COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE

One Federal St., Suite 700 Boston, MA 02110
(617) 521-7794 • FAX (617) 753-6830 • Toll-free (877) 563-4467
http://www.mass.gov/doi•CSSComplaints@mass.gov

MAURA HEALEY
GOVERNOR

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LIEUTENANT GOVERNOR

MICHAEL T. CALJOUW
COMMISSIONER OF INSURANCE

INSURANCE COMPLAINT FORM

Before you file a complaint with the Massachusetts Division of Insurance, you should first contact the insurance company or producer in an effort to resolve the issue(s). If you do not receive a satisfactory response, then complete this form and attach copies of any important papers that relate to your complaint. Please mail or fax your completed form to the address shown above.

If your complaint involves ongoing litigation, DO NOT complete this form.

Mr. ○ **Mrs.** ○ **Ms.** ○ _____ _____

Address: _____

City: _____ **State:** MA **Zip:** _____

Phone #: _____ **E-mail:** _____

Is the complaint about your policy? No ○ Yes ○

Which state did you reside in at the time this policy was purchased? MA

Whom is the complaint against? Please provide the exact name of the company or producer. _____

Group/certificate #(If Applicable):_____ Policy/ID #:_____

Claim #: _____ Date of Loss/Service:_____

Please note, in order to process your complaint in a timely manner, please be sure to include the name of insurance company, your policy number and claim numbers.

Type of Insurance (check one):

Bond ○ **Title** ○ **Long-Term Care** ○ **Renters** ○ **Disability** ○

Life ○ **Health** ○ **Private Auto** ○ **Homeowners** ○ **Workers Comp** ○

Annuity ○ **Medigap** ○ **Commercial Auto** ○ **Mobile Homeowners** ○

Trip Cancellation ○ **Other** ○ _____

Have you reported this to the Attorney General's Office, the Office of Consumer Affairs and Business Regulation or any other government agency? No ○ Yes ○ If yes, please provide:

Name of agency: _____ File #: _____

DETAILS OF YOUR COMPLAINT

Please be sure to include all relevant information when you submit your complaint. If you need to send additional documents, please email them to CSSComplaints@mass.gov. If you do not have email access, you may mail additional documents to the address listed above on this form.

☐ By Entering my name below, I certify that: (required)

By submitting this consumer complaint, I certify that all the above information is true and correct to the best of my knowledge. I authorize the Massachusetts Division of Insurance to send a copy of this complaint and related material to any company, producer, or licensee to investigate my complaint, and/or to refer this complaint to any government agency as necessary.

I acknowledge that complaint files are public record pursuant to Massachusetts law once the complaint file is closed and may be released upon request. The Division of Insurance will maintain the confidentiality of any personally identifiable information and personal health information to the extent required by law.

SIGNATURE:_____ DATE:_____

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