

State of Nevada
Department of Business and Industry
DIVISION OF INSURANCE – COMPLAINT FORM

Mail to: 788 Fairview Dr #300
Carson City, NV 89701
(775) 687-4270 Tel
(775) 687-3937 Fax

Mail to: 2501 E Sahara Ave #302
Las Vegas NV 89104
(702) 486-4009 Tel
(702) 486-4007 Fax

Initial this box if you wish the Division of Insurance to treat records of your complaint as confidential

ARE YOU REPRESENTED BY AN ATTORNEY? Yes _____ No _____
If yes, please be advised the Division can not intercede on your behalf.

*****Please complete this form as accurately as possible and return it to the office checked above*****

Your Name: _____

Your Address: _____

City: _____ State: _____ Zip: _____

Telephone No: _____ E-mail _____

Is this a claim against a policy you purchased? Yes _____ No _____ NV License Plate No: _____

If no, whose policy are you making a claim under? _____
Individual's Name

REMEMBER INSURANCE AGENT AND INSURANCE COMPANY ARE NOT THE SAME

Name of Insurance Company: _____

Policy No: (If known): _____ Claim No. : _____

Date of Loss/Accident/Illness: _____

Agent's Name (If known): _____ Phone No. : _____

Adjuster's Name (If known): _____ Phone No. : _____

RELEASE FOR INFORMATION:

- I certify that the information furnished by me in support of this complaint is to the best of my knowledge true and correct.
- If this complaint involves medical records, I hereby authorize my medical providers to release those records and information relating to this complaint. Any medical information released to the Division will be kept confidential.
- I have read and understand this release.

Signature: _____ Date: _____

