



Insurance Complaint Form Door rates & Short pay

Date _____

Person Filing the Complaint

Name _____

Business Name _____

Mailing Address _____

City _____ State _____ Zip _____

E-mail Address _____ Phone (Day) _____

Vehicle Owner

Name _____

Mailing Address _____

City _____ State _____ Zip _____

E-mail Address _____ Phone (Day) _____

Vehicle Owner is: Claimant _____ Insured _____

Vehicle/Insurance

Make _____ Model _____ Year _____

VIN _____ Date of Loss _____

Insurance Company _____ Claim # _____

Insurance Contact Name _____

E-mail _____ Phone _____

Details of Complaint

6.11(3)(a)4. Insurance company is engaging in unfair claims settlement practices by failing to attempt in good faith to effectuate fair and equitable settlement of claims submitted in which liability has become reasonably clear.

The insurance company refuses to pay our posted door rates, or short pays the final bill with no explanation of what they are not paying for. This forces the vehicle owner to pay the difference, even though there is no mention of a co-pay in the owner’s policy, or the owner is a claimant.

(Attach any supporting documents that you feel are pertinent)

The information that I have given above is true and accurate to the best of my knowledge and belief. The information may be forwarded to the insurance company involved.

Signature_____ Date_____

Send to: wcrpinfo@gmail.com Or mail to:
Wisconsin Collision Repair Professionals Inc - WCRP
PO Box 841
Merrill, WI 54452-0841
Questions on how to fill out call Andy Grundman @ (715)432-8123