Print Form

INSURANCE DIVISION
STATE OF HAWAII
P.O. Box 3614
Honolulu, Hawaii 96811
Telephone (808) 586-2790

FOR INTERNAL USE ONLY

CMP NO._____
INVESTIGATOR_____
DISP: REF___RO___INQ___RSL___
DATE CLOSED:_____

COMPLAINT/INQUIRY FORM

ASSISTANCE IS NEEDED CONCERNING: ☐ A Complaint ☐ An Inquiry

PLEASE PRINT OR TYPE:

Your Name	Name of Insurance Company/Agency/ Individual Involved
Address	Address
City, State, Zip Code	City, State, Zip Code
Bus / Res. Telephone Number	Telephone Number

Please indicate policy number and/or claim number, if known: _____

STATE THE RELIEF SOUGHT:

STATE A SUMMARY OF COMPLAINT/INQUIRY:

(Continuation of Summary of Complaint/Inquiry)

ATTACH COPIES OF PERTINENT DOCUMENTS. **DO NOT SEND ORIGINALS.**

NOTICE: A copy of this form may be sent to the insurance company And/or individual involved.

Your Signature _____ Date _____

Rev. 8/25/06