



**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	Date of Birth: _____
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 #:	_____

## WVOIC Life and Health Consumer Complaint/Inquiry Form

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](http://www.wvinsurance.gov)