Department of Commerce

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
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OFFICE OF THE INSURANCE COMMISSIONER

COMPLAINT QUESTIONNAIRE

INSTRUCTIONS:
Give us a brief statement as to what the insurance company/agent has done or has failed to do, and what you would like the Insurance Commissioner to do to help you.

Date:__________________ Phone Number:__________________

Complainant:____
Last Name First Name Middle Initial

Address:______________________ City:_________________State:______Zip:_______

Insured: (if other than complainant:____

Address:______________________ City:_________________State:______Zip:_______

Name of Insurance Company:________________________ Policy:__________________
(Life, Hospitalization, Auto, Fire, etc)

I submit the following information and represent that such information is accurate to the best of my knowledge and ability:

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You may use reverse side to complete your statement

By my signature, I hereby acknowledge that the facts relating to the complaint will become a matter of public record.

Signature:________________________________

You will hear from us in writing as soon as we have definite information.