



**Illinois Department of Insurance
Consumer Complaint Form
Life, Accident, Health, HMO and PPA**

Illinois Department of Insurance
320 West Washington Street
Springfield, IL 62767-0001
1-866-445-5364 (toll -free)
TDD 217/524-4872 / Fax: 217/558-2083
insurance.illinois.gov

Attention: A complaint may be filed by the policyowner, certificate holder, member or insured, or their designee or guardian if specific written permission is provided. Health care providers should file a complaint using the Health Care Provider Complaint Form. Any person who files a complaint or grievance under false pretenses may be subject to criminal or civil action as the law may allow.

Please Print Clearly			
Name (<i>Mr., Mrs., Mr. & Mrs., Ms., Dr., etc.</i>)			Date
Address	City	State	Zip code
Home phone	Work phone		
Name of insured (if different from above)	Your relationship to insured person		
My complaint is against (agency) (insurance company). (Give specific name of insurance company, not group name.)			
Address of agency or insurance company			State of purchase
Policy #	Claim #	Date of loss	
Has this complaint been filed before? <input type="checkbox"/> Yes <input type="checkbox"/> No		E-mail Address (provide only if you wish E-mail communication from the Department of Insurance)	
If yes, please state complaint number.			
If complaint is against group insurance, give name of employer.			
Please state your complaint (attach all supporting documents and use Page 2 if necessary)			
I authorize the Department of Insurance to investigate my complaint and to obtain personal health information, if necessary, to conduct the investigation.			
<div style="text-align: right;"> _____ Signature </div>			
Important Notice: Complaints filed with the Department of Insurance are confidential records and will not be released to any person or organization except the policyholder, insured or enrollee (or their designee) who originated the complaint or the party against whom the complaint has been filed.			

