GOVERNMENT OF THE UNITED STATES VIRGIN ISLANDS
OFFICE OF THE LIEUTENANT GOVERNOR
DIVISION OF BANKING AND INSURANCE

CONSUMER ASSISTANCE PROGRAM
COMPLAINT FORM

Complaint No.: _____
Date Opened: _____
Date Resolved/Closed: _____

COMPLAINANT:

Insured/Provider: _____

Mailing Address: _____

Telephone No.: **(_____) _____** (Home) (_____)_____(Work)
(_____) _____(Other) E-Mail:_____

Gender: ❑ Male ❑ Female Date of Birth (mm/dd/yyyy): _____

Language: ❑ English ❑ Spanish ❑ Other _____

Status: ❑ Insured ❑ Uninsured

Insurer: _____ Policy Number: _____

STATUS OF COMPLAINANT:

❑ INSURED ❑ PROVIDER ❑ EMPLOYER ❑ BROKER ❑ AGENT ❑OTHER

COMPLAINT AGAINST:

❑ AGENT ❑ BROKER ❑ PROVIDER ❑ EMPLOYER/ADMINISTRATOR X INSURANCE COMPANY ❑ OTHER

Indicate Individual's/Company's Name: _____
Address: _____

Telephone No.: _____ Facsimile No.: _____

E-Mail: _____

TYPE OF COVERAGE:

❑ AUTOMOBILE BODILY INJURY ❑ INDIVIDUAL HEALTH ❑ GROUP HEALTH

❑ OTHER _____

REASON FOR COMPLAINT:

❑ PREMIUM RATES ❑ REFUSAL TO INSURE ❑ ACCESS/COVERAGE

❑ CANCELLATION/RENEWAL/RECISSION ❑ AGENT HANDLING

❑ REIMBURSEMENT CHALLENGES ❑ CARE IS EXPIREMENTAL/INVESTIGATIONAL

❑ MISLEADING ADVERTISING ❑ DENIAL OF CLAIM/NON PAYMENT

❑ CLAIM HANDLING DELAYS ❑ UNSATISFACTORY SETTLEMENT

❑ PREEXISTING CONDITION ❑ NOT ELIGIBLE FOR HEALTH PLAN/BENEFITS

❑ CARE IS NOT MEDICALLY NECESSARY ❑ QUALITY OF SERVICE

❑ MISREPRESENTATION ❑ OTHER: _____

SUMMARY / REASON FOR COMPLAINT:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**

EXAMINER'S FINDINGS:

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature **Date**

Hearing Requested By: _____ Hearing Date: _____

Notice of Penalty: _____ Penalty Imposed: _____

Court Action: _____ Date: _____