State of New Mexico
Office of Superintendent of Insurance

Mailing Address: P O Box 1689
Santa Fe, NM 87504-1689

Location: 1120 Paseo de Peralta
Santa Fe, NM 87501

John Franchini, Superintendent of Insurance

CONSUMER ASSISTANCE BUREAU

Toll Free Number: 1-855-427-5674
Direct Number: 505-827-4601
Fax: 505-827-4253
Web Site: www.OSI.state.nm.us

INSURANCE COMPLAINT FORM

6' The **Office of Superintendent of Insurance**, **Consumer Assistance Bureau** investigates complaints involving insurance companies and agents. The Bureau **cannot** act as your lawyer, provide legal advice, or recommend or rate insurance companies. You may consult with a private attorney to explore what private rights of action or other redress options you may have based on the circumstances of your particular case, such as contacting your county's small claims or municipal court if your inquiry involves a claim dispute.

JF{ **Complete this Form**, **Print** Clearly and **Return** to the **Address Above**. A copy of your completed form will be forwarded to the Insurance Company or agent requesting a written response and information. Upon receipt of company response, the case will be reviewed and, if necessary, further investigation will be conducted. You will be notified of the results.

SECTION A: YOUR INFORMATION

DATE:	PHONE:	WORK PHONE:	
LAST NAME:	FIRST NAME:	MIDDLE NAME:	
MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:
STREET ADDRESS OF PROPERTY:	CITY:	STATE:	ZIP CODE:
May we contact you by email? D YES D NO	Email Address:		
Are represented by an attorney? D YES D NO	Have you filed a Lawsuit in Court? D Yes D No		

Section B: Reason for Complaint

What Type of Issue is Your Complaint Regarding? (CHECK ALL THAT APPLY.)			
D CLAIM DENIAL	D DELAYS	D POLICY CANCELLATION	D COMPANY SERVICE
D PREMIUM RATE	D REFUSAL TO INSURE	D AGENT SERVICE	D OTHER INSURANCE COMPANY (Liability Claim)
D OTHER (PLEASE DESCRIBE)			

SECTION C: INFORMATION ABOUT THE INSURANCE COMPANY

Insurance Company Name:			Is this your Insurer? D YES D NO		Policy No.:
Policy Owner's Name:			Insured's Name:		
Policy Issue or Effective Date:	State of Purchase:	**Sales Agent's Name:**		**Current Servicing Agent's Name:**	
Type of Insurance:	D AUTO	D HOME	D HOME - LANDLORD	D COMMERCIAL INSURANCE	
	D LIFE	D HEALTH*	D GROUP	D INDIVIDUAL	
	*HEALTH, OTHER THAN PPO OR HMOS		D OTHER (please specify)	D ANNUITIES	
Claim #:			Date Loss Occurred or Began:		
Adjuster's Name:			Adjuster's Phone #:		

Full Name: **Date:**

SECTION D: STATEMENT OF FACTS

Explain below the details of your complaint. Provide copies of any documentation you believe will support your complaint. Do not send originals.

SECTION E: STATEMENT OF OBJECTIVES

Explain below what you believe would be a fair resolution of this matter.

The information provided on and with this form is true and correct to the best of my knowledge and belief. I am enclosing copies of any correspondence or other documentation in my possession that may be of assistance. I fully understand that a copy of this form and any or all of the enclosed information may be forward to the involved insurance company or agent. I also understand that the facts relating to this matter will become a matter of public record pursuant to New Mexico law once my filed is closed.

Signature: ______________________________ **Date:** ______________

Contact the **Consumer Assistance Bureau** Staff with **Questions** Regarding Completing this **Form**

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