Department of Commerce & Consumer Affairs (DCCA)

upholding fairness in the marketplace

INSURANCE DIVISION - HEALTH BRANCH
PO BOX 3614
HONOLULU, HAWAI`I 96811-3614
PHONE NO: (808) 586-2804
FAX NO: (808) 587-5379
http://cca.hawaii.gov/ins/

COMPLAINT/INQUIRY FORM

ASSISTANCE IS NEEDED CONCERNING: ☐ A Complaint ☐ An Inquiry

YOUR INFORMATION

First ________ MI ____ Last ________

Street Number & Name ________ City ________ State ____ Zip Code ____ Island ________

Home Phone ________ Business Phone ________ Fax ________

Mobile Phone ________ Email address ________

Name of insured person if different from above ________

Your relationship to insured person ________ Authorized to represent ☐ Yes ☐ No

INSURER INVOLVED

My complaint/inquiry is about:

Note: The Insurance Division's Health Branch only has jurisdiction over insurers who provide private, fully insured health care insurance issued in Hawaii. The Health Branch does not have jurisdiction over federal plans such as Medicare, Medicaid (QUEST), TRICARE and the Federal Employees Health Benefits Program. The Health Branch also has no jurisdiction over hospitals, doctors, dentists or other health care providers, employers, health discount plans, or Worker's Compensation Insurance. If you have a complaint about other lines of insurance, contact the Insurance Division's Compliance and Enforcement Branch at (808) 586-2790.

Name of Insurance Company/Agency/Insurance Agent ________

INSURANCE INFORMATION

The insurance policy related to the complaint/inquiry is: (check all that apply [**only if you know**])

First Level ☐ Group (coverage through an employer is group) ☐ Individual ☐ COBRA ☐ HIPAA Conversion

Second Level ☐ Health ☐ Dental ☐ Vision ☐ Prescription ☐ Long-Term Care

☐ Medicare Supplement (Medigap) Specify ____

☐ Other Specify ________

Third Level ☐ PPO ☐ HMO

Subscriber name ________ Subscriber Number ________

Policy Number ________ Claim number ________

SUMMARY OF COMPLAINT OR INQUIRY

Provide a Summary of your complaint or inquiry. Include (1) all information you believe to be relevant to your claim and (2) the issues of concern. **If you need more space please prepare and attach additional sheet(s).**

RELIEF

State what you would consider to be a satisfactory resolution to your concerns:

SIGN

ATTACH COPIES OF DOCUMENTS YOU FEEL WILL SUPPORT YOUR COMPLAINT OR INQUIRY. **DO NOT SEND ORIGINALS**

NOTICE: A copy of this form (and any attachments) may be sent to the insurance company for a response and may be shared with other regulatory agencies with jurisdiction over this matter.

Date

Signature