STATE OF CONNECTICUT
INSURANCE DEPARTMENT
Consumer Affairs Division
P.O. Box 816 – Hartford CT 06142-0816

PHONE 860.297.3900 | **FAX** 860.297.3872
EMAIL insurance@ct.gov | **WEBSITE** www.ct.gov/cid

CONSUMER COMPLAINT FORM

Complainant Name: _____

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone: _____ **Email:** _____

Relationship to Insured/Claimant: _____

Name of Insured/Claimant *(If different than above)*: _____

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Insurance: ☐ Auto ☐ Home/Renters ☐ Life ☐ Annuity ☐ Commercial ☐ Travel ☐ Pet
☐ Individual Health ☐ Group Health - Employer Name: _____
☐ Disability ☐ Dental ☐ Long Term Care ☐ Other _____

Name of Insurance Company: _____

Policy # / Subscriber ID#: _____

If this complaint is related to a claims delay or claims denial:

Property & Casualty Complaints: Date of Loss: _____ Claim #: _____

Health or Dental Complaints: Date(s) of Service: _____
Name of Healthcare Provider: _____

Name of Agent/Agency *(If applicable)*: _____

Address: _____

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Please enter a description of your complaint in the space provided below. You may also attach documents pertinent to your complaint to this form.

Please do not send originals.

I have enclosed copies of correspondence and documents relating to this matter to assist your investigation of the complaint. I understand that copies of this form and any of the enclosed documents which may contain insurance and health information may be forward to the insurance company and/or agent involved as deemed necessary by the Connecticut Insurance Department to complete your investigation, and to any other state or federal agency that may be able to assist you.

Signature of Complainant:		**Date:**	