

Life and Health Insurance Complaint/Appeal Form

Mail to:

State Corporation Commission Bureau of Insurance Life and Health Division P.O. Box 1157 Richmond, VA 23218

scc.virginia.gov/pages/Insurance

Toll-free: 1-877-310-6560 | Fax: (804) 371-9944

File a Complaint Online

You can call the Bureau of Insurance (BOI) for general information and assistance, or to confirm we are the appropriate agency to assist with your complaint or appeal. To file a complaint or request assistance in appealing a denial, please complete this form. Additional information may be required.

l am filing (check all applicable):	
 ☐ A complaint against a(n): ☐ Insurance company ☐ Insurance Agent ☐ A request for assistance in appealing an adverse determination by a Managed Care Health Insurance Plan 	
Type of Insurance Coverage:	
☐ Health (☐ HMO ☐ PPO Other) ☐ Dental ☐ Long-Term Care ☐ Medigap ☐ Disability ☐ Life ☐ Annuity ☐ Credit ☐ Other	
f you checked Health or Dental above, did you purchase coverage through the Health Insurance Exchange/ Marketplace? □Yes □ No □ I don't know	
nsured Information: Please provide information about the Insured person who needs help.	
me: Mr./Ms Date of Birth:	
Address:	
City: State: Zip Code:	
Preferred phone number: () Email:	
Representative Information: Complete this section if you are NOT the Insured but are requesting help on behalf of the Insured. Note: For the BOI to help the Insured, the Insured or applicable parent or legal guardian will have to sign this form unless the Insured is deceased, incapacitated, or under 18 years of age. In order for the BOI to discuss this complaint/appeal with the Representative below, the Insured or applicable parent or legal guardian must complete and sign the Representative Authorization statement on the back of his form.	
Name: Mr./Ms	
Relationship to the Insured: Date of Birth:	
Address:	
City: State: Zip Code:	
Preferred phone number: () Email:	

Complete Name of Insurance Company:			
☐ Policy Number ☐ Certificate Number □	□ ID Number:		
Source of Insurance Coverage: Group			
If your complaint involves an (circle one): Agent, Web Broker, Navigator, or other Assister, provide the following: Name: Organization/Agency:			
Address:		Zin Codo	
Street	City State separate sheet if necessary, and attach corre	<u>'</u>	
insurer if applicable.			
Insured Authorization: I have enclosed copies of correspondence related to this complaint and authorize the BOI to send a copy of this form and any or all enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I authorize the release of all medical records related to this complaint and authorize release of these medical records to the BOI and insurance company. I also authorize the BOI to obtain any information required to assist me.			
Signature of Insured (if 18 or over), parent or legal guardian (if Insured is under 18)			
	Date:		
<u>Representative Authorization:</u> If the Insured or (parent or legal guardian) authorizes the BOI to discuss this complaint/appeal and share information with the Representative named on the front of this form, the Insured or parent or legal guardian must complete and sign the following:			
appeal with, and (ii) share medical inform (Authorized Representative). Note: This a	t or legal guardian), authorize the BOI to: (i) distribution related to this complaint/appeal withuthorization is not necessary if the Represents of age, or if the Insured is deceased or incapa	ative is the parent or	
Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18)			
	Date:		