INDIANA DEPARTMENT OF INSURANCE
CONSUMER SERVICES DIVISION
311 West Washington Street
Indianapolis, Indiana 46204-2787
(317) 232-2395 or (800) 622-4461
FAX (317)234-2103

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address.
Please do not include any Social Security Numbers.

COMPLETE BOTH SIDES OF THIS FORM and PRINT CLEARLY.

Name:		
Address:		County:
City:	State:	Zip Code:
Phone #:	E-mail:	

1. (A) Type of Insurance (Please Check One):

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life ☐ ACA

☐ Health ☐ Medicare Supplement ☐ Business ☐ Navigator ☐ Other_____

1. (B) If your complaint is about a Medicare Supplement policy, please give type of policy:

A though J _____

2. My complaint is against:

Name of Insurance Company _____

3. What State was your policy issued/purchased in: _____

4. If an agent is involved, please give the agent's name and address:

Agent Name:		
Street Address:		
City:	State:	Zip Code:

5. If Navigator was involved, please give name: _____

6. Policy Number: _____

Claim Number (If known): _____

7. Named Insured: _____

8. If group insurance, please give the name of the employer:

Employer Name:		
Street Address:		
City:	State:	Zip Code:

9. If a loss or an accident is involved, please give the location and/or date of the loss: Date: ____/____/____

Location:		
City:	State:	Zip Code:

10. Briefly describe your problem. If more space is needed, please attach additional sheets. **Please do not include Social Security Numbers.**

I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records WILL NOT be public records at any time.

Signature: _____ Date: ____ ____ ____

Print Name: _____

IF YOU HAVE ANY QUESTIONS, PLEASE CALL US AT 317-232-2395