Clear Form Print

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
www.scc.virginia.gov/boi
1-877-310-6560 or TDD 804-371-9206; Fax# 804-371-9944

You can call the Bureau for general information and assistance. To file a complaint or request assistance in appealing a denial, please complete this form. We may have to ask you for more information.

I am filing (check all applicable):
☐ A complaint against a(n):
☐ Insurance company ☐ Insurance Agent/Web Broker ☐ Navigator ☐ Other Assister
☐ A request for assistance in appealing an adverse determination made by a Managed Care Insurance Plan

Type of Insurance Coverage:
☐ Health (☐ HMO ☐ PPO ☐ Other) ☐ Dental ☐ Long-Term Care ☐ Medigap
☐ Disability ☐ Life ☐ Annuity ☐ Credit ☐ Other _____

If you checked HMO, PPO or Dental, was your coverage purchased through the Health Insurance Exchange/ Marketplace or SHOP Marketplace?
☐ Yes ☐ No ☐ I don't know If Yes, do you have a Multi-state Plan? ☐ Yes ☐ No ☐ I don't know

If you checked Health, HMO or PPO under Type of Insurance Coverage and you have Individual coverage or coverage through a Small Employer, what level of coverage do you have?
☐ Platinum ☐ Gold ☐ Silver ☐ Bronze ☐ Catastrophic ☐ None of these ☐ I don't know

Please provide information about the insured person who needs help.

Name: ☐ Mr. ☐ Ms._____ Date of Birth: _____

Address: _____
Street City ST Zip Code

Home Telephone No.: (_____)_____ Cell Telephone No.: (_____)_____

Business Telephone No.: (_____)_____ E-Mail: _____

Complete this section if you are NOT the insured person and you are requesting help on behalf of the insured person. Note: In order for the Bureau to help the insured person, the individual will have to sign the form.

Name/Relationship to the Insured Person: ☐ Mr. ☐ Ms._____

Address: _____
Street City ST Zip Code

Home Telephone No.: (_____)_____ Cell Telephone No.: (_____)_____

Business Telephone No.: (_____)_____ E-Mail: _____

Complete Name of Insurance Company: _____

☐ Policy Number ☐ Certificate Number ☐ ID Number: _____

Source of Insurance Coverage: ☐ Group _____ ☐ Individual
(Name of employer or group association)

If your complaint involves an Agent, Web Broker, Navigator, or other Assister, (circle one) please provide the following:

Name: _____ Organization/ Agency: _____

Address: _____
Street City ST Zip Code

Web Broker Website Address: _____

Describe the issues involved in your complaint or appeal. Attach a separate sheet if necessary, and attach correspondence from insurer if applicable.

I am enclosing copies of all correspondence or other papers relating to this matter that may assist the Bureau of Insurance (BOI) in its evaluation of my complaint/appeal. I understand and agree that the BOI may send a copy of this form and any or all of the enclosed information to the party complained against, other regulated entities, or the appropriate state or federal agency. I also authorize the insurance company to release all medical records relating to this complaint/appeal to the BOI, and I authorize the BOI to release medical records relating to this complaint/appeal to the insurance company. I also agree that by signing this form, I authorize the BOI to obtain any other information required to evaluate my complaint/appeal.

Signature of person requesting assistance: _____

Signature of Insured Person
(if 18 or over and if different from above): _____

Date: _____

For questions concerning a complaint, you may contact the BOI's Consumer Services Section at 804-371-9691 or toll free in Virginia at 1-800-552-7945 or 1-877-310-6560. If you have any questions about filing an appeal, you may contact the BOI's Office of the Managed Care Ombudsman at 804-371-9032 or toll free at 1-877-310-6560.