Clear Form Print

Life and Health Insurance Complaint/Appeal Form

Mail to:
State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
scc.virginia.gov/pages/Insurance
Toll-free: 1-877-310-6560 | Fax: (804) 371-9944
File a Complaint Online

You can call the Bureau of Insurance (BOI) for general information and assistance, or to confirm we are the appropriate agency to assist with your complaint or appeal. To file a complaint or request assistance in appealing a denial, please complete this form. Additional information may be required.

I am filing (check all applicable):

☐ A complaint against a(n):
☐ Insurance company ☐ Insurance Agent ☐ Navigator ☐ Other Assister
☐ A request for assistance in appealing an adverse determination by a Managed Care Health Insurance Plan

Type of Insurance Coverage:

☐ Health (☐ HMO ☐ PPO ☐ Other) ☐ Dental ☐ Long-Term Care ☐ Medigap
☐ Disability ☐ Life ☐ Annuity ☐ Credit ☐ Other _____

If you checked Health or Dental above, did you purchase coverage through the Health Insurance Exchange/ Marketplace?
☐ Yes ☐ No ☐ I don't know

Insured Information: Please provide information about the Insured person who needs help.

Name: Mr./Ms. _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred phone number: (____)_____ Email: _____

Representative Information: Complete this section if you are NOT the Insured but are requesting help on behalf of the Insured. **Note:** For the BOI to help the Insured, the Insured or applicable parent or legal guardian will have to sign this form unless the Insured is deceased, incapacitated, or under 18 years of age. In order for the BOI to discuss this complaint/appeal with the Representative below, the Insured or applicable parent or legal guardian must complete and sign the Representative Authorization statement on the back of this form.

Name: Mr./Ms. _____

Relationship to the Insured: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Preferred phone number: (____)_____ Email: _____

Complete Name of Insurance Company: _____

☐ Policy Number ☐ Certificate Number ☐ ID Number: _____

Source of Insurance Coverage: ☐ Group _____ ☐ Individual
(Provide the complete name of employer or group association)

If your complaint involves an (circle one): Agent, Web Broker, Navigator, or other Assister, provide the following:

Name: _____ Organization/Agency: _____

Address: _____

Street City State Zip Code

Describe your complaint or appeal. **Attach a separate sheet if necessary, and attach correspondence from insurer if applicable.**

Insured Authorization: I have enclosed copies of correspondence related to this complaint and authorize the BOI to send a copy of this form and any or all enclosed documents to the party complained against, other regulated entities, or the appropriate state or federal agency. I authorize the release of all medical records related to this complaint and authorize release of these medical records to the BOI and insurance company. I also authorize the BOI to obtain any information required to assist me.

Signature of Insured (if 18 or over), parent or legal guardian (if Insured is under 18)

_____ Date: _____

Representative Authorization: If the Insured or (parent or legal guardian) authorizes the BOI to discuss this complaint/appeal and share information with the Representative named on the front of this form, the Insured or parent or legal guardian must complete and sign the following:

I, _____ (insured, parent or legal guardian), authorize the BOI to: (i) discuss this complaint/ appeal with, and (ii) share medical information related to this complaint/appeal with _____ (Authorized Representative). **Note:** This authorization is not necessary if the Representative is the parent or legal guardian of an insured under 18 years of age, or if the Insured is deceased or incapacitated.

Signature of Insured (if 18 or over) or parent or legal guardian (if Insured is under 18)

_____ Date: _____