



WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER

Property & Casualty Complaint Form

Please be advised that any materials, medical records, or documents that you provide at any time in connection with your complaint will be shared with the insurance companies, adjusters or agents against whom your complaint is filed, and their counsel. These documents may also be distributed to other parties engaged in your contested case or other matters pending before the Insurance Commissioner, including but not limited to hearing examiners, Office of Consumer Advocate, Board of Review, Third Party Administrator staff and other appropriate employees of this agency. Documents other than those that are exempt under the West Virginia Freedom of Information Act may also be released if we receive a request for the records under that Act. By signing the complaint below, you are specifically authorizing the Offices of the Insurance Commissioner of West Virginia to disseminate or distribute to any party or entity described above any private information that you have filed at any time with the Consumer Services Division that relates to your complaint. You further authorize such other distribution of this information as the laws of the United States and the State of West Virginia permit or require.

Contact information

Name: _____ Company name (if applicable): _____
Address: _____ County: _____
City: _____ State: _____ Zip Code: _____
Preferred Phone #: _____ Email Address: _____

Insurance information

Claimant's name (if other than yourself): _____ Date of Injury or Loss: ____ / ____ / ____
Insured Name (if other than yourself): _____ Other Entities/individuals involved: _____
Insurance Company/Agent Name: _____
Type of Coverage: Auto Homeowners Worker's Comp Other: _____
Policy #: _____ Claim #: _____

Reason for complaint / Relief requested

Please describe the facts and circumstances which form the basis of your complaint and include specific policy language and or statute / rule provision in question if known. Please attach copies of any relevant correspondence, policy provisions, etc. You may attach additional pages if necessary: _____

A complaint filed on behalf of a corporation must be signed by an officer of the corporation. For the Division to take action on your complaint, you must sign and date this form indicating your agreement to the following:

I hereby authorize the insurance company, or their representative, to provide to the West Virginia Offices of the Insurance Commissioner documents, claim-related data, or other information necessary for consideration of this complaint, including but not limited to medical records, billing information and/or private or personal information requested.

Signature: _____ **Date:** ____ / ____ / ____

Please complete, sign, date, and return the original form with any attachments to:

**Consumer Services Division WV Offices of
the Insurance Commissioner**
Post Office Box 50540
Charleston, West Virginia 25305-0540

Phone: (304) 558-3386
OICConsumerServices@wv.gov
Fax: (304) 558-4965
Internet: www.wvinsurance.gov

**FOR ASSISTANCE WITH COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT
1-888-TRY-WVIC (1-888-879-9842)**