STATE OF CONNECTICUT
INSURANCE DEPARTMENT

CONSUMER COMPLAINT FORM

I WISH TO FILE A COMPLAINT:

Name:						
Street:						
City:			State:		Zip Code:	
Phone:	Home:		Business:			
	Cell:		Fax:			
Email:						

1) IF COMPLAINT INVOLVES *YOUR* INSURANCE COVERAGE OR POLICY, COMPLETE THE FOLLOWING:

(a) Name of ***Your*** Insurance Company:				
Street:				
City:		State:		Zip Code:
(b) ***Your*** Agent/Broker:				
Agency:				
Other:				

Name of Insured: ***(If different than above)***				
Street:				
City:		State:		Zip Code:
*If you are **not** the insured, cite your relationship to insured:*				

2) PLEASE FURNISH US WITH THE FOLLOWING INFORMATION THAT IS PERTINENT TO YOUR COMPLAINT:

(a) Claim Number:		Date of Loss:	
If Claim, Date Submitted:		Amount of Claim:	
(b) Policy Number:			
Policy Cancellation Date:		Policy Expiration Date:	
(c) Date of Notice of Nonrenewal:			
(d) Effective Date of Coverage:			
(e) Premium(s) Paid:			

(OVER)

(860) 297-3900
Consumer Affairs Division
Mail To > P.O. Box 816 Hartford, CT 06142-0816 **< Mail To**
Email: cid.ca@ct.gov

STATE OF CONNECTICUT
INSURANCE DEPARTMENT

3) IF COMPLAINT INVOLVES *ANOTHER* PERSON, PLEASE COMPLETE THE FOLLOWING:

Name of Insured:					
Insured's Policy Number, if available:					
Insured's Claim Number, if available:					
Insured's Insurance Company:					
Street:					
City:		State:		Zip Code:	

4) EXPLAIN YOUR COMPLAINT FULLY IN THE ORDER OF EVENTS IN THE SPACE PROVIDED BELOW. PLEASE SIGN, DATE AND RETURN THIS FORM TO THIS DEPARTMENT WITH COPIES OF ANY AVAILABLE MATERIAL/DOCUMENTS PERTINENT TO AND IN SUPPORT OF YOUR COMPLAINT, I.E., REPAIR ESTIMATES, STATEMENTS OF VALUE OR BILLS, POLICE REPORT DESCRIBING ACCIDENT, PREMIUM RECEIPTS, BINDERS, CERTS OF INSURANCE, I.D. CARDS, CORRESPONDENCE YOU HAVE WRITTEN OR RECEIVED, MEDICAL BILLS, CONTRACTS, MEDICAL REPORTS, NOTICE OF DECLINATION, CANCELLATION, OR NONRENEWAL, ETC., OR ANY OTHER DOCUMENTATION CONCERNING YOUR COMPLAINT. IF YOUR COMPLAINT CONCERNS AN INSURANCE ADVERTISEMENT, ATTACH A COPY OF THE ADVERTISEMENT. PLEASE TYPE, PRINT, OR WRITE CLEARLY. USE ADDITIONAL SHEETS, IF NECESSARY:

PLEASE DO NOT SEND ORIGINALS

I HAVE ENCLOSED COPIES OF CORRESPONDENCE AND DOCUMENTS RELATING TO THIS MATTER WHICH WILL ASSIST YOUR INVESTIGATION OF THE COMPLAINT. I UNDERSTAND THAT COPIES OF THIS FORM AND ANY OF THE ENCLOSED DOCUMENTS WILL BE SENT TO ANY PERSON AND/OR FIRM DEEMED NECESSARY BY YOU TO COMPLETE YOUR INVESTIGATION AND TO ANY OTHER STATE OR FEDERAL AGENCY THAT MAY BE ABLE TO ASSIST YOU.

Signature of Complainant:		Date:	

(860) 297-3900
Consumer Affairs Division
Mail To > P.O. Box 816 Hartford, CT 06142-0816 **< Mail To**
Email: cid.ca@ct.gov