Minnesota Insurance Division Consumer Complaint Form

Thank you for contacting the MN Department of Commerce Consumer Protection and Education Division. Please provide the information requested below and allow sufficient time for us to complete our inquiry. A copy of this form and any or all information you provide may be sent to the party complained against.

1. Complainant

Your name: ______________________

Street address: ______________________

City: __________ State: __________ ZIP code: __________

Home phone: __________ Work phone: __________ Email address: __________

2. Insured

Name (if same, write "same"): ______________________

Relationship to the insured: ______________________

3. Who is the complaint against?

Name of company/agent/broker: ______________________

City: __________ State: __________ ZIP code: __________

Name of company/agent/broker: ______________________

City: __________ State: __________ ZIP code: __________

Name of company/agent/broker: ______________________

City: __________ State: __________ ZIP code: __________

4. Type of insurance involved (pick one)

- ☐ Individual life
- ☐ Individual health
- ☐ Group life
- ☐ Group health
- ☐ Long term care
- ☐ Workers compensation
- ☐ Medicare Supplement
- ☐ Other

5. Policy information

Policy number: ______

Group of certificate number: ______

Name of employer/association (if group insurance): ______

Effective date: ______

6. Claim information

Claim number: ______

Date of loss/treatment ______

7. Reason for complaint (check one or more)

- ☐ Claim denial
- ☐ Claim dispute/delay
- ☐ Sales/service
- ☐ Premium/ rating problem
- ☐ Cancellation/ non-renewal
- ☐ Medical necessity/ usual and customary reduction
- ☐ Other (specify)

Details of my complaint: Attach additional sheets if necessary. *(Please attach copies of all relevant documents including most recent correspondence from the company)*

Declaration/Authorization*

I hereby declare that I am authorized to make this complaint. I further declare that all of the information submitted in this complaint and attachments is true and accurate to the best of my knowledge. I authorize release of any submitted information, including medical records, if applicable, to the party complained against, other regulated entities, or an appropriate state or federal agency, where such release will aid the Department's investigative process, or assist other state or federal agencies to investigate the facts contained in this complaint. I authorize this release, notwithstanding any statutory provisions to the contrary.

Date ______ Signature of Complainant ______

Mail written complaints to:

Minnesota Department of Commerce
Attn: Consumer Protection & Education Division
85 7th Place East, Suite 280, St. Paul, MN 55101