Arkansas Insurance Department

CONSUMER COMPLAINT FORM

1 **Name** _____

Address _____

City _____ **State** _____

Zip _____ **Telephone No.** _____

Email _____

Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749
E-mail: insurance.consumers@arkansas.gov
Website: http://insurance.arkansas.gov/csd.htm

2 **Company** _____

Insured _____

Policy No. _____

Effective Date _____

Claim No. _____

Date of Occurrence _____

Agent _____

3 **Type of Insurance**

- ☐ Automobile
- ☐ Homeowners
- ☐ Life
- ☐ Health
- ☐ Other

How were you referred?

_____

4 Explain below the problem you are experiencing. Also, please attach copies of any information you have regarding this inquiry.

Release of Information: My signature on this form constitutes my authorization for the Arkansas Insurance Department to obtain any information or documentation from any legal entity it deems necessary for the resolution of my complaint/inquiry. A photocopy of this form will be considered valid authorization.

SIGNATURE _____ **DATE** _____

The following information must be included with your complaint:

- Name, address and telephone number of person filing the complaint
- Name of the insurance company
- Name of person insured
- Policy number and claim number (if applicable)
- Agent or adjuster's name
- Date of occurrence
- A brief description of why the complaint is being filed. Attach copies of documents that will help with the investigation.

Once we receive your correspondence, it will be assigned to an investigator who will review it and take the necessary steps to resolve this matter.

Our job is to serve the citizens of Arkansas and assist them with their insurance questions or problems. We appreciate your interest.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE ARKANSAS INSURANCE DEPARTMENT

I,_____authorize_____
(name of consumer) (name of insurer or other party)

to disclose the following health information to the employees of the Arkansas Insurance Department upon request:

_____

_____

_____

_____

(specific and meaningful description of the information to be provided)

This authorization is valid for 24 months from the date of signature, unless revoked. If I wish to revoke this authorization, I can do so by sending a written request to the Arkansas Insurance Department.

I understand that I have the right to revoke this authorization in writing, unless_____
has already taken action under the authorization. (name of covered entity)

Certain information received by the Arkansas Insurance Department may be subject to disclosure by the Department and will not be protected by federal law. The Arkansas Insurance Department will not disclose your health information except as allowed by law.

_____

Signature of consumer (or personal representative of consumer, along with description of the representative's authority)

_____

Date