COMPLAINT QUESTIONNAIRE

NORTH DAKOTA STATE INSURANCE DEPARTMENT

SFN 18956 (12-2006)

☐ **COMPANY L/H**
☐ **COMPANY P/C**

Issue No.:
Sent By:
Date

Name of Insured		Home Telephone Number	Work Telephone Number	
Address	City		State	Zip Code

If you are filing this complaint on behalf of insured, please list your name and address and, if possible, have insured sign the bottom of complaint form.

Name of Complainant		Home Telephone Number	Work Telephone Number	
Address	City		State	Zip Code

Is this the only complaint you have filed with this Department regarding this matter? ☐ Yes ☐ No

Name of Insurance Company(ies) Involved			
Name of Agent(s) Involved			
Address	City	State	Zip Code
Policy Number(s)		Date of Loss/Confinement	
Name of Adjusting Company			
Address	City	State	Zip Code
Name of Adjuster		Telephone Number	
Amount Claimed $	Amount Offered $		
Assistance Requested From Department (i.e., payment of claim, refund, etc.)			

Please use the space below or attach additional pages to give a detailed summary of your complaint. Please enclose with complaint a copy of your insurance policy and a copy of all correspondence between you and the insurance company and/or agent.

If complaint involves a health or an injury claim, please complete the following: I authorize the above listed insurance company to release medical information in their possession to the North Dakota Insurance Department pertaining to _____, who is insured under Policy No. _____. I expressly release the above named insurance company from any and all liability in connection with the release of this medical information. 45 CFR 164.512 allows the release of the information to the Department. I understand that the release of the above information is for investigative purposes only. I further understand that the facts relating to this complaint, except for personal non-public financial information, will become a matter of public record, and I agree to the release of such information if requested by a member of the public.

Signature of Insured/Complainant **X**			
On Behalf Of (If applicable)		Telephone Number	
Address	City	State	Zip Code

BEFORE COMPLETING THIS COMPLAINT QUESTIONNAIRE, MAKE SURE YOU HAVE DONE ALL OF THE FOLLOWING:

TO CANCEL A POLICY
Complete the complaint form only if the company or agency has refused to cancel. Include a copy of the denial letter you received from the company or agent.

NEVER RECEIVED YOUR POLICY
Complete the complaint form after you have notified the agent or company (in writing) and received no response within 4-6 weeks.

CLAIMS
1. Have you contacted your agent for help?

2. Have you sent the insurance company the information they requested?

3. Have you asked the company to explain the reason for not paying your claim?

IF YOU HAVE AN HMO CONTRACT, HAVE YOU FOLLOWED THE INSTRUCTIONS OUTLINED IN THE GRIEVANCE PROCEDURES SECTION OF THE CONTRACT?

IF YOU HAVE A BLUE CROSS BLUE SHIELD CONTRACT, HAVE YOU ASKED TO HAVE YOUR CLAIM REVIEWED BY THE MEDICAL REVIEW BOARD?

If you have done all of the above and still feel the company is not treating you fairly, please fill out the Complaint Questionnaire. Provide as much detail as possible, and include the following with the Questionnaire:

1. A copy of your insurance policy, if available (except for Blue Cross Blue Shield).

2. A copy of the denial letter you received from the insurance company.

3. Any letters you received from the insurance company or agent related to this complaint.

THE MORE INFORMATION YOU PROVIDE, THE FASTER WE CAN PROCESS YOUR COMPLAINT. BE ASSURED WE WILL DO EVERYTHING IN OUR STATUTORY POWERS TO RESOLVE YOUR COMPLAINT IN A FAVORABLE MANNER.

RETURN FORM TO:

North Dakota Insurance Department
600 East Boulevard Avenue
Bismarck, ND 58505-0320