FORM A

Department of Health Regulatory Services
HEALTH INSURANCE COMMISSION
Complaint Intake Form

Remain Anonymous Y N **Resident Y N**

FORM MUST BE SIGNED AND WITNESSED. PLEASE COMPLETE IN INK & BLOCK LETTERS.

Last Name	First Name	Middle Initial	Date of Birth (dd/mm/yy)	Gender:

Physical Address (Complainant):	Postal Address (Complainant):	Telephone Contact # (Complainant):
Email Address (Complainant):	Employer's Contact #	Employer's Postal Address:
Employer(s) Name	Operating or T/A name (if different)	Employer's Email Address:
Employer's Physical Address		Start Date of Employment:
Insured's Name (if different)		End Date of Employment (if applicable)
Name of Insurance Company		Occupation:
Policy or Contract ID Number		
Policy Start Date (if applicable)	Policy End Date (if applicable)	Reason for Policy Termination (if applicable)

Briefly describe your complaint. Please attach copies of all relevant documents.

If you need more space, please attach additional sheets.

How would you like your problem resolved?

After fully understanding the following, please sign and date this form below:
To the best of my knowledge, the above statements are correct. I understand that a copy of this form and any attachments that are needed may be shared with necessary organizations or individuals (e.g. approved insurer, employer). I authorize the approved insurer, medical facility/practitioner or employer to release all necessary records relating to this complaint to the Health Insurance Commission (HIC) and I authorize the HIC to release only essential information, relating to this complaint to required persons in order to assist with the investigation. I also give authorization to the HIC to obtain records from practitioners, medical departments (private or public) and employers on my behalf. I represent that I have the proper authority to execute this release.

Signature (Complainant)	Print Name	Date (dd/mm/yy)
Signature of Witness:	Print Name	Date (dd/mm/yy)

133 Elgin Avenue Government Administration Building, George Town
P.O. Box 132 Grand Cayman KY1-9000 Cayman Islands
Tel: 345.946.2084 Fax: 345.946.2845
E-mail: hic@gov.ky Website: www.dhrs.gov.ky