WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER File # _____
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, Office of Judges, 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.

NAME: _____ **COMPANY NAME (**if applicable**):** _____

ADDRESS: _____

_____ **COUNTY:** _____

TELEPHONE #: _____ **EMAIL ADDRESS:** _____

CLAIMANT'S NAME (if other than yourself**):** _____ **DATE OF LOSS / INJURY:** _____

INSURED NAME (if other than yourself**):** _____

INSURANCE COMPANY / AGENT NAME: _____

PHARMACY BENEFIT MANAGER (if applicable)**:** _____

OTHER ENTITIES / INDIVIDUALS INVOLVED: _____

TYPE OF COVERAGE (example: Auto, Homeowners, Workers' Compensation, Life, Health**):** _____

POLICY #: _____ **MEMBER ID #:** _____ **CLAIM #:** _____

SPECIFIC STATUTE / RULE IN QUESTION (if known**):** _____

SPECIFIC POLICY LANGUAGE IN QUESTION (if known**):** _____

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.

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_____

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
Toll-free in WV: 1-888-TRY-WVIC
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)