



The Office of the Commissioner of Insurance (OCI) assists consumers with their insurance problems. In order for us to investigate your complaint, please complete this form as thoroughly as you can. Mailing details are available on the last page of this form. A copy of your complaint will be sent to the company or agent with a request to respond directly to you and to advise our office of the action taken. You should hear from the company or agent in about 25 days from the date you send us your complaint. When we receive the information from the company or agent, we will review the file to determine what action we can take. We will notify you of our determination. If our office is unable to obtain the resolution you desired, you may consider contacting a private attorney for advice. If your complaint involved a claim dispute, you may want to contact your county's small claims court.

**TYPE OR PRINT CLEARLY WITH A BLACK PEN. COMPLETE BOTH SIDES OF THIS FORM.**

<p>1. Your Name _____</p> <p>Mailing Address _____</p> <p>City _____ State _____ Zip Code _____</p> <p>Email Address _____ (initial correspondence from OCI will be sent via email)</p> <p>Phone number where we can reach you between 8 a.m.- 4:30 p.m. _____</p>	
<p>2. Name of Insurance Company Involved _____</p> <p><b>(Please provide the PRECISE NAME of the insurance company. Incorrect names will delay the handling of your complaint. The name of the company can be found on your insurance policy, usually on the first page.)</b></p>	
<p>3. I am filing this complaint as:</p> <p><input type="checkbox"/> Insured                      <input type="checkbox"/> Agent                      <input type="checkbox"/> Third-Party</p> <p><input type="checkbox"/> Provider                      <input type="checkbox"/> Other (specify) _____</p>	
<p>4. Type of Insurance</p> <p><input type="checkbox"/> Auto                      <input type="checkbox"/> Individual Acc/Health                      <input type="checkbox"/> Business                      <input type="checkbox"/> Annuity                      <input type="checkbox"/> Worker's Compensation</p> <p><input type="checkbox"/> Home                      <input type="checkbox"/> Group Acc/Health                      <input type="checkbox"/> Life                      <input type="checkbox"/> Other (specify) _____</p>	
<p>5. Name of Insurance Agent and/or Agency Who Sold the Insurance and Their Address <b>(Not the same as 2., above)</b></p> <p>Agent Name _____ Agency Name _____</p> <p>Address _____</p>	
<p>6. Name and Address of Public Adjuster/Public Adjusting Firm <b>(Not the same as 2., above and not the insurer's adjuster)</b></p> <p>Public Adjuster Name _____ Public Adjusting Firm _____</p> <p>Address _____</p>	
<p>7. Name of Policyholder (if other than 1., above)</p>	<p>8. Policy or Certificate #</p>
<p>9. Date Policy or Certificate Was Sold</p>	<p>10. State in Which Policy or Certificate Was Sold</p>
<p>11. Claim or File #, If Applicable</p>	<p>12. Date Loss Occurred or Began, If Applicable</p>



14. Please indicate how you think your problem should be resolved.

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15. Have you previously reported this problem to us or any other governmental agency?

Yes

No

If yes, state which agency and what action was taken?

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### Consent to Release Information

The information I have given above is true and accurate to the best of my knowledge and belief. This information may be forwarded to the insurance company and/or agent involved. Any medical information which I have provided, may be shared with the insurance company, if necessary, for the investigation of this matter. I understand that under Wisconsin's Open Records Law all information which is in my file, including personal and health information, may become a public record once my file is closed. Only actual medical records which are obtained from a health care provider are confidential under s. 146.82, Wis. Stat.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Submission Details

If you would like to email, fax, or mail the form instead of submitting it online, please use the contact information below. If you have questions or problems, call us toll-free at 1-800-236-8517 (within Wisconsin) or 1-608-266-0103 (outside of Wisconsin) or send an e-mail to us at [ocicomplaints@wisconsin.gov](mailto:ocicomplaints@wisconsin.gov).

Email: [ocicomplaints@wisconsin.gov](mailto:ocicomplaints@wisconsin.gov)

Fax: (608) 264-8115

Mail:  
*Office of the Commissioner of Insurance*  
*P.O. Box 7873*  
*Madison, WI 53707-7873*

If you are sending your complaint by FedEx, UPS, Overnight Mail, etc., please use our physical address:  
*Office of the Commissioner of Insurance*  
*101 E. Wilson Street*  
*Madison, WI 53703-3474*

*Pursuant to s. 601.72, Wis. Stats. Personal information you provide may be used for purposes other than that for which it was originally collected (s. 15.04(1)(m), Wis. Stats.)*