Consumer Complaint Form

Print and complete this form if you plan to scan, fax or mail your complaint to our office. If you would like to submit your complaint online directly to our office, **CLICK HERE** to go to our online submission form.

***First Name:** **Middle Name:**

***Last Name:**

***Address:**

***City:** ***State:** ***ZIP:**

County: ***Phone Number:**

Email address:

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

Name of Insurance Company:

Name of Insurance Agent/Agency:

Name of Insurance Adjuster or Appraiser:

Policy Number: **Claim Number:**

Date of Loss: **Amount Disputed:**

***Type of Insurance (choose one):**

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

***Reason for Complaint (choose one):**

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

***Denotes a required field**

***Details of Complaint**

Don't forget to attach any supporting documentation you'd like to give our office when you fax or mail this form.

When you have completed this form, send it to:

Kansas Insurance Department
Attn: Consumer Assistance Division
420 SW 9th Street
Topeka, KS 66612-1678
Fax: (785) 296-5806
Email: webcomplaints@ksinsurance.org