



Mail to:

State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
Life and Health Insurance Complaint/Appeal Form
www.scc.virginia.gov/boi
1-877-310-6560 or TDD 804-371-9206
Fax# 804-371-9944

You can call the Bureau for general information and assistance. If you want to file a complaint against an insurance company or request assistance in appealing a denial issued by an insurance company, please complete this form. The Bureau may have to ask you for additional information depending on the type of problem you have.

I am filing (check one):

- A complaint against an insurance company or an insurance agent or
 A request for assistance in appealing an adverse decision made by a Managed Care Health Insurance Plan (MCHIP)

Type of Insurance Coverage:

- Medigap Long-Term Care Disability Life Annuity Credit Dental
 Health MCHIP: (HMO PPO)

Please provide information about the insured person who needs help.

Name: _____ Age: _____

Address: _____
Street

City State Zip Code

Telephone No.: (____) _____ (____) _____ (____) _____
Home Work Cell

E-Mail: _____

Complete this section if you are NOT the insured person and you are requesting help on behalf of the insured person. Note: In order for the Bureau to help the insured person, the individual will have to sign the form.

Name and Relationship to the insured person: _____

Address: _____
Street

City State Zip Code

Telephone No.: (____) _____ E-Mail: _____

Name of Insurer Agent: _____

Address: _____
Street

_____ City _____ State _____ Zip Code

Policy Certificate ID Number: _____

Source of Insurance Coverage Group _____ Individual
(Name of employer or group association)

Describe the issues involved in your complaint or appeal. Attach a separate sheet if necessary and attach correspondence from insurer if applicable.

I am enclosing copies of all correspondence or other papers relating to this matter that may assist the Bureau of Insurance (BOI) in its evaluation of my complaint/appeal. I understand and agree that the BOI may send a copy of this form and any or all of the enclosed information to the party complained against, other regulated entities, or the appropriate state or federal agency. I also authorize the insurance company to release all medical records relating to this complaint/appeal to the BOI, and I authorize the BOI to release medical records relating to this complaint/appeal to the insurance company. I also agree that by signing this form, I authorize the BOI to obtain any other information required to evaluate my complaint/appeal.

Print Name: _____

Signature: _____

Signature of Insured Person
(if 18 or over and if different from above): _____

Date: _____

For questions concerning a complaint, you may contact the BOI's Consumer Services Section at 804-371-9691 or toll free in Virginia at 1-800-552-7945 or 1-877-310-6560. If you have any questions about filing an appeal, you may contact the BOI's Office of the Managed Care Ombudsman at 804-371-9032 or toll free at 1-877-310-6560.