

INSURANCE COMPLAINT FORM



State of Wisconsin
Office of the Commissioner of Insurance
125 South Webster Street
P.O. Box 7873
Madison, WI 53707-7873
oci.wi.gov

Complaint Phone Numbers (608) 266-0103 In Madison
1-800-236-8517 Statewide
Fax Number (608) 264-8115

The Office of the Commissioner of Insurance assists consumers with their insurance problems. In order for us to investigate your complaint, please complete this form as thoroughly as you can and return it to us at the address shown above. A copy of your complaint will be sent to the company or agent with a request to respond directly to you and to advise our office of the action taken. You should hear from the company or agent in about 25 days from the date you send us your complaint. When we receive the information from the company or agent, we will review the file to determine what action we can take. We will notify you of our determination. If our office is unable to obtain the resolution you desired, you may consider contacting a private attorney for advice. If your complaint involved a claim dispute, you may want to contact your county's small claims court.

TYPE OR PRINT CLEARLY WITH A BLACK PEN. COMPLETE BOTH SIDES OF THIS FORM.

1. Your Name _____ Street Address _____ City _____ State _____ Zip Code _____ Phone number where we can reach you between 8:00 - 4:30 p.m. _____	
2. Name of Insurance Company Involved _____ (Please provide the PRECISE NAME of the insurance company. Incorrect names will delay the handling of your complaint. The name of the company can be found on your insurance policy, usually on the first page.)	
3. I am filing this complaint as: <input type="checkbox"/> Insured <input type="checkbox"/> Agent <input type="checkbox"/> Third-Party <input type="checkbox"/> Provider <input type="checkbox"/> Other (specify) _____	
4. Type of Insurance <input type="checkbox"/> Auto <input type="checkbox"/> Individual Acc/Health <input type="checkbox"/> Business <input type="checkbox"/> Life/Annuity <input type="checkbox"/> Home <input type="checkbox"/> Group Acc/Health <input type="checkbox"/> Other (specify) _____	
5. Name of Insurance Agent Who Sold the Insurance (Not the same as 2., above)	
6. Name and Address of Insurance Agency, If Applicable (Not the same as 2., above)	
7. Name of Policyholder (if other than 1., above)	8. Policy or Certificate #
9. Date Policy or Certificate Was Sold	10. State in Which Policy or Certificate Was Sold
11. Claim or File #, If Applicable	12. Date Loss Occurred or Began, If Applicable

(OVER)

