

ICB REFERENCE NO.	
(For official use only)	

COMPLAINT FORM

СО	MPLAINANT INFORMATION					
Full Name: Address:			P.O. Box:			
			D.O. B			
Tel			(work)	(mobile)		
	ail address:					
Rel	ationship to the Policyholder/Insu	ıred:				
РО	LICYHOLDER INFORMATION					
Are	you the policyholder? YES	NO ☐ (If NO, plea	se give policyholder details below):			
Ful	Name:		P.O. Box:			
Ad	dress:		D.O. B			
Tel	ephone:(home)	(work)	(mobile)		
Em	ail address:					
PO	LICY INFORMATION					
	_	Home ☐ Life	☐ Medical ☐ Other			
Pol	icy Number	Nam	ne of Insurance Company			
СО	MPLAINT INFORMATION					
1.	Have you officially filed a comple	aint with your insura	ince company?	YES 🗆	NO □	
2.	Has the insurance company give	n you its final positi	on in writing regarding your complaint?	YES 🗆	νо □	
3.					νо □	
	(If YES, please provide details):					
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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 I	pelow):		
WILLAT DO VOLL	WANT THE COMMI					
WHAT DO TOO	WANT THE COMMI	5510N 10 DO?				
Printed Name:						
Signature:				<u> </u>		
Date:						

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