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DIFP
Department of Insurance, Financial Institutions & Professional Registration

Consumer Complaint Report

MAIL TO
Missouri DIFP
PO Box 690
Jefferson City, MO 65102
800-726-7390
573-751-2640
TDD: 573-526-4536

My complaint is against (one or more): ☐ Insurance company ☐ Agent/producer ☐ Bail bond agent ☐ Public adjuster

Please complete all information and enclose copies of correspondence and other papers that will help us investigate your complaint. Sign and date on back side at bottom. **Note:** A copy of this form and any of the enclosed information will be sent to the party you are complaining about. Send form and attachments to the above address.

PLEASE PRINT, TYPE OR WRITE CLEARLY IN BLACK OR BLUE INK

1 COMPLAINANT INFO

☐ Mr. ☐ Ms.

LAST NAME _____ FIRST _____ MI _____

ADDRESS _____ STREET

_____ CITY _____ STATE _____ ZIP CODE

_____ COUNTY _____ EMAIL

PHONE ( ) _____ HOME ( ) _____ CELL ( ) _____ WORK

RELATIONSHIP TO INSURED _____

2 INSURED INFO (Person with insurance problem)

AGE ☐ 1-24 ☐ 25-49 ☐ 50-64 ☐ 65+

LAST NAME _____ FIRST _____

ADDRESS Leave blank if same as claimant _____ STREET

_____ CITY _____ STATE _____ ZIP CODE

EMPLOYER NAME (if group health policy) _____

POLICY-HOLDER NAME _____

3 INFO ON COMPANY/PERSON THAT COMPLAINT IS ABOUT

_____ NAME OF COMPANY OR INDIVIDUAL YOU ARE COMPLAINING ABOUT

ADDRESS If known _____ STREET

_____ CITY _____ STATE _____ ZIP CODE

4 POLICY INFORMATION

_____ GROUP **or** POLICY NUMBER _____ ISSUE DATE

_____ ID **or** CERTIFICATE NUMBER _____ ISSUE DATE

_____ CLAIM NUMBER _____ DATE OF LOSS

_____ AGENT NAME, if applicable

5 TYPE OF POLICY (Check one)

☐ Homeowners
☐ Renters
☐ Mobile homeowners
☐ Private auto
☐ Commercial auto
☐ Individual health
☐ Group health
☐ Individual life
☐ Group life
☐ Workers' comp
☐ Disability
☐ Long-term care
☐ Annuity
☐ Bond
☐ Title
☐ Warranty
☐ Medigap (Med Supplement) Specify plan A-L _____
☐ Commercial/Business
☐ Other _____

6 REASON FOR COMPLAINT (Check one)

☐ Claim problem ☐ Nonrenew/ Cancellation ☐ Sales problem ☐ Premium problem ☐ Policy problem ☐ Other

7 DETAILS OF COMPLAINT (Attach separate sheet if needed)

7 SIGNATURE

I declare the information I have provided is true and accurate. I hereby authorize the insurer or persons or entities complained against to release all claim and policy information and documents, including medical records, to the Missouri Department of Insurance on request.

Signature of complainant _____ DATE _____