South Carolina Department of Insurance
Office of Consumer Services
Street Address: 1201 Main Street, Suite 1000, Columbia SC 29201
Mailing Address: P.O. Box 100105, Columbia, S.C. 29202-3105
Telephone: (803) 737-6180 or 1 (800) 768-3467
Fax: (803) 737-6231 | Email: consumers@doi.sc.gov

DOI use only

File# _____

Analyst _____

Consumer Complaint Form

My complaint is against (one or more): ☐ Insurance Company ☐ Agent/Broker ☐ Other

Please complete all information and enclose copies of correspondence and other papers that will help us investigate your complaint. Sign and date on back side at the bottom. Please Note: a copy of this form and any enclosed information will be sent to the party you are complaining about.

Section 1. Info of Person Filing Complaint (Complainant)

☐ Mr. ☐ Ms. Name _____

Street/Mailing Address _____

City _____ County _____ State _____ Zip _____

Phone: (Home) _____ (Cell) _____ (Work) _____ Email _____

Section 2. Policyholder Info

Age ☐ 1-24 ☐ 25-49 ☐ 50-64 ☐ 65+

Policyholder's Name _____

Policy # _____ Claim # _____ Date of Loss _____

Name of the Insurance Company You are Complaining About _____

Name of Agent/Agency/Adjustor _____

If Group Health Policy: Name of Employer _____ Group # _____

Section 3. Type of Policy (check one)

☐ Annuity
☐ Disability
☐ Life
☐ Warranty
☐ Personal Auto/ Motorcycle
☐ Individual Health
☐ Long Term Care
☐ Workers' Comp
☐ Commercial Auto
☐ Group Health
☐ Medicare Supplement
☐ Other
Specify plan A-L: _____
☐ Dental
☐ Homeowners/ Renters/ Mobile Homeowners

Section 4. Reason for Complaint (check one)

☐ Claim Delay
☐ Claim Denial
☐ Agent Handling
☐ Adjuster Handling
☐ Info Requested
☐ Misrepresentation
☐ Premium Problem
☐ Policy Problem
☐ Unsatisfactory Offer
☐ Non-Renewal
☐ Cancellation
☐ Other

Section 5. Details of Complaint (attach separate sheet if needed)

What do you consider to be a fair resolution to your problem?

Section 6. Attorney Representation

Does an attorney represent you in this matter? ☐ Yes ☐ No

If yes, we will need written authorization from your attorney in order for us to intervene in this matter. You may have your attorney co-sign this form or include a signed letter of authorization that is on the attorney's letterhead with this form.

Section 7. Signature Authorization

I declare that the information I have provided is true and accurate to the best of my knowledge. This information will be forwarded to the insurance company (and/or other party that is the subject of your complaint) for the investigation of this matter. I understand that, under South Carolina's Freedom of Information Act, this complaint becomes a public record once my file is closed (medical and personal records will remain confidential). By submitting this form, I am authorizing the SC Department of Insurance to pursue an investigation into my complaint and the party(ies) complained against to release all relevant information, documents, and records to the SC Department of Insurance.

Signature of Complainant: _____ Date: _____

***Please remember to include all relevant documents pertaining to your complaint that will assist with our investigation.