

**MISSISSIPPI INSURANCE DEPARTMENT**

P.O. BOX 79

JACKSON, MS 39205-0079

Phone: 601-359-3569 or 1-800-562-2957

FAX: 601-359-2474

**COMPLAINT FORM (AGENT COMPLAINT)**

**Documents that you submit to the Mississippi Department of Insurance to assist us in examining your complaint may be subject to the Mississippi Public Records Act of 1983. ALL SPACES APPLICABLE MUST BE COMPLETED.**

**INSTRUCTION FOR COMPLETION OF FORM:**

1. Fill in the information below applicable to your complaint.
2. TYPE OR PRINT IN BLUE/BLACK INK AND WRITE CLEARLY.
3. Please send proof of payment or other documentation to support your position. (Copies only, no originals)

1. YOUR NAME AND RELATIONSHIP TO INSURED

2. NAME OF COMPLAINANT

3. MAILING ADDRESS (STREET) (CITY) (COUNTY) (STATE) (ZIP CODE)

4. DAYTIME TELEPHONE NUMBER

5. NAME OF INSURED

6. MAILING ADDRESS (STREET) (CITY) (COUNTY) (STATE) (ZIP CODE)

7. DAYTIME TELEPHONE NUMBER

8. COMPLETE NAME OF INSURANCE COMPANY, AGENT OR AGENCY COMPLAINT IS AGAINST

9. ADDRESS OF ABOVE (IF KNOWN) (STREET) (CITY) (ZIP CODE)

10. TYPE OF COVERAGE(CIRCLE ONE)

AUTO	HOMEOWNERS	COMMERCIAL	LIABILITY	LIFE	HEALTH	DISABILITY INCOME
DENTAL	LONG TERM CARE	ANNUITY	MEDICARE SUPPLEMENT	OTHER _____		

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