



Department of Consumer and Business Services  
**Insurance Division — 2**  
 P.O. Box 14480, Salem, Oregon 97309-0405  
 Phone: 503-947-7984, Fax: 503-378-4351  
 888-877-4894 (toll-free)  
 350 Winter St. NE, Salem, Oregon  
 E-mail: dcbs.inmail@state.or.us  
 www.insurance.oregon.gov

Department use only

File # \_\_\_\_\_

CO # \_\_\_\_\_

**Consumer Complaint**

Mr.

Mrs.

Your name:  Ms. \_\_\_\_\_

Address: \_\_\_\_\_  
 Street City ZIP County

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Other persons (if any) involved in this problem:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

My complaint is against: \_\_\_\_\_

Insurance company: \_\_\_\_\_

Insurance agency: \_\_\_\_\_

Insurance agent: \_\_\_\_\_

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OR ID #: \_\_\_\_\_ NAIC #: \_\_\_\_\_

OR ID #: \_\_\_\_\_ FEIN #: \_\_\_\_\_

OR ID #: \_\_\_\_\_ FEIN #: \_\_\_\_\_

Policy no.: \_\_\_\_\_ Claim no.: \_\_\_\_\_ Date of loss: \_\_\_\_\_

Kind of policy:  Life  Health  Auto  Property  Workers' Comp.  Other: \_\_\_\_\_

Check cause(s) of problem and explain on back of form:

- Claim denial  Claim settlement  Cancellation  Poor service  Information
- Claim delay  Premium problem  Non-renewal  Misrepresentation  Other: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Note: To obtain additional information, a copy of this inquiry will be sent to the insurers or agents involved.**

**Release of medical information**

I hereby authorize any medical provider or insurer to provide copies of medical records to the Oregon Insurance Division. A photocopy of this authorization shall be as valid as the original.

Signature of patient/guardian: \_\_\_\_\_ Date: \_\_\_\_\_



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Date opened: \_\_\_\_\_ by: \_\_\_\_\_ Related files: \_\_\_\_\_

Date closed: \_\_\_\_\_ by: \_\_\_\_\_

