIS Consumer Services
PO Box 30220
Lansing MI 48909-7720
Or fax to: (517) 241-3991
Or Email to: ofis-ins-info@michigan.gov

I authorize the release of any information regarding this complaint to help the Office of Financial and Insurance Services with their review. A copy of this complaint and related documents may be sent to any company, agency or licensee involved in this matter.

Signature _____ Date signed _____

