

## Ohio Department of Insurance

Ted Strickland – Governor  
 Mary Jo Hudson – Director



# Consumer Complaint

**Please note:** This complaint form, all documents you send us, and any document received by our office as a result of handling your complaint may be a public record, subject to Ohio's Public Records Act. This law requires all public records to be available for inspection by anyone, upon request. **WARNING: All documentation we receive will be imaged, then destroyed. Make copies of your documents and send the copies to us. Do not send original records.**

If completing this form by hand, please use black or blue ink. **DO NOT USE PENCIL.**

Name			
Address		County	
City	State	Zip	Phone
Insured's Name (if different)			
Name of Insurance Company			
Policy or ID Number (if your ID is your Social Security Number, give only the last four digits)			
Group or Employer Name			
Name and Address of Agent/Broker (if involved)			
<b>Type of Insurance</b> (check only one)			
<input type="checkbox"/> Auto	<input type="checkbox"/> Credit Life/Credit Disability	<input type="checkbox"/> Disability Income	<input type="checkbox"/> Home <input type="checkbox"/> Life <input type="checkbox"/> Annuity <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Other
<b>Small Business Owners:</b> Name of business			
If you are a small business employer, please check here <input type="checkbox"/>			
<b>Type of Problem</b> (check one or more):			
<input type="checkbox"/> Cancellation or non-renewal	<input type="checkbox"/> Cash surrender/cash value not received	<input type="checkbox"/> Claim dispute or delay	<input type="checkbox"/> Payment not credited
<input type="checkbox"/> Misrepresentation	<input type="checkbox"/> Claim denial	<input type="checkbox"/> Policy not received	<input type="checkbox"/> Open enrollment
<input type="checkbox"/> Other			
<b>If this is a health insurance complaint, please attach the most recent response you received from the company.</b>			
Health Insurance Claim #		Date of Service	
<b>If the problem is a claim dispute regarding auto, home, or other property Insurance:</b>			
Date and Location of Accident or Loss		Claim #	
<b>Briefly describe your complaint. Please attach copies of all relevant documents.</b>			
If you need more space, please attach additional sheets.			
<b>How would you like to see your complaint resolved?</b>			
<b>Please sign and date:</b> To the best of my knowledge the above statement is correct. I understand that a copy of this form and any attachments may be sent to the insurance company or agent involved. I authorize the insurance company to release all the medical records relating to this complaint to the Ohio Department of Insurance, and I authorize the Ohio Department of Insurance to release medical records relating to this complaint to the insurance company or agent as necessary in order to resolve this complaint. I represent that I have the proper authority to execute this release.			
Your Signature			Date