



## ASSISTANCE FORM

My complaint is against (one or more): ☐ Insurance company ☐ Pre-need company ☐ HMO  
☐ Agent or broker ☐ Others \_\_\_\_\_

Please completely fill out this form and attach the documents listed below, as well as other documents and correspondence that will help us investigate your complaint. You may mail or personally deliver the filled-out form and its attachments to the Insurance Commission's Main Office and District Offices, or email it to [publicassistance@insurance.gov.ph](mailto:publicassistance@insurance.gov.ph). Please note that a copy of this form and its attachments may be forwarded to the company / party you are complaining against.

### REQUIRED ATTACHMENTS

#### For complaints against non-life insurance companies:

- (1) Copy of the policy;
- (2) Copy of the denial letter, if any; and
- (3) Copy of supporting documents, if any.

#### For complaints against HMOs:

- (1) Copy of the contract

#### For complaints against life insurance companies:

- (1) Copy of the policy;
- (2) Copy of the denial letter, if any; and
- (3) Copy of the supporting documents, if any.

#### For complaints against pre-need companies:

- (1) Copy of the contract; and
- (2) Copy of the Certificate of Full Payment

PLEASE PRINT, TYPE OR WRITE LEGIBLY IN BLACK OR BLUE INK

### 1 COMPLAINANT'S INFORMATION

☐ Mr. ☐ Ms. ☐ Mx. \_\_\_\_\_  
LAST NAME FIRST NAME MI  
ADDRESS \_\_\_\_\_  
PHONE NO. \_\_\_\_\_ MOBILE NO. \_\_\_\_\_  
EMAIL \_\_\_\_\_

### 2 POLICY / CONTRACT INFORMATION

NAME OF POLICYHOLDER / PLANHOLDER / MEMBER \_\_\_\_\_  
ISSUING COMPANY \_\_\_\_\_  
POLICY / PLAN / CERTIFICATE NO. \_\_\_\_\_ DATE ISSUED \_\_\_\_\_  
NAME OF POLICY / PLAN / PRODUCT \_\_\_\_\_  
NAME OF AGENT / BROKER / INTERMEDIARY (if applicable) \_\_\_\_\_

### 3 TYPE OF PRODUCT

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Fire insurance   | <input type="checkbox"/> Marine insurance            | <input type="checkbox"/> Motor car insurance   |
| <input type="checkbox"/> Health insurance | <input type="checkbox"/> Personal accident insurance | <input type="checkbox"/> Engineering insurance |
| <input type="checkbox"/> Life insurance   | <input type="checkbox"/> Microinsurance              | <input type="checkbox"/> HMO                   |
| <input type="checkbox"/> Pre-need         | <input type="checkbox"/> Others _____                |  |

### 4 REASON FOR COMPLAINT (Choose all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Denial of claim                    | <input type="checkbox"/> Issues with claims payment | <input type="checkbox"/> Issues with premium / fee |
| <input type="checkbox"/> Issues with renewal / cancellation | <input type="checkbox"/> Others _____               |  |

## This image shows a full page of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page, typical of notebook or legal stationery. There are no margins, text, or other markings on the page.

I declare that the information I have provided is true and accurate. I hereby authorize the entities / persons complained against to release all relevant claim and policy information, as well as documents, to the Insurance Commission upon request.

Signature over printed name of complainant \_\_\_\_\_ Date \_\_\_\_\_