



P.O. BOX 79 JACKSON, MS 39205-0079 Phone: 601-359-2453 or 1-800-562-2957 • FAX: 601-359-1077 www.mid.ms.gov

CONSUMER COMPLAINT FORM (Company Complaint)

Documents that you submit to the Mississippi Department of Insurance to assist us in examining your complaint may be subject to the Mississippi Public Records Act of 1983. ALL SPACES APPLICABLE MUST BE COMPLETED. Before you file a complaint with the Department of Insurance, you should first contact the insurance company, agent or broker in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, attach copies (no originals) of any important papers that relate to your complaint and mail or fax to the address / number shown above.

- INSTRUCTIONS FOR COMPLETION OF FORM:
• Fill in the information below that is applicable to your complaint.
• TYPE OR PRINT IN BLUE/BLACK INK AND WRITE CLEARLY. SIGN AND DATE FORM.
• Please allow (20) working days for the insurance company or agency to respond to your request.
• WE WILL NOTIFY YOU IN WRITING OF OUR FINDINGS.

Complainant

Your Name: Relationship to insured: (if applicable) Mailing Address: City: County: State: Zip Code: Daytime Telephone Number: E-mail Address:

Insured

Your Name (if same, write "same"): Mailing Address: City: County: State: Zip Code: Daytime Telephone Number: E-mail Address:

Insurance Company Information

Complete Name of insurance company, agent or agency complaint is against: Address (if known):

Type of Coverage

Auto Homeowners Commercial Liability Life Health Disability Income Dental Long Term Care Annuity Medicare Supplement Other (List):

Have you previously written to the Mississippi Dept. of Insurance about this matter? Yes No If yes, give name complaint was filed: Dept. File Number:

Policy Information:

Policy Number: Claim Number: Date of Loss:

Reason for Complaint

Claim Delay Claim Denial Premium Increase Cancellation Non-Renewal Unsatisfactory Settlement Premium Refund Other:

ONLY COMPLETE THIS SECTION IF THIS A MEDICARE SUPPLEMENT COMPLAINT

Indicate Plan Type (A-N): _____ Your Age: _____

Details of Complaint:
(Use additional paper, if needed)

Signature: _____ **Date:** _____