



## Minnesota Insurance Division Consumer Complaint Form

Thank you for contacting the MN Department of Commerce Consumer Protection and Education Division. Please provide the information requested below and allow sufficient time for us to complete our inquiry. A copy of this form and any or all information you provide may be sent to the party complained against.

### 1. Complainant

Your name: \_\_\_\_\_

Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Email address: \_\_\_\_\_

### 2. Insured

Name (if same, write "same"): \_\_\_\_\_

Relationship to the insured: \_\_\_\_\_

### 3. Who is the complaint against?

Name of company/agent/broker: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Name of company/agent/broker: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Name of company/agent/broker: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

### 4. Type of insurance involved (pick one)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Individual life   | <input type="checkbox"/> Group health         | <input type="checkbox"/> Medicare Supplement |
| <input type="checkbox"/> Individual health | <input type="checkbox"/> Long term care       | <input type="checkbox"/> Other               |
| <input type="checkbox"/> Group life        | <input type="checkbox"/> Workers compensation |  |

## 5. Policy information

Policy number: \_\_\_\_\_

Group of certificate number: \_\_\_\_\_

Name of employer/association (if group insurance): \_\_\_\_\_

Effective date: \_\_\_\_\_

## 6. Claim information

Claim number: \_\_\_\_\_

Date of loss/treatment \_\_\_\_\_

## 7. Reason for complaint (check one or more)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Claim denial        | <input type="checkbox"/> Premium/ rating problem                          | <input type="checkbox"/> Other (specify) |
| <input type="checkbox"/> Claim dispute/delay | <input type="checkbox"/> Cancellation/ non-renewal                        |  |
| <input type="checkbox"/> Sales/service       | <input type="checkbox"/> Medical necessity/ usual and customary reduction |  |

**Details of my complaint:** Attach additional sheets if necessary. *(Please attach copies of all relevant documents including most recent correspondence from the company)*

I hereby affirm that the foregoing statements and photocopies of all attached documents are true and correct

Date \_\_\_\_\_ Signature of Complainant \_\_\_\_\_

Mail written complaints to:

Minnesota Department of Commerce  
Attn: Consumer Protection & Education Division  
85 7th Place East, Suite 280, St. Paul, MN 55101