Consumer Complaint Form

Print and complete this form if you plan to scan, fax or email your complaint to our office. If you would like to submit your complaint online directly to our office, visit www.ksinsurance.org.

* Name: ________________________________________

* Address: _______________________________________

* City: __________________________________________

* State: _______ * ZIP: ____________________________

* County: _______________________________________

* Phone Number: _________________________________

* Email: _________________________________________

* If we need to contact you, what is your:

Preferred mode of contact (choose one):  
☐ Phone ☐ Email ☐ Mail

Preferred time: ☐ A.M. ☐ P.M.

Department hours:  
M-F 8 a.m. to 5 p.m.

* Who is the complaint against? Provide the name of the one or more of the following:

Name of Insurance Company: ________________________________

Name of Insurance Agent/Agency: ________________________________

Name of Insurance Adjuster or Appraiser: ________________________________

Name of Insured: _____________________________________________

Policy Number: ________________________________ Claim Number: ________________________________

Date and Location of Loss: ________________________________ Amount Disputed: ________________________________

* Type of Insurance (choose one):

☐ Annuity ☐ Disability ☐ Life ☐ Title
☐ Auto ☐ Group Health ☐ Long-Term Care ☐ Workers Compensation
☐ Commercial ☐ Home ☐ Medicare Supplement ☐ Other:
☐ Dental ☐ Individual Health ☐ Renters ☐

* Reason for Complaint (choose one):

☐ Agent Handling ☐ Delays/No Response ☐ Premium & Rating ☐ Unsatisfactory
☐ Cancellation ☐ Information Requested ☐ Premium Notice/Billing Settlement/Offer
☐ Claim Delay ☐ Misrepresentation ☐ Billing ☐ Other:
☐ Claim Denial ☐ Non-renewal ☐ Premium Refund ☐

ADDITIONAL INFORMATION IS REQUIRED ON THE BACK SIDE OF THIS FORM
When you have completed this form, send it to:

Kansas Insurance Department:  
Attn: Consumer Assistance Division  
Fax: 785-296-5806  
1300 SW Arrowhead Rd.  
Topeka, KS 66604  
Email: kid.webcomplaints@ks.gov

What is your desired outcome?:

* Signature: ____________________________

Authorization

The Insurance Commissioner is authorized to send a copy of this complaint and any follow-up documents to any insurance company or agent/agency in order to investigate my concerns. I authorize the release of all relevant information, including medical records, to the Insurance Commissioner’s office cannot provide legal advice, I further understand and agree that the contents herein may be forwarded to other appropriate state or federal agencies, as well as become accessible to others under the Kansas Open Records Act. Finally, I declare and verify under penalty of perjury and the laws of Kansas that all of the above information is true and correct to the best of my knowledge.

* Signature: ____________________________

Attach any supporting documentation relating to your complaint review.  
Keep original copies.