



INSURANCE DIVISION - HEALTH BRANCH
PO BOX 3614
HONOLULU, HAWAII I 96811-3614
PHONE NO: (808) 586-2804
FAX NO: (808) 587-5379
http://cca.hawaii.gov/ins/

COMPLAINT/INQUIRY FORM

ASSISTANCE IS NEEDED CONCERNING: [] A Complaint [] An Inquiry

YOUR INFORMATION

First MI Last

Street Number & Name City State Zip Code Island

Home Phone Business Phone Fax

Mobile Phone Email address

Name of insured person if different from above

Your relationship to insured person Authorized to represent [] Yes [] No

INSURER INVOLVED

My complaint/inquiry is about:

Note: The Insurance Division's Health Branch only has jurisdiction over insurers who provide health care insurance; the Health Branch does not have jurisdiction over hospitals, doctors, dentists or other health care providers, or employers. We also do not have jurisdiction over companies that sell health discount cards, Med-Quest or Worker's Compensation insurance. If you have a complaint about other lines of insurance or a producer (agent) selling insurance, contact the Insurance Division's Compliance and Enforcement Branch at (808) 586-2790.

Insurance Company

INSURANCE INFORMATION

The insurance policy related to the complaint/inquiry is: (check all that apply [only if you know])

First Level [] Group (coverage through an employer is group) [] Individual [] COBRA [] HIPAA Conversion
Second Level [] Health [] Dental [] Vision [] Prescription [] Long-Term Care [] Original Medicare
[] Medicare Advantage (Medicare + Choice) [] Medicare Supplement (Medigap) Specify
[] Medicare Select [] Medicare Prescription (Part D)
[] Other Specify
Third Level [] PPO [] HMO

Subscriber name Subscriber Number

Policy Number Claim number

Provide a Summary of your complaint or inquiry. Include (1) all information you believe to be relevant to your claim and (2) the issues of concern. **If you need more space please prepare and attach additional sheet(s).**

SUMMARY OF COMPLAINT OR INQUIRY

State what you would consider to be a satisfactory resolution to your concerns:

RELIEF

ATTACH COPIES OF DOCUMENTS YOU FEEL WILL SUPPORT YOUR COMPLAINT OR INQUIRY. **DO NOT SEND ORIGINALS**

NOTICE: A copy of this form (and any attachments) may be sent to the insurance company for a response and may be shared with other regulatory agencies with jurisdiction over this matter.

SIGN

Signature

Date