The State of New Hampshire
Insurance Department

21 South Fruit St., Suite 14
Concord NH 03301-2430

Email: consumerservices@ins.nh.gov
Toll Free: 800-852-3416
Phone: 603-271-2261; Fax: 603-271-7066
TDD Access: Relay NH 1-800-735-2964
Website: www.nh.gov/insurance

Christopher R. Nicolopoulos
Commissioner

David J. Bettencourt
Deputy Commissioner

IMPORTANT CUSTOMER INFORMATION

The Insurance Department's primary responsibility is to enforce the insurance laws and rules of the state. Consistent with that responsibility, the Consumer Services Division (CSD) fulfills a threefold mission: educate residents about insurance products, companies and producers; assist residents who request help navigating the complexities and intricacies of the insurance industry; and work with other Department staff to investigate customer grievances to ensure that licensees, including companies and producers, comply with NH insurance laws and rules. With more than 100 years of insurance industry experience, the Department's Consumer Service Officers (CSO's) take great pride in their ability to assist customers and strive to satisfactorily reconcile grievances and mediate disputes.

If you have a question, issue of concern or need assistance, please contact the Department's Consumer Services Unit at 800-852-3416 or via email at consumerservices@ins.nh.gov. If you believe one of the Department's licensees has violated a New Hampshire insurance law or regulation or if you wish to submit a formal complaint, please submit the attached form. After reviewing your submission, if the CSO assigned to your case determines the Department has the jurisdictional authority to intervene on your behalf, he/she will forward your submission to the appropriate licensee for a response. Please note, while not all submissions rise to the level of a formal complaint, the Department treats all inquiries and assistance requests as confidential matters pursuant RSA 400-A:16, as they trigger investigations by the Department.

Also, please be aware that while the Department's CSO's will do everything within their regulatory authority to facilitate a customer friendly resolution, the Insurance Department is not always able to negotiate the remedy you desire.

If the issue of your submission does not fall within the jurisdiction of the Insurance Department, your CSO will attempt to determine which federal or state agency has jurisdictional authority and will refer your complaint to that agency, and will inform you of the referral by letter.

If, after submitting your complaint, you have any questions, issues or concerns, do not hesitate to contact a CSO, toll free, at 800-852-3416.

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CONSUMER COMPLAINT FORM

Please type or print clearly and return the completed form to either the physical or email address above.

1. Name of Complainant (Last, First, MI):

2. Mailing Address: (Street) (City) (State) (Zip Code)

3. Daytime Telephone Number: **Email Address:**

4. Name of Insured:

5. Who is the complaint against?

☐ **Company** ☐ **Agency** ☐ **Agent, Broker, Producer** ☐ **Adjuster** ☐ **Other:** _____

Name:_____

3. Address of above (if known): (Street) (City) (State) (Zip Code)

6. Group or Policy Number **Date of Issue**

7. Claim Number **Date of Loss**

8. Type of insurance (check one):

Property & Casualty Ins.: ☐ Automobile ☐ Homeowners ☐ Commercial ☐ Liability

Life, Accident & Health Ins.: ☐ Life ☐ Annuity ☐ Health ☐ Dental ☐ Long Term Care ☐ Disability Income

☐ Medicare Supplement ☐ Other: _____

9. Reason for complaint (check one):

☐ **Claim Delay / Denial** ☐ **Premium** ☐ **Cancellation** ☐ **Other:** _____

10. Have you attempted to resolve this matter with the company, agency, agent or other individual? ☐ **No** ☐ **Yes**

If yes, on what date _____ **Name of Person you spoke with (if known):** _____

Telephone Number(s): (____) _____, **(____)** _____, **(____)** _____

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11. Please describe your problem in detail. Attach additional pages, if necessary. Please include copies (not originals) of important papers, letters or other information that is relevant to this matter.

12. What would you consider to be a fair resolution of your problem?

********** **COMPLAINT INVESTIGATION DISCLOSURE** **********

The submittal of this complaint form will initiate an investigation of any Department licensee who is the subject of the identified complaint. Pursuant to RSA 400-A:16, II the Department will request and receive information and documentation, relevant to this investigation, from the named parties. Please note relevant information may include medical records. Also, the Department may share with the Department licensee any medical information and/or records provided in connection with this complaint.