VERMONT

Department of Financial Regulation

Insurance Complaint Form

How the Vermont Insurance Division Handles your Complaint:

- We will write to the company and request a written response to your complaint
- Suggest actions or procedures that may resolve your insurance complaint.
- Review the complaint information and take action if there is non-compliance with applicable laws and regulations.
- Provide information about insurance and insurance laws.
- Verify that an insurance product is approved for use in Vermont.
- Explain the provisions of your insurance policy.
- Determine if the dispute qualifies for independent external review of medically-based health insurance denials of coverage.
- The length of the review process will depend on how complicated the issues are.

Limitations of the Complaint Process

- We review each complaint to ensure that insurance companies and their representatives are complying with Vermont Laws and Regulations.
- We are unable to act as your advocate or lawyer or give you legal advice.
- We are unable to decide legal disputes that must be decided by a court.
- Medically-based disputes should be decided by independent external review.
- The Department does not have the ability to force an insurer to satisfy you if no laws have been broken – even if you believe they have been unfair.
- Please note, the consumer complaint process is not an adjudicatory process and some disputes can only be settled by going to a court of law.

Return completed form to:
Consumer Services
Department of Financial Regulation
89 Main Street
Montpelier VT 05620-3101
Phone: (800) 964-1784 Fax: (802) 828-1446

We appreciate the opportunity to be of service to you.

Notice Regarding Confidentiality

The information you provide the Department in connection with your complaint is not available for public inspection under the Vermont Public Records Act. The Department will not provide the public with access to your complaint. While your complaint is not subject to disclosure as noted above, it is possible that a court of law would rule the information contained in your complaint is subject to disclosure in a civil or criminal matter.

Insurance Complaint Form

Please complete all sections of this form so that we can review your insurance problem. As part of our review we will send a copy of your complaint to the insurance company (and agent/broker if relevant) and ask for a response. We may need to obtain additional information. We will keep you updated and advise you of our findings.

Do you have an attorney handling this matter for you? ☐ *Yes* ☐ *No*
***If you answered yes, stop here**. We cannot accept this form without written approval from your attorney.*

Complainant's Name:	
Telephone number(s) [*where we can reach you during business hours or leave a message*]**:**	
Email Address:	
Street Address/P.O. Box:	
City:	**Zip Code:**

Name of Insurance Company		
Policy Number:	**Claim Number(s)**:	**Date(s) of Loss**
Date of Service(s):	**Type of Service(s):**	

Type of Coverage (check one):

☐ Auto ☐ Homeowners ☐ Commercial ☐ Life ☐ Annuity ☐ Other
☐ Comprehensive/Major Medical ☐ Disability ☐ Dental ☐ Long Term Care
☐ Other Health (such as limited benefit, accident, student): _____
☐ Medicare Supplement ☐ Medicare Part C or D

Is this a: ☐ Group Policy ☐ Individual Policy

If you also want to file the complaint against an insurance agent or broker, please complete the following information:

Agent/Broker Name:	**Telephone #:**
Address (include street, P.O. Box, City, State and Zip Code)	

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CONSENT TO RELEASE INFORMATION

I, _____, request and authorize my insurer(s) and any agent or broker named in this form and their contractors to disclose any and all information relevant to this complaint to the Vermont Department of Financial Regulation for investigation and follow-up related to my complaint. Relevant information may include medical records or other medical information, including records or information concerning treatment for mental health, alcohol or drug abuse, or sexually transmitted infections.

If this complaint is about Catamount Health and involves premium assistance, the Department has my permission to release and exchange information about my complaint with the Department of Vermont Health Access (DVHA).

The Department has my permission to exchange any information I provide to the Department with my insurer(s), agent/broker and their contractors if relevant, and any representative or other person I have named below.

My representative for purposes of this complaint is:

_____

I do not have a representative, but I want the Department to be able to discuss my complaint with (for example, family member or friend, health care provider, attorney, agent/broker, etc.).

Please identify:

_____

_____ _____

Signature of Insured **Date**

_____ _____

Signature of Parent or Guardian **Date**
(*or other person authorized to sign*)

You may revoke this consent at any time unless the Department or any person or entity named above has already taken action in reliance on it. If not revoked previously, this consent will terminate upon the Department's closure of this complaint or when the Department has completed any needed follow-up.

PLEASE DESCRIBE YOUR PROBLEM IN DETAIL. ATTACH ADDITIONAL PAGES, IF NECESSARY. PLEASE INCLUDE COPIES (DO NOT SEND ORIGINALS) OF ALL IMPORTANT PAPERS, LETTERS OR OTHER DOCUMENTATION RELEVANT TO THIS MATTER.
WHAT WOULD YOU CONSIDER TO BE A FAIR RESOLUTION OF YOUR PROBLEM?