DCI Consumer Complaint Report

Missouri Department of Commerce & Insurance

MAIL TO
Missouri DCI
PO Box 690
Jefferson City, MO 65102
800-726-7390 / 573-751-2640
Fax 573-526-4898
RelayMO TTY Dial 711 or
1-800-735-2966

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

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

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 _____

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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)

8 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 Commerce & Insurance on request.

Signature of complainant _____ DATE _____