Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
- (614) 644-2673
- (800) 686-1526
- TTY (614) 644-3745
- Fax (614) 644-3744

www.ohioinsurance.gov

Ohio Department of Insurance

Ted Strickland – Governor
Mary Jo Hudson – Director

Consumer Complaint

Please note: This complaint form, all documents you send us, and any document received by our office as a result of handling your complaint may be a public record, subject to Ohio's Public Records Act. This law requires all public records to be available for inspection by anyone, upon request. **WARNING: All documentation we receive will be imaged, then destroyed. Make copies of your documents and send the copies to us. Do not send original records.**

If completing this form by hand, please use black or blue ink. DO NOT USE PENCIL.

Name

Address County

City State Zip Phone

Insured's Name (if different)

Name of Insurance Company

Policy or ID Number (if your ID is your Social Security Number, give only the last four digits)

Group or Employer Name

Name and Address of Agent/Broker (if involved)

Type of Insurance (check only one)

☐ Auto ☐ Home ☐ Health
☐ Credit Life/Credit Disability ☐ Life ☐ Dental
☐ Disability Income ☐ Annuity ☐ Other

Small Business Owners: Name of business
If you are a small business employer, please check here ☐

Type of Problem (check one or more):

☐ Claim dispute or delay ☐ Claim denial
☐ Cancellation or non-renewal ☐ Payment not credited ☐ Policy not received
☐ Cash surrender/cash value not received ☐ Misrepresentation ☐ Open enrollment ☐ Other

If this is a health insurance complaint, please attach the most recent response you received from the company.

Health Insurance Claim # Date of Service

If the problem is a claim dispute regarding auto, home, or other property Insurance:

Date and Location of Accident or Loss Claim #

Briefly describe your complaint. Please attach copies of all relevant documents.

If you need more space, please attach additional sheets.

How would you like to see your complaint resolved?

Please sign and date: To the best of my knowledge the above statement is correct. I understand that a copy of this form and any attachments may be sent to the insurance company or agent involved. I authorize the insurance company to release all the medical records relating to this complaint to the Ohio Department of Insurance, and I authorize the Ohio Department of Insurance to release medical records relating to this complaint to the insurance company or agent as necessary in order to resolve this complaint. I represent that I have the proper authority to execute this release.

Your Signature Date