OFFICE OF
INSURANCE AND SAFETY FIRE COMMISSIONER

JOHN W. OXENDINE
COMMISSIONER OF INSURANCE
SAFETY FIRE COMMISSIONER
INDUSTRIAL LOAN
COMMISSIONER
COMPTROLLER GENERAL

SEVENTH FLOOR, WEST TOWER
FLOYD BUILDING
2 MARTIN LUTHER KING JR. DRIVE
ATLANTA, GEORGIA 30334
(404) 656-2056 or (404) 656-4031
www.gainsurance.org

Memorandum

To: Consumers

From: Consumer Services Division

Re: Instructions for completing CCF (Consumer Complaint Form, GID-CS-CF-1)

Please use the complaint form attached when mailing or faxing your insurance issues to the department.

- Please include your e-mail address for communication purposes
- Complete form along with date and signature
- Attach copies of pertinent documents to support your complaint
- Maintain originals for your records
- Mail or fax (not both) the completed form and all documents to the address below.

On receipt of your complaint, a case will be created and assigned to an investigator in the Consumer Services Division. You will receive an acknowledgement letter stating your case number and the name of your investigator.

Once a response is received from the carrier, the investigator will notify you with a written response. Please allow adequate time for the process.

Mailing address: Georgia Insurance Commissioner's Office
Consumer Services Division
2 Martin Luther King Jr., Drive
Suite 716 West Tower
Atlanta, GA 30334

THE OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN, SEX, RELIGION, AGE OR DISABILITY IN EMPLOYMENT OR THE PROVISION OF PROGRAMS OR SERVICES.

OFFICE OF INSURANCE AND SAFETY FIRE COMMISSIONER

John W. Oxendine, Commissioner

CONSUMER SERVICES DIVISION

2 MARTIN LUTHER KING, JR., DRIVE, SUITE 716, WEST TOWER, ATLANTA, GA 30334

www.gainsurance.org

COMPLAINT FORM

FORM GID-CS-CF-1

Rev. 07/07

Telephone: (404) 656-2070 **TDD: (404) 656-4031** **Fax: (404) 657-8542**

Type of Insurance:

_____ Automobile _____ Homeowners _____ Life & Annuity _____ Accident & Health _____ Commercial _____ Miscellaneous

FOR OFFICIAL USE ONLY
OP. DATE: _____ *CL. DATE:* _____ *CASE#:* _____
INQ: _____ *REGARDING:* _____ *TYPE:* _____ *REASON:* _____
DISPOSITION: _____ *COUNTY:* _____ *NAIC#:* _____
INVESTIGATOR: _____

COMPLAINANT INFORMATION

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

INSURED INFORMATION
(If different from complainant)

NAME: _____

ADDRESS: _____

_____

HOME PHONE: _____

WORK PHONE: _____

CELL PHONE: _____

EMAIL: _____

INSURANCE COMPANY INFORMATION

COMPANY NAME: _____

TELEPHONE: _____

POLICY NO.: _____

CLAIM NO.: _____

DATE OF LOSS: _____

POLICY PERIOD: _____

ID. NUMBER: _____

AGENCY/ADJUSTER INFORMATION

AGENCY NAME: _____

AGENT/ADJUSTER NAME: _____

_____

ADDRESS: _____

PHONE: _____

Explain your complaint fully in the order of events. Use the back of this form or additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Authorization & Release: By signing below, I hereby authorize Commissioner John Oxendine and members of his staff to receive and disclose such information, including protected health or financial information, as they may deem necessary and appropriate for purposes of making inquires into the subject matter contained herein and all matters related thereto. I further acknowledge that the information contained in this form is accurate to the best of my knowledge. A copy of this request may be shared with any/all parties involved.

_____ Date

_____ Signature

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Print the Form

Reset Form