



**Illinois Department of Insurance
Consumer Complaint Form
Life and Annuity**

320 W. Washington Street
Springfield, IL 62767
Phone 866-445-5364
TDD 217-524-4872
Fax 217-558-2083
doi.complaints@illinois.gov

Attention: A complaint may be filed by the policy owner only (unless deceased then by beneficiary or executor of the estate) or authorized representative if specific written permission is provided.*

| | | | |
|--|-----------------------|-------------------------------------|----------|
| Complainant Name (Person completing the form) (Mr. Ms. Mrs. Dr., etc.) | | Date | |
| Address | City | State | Zip Code |
| Phone Number(s) | Email Address | | |
| Name of Policy owner and/or Insured (if different from above) | | Your relationship to insured person | |
| Address | City | State | Zip Code |
| Phone Number(s) | Email Address | | |
| Insurance Company/Agency Name and Address | | Policy Number | |
| If Group Coverage, Name of Employer or Group | Employee Name | | |
| State of Purchase | Date of Claim or Loss | | |
| Your relationship to policy owner (one option must be selected and signed): | | | |
| <input type="checkbox"/> Self (Please read, sign and date) | | | |
| I authorize the Department of Insurance to investigate this complaint and to obtain financial and personal health information, if necessary, to conduct the investigation. | | | |
| Your Signature _____ Date _____ | | | |
| <input type="checkbox"/> Authorized Representative (If complainant is not policy owner, this section must be signed and dated by the policy owner unless deceased)* | | | |
| I authorize the Department of Insurance to investigate this complaint and to obtain financial and personal health information, if necessary, to conduct the investigation. I further authorize the above named complainant to file this complaint on my behalf and to have access to my financial and personal health information. | | | |
| Signature of Policy owner _____ Date _____ | | | |
| Please state your complaint (attach copies of all supporting documentation, and use back of page if necessary) | | | |
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Complainant Signature: _____ Date _____

Important Notice: Complaints filed with the Department of Insurance are confidential records and will not be released to any third parties, except the policy owner or authorized representative, or the party against whom the complaint has been filed.

