REQUEST FOR ASSISTANCE

TO

OKLAHOMA INSURANCE DEPARTMENT 400 NE 50th Street Oklahoma City, OK. 73105

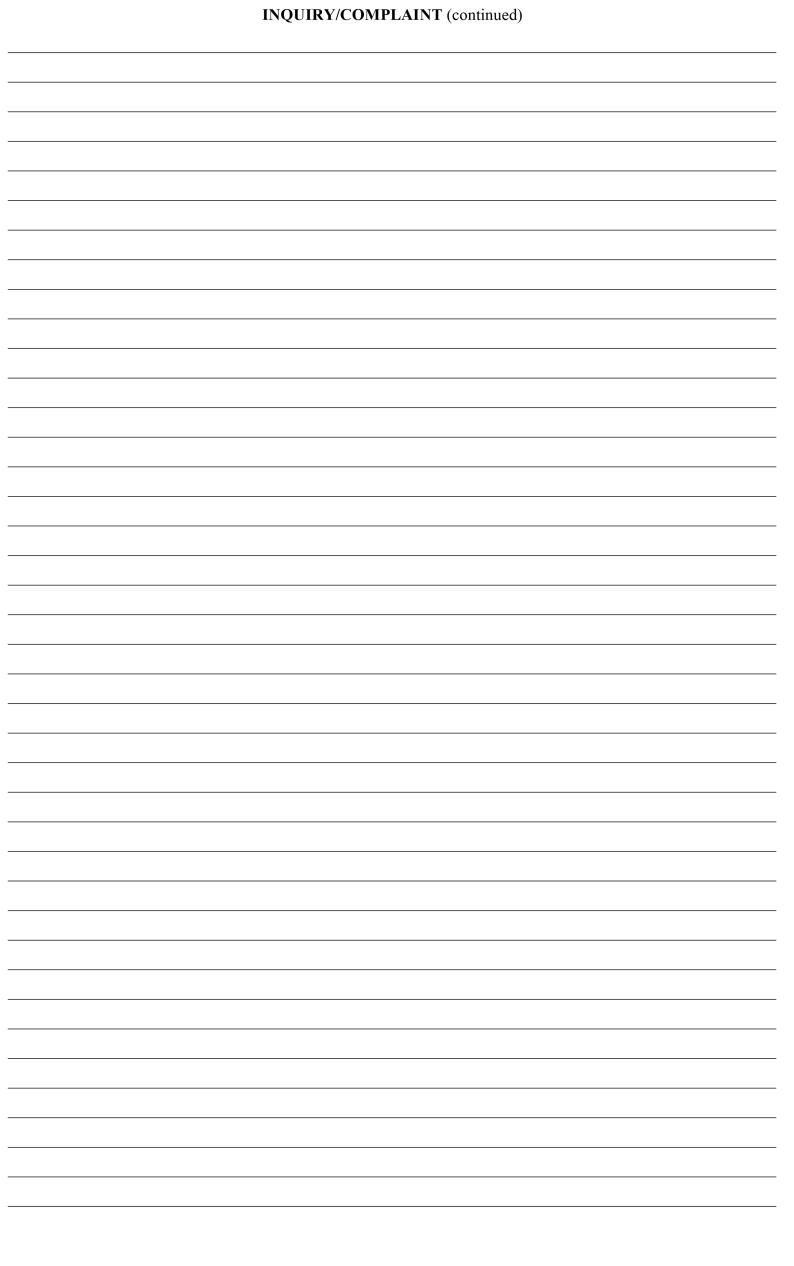


DATE: ______
Consumer Assistance
Phone: 1-800-522-0071

Local: 405-521-2991 Fax: 405-521-6652

□Mr. □Mrs. FROM: □Ms.		Т	Felephone # (
			Zip:
			erson requesting assistance, complete the
Insured or HMO Member ³	's name:	T	Selephone #: ()
			Zip:
Name of INSURANC	E CO. about which you are	requesting assistance:	
Address:		City/State:	Zip:
Policy Number:	Effective Date:	Type of Ins	surance: (Auto, Home, Commercial, Accident & Health)
Agent's Name:		Telephone No.: _((Auto, nome, Commercial, Accident & nearth)
Address:		City/State	Zip
Adjuster's Name:		Telephone No.: _(_))
Address:		City/State	Zip
Name of HMO shouts		iatanaa	
	, ,		<i>T</i>
			Zip:
)
Address:		City/State	Zip
Provider's (Hospital) Nam	ıe:	Telephone No.: _(_)
Please give as detailed infor Other correspondence relate	mation as possible including dates	RY/COMPLAINT s, explanation, and what solut	tion you feel is correct, Attach copies of any
identity and release the OKI		TMENT and its duly authori	(Continue on the back) cords including any information concerning m zed agents and employees from any liability in
Signature:		Date:	
	FOR INSURANCE	DEPARTMENT USE	ONLY
Complaint number	Claim Analyst	Date Entered	Med. Supl. (A-J)
Complainant type	Complainant letter	Coverage	1 2 3
Entity number 1	2 3		1 2 3
Entity type 1	2 3		1 2 3
Entity function 1	2 3	Inquirer	(If not same as above)
Entity letter 1	2 3		Amount \$

CLAIMS OID 11/04



CLAIMS OID 11/03