MISSISSIPPI
INSURANCE DEPARTMENT

MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

DAVID BROWNING
Deputy Commissioner of Insurance

P.O. BOX 79
JACKSON, MS 39205-0079
Phone: 601-359-2453 or 1-800-562-2957 • FAX: 601-359-1077
www.mid.ms.gov

CONSUMER COMPLAINT FORM (Company Complaint)

Documents that you submit to the Mississippi Department of Insurance to assist us in examining your complaint may be subject to the Mississippi Public Records Act of 1983. ALL SPACES APPLICABLE MUST BE COMPLETED. Before you file a complaint with the Department of Insurance, you should first contact the insurance company, 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 (no originals) of any important papers that relate to your complaint and mail or fax to the address / number shown above.

INSTRUCTIONS FOR COMPLETION OF FORM:

- **Fill in the information below that is applicable to your complaint.**
- **TYPE OR PRINT IN BLUE/BLACK INK AND WRITE CLEARLY. SIGN AND DATE FORM.**
- **Please allow (20) working days for the insurance company or agency to respond to your request.**
- **WE WILL NOTIFY YOU IN WRITING OF OUR FINDINGS.**

Complainant

Your Name: _____
Relationship to insured: (if applicable) _____
Mailing Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Daytime Telephone Number: _____ E-mail Address: _____

Insured

Your Name (if same, write **"same"**): _____
Mailing Address: _____
City: _____ County: _____ State: _____ Zip Code: _____
Daytime Telephone Number: _____ E-mail Address: _____

Insurance Company Information

Complete Name of insurance company, agent or agency complaint is against:

_____

Address (if known): _____

Type of Coverage

☐ Auto ☐ Homeowners ☐ Commercial ☐ Liability ☐ Life ☐ Health
☐ Disability Income ☐ Dental ☐ Long Term Care ☐ Annuity ☐ Medicare Supplement
☐ Other (List): _____

Have you previously written to the Mississippi Dept. of Insurance about this matter? ☐ Yes ☐ No
If yes, give name complaint was filed: _____ Dept. File Number:_____

Policy Information:

Policy Number: _____ Claim Number: _____
Date of Loss: _____

Reason for Complaint

☐ Claim Delay ☐ Claim Denial ☐ Premium Increase ☐ Cancellation ☐ Non-Renewal
☐ Unsatisfactory Settlement ☐ Premium Refund ☐ Other: _____

ONLY COMPLETE THIS SECTION IF THIS A MEDICARE SUPPLEMENT COMPLAINT

Indicate Plan Type (A-N): _____ Your Age: _____

Details of Complaint:
(Use additional paper, if needed)

Declaration/Authroization*

PLEASE READ THE FOLLOWING STATEMENT AND SIGN:
To the best of my knowledge, the information contained herein is true and accurate. I understand that a copy of this form and any or all of the information attached, including medical records, if applicable, may be sent to the party complained against.

Signature: _____ Date: _____

Revised 09/2020

PRINT FORM RESET FORM