



COMMONWEALTH OF MASSACHUSETTS

Office of Consumer Affairs and Business Regulation

DIVISION OF INSURANCE

One South Station • Boston, MA 02110-2208

(617) 521-7794 • FAX (617) 521-7575

Springfield Office (413) 785-5526

TTY/TDD (617) 521-7490

<http://www.mass.gov/doi>

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
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DANIEL O'CONNELL
SECRETARY OF HOUSING AND
ECONOMIC DEVELOPMENT

DANIEL C. CRANE
DIRECTOR

NONNIE S. BURNES
COMMISSIONER OF INSURANCE

Consumer Service responds to inquiries and intervenes on behalf of consumers to resolve complaints against insurers, producers (formerly known as agents or brokers), and other licensees. Consumer Service provides consumers with general insurance information and advises them, when appropriate, of their rights under their insurance policy and the applicable Massachusetts insurance laws.

Consumer Service can only help you obtain rights and benefits that you are entitled to under your insurance contract and the Massachusetts insurance laws. We help consumers determine if we have any jurisdiction, and if not, let them know where help might be found.

If you are represented by an attorney, do not complete this form. Consumer Service is not authorized to intervene between attorneys and their clients, nor do we perform work on behalf of attorneys. We are not authorized to render legal opinions.

If your complaint involves a workers compensation claim, do not complete this form. The Division of Industrial Accidents is the agency with the appropriate jurisdiction.

For us to assist you requires your cooperation. That is why we ask you to give certain key information such as the name of the **insurance companies** and **producers** involved, your **policy and claim numbers** as well as the **names** and **phone numbers** of the people you have been dealing with. Please complete the attached Insurance Complaint Form and include copies of any materials relating to your insurance complaint (i.e. bills, explanation of benefits sheets, vehicle appraisals, police reports).

Please be aware that complaints filed are not confidential. Consumer Service will send a copy of your complaint and any related materials to any company, producer or licensee involved in this matter.

If your situation involves health insurance, you should be aware that many health plans such as "ERISA" plans and "self-funded" plans are regulated by the federal government. The benefits coordinator at your place of employment can tell you what kind of health plan you are in and direct you to the appropriate source of help. If this is an employer sponsored health plan, the employer must fill out the form on behalf of the group.

We understand that insurance matters can be complex, often confusing, and sometimes lead to frustration. While we cannot resolve every situation, Consumer Service is available to help you in resolving your complaint.



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INSURANCE COMPLAINT FORM

(PLEASE PRINT ALL INFORMATION CLEARLY)

Please indicate: Ms.: ____ Mrs.: ____ Mr.: ____

Name: _____ Daytime Phone #: _____

Address: _____ E-mail Address: _____

City: _____ State: _____ Zip: _____

Before you file a complaint with the Massachusetts Division of Insurance, you should first contact the insurance company, producer (formerly known as agent or broker) in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form, attach copies of any important papers that relate to your complaint. If you are represented by an attorney, do **NOT** complete this form. If this is an employer sponsored plan, the employer must fill out the form on behalf of the group. Do **NOT** send original documents. Please mail or fax your completed form to the address shown above.

Type of Insurance: Auto____ Health____ Homeowners____ Life____ Other: _____

Please provide the name of the insurance company or insurance producer your complaint is against. _____

Is the complaint about your policy or someone else's? _____

What state did you reside in at the time this policy was purchased/issued? _____

If this is a group policy, provide the group/employer name. _____

Policy/Claim #: _____ Date of Loss: _____

Have you contacted the insurance company or producer? If yes, indicate the person(s) and date(s) contacted in your explanation.

Have you previously written to the Division of Insurance about this matter?
Yes____ No____ DOI File #: _____ Date: _____

