File #_____

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER
WORKERS' COMPENSATION 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 the Office of Judges, the 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 Service 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.

YOUR NAME: _____

YOUR COMPANY (if applicable): _____ **FEIN:** _____

TYPE OF COMPLAINT (circle one): **CLAIMANT** **EMPLOYER** **VENDOR** **OTHER**

CLAIM / POLICY / VENDOR NUMBER: _____

YOUR ADDRESS: _____

YOUR TELEPHONE NUMBER: _____ **FAX:** _____

YOUR E-MAIL ADDRESS: _____

INSURANCE COMPANY: _____

SPECIFIC POLICY LANGUAGE IN QUESTION(if known): _____

STATUTORY / RULE PROVISION(S) IN QUESTION(if known): _____

REASON FOR COMPLAINT / RELIEF REQUESTED: Please describe the facts and circumstances which form the basis of your complaint. You may attach additional pages if necessary. Please attach copies of any relevant correspondence, policy provisions, etc. _____

_____

_____

A complaint filed on behalf of a corporation must be signed by an officer of the corporation.

In order for this division to take any action on your complaint, you must sign and date this form, indicating your agreement to the following:

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

Signature: _____ **Date:** _____

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

Consumer Service 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

IF YOU HAVE ANY QUESTIONS OR PROBLEMS COMPLETING THIS FORM, PLEASE CALL OUR OFFICE AT 1-888-TRY-WVIC (1-888-879-9842) AND WE WILL ASSIST YOU.

Revised 1/08