



CONSUMER COMPLAINT FORM

OCI assists consumers with their insurance problems. Please complete this form as thoroughly as you can. Your complaint will be sent to the company and/or agent for a response. The company and/or agent may contact you directly regarding your complaint. We will review the company and/or agent response and notify you of our determination.

TYPE OR PRINT CLEARLY WITH A BLACK PEN. COMPLETE ALL REQUIRED INFORMATION.

Date:* _____

Complainant's Information

Are you the insured? Yes No

What is your relationship with the insured?

Beneficiary Child Claimant (other party's insurer) Healthcare Provider
 Legal Representative Parent Relative Spouse State or Federal Agency
 Self Other: _____

Are you currently represented by an attorney for this matter? Yes No

First Name: * _____ Middle Name: _____ Last Name: * _____

Address Line 1: * _____

Address Line 2: _____

City:* _____ State:* _____ Zip Code:* _____

County: _____

Country:* United States Other: _____ International Zip: _____

Email Address: _____

Phone Number:* _____ Extension: _____

Alternate Phone Number: _____ Extension: _____

How do you prefer to be contacted? : Email Phone U.S. Mail

Information collection continued on next page

Insured's Information (if different than above)

First Name: _____ Middle Name: _____ Last Name: _____

Other Parties involved in this problem

First Name: _____ Middle Name: _____ Last Name: _____

Description: _____

First Name: _____ Middle Name: _____ Last Name: _____

Description: _____

First Name: _____ Middle Name: _____ Last Name: _____

Description: _____

First Name: _____ Middle Name: _____ Last Name: _____

Description: _____

Insurance Information

* Who is the complaint against? Provide the name of one or more of the parties you are complaining against.

a. Name of Insurance Company: _____

b. Name of Insurance Agency: _____

c. Name of Agent, Adjuster, Appraiser:

First Name: _____ Last Name: _____

In what state did you purchase this plan?: _____

How was the Policy Purchased?: Agent Company Employer Market Place/ Exchange
 Navigator Other Website or phone solicitor

Are you presently in litigation? Yes No

Have you litigated your claim? Yes No

If you answered "Yes" what was the court's decision?: (please limit response to 4000 characters)

Policy Number: _____ Certificate Number: _____ Claim Number: _____

Date of Loss/Service: _____ Date of Purchase: _____ Date of Cancellation: _____

Insured Age Group: <25 25 to 49 50 to 65 65+ Unknown

Amount in Dispute: _____

Type of Insurance:*

Commercial Auto	Crop / Hail	Dental	Disability	Farm / Ranch Owner
Fire	Group Health	Group Life	Homeowners	Individual Health
Individual Life	Long Term Care	Medicare Part D	Medicare Supplement	
Mobile Homeowner	Private Auto	Renters	Workers Compensation	

Other: _____

Reason for Complaint:*

Agent Handling	Cancellation	Claim Delay	Claim Denial	Delays / No Response
Information Requested	Misrepresentation	Non-Renewal	Premium & Rating	Premium Notice / Billing
Premium Refund	Unsatisfactory Settlement/ Offer		Other: _____	

Details and Supporting Documents

Details Of Complaint: * (Please try to limit your response to 4000 characters)

What do you consider to be a fair resolution?: * (Please try to limit your response to 4000 characters)

Note: After completion, please attach form and other supporting documents and email to ocicomplaints@wisconsin.gov

Authorization

The information I have given is true and accurate to the best of my knowledge. This information may be forwarded to the insurance company, if necessary, for the investigation of this matter. The Wisconsin Office of the Commissioner of Insurance has my permission to exchange any information I provide to the Wisconsin Office of the Commissioner of Insurance with my insurer(s), agent/broker and their contractors if relevant, and any representative or other person I have named in this complaint.

Authorization* Yes No

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 (outside of Wisconsin) or 1-608-266-0103 (within Wisconsin) or send an e-mail to us at ocicomplaints@wisconsin.gov.

Email: ocicomplaints@wisconsin.gov

Fax: (608) 264-8115

Complaint Phone Numbers	(608) 266-0103	(Wisconsin)
	(800) 236-8517	(Outside of Wisconsin)
	(608) 264-8115	(Fax)