



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: 603-271-1406

TDD Access: Relay NH 1-800-735-2964

Website: www.nh.gov/insurance

John Elias
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

IMPORTANT CONSUMER 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) acts as an intermediary to help resolve problems between consumers and department licensees, which include insurance companies and insurance agents. The Department's Consumer Service Officers (CSO's) strive to satisfactorily reconcile grievances and mediate disputes; and with more than 100 years of insurance industry experience, the Department's CSO's take great pride in their ability to assist consumers.

After reviewing your complaint, if the CSO assigned to your case determines the Department has the jurisdictional authority to intervene on your behalf, he/she will forward your complaint to the appropriate licensee for a response. By law (RSA 400-A:16 II), a licensee must provide its response to the Department within ten business days of receipt. If the complexity of the complaint requires additional time for the licensee to respond, an extension may be granted. Be assured, however, the Department will work diligently to ensure that your concerns are addressed as quickly as possible.

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

If the issues of your complaint do not fall within the jurisdiction of the Insurance Department, your CSO will attempt to determine which federal or state agency does have 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? <input type="checkbox"/> Company <input type="checkbox"/> Agency <input type="checkbox"/> Agent, Broker, Producer <input type="checkbox"/> Adjuster <input type="checkbox"/> 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.: <input type="checkbox"/> Automobile <input type="checkbox"/> Homeowners <input type="checkbox"/> Commercial <input type="checkbox"/> Liability Life, Accident & Health Ins.: <input type="checkbox"/> Life <input type="checkbox"/> Annuity <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Long Term Care <input type="checkbox"/> Disability Income <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Other: _____			
9. Reason for complaint (check one): <input type="checkbox"/> Claim Delay / Denial <input type="checkbox"/> Premium <input type="checkbox"/> Cancellation <input type="checkbox"/> Other: _____			
10. Have you attempted to resolve this matter with the company, agency, agent or other individual? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, on what date _____ Name of Person you spoke with (if known): _____ Telephone Number(s): (____) _____, (____) _____, (____) _____			

