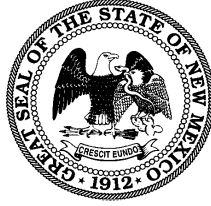


# State of New Mexico

## Office of Superintendent of Insurance



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

**John Franchini, Superintendent of Insurance**

**Location:** 1120 Paseo de Peralta  
Santa Fe, NM 87501

**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](http://www.OSI.state.nm.us)**

### INSURANCE COMPLAINT FORM



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.

**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? <input type="checkbox"/> YES <input type="checkbox"/> NO		Email Address:		
Are represented by an attorney? <input type="checkbox"/> YES <input type="checkbox"/> NO		Have you filed a Lawsuit in Court? <input type="checkbox"/> Yes <input type="checkbox"/> No		

#### Section B: Reason for Complaint

<b>What Type of Issue is Your Complaint Regarding?</b> (CHECK ALL THAT APPLY.)			
<input type="checkbox"/> CLAIM DENIAL	<input type="checkbox"/> DELAYS	<input type="checkbox"/> POLICY CANCELLATION	<input type="checkbox"/> COMPANY SERVICE
<input type="checkbox"/> PREMIUM RATE	<input type="checkbox"/> REFUSAL TO INSURE	<input type="checkbox"/> AGENT SERVICE	<input type="checkbox"/> OTHER INSURANCE COMPANY (Liability Claim)
<input type="checkbox"/> OTHER (PLEASE DESCRIBE)			

#### SECTION C: INFORMATION ABOUT THE INSURANCE COMPANY

Insurance Company Name:		Is this your Insurer? <input type="checkbox"/> YES <input type="checkbox"/> 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:	
	<input type="checkbox"/> AUTO	<input type="checkbox"/> HOME	<input type="checkbox"/> HOME - LANDLORD	<input type="checkbox"/> COMMERCIAL INSURANCE
	<input type="checkbox"/> LIFE	<input type="checkbox"/> HEALTH*	<input type="checkbox"/> GROUP	<input type="checkbox"/> INDIVIDUAL
*HEALTH, OTHER THAN PPO OR HMOS		<input type="checkbox"/> OTHER (please specify)		
Claim #:		Date Loss Occurred or Began:		
Adjuster's Name:		Adjuster's Phone #:		

<b>Full Name:</b>	<b>Date:</b>
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**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:** \_\_\_\_\_