



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):

