Louisiana Department of Insurance

P.O. Box 94214, Baton Rouge, LA 70804-9214

Statewide, call toll free, 1-80-259-5300, Outside Louisiana, call (225) 342-5900

PLEASE TYPE OR PRINT CLEARLY

Section I

Your Name: _____ Daytime Telephone:

Address: _____ Home: ( ) _____

City: _____ State: _____ Zip Code: _____ Work: ( ) _____

Insured: _____

Claimant: _____
If same, indicate "same"

Social Security # _____

Age Group: _____Under 25 _____25-49 _____50-64 _____65+

Section II

1. What type of coverage does this involve?

(A) Auto _____ Fire/Homeowners _____ Workmen's Compensations _____

Life _____ Health _____ Medicare Supplement _____

Other: _____

(B) If involving group insurance, please provide the name of employer

_____

2. Who is the complain against? (FULL and EXACT name of the company, broker and/or agent):

_____

Address (if known)_____

_____

3. (A) Policy Number _____

(B) Group Number _____

(C) Claim Number _____

4. If your complaint is against another person's insurance company, that person's name and policy number

_____

5. Date of Loss _____

Section III

1. Do you have an attorney representing you? Yes_____ No_____

2. Is there any court action pending? Yes_____ No_____

3. Have you previously reported this problem to our Office or any other Agency?

Yes_____ No_____

If yes, to whom? _____

4. Please check the reasons that apply to your complaint.

_____Claim Denial _____Claim Delay _____Unfair Offer/Payment

_____Premium Problem _____Premium Refund _____Agent Handling

Other:_____

5. Describe your problem in your own words. If more space is needed, please use extra sheets. Enclose copies (**NOT ORIGINALS**) of available documentation relative to your complaint.

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

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Please read and sign the following statement:

To the best of my knowledge, the information contained herein is true and accurate. I understand that a copy of This form and any or all of the information attached may be sent to the party complained against.

_____(Signature) _____(Date)

Life, health or injury claimants, please complete the following:

I hereby authorize the release of medical information concerning this matter to the Louisiana Department of Insurance. It is understood that this information is for evaluation purposes relative to my complaint.

_____(Signature) _____(Date)