

Request for Assistance (RFA)

Required fields are marked with an asterisk. *

| Complainant's Information | n | |
|-----------------------------|-----------------------|------------------------------------|
| *First Name | Middle Name | *Last Name |
| *Address Line 1 | | |
| Address Line 2 | | |
| *City | *State | *Zip |
| County | *Country | International Zip |
| Email Address | | |
| *Phone | EXT | How do you prefer to be contacted? |
| Alternate Phone | EXT | |
| Insured's Information (if d | lifferent than above) | |
| First Name | Middle Name | Last Name |
| | | |
| Other Parties Involved in t | this Problem | |
| First Name | Last Name | Description |
| First Name | Last Name | Description |

| Other Parties Involved | d in this Problem <i>(cont.)</i> | | | |
|--------------------------|----------------------------------|------------------------|--|--|
| First Name | Last Name | | Description | |
| First Name | Last Name | | Description | |
| | | | | |
| * Who is the complaint | | e of one or more of th | ne parties you are complaining against.) | |
| a. Name of Insurance (| • | e of one of more of an | e parties you are complaining against.) | |
| b. Name of Insurance A | - √gency | | | |
| c. Name of Agent | me of Agent | | d. Name of Adjuster/Appraiser | |
| First Name | Last Name | First Name | Last Name | |
| In what state did you po | urchase this plan? | How was the F | Policy purchased? | |
| Policy Number | Certificate N | lumber | Claim Number | |
| Date of Loss/Service | Date of Purc | chase | Date of Cancellation | |
| Insured Age Group | Amount in D | Dispute | * Type of Insurance | |
| * Reason for Complain | t (use additional paper if ne | eded): | | |
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| Details and Supporting Documents |
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| * Details of Complaint (use additional paper if needed): |
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| In order for us to effectively begin our investigation, please provide any supporting documentation you may have related to this matter along with this Request for Assistance (RFA) form. |
| If mailing this form and any supporting documents, send to: Oklahoma Insurance Department Consumer Assistance/Claims Division 400 NE 50th Street Oklahoma City, OK 73105 |
| If faxing this form and any supporting documents, send to: (405) 521-6652 |
| Authorization |
| * The Insurance Commissioner is authorized to send a copy of this complaint and any follow-up documents to any insurance company or agent/agency in order to investigate my concerns. I authorize the release of all relevant information, including medical records, to the Oklahoma Insurance Department (OID) for its review of this matter. I understand OID cannot act as my attorney, cannot file a private action on my behalf, and cannot provide legal advice. I further understand and agree that the contents herein may be forwarded to other appropriate state or federal agencies, as well as become accessible to others under the Oklahoma Open Records Act. Finally, I declare and verify under penalty of perjury and the laws of Oklahoma that all of the above information is true and correct to the best of my knowledge. |
| * Authorization: Signature: |