



COMPLAINT QUESTIONNAIRE - AGENT
 NORTH DAKOTA STATE INSURANCE DEPARTMENT
 SFN 19050 (12-2006)

Issue No.:
Sent By:

600 East Boulevard Avenue
 Bismarck, ND 58505-0320

Name of Insured		Daytime Telephone Number	Other Telephone Number	
Address		City	State	Zip Code

Date

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		Daytime Telephone Number	Other 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		
Agent's Address (if known)	City	State Zip Code
Policy Number(s)		
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 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
X
On Behalf Of (If applicable)