FINANCIAL
INSTITUTIONS
REGULATION BRANCH

# COMPLAINT FORM

The Superintendent of Insurance office will be sharing the information on this complaint form, and any additional information that you supply about your complaint, with the insurance company with whom you have the complaint.

The person you may contact about this matter is:

Superintendent of Insurance
Financial Institutions Regulation Branch
500-400 St. Mary Avenue
Winnipeg, Manitoba R3C 4K5
Telephone: (204) 945-2542
Toll Free Number outside Winnipeg: 1-800-655-5244

**CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION:**

I consent to the office of the Superintendent of Insurance for Manitoba collecting, using and disclosing the information contained on my complaint form. I also consent to the office of the Superintendent of Insurance for Manitoba collecting and using any additional information that I supply about my complaint, with the insurance company with whom I have the complaint, and with my agent or broker.

DATE _____ SIGNATURE _____

PRINT NAME _____

# COMPLAINT FORM

The office of the Superintendent of Insurance for Manitoba regulates insurance companies in accordance with the Insurance Act, and **does not** have the authority to settle claims. Complaints are reviewed to determine whether the insurance company has acted according to the Insurance Act.

**PLEASE FILL IN EVERY SECTION AS COMPLETELY AS YOU CAN.**

1. YOUR NAME _____

   ADDRESS _____

   _____

   PHONE NUMBER (  ) _____ Best time to call _____

2. INSURED'S NAME (If different from #1.) _____

   ADDRESS _____

   _____

   PHONE NUMBER (  ) _____

3. Have you contacted your insurance company about your complaint?
   (  ) YES (  ) NO

   **If you answered NO** to this question, please contact the company before filling out the rest of this form. The Superintendent of Insurance for Manitoba will not take any action on your complaint until you have made an effort to deal with it yourself.

4. How did you contact the insurance company?

   (  ) IN PERSON (  ) BY TELEPHONE (  ) BY LETTER

5. PERSON CONTACTED _____
   TITLE _____

   LOCATION _____

**COMPLAINT FORM** (Cont.)

6. INSURER'S NAME _____
LOCATION _____
POLICY NO. _____ CLAIM NO. _____

7. What is your complaint with the insurance company? Please give a brief description.

_____

_____

_____

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_____

8. Contact person's reply.

_____

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**COMPLAINT FORM** (Cont.)

If you contacted the insurance company by letter, please attach a copy of your letter to this form. Also attach a copy of the company's response if you received one.

Please attach copies (**DO NOT** send originals), of any documents that relate to this complaint.

**DO NOT SEND ANY MEDICAL INFORMATION**

Once your complaint has been reviewed, you will be contacted either by phone or by letter.