

Filing a Consumer Complaint

The Kentucky Department of Insurance's Consumer Protection Division was created to assist consumers with issues related to the insurance industry.

One main function is the handling of consumer complaints. If you are unable to resolve an insurance problem to your satisfaction by contacting the agent, company, etc., you may want to file a complaint with our Department.



A complaint must be submitted in writing or electronically. We cannot accept verbal complaints. Submitting the complaint in writing avoids any miscommunication and should allow a more accurate answer to your complaint.



You may submit your complaint to us by mail or fax, or by using the online complaint form at our Web site (<http://insurance.ky.gov/>) under Consumer Protection. Please be advised that if you send your complaint electronically, the Department of Insurance cannot guarantee privacy during transmission. Please do not include any sensitive or personal information in your electronic submission.

After submission, you will receive written notice that your complaint has been received. The staff member assigned to your case may contact you if she/he has additional questions. Therefore, it is very important that you include your name, address and daytime telephone number.

If you have questions that aren't covered by this information sheet or if you just want to discuss your case prior to filing a complaint, please contact us at **800-595-6053** (KY only) or 502-564-6034. The TDD line for the deaf/hard-of-hearing is 800-648-6056.

Tips for an effective complaint

Your written complaint should include:

- Your name, address and daytime telephone number. (Please include your street address if your mailing address is a P.O. Box.)
- The type of insurance involved (i.e. homeowners, health, auto, life).
- The company and/or agent involved in your complaint.
- Your policy, claim, ID or group number (include any that apply). If your complaint is related to health insurance, please attach a copy of both sides of your health plan identification card.
- A detailed summary of your complaint, including copies of any related documents. (Please do not send originals.)

Once your written complaint is received, a copy of your complaint will be sent to the company. The company is asked to respond within 15 calendar days. This deadline is strictly enforced and your complaint is monitored to be certain it is being handled in a timely manner. *A normal case should be completed within 30 days.*

Filing a complaint on behalf of another person

If you are not the insured and are filing a complaint on their behalf, please have the insured complete the section on the back page of the complaint form. This authorizes you to act as the insured's representative for the purposes of filing and investigating the complaint. If the insured is unable to complete the section on the complaint form, you may be required to furnish a copy of your Power of Attorney or other documentation.

Kentucky Department of Insurance
Consumer Protection Division
P.O. Box 517, Frankfort, KY 40602-0517
Toll-Free (KY only): 800-595-6053
Consumer Protection: 502-564-6034, Fax: 502-564-6090

Consumer Complaint Form

PLEASE NOTE: In order to assist you, we need a detailed summary of the problem from your perspective, in addition to the information below. Attach more sheets as needed. Please type or print and attach copies of any documents related to your complaint. Do not send originals.

1. Your name _____ Address _____

2. City, State, ZIP _____

3. Daytime telephone _____ Cell phone _____

4. Type of insurance involved (please circle one):

Auto Homeowners Life Health Disability
Workers' compensation Commercial Other, please specify _____

5. My complaint is against (please circle all that apply):

Insurance company Adjuster Agent Other

6. This complaint involves (please circle one):

My policy Someone else's policy

7. If you are filing a complaint on behalf of another person, what is your relationship to the policyholder/insured? _____

8. Information on my policy: (complete any that apply)

Insurance company: _____

Policy number: _____

Group number: _____

ID number: _____

Agent/adjuster's name: _____

Agent/adjuster's address: _____

9. Information on the **other person's** policy (complete any that apply):

Insured's name: _____

Insurance company: _____

Policy number: _____ Group number: _____

ID number: _____

Agent/adjuster's name and address: _____

10. Are you represented by an attorney? Please circle one. Yes No

Today's date: (MM/DD/YY) ____ / ____ / ____

Signature _____

Please use the space below to provide a detailed description of the problem from your point of view. Attach additional sheets if needed.

Designation of Authority for Third-Party Complaints

"I hereby designate _____ as my authorized representative for the purposes of filing and investigating my complaint. I authorize the Consumer Protection Division of the Department of Insurance to investigate the complaint received on my behalf and to respond directly to my representative. I understand and acknowledge that by designating the individual named above as my authorized representative, the individual may obtain, on my behalf, any and all documents and information which may become known as a result of the investigation, some of which might otherwise be considered confidential. Information released to the third party may include, but is not limited to the following: Social Security numbers, personal contact information, financial information, nonpublic personal health information, medical records and any documentation included as part of the Consumer Protection investigation. Additionally, I understand and acknowledge that this third party authorization does not constitute a power of attorney and does not allow negotiation with anyone other than the actual claimant. By signing this authorization, I hereby release the Department of Insurance from any liability that might accrue from disclosing information that might be deemed confidential."

Insured Signature

Insured Name (Printed)

Date

Additional information

Keep in mind that the Department of Insurance does not have authority over cases involving matters outside its jurisdiction. In those circumstances, you may be referred to another agency. For instance, some self-funded insurance plans fall under federal regulations so we will give you the necessary information to report those issues to the U.S. Department of Labor.

Be certain to review your policy carefully. Knowing the specifics of your coverage can avoid problems and complaints.

The Kentucky Department of Insurance will take any appropriate action following the investigation of your case.



**Kentucky Public Protection Cabinet
Department of Insurance**

Printed with state funds on
recycled paper



P.O. Box 517, Frankfort, KY 40602-0517
Toll free (KY only) 800-595-6053 or 502-564-3630
Deaf/hard-of-hearing 800-648-6056
<http://insurance.ky.gov/>

The Kentucky Department of Insurance does not discriminate on the basis of race, color, religion, sex, national origin, sexual orientation or gender identity, ancestry, age, disability or veteran status. The cabinet provides, on request, reasonable accommodations necessary to afford an individual with a disability an equal opportunity to participate in all services, programs and activities. To request materials in an alternate format, contact the Department of Insurance, Communications Office, P.O. Box 517, Frankfort, KY 40602-0517, toll-free (KY only) 800-595-6053 or 502-564-3630. Hearing and speech-impaired persons can contact an agency by using the Kentucky Relay Service, a toll-free telecommunication service. For Voice to TDD call 800-648-6057. For TDD to Voice call 800-648-6056.

March 2010

Kentucky
UNBRIDLED SPIRIT™