Print Form

INSURANCE DIVISION
STATE OF HAWAII
P.O. Box 3614
Honolulu, Hawaii 96811
Telephone (808) 586-2790

FOR INTERNAL USE ONLY

CMP NO _____
INVESTIGATOR _____
DISP: REF___ RO___ INQ___ RSL___
DATE CLOSED:_____

COMPLAINT/INQUIRY FORM

ASSISTANCE IS NEEDED CONCERNING: (check one) ☐ A Complaint ☐ An Inquiry

Your Name	Name of Insurance Company/Agency/Individual
Address	Address
City State Zip Code	City State Zip Code
Business Telephone Home Telephone	Telephone

Please indicate policy number and/or claim number, if known: _____

State the relief sought:

State a Summary of the Complaint/Inquiry:

ATTACH COPIES OF PERTINENT DOCUMENTS. **DO NOT SEND ORIGINALS.**

NOTICE: A copy of this form may be sent to the insurance company and/or individual involved.

Your Signature: _____ **Date:** _____