

Kentucky Department of Insurance Consumer Protection Division 500 Mero Street, 2 SE 11, Frankfort, KY 40601 Phone: 502-564-6034 & Fax: 502-564-6090 Email: DOI.ConsumerComplaints@ky.gov

Consumer Complaint Form

A con	nplaint	MUST be	e submitted	in writing	or elect	ronically	. Once com	plete,	please r	<u>eturn</u>
by m	ail, fax,	, or emai	I. (*Requir	ed informa	ation)				-	

*<u>Section 1: Your Information (Policyholder/Insured)</u>

First Name:	_Middle:		_Last:							
Address:		City, ST ZIP:								
Phone ()	_ Email:									
Signature: (If filing on your own behalf)			_ Date:							
Are you represented by an attorn	ney?	□Yes □No								
Is this situation currently in litiga	ation?	□Yes □No								
Person completing form on behalf of Policyholder/Insured										
First Name:	_Middle:		_Last:							
Address:		City, ST ZIP:								
Phone ()	_ Email:									
Signature:			_ Date:							
Section 2: Insurance Company Information (Submit a copy of Health Insurance Card for Health Complaint) *Type of Insurance Involved: □Auto □Homeowners □Life □Health □Other: *Insurance Company Name:*Claim Number: Agent/Adjuster Name (if Applicable):										
Agent/Adjuster Address:										
		Con	tinue to Next Page $ ightarrow$							

Third-Party Authorization

If the person you are filing this complaint on behalf of is <u>over 18</u>, please have them sign below:

"I,____ hereby designate (Insured) (Authorized Representative) as my authorized representative for the purposes of filing and investigating my complaint. I authorize the Consumer Protection Division of the Kentucky Department of Insurance to investigate the complaint received on my behalf and to respond directly to my representative. I understand and acknowledge that by designating the individual named above as my authorized representative, the individual may obtain, on my behalf, any and all documents and information which may become known as a result of the investigation, some of which might otherwise be considered confidential. Information released to the third party may include but is not limited to the following: Social Security numbers, personal contact information, financial information, nonpublic personal health information, medical records and any documentation included as part of the Consumer Protection investigation. Additionally, I understand and acknowledge that this third party authorization does not constitute a power of attorney and does not allow negotiation with anyone other than the actual claimant. By signing this authorization, I hereby release the Department of Insurance from any liability that might accrue from disclosing information that might be deemed confidential."

Print Name:_____

Signature:

Date:

*<u>If this person is unable to sign, please provide a copy of Power of Attorney or</u> <u>Guardianship documents.</u>

Please use the space below to provide a detailed description of the problem, from your point of view. Attach additional sheets if needed.