

Investigation Request Form

Use this form to request an investigation of an insurance agent, adjuster or broker.

* Indicates a required field

I. Your contact information

* Name: _____
* Address: _____
* City: _____ * State: _____ * Zip: _____
* Home phone: () _____ Work phone: () _____
Cell phone: () _____ Email: _____

Insured contact information (* if different than above)

Name of policyholder: _____
Address: _____
City: _____ State: _____ Zip: _____
Home phone: () _____ Work phone: () _____
Cell phone: () _____ Email: _____

2. Insurance information

* Insurance company: _____
Policy #: _____

3. Insurance agent or agency information

* Agent/Broker name: _____
Company name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: () _____

4. What is the problem you want investigated?

* Give a brief explanation of the problem: _____

5. Authorization for records & public records disclosure

I authorize any insurance company, health care service contractor, health maintenance organization, or Multiple Employer Welfare Arrangement that has any record of, or knowledge about, the insured named on this form, to provide that information to the Washington State Office of the Insurance Commissioner. The information shared may be copies of any records or any other information. This includes any medical records and claim files. A photographic copy of this authorization is as valid as the original.

Some parties, such as health care providers, may require you to complete an additional authorization or release before they release your medical records to us. Whether we receive your medical records may depend on whether you complete the additional authorization or release. If we need additional information from you, we will request it. We will share your information only if we need to in order to provide the services you requested, or if we are required to do so by law.

Your complaint and any related documents you submit will become public records. Under state law, public records are subject to public records disclosure requests. We will protect information you provide us to the maximum extent of the law. However, under some circumstances, your complaint and related documents may be seen by other people. Please keep this in mind when you give us personal information.

* Insured or representative signature: _____

* Date: ____ / ____ / ____

* Nature of representation (parent, guardian, power of attorney, etc.): _____

6. Submit documents

Are you sending supporting documents? Yes No

If yes, please do not send original documents, copies only please.

Once you have completed this form, please mail or fax it and all (if any) supporting documents to:

Washington State Office of the Insurance Commissioner

P.O. Box 40255

Olympia, WA 98504-0257

or Fax to: (360) 664-2782

7. Declaration

By filling in my name and date below, I declare the information contained on this form is true and accurate.

* Name: _____ * Date: ____/____/____

If you have any questions, please contact investigations at (360) 725-7060
or email InvestigationRequest@oic.wa.gov