



Department of Consumer & Business Services
Insurance Division 2
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Department use only File

CO

Consumer Complaint

Mr.

Mrs.
 Your
 Address: Ms.

Street City

ZIP

County

Home phone: Work phone:

E-mail:

Other persons (if any) involved in this problem:

- 1.
- 2.
- 3.

My complaint is against:

Insurance company:

Insurance agency:

Insurance agent:

Department use only

OR ID

NAIC #:

#:

OR ID

FEIN #:

#:

OR ID

Date of loss: FEIN #:

#:

Policy no.: Claim no.:

id of policy: Life Health Auto Property Workers' Comp.
 Other: Check cause(s) of problem and explain on back of form: Claim denial

Claim settlement Information problem Cancellation Premium Poor service Non-renewal Misrepresentation Other:

Signature: Date:

Note: To obtain additional information, a copy of this inquiry will be sent to the insurers or agents involved.

Release of medical information

I hereby authorize any medical provider or insurer to provide copies of medical records to the Oregon Insurance Division. A photocopy of this authorization shall be as valid as the original.

Signature of patient/guardian: Date:



Date opened: by: Related files:

440-3600 (3/08/COM)

Date closed: by:

Consumer complaint

1. My complaint is:

2. What do you consider to be a fair resolution to your problem?

If you need more space, please attach additional sheets.

440-3600 (3/08/COM) Please do not write below this line