

## Kentucky Department of Insurance Consumer Protection Division 500 Mero Street, 2 SE 11, Frankfort, KY 40601 Phone: 502-564-6034 Fax: 502-564-6090

Email: DOI.ConsumerComplaints@ky.gov

## **Consumer Complaint Form**

A complaint MUST be submitted in writing or electronically. Once complete, please return by mail, fax, or email. (\*Required information)

\*Section 1: Your Information (Policyholder/Insured)

		<del>-</del>	
First Name:	Middle:_	Last:	
Address:		City, ST ZIP:	
Phone ()	Email:_		
<b>Signature:</b> (If filing on your own behalf)			Date:
Are you represented by	an attorney?	□Yes □No	
Is this situation currently	/ in litigation?	□Yes □No	
Person completing fo	rm on behalf of	Policyholder/Insured	<u>I</u>
First Name:	Middle:_	Last:	
Address:		City, ST ZIP:	
Phone ()	Email:_		
Signature:			Date:
Section 2: Insurance (Submit a copy of Health	n Insurance Card		aalth □Other:
Trisurance Company Na	e.		
*Policy Number:	_	*Claim Number:	
Agent/Adjuster Name (i	f Applicable):		
Agent/Adjuster Address	: <u> </u>		

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## **Third-Party Authorization**

	his complaint on behalf of is <u>over 18</u> , please have them sign below:
"I,	hereby designate
I authorize the Consumer to investigate the complerepresentative. I understate above as my authorized reall documents and information of which might other third party may include personal contact information, medical reconformation, medical reconformation investigation. A authorization does not conformation of the reconformation	(Authorized Representative) Itative for the purposes of filing and investigating my complaint. Protection Division of the Kentucky Department of Insurance aint received on my behalf and to respond directly to my nd and acknowledge that by designating the individual named expresentative, the individual may obtain, on my behalf, any and ation which may become known as a result of the investigation, exwise be considered confidential. Information released to the out is not limited to the following: Social Security numbers, nation, financial information, nonpublic personal health rds and any documentation included as part of the Consumer additionally, I understand and acknowledge that this third party estitute a power of attorney and does not allow negotiation with ual claimant. By signing this authorization, I hereby release the from any liability that might accrue from disclosing information
Print Name:	
<del>-</del>	Date: le to sign, please provide a copy of Power of Attorney or
Guardianship documer	nts.
Please use the space belopoint of view. Attach addi	w to provide a detailed description of the problem, from your
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