

IDAHO DEPARTMENT OF INSURANCE

Consumer Affairs Section
700 West State Street
Boise, ID 83720-0043

Telephone: (208)334-4250
Fax: (208)334-4398

CONSUMER COMPLAINT REPORT

The following information is needed to act on your report. Please complete this form where applicable and return it to us at the address shown above. Attach copies of important papers or letters if they relate to your request. You may complete our online complaint form at www.doi.idaho.gov.

Please print or type.

1. Your name: _____

Mailing address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: () _____ E-mail address: _____

2. Name of insurance company involved: _____

3. (a) Name of policyholder if different from your name: _____

(b) If a group policy, provide the group name: _____

4. Policy identification or certificate number: _____

5. Claim number (if applicable): _____

6. Date loss occurred or began (if applicable): _____

7. Agent/broker (if applicable): _____

Street address: _____

City: _____ State: _____ Zip: _____

8. Have you previously written to the Department of Insurance about this matter?

Yes _____ No _____ If yes, please give:

(1) File number: _____ (2) Date written: _____
(if available)

(COMPLETE REVERSE SIDE)

9. Have you reported this to other governmental agencies? Yes _____ No _____

If yes, please state name of agency and give file number, if known: _____

10. Do you have an attorney representing you? Yes _____ No _____

11. Is there a court action pending? Yes _____ No _____

12. Reason for referral (use additional pages if necessary): _____

13. Additional parties involved: _____

14. Comments: _____

15. What do you consider to be a fair resolution to your problem? _____

(Signature)

(Date)