FORM 130

The Commonwealth of Massachusetts
Department of Industrial Accidents – Department 130
1 Congress Street, Suite100, Boston Massachusetts 02114-2017
Info. Line 800-323-3249 ext. 7470 in Mass. Outside Mass. - 617-727-4900 ext. 7470
http://www.mass.gov/dia

DIA Board # (If Known):

COMPLAINT OF IMPROPER CLAIMS HANDLING AGAINST AN INSURER

The purpose of this form is to request the Department of Industrial Accidents (DIA), Office of Claims Administration to conduct a preliminary investigation into the claims handling practices of an Insurer. Upon completion of our investigation you will be notified of our findings. Please note- The DIA can only determine if the matter should be further investigated by the Division of Insurance. The DIA can NOT award damages or any type of award or compensation to a complainant.

1. Complainant's Name (Last, First, MI):	2. Complainant's Telephone Number:
3. Complainant's Address (No. and Street, City, State, Zip Code):	
4. DIA Board Number (if known):	5. Date of Injury (mm/dd/yyyy):
6. Complainant's Social Security Number*:	
7. Name of Complainant's Attorney:	8. Telephone Number of Complainant's Attorney:
9. Attorney's Address:	
10. Employer's Name & Address (No. and Street, City, State, Zip Code):	
12. Name & Address of Insurer's Attorney:	13. Telephone Number of Insurer's Attorney:
14. Workers' Compensation Insurance Carrier:	15. Insurance Carrier's Case File Number (if known):
16. Claims Representative's Name:	17. Claims Representative's Tel. Number:

NATURE OF COMPLAINT (attach additional sheets if necessary)
Specify dates of complaint, date claim has been paid through, any weeks not paid, etc.

18. Complainant's Signature:	**19. Date Prepared (mm/dd/yyyy):**

***Disclosure of Social Security Number is Voluntary. It will aid in the processing of documents.**
Please Print Clearly or Type. Unreadable forms will be returned.