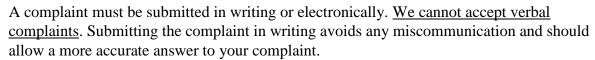
Filing a Consumer Complaint

The Kentucky Department of Insurance Division of Consumer Protection was created to assist consumers with issues related to the insurance industry.

One main function is the handling of consumer complaints. If you are unable to resolve an insurance problem to your satisfaction by contacting the agent, company, etc., you may want to file a complaint with our department.







You may submit your complaint to us by mail or fax, or by using the online complaint form at our website (http://insurance.ky.gov/) under File a Complaint or Consumer Protection. Upon completion of the online complaint form, you will receive a tracking number as confirmation that your complaint was submitted successfully. You may use that tracking number to reference your complaint when calling the department. Please be advised that if you send your complaint electronically, the Department of Insurance cannot guarantee privacy during transmission.

After submission, you will receive written notice that your complaint has been received. The staff member assigned to your case may contact you if she/he has additional questions. Therefore, it is very important that you include your name, address and best daytime telephone number.

If you have questions that aren't covered by this information sheet or if you just want to discuss your case prior to filing a complaint, please contact us at **800-595-6053** (**Option 1**) (KY only) or 502-564-6034. The TDD line for anyone that may be hearing impaired is 800-648-6056.

Tips for an effective complaint

Your written complaint should include:

- Your name, address and best daytime telephone number. (Please include your street address if your mailing address is a P.O. Box.)
- The type of insurance involved (i.e. homeowners, health, auto, life).
- The company and/or agent involved in your complaint.
- Your policy, claim, ID or group number (include any that apply). If your complaint is related to health insurance, please attach a copy of both sides of your health plan identification card.
- A detailed summary of your complaint, including copies of any related documents. (Please do not send originals.)

Once your written complaint is received, a copy of your complaint will be sent to the company. The company is asked to respond within 15 calendar days. This deadline is strictly enforced and your complaint is monitored to be certain it is being handled in a timely manner. *The majority of cases are completed within 30 days*.

Filing a complaint on behalf of another person

If you are not the insured and are filing a complaint on their behalf, please have the insured complete the section on the back page of the complaint form. This authorizes you to act as the insured's representative for the purposes of filing and investigating the complaint. If the insured is unable to complete the section on the complaint form, please furnish a copy of your Power of Attorney or other documentation.

Additional information

Keep in mind that the Department of Insurance does not have authority over cases involving matters outside its jurisdiction. In those circumstances, you will be referred to the appropriate agency.

Be certain to review your policy carefully. Knowing the specifics of your coverage can avoid problems and complaints.

The Kentucky Department of Insurance will take any appropriate action following the investigation of your case.



Kentucky Public Protection Cabinet **Department of Insurance**

P.O. Box 517, Frankfort, KY 40602-0517 Toll free (KY only) 800-595-6053 or 502-564-3630 Deaf/hard-of-hearing 800-648-6056 http://insurance.ky.gov/ Printed with state funds on recycled paper



The Kentucky Department of Insurance does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation or gender identity, ancestry, age, disability or veteran status. The cabinet provides, on request, reasonable accommodations necessary to afford an individual with a disability an equal opportunity to participate in all services, programs and activities. To request materials in an alternate format, contact the Department of Insurance, Communications Office, P.O. Box 517, Frankfort, KY 40602-0517, toll-free (KY only) 800-595-6053 or 502-564-3630. Hearing and speech-impaired persons can contact an agency by using the Kentucky Relay Service, a toll-free telecommunication service. For Voice to TDD call 800-648-6057. For TDD to Voice call 800-648-6056.

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Kentucky Department of Insurance Division of Consumer Protection P.O. Box 517, Frankfort, KY 40602-0517 Toll-Free (KY only): 800-595-6053

Consumer Protection: 502-564-6034, Fax: 502-564-6090

Consumer Complaint Form

Are you filing this complaint on behalf of someone else? ☐ Yes (Please fill out Sections 1, 2, 3 & 4) ☐ No (Please fill out Sections 1, 2 & 3)				
Section 1 General Information				
	Type of insurance involved (Please check one):			
	□Auto □Homeowners □Life □Health □Disability □Commercial			
	□Workers' Compensation □Other, please specify			
	My Complaint is against (please check all that apply):			
	□Insurance company □Agent □Adjuster □Other, please specify			
	Are you represented by an attorney? \square Yes \square No			
	Is this situation currently in litigation? \square Yes \square No			
	If your complaint falls under another jurisdiction, may we forward it to the appropriate office? □Yes □No			
Section 2 Insured (individual harmed)				
	First Name Last Name			
	Address City, State, ZIP code			
	Best phone number where you may be reached:			
	Today's Date: (MM/DD/YY)/ Email:			
	Signature (if filing on your own behalf):			
Sect.	ion 3 Complaint filed against (include copy of ID card or policy)			
	Insurance Company Name			
	Group Number			
	Policy/ID Number			
	Agent/Adjuster Name			
	Agent/Adjuster Address			

Section 4 Person completing form on behalf of Insured

First Name	Middle Name	Last Name
Address	City, State, ZII	P code
Best phone number	where you may be reached:	
Today's Date: (MN	M/DD/YY)/	
Signature:		
If the person you are filing	g this complaint on behalf of is <u>over 18</u>	please have them sign below:
"I,(insured)	hereby designate	as my
directly to my representative authorized representative, the become known as a result of released to the third party ma information, financial informincluded as part of the Consu- party authorization does not a actual claimant. By signing th	e. I understand and acknowledge that by de individual may obtain, on my behalf, any a the investigation, some of which might other ay include, but is not limited to the following nation, nonpublic personal health informationer Protection investigation. Additionally, constitute a power of attorney and does not	complaint received on my behalf and to respondesignating the individual named above as my and all documents and information which magerwise be considered confidential. Information and Social Security numbers, personal contaction, medical records and any documentation, I understand and acknowledge that this third tallow negotiation with anyone other than the ment of Insurance from any liability that might
Insured Signature	Insured Name (printed) Date
If this norson is unable to s	ian nlease provide a copy of Power of A	Attorney papers or Guardianship papers.
		e problem from your point of view. Attacl