THE INSURANCE COMMISSION
OF THE BAHAMAS

ICB REFERENCE NO. _____
(For official use only)

COMPLAINT FORM

COMPLAINANT INFORMATION

Full Name: _____ P.O. Box: _____

Address: _____ D.O. B. _____

Telephone: _____ (home) _____(work) _____ (mobile)

Email address: _____

Relationship to the Policyholder/Insured: _____

POLICYHOLDER INFORMATION

Are you the policyholder? YES ☐ NO (If NO, please give policyholder details below):

Full Name: _____ P.O. Box: _____

Address: _____ D.O. B. _____

Telephone: _____ (home) _____ (work) _____ (mobile)

Email address: _____

POLICY INFORMATION

Type of Insurance Policy: Auto ☐ Home ☐ Life ☐ Medical ☐ Other _____

Policy Number_____ Name of Insurance Company _____

COMPLAINT INFORMATION

1. Have you officially filed a complaint with your insurance company? YES ☐ NO ☐
2. Has the insurance company given you its final position in writing regarding your complaint? YES ☐ NO ☐
3. Has there been any court/tribunal/arbitration proceeding related to this complaint? YES ☐ NO ☐

   (If YES, please provide details):

_____

_____

_____

_____

THE INSURANCE COMMISSION
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Provide the name of the person(s) you contacted at the insurance company.

Full Name _____

Full Name _____

SUMMARY OF YOUR COMPLAINT (Please provide full details of complaint below):

WHAT DO YOU WANT THE COMMISSION TO DO?

Printed Name: _____

Signature: _____

Date: _____