Consumer Complaint Form

Important Notice:

Under Illinois Insurance laws, disclosure of this information is **voluntary.** However, failure to supply complete information may result in this complaint not being processed.

Your Name: _____
Address: _____
City, State and Zip: _____
Home Phone: _____
Work Phone: _____
e-mail: _____
Name of Person Insured: _____
Name of Insurance Co: _____
Name of Agent: _____
Address of Agent: _____
Type of Insurance: _____
Policy Number: _____
Claim Number: _____

Please state your complaint. You may be asked to send supporting documents by mail or fax.

Complete form and mail or fax to:

Illinois Department of Insurance
Consumer Services
320 West Washington Street
Springfield, IL 62767-0001
FAX (217) 782-5020

www.state.il.us/ins/