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

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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?

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)