WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
Life and Health Consumer Complaint/Inquiry 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 the 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, Office of Judges, Board of Review, Third Party Administrator staff, the Consumer Advocate, hearing examiners, 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 the 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: _____ Business Name (if applicable): _____

Preferred Telephone #: _____ ☐ Home ☐ Cell ☐ Work

Address: _____

City: _____ State: _____ Zip Code: _____

County: _____ Email Address: _____

INSURANCE INFORMATION

Claimant Name (if other than yourself): _____ Date of Service/Loss: _____

Relation to Claimant (spouse child, parent, other): _____

Policyholder Name (if other than yourself): _____

Insurance Company/Agent Name: _____

Pharmacy Benefit Manager (if applicable): _____

Type of Insurance: ☐ Health ☐ Dental ☐ Vision ☐ Long-Term Care ☐ Medicare Supplement
☐ Disability ☐ Life ☐ Annuity ☐ Other: _____

If you checked Health or Dental above, did you purchase coverage through the Health Insurance Exchange/Marketplace? ☐ Yes ☐ No ☐ I don't know

Policy #: _____ Member ID#: _____ Claim #: _____

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Concerning the reason for your complaint/inquiry, please provide the following information: the statutory/rule provision violated (if known) the facts and circumstances which form the basis of your complaint, the name of any individual or other entity involved, and any references to specific policy language that are relevant to the complaint. 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 request.

Signature: _____ Date: _____

If you need assistance completing this form, please call our office; otherwise, please complete, sign, date, and return the original form with any attachments to:

Life and Health Division
WV Offices of the Insurance Commissioner
Post Office Box 50540
Charleston, WV 25305-0540

Telephone: (304) 558-3386
Toll-free in WV: 1-888-TRY-WVIC
Fax: (304) 558-4965
www.wvinsurance.gov