Insurance Complaint Form
O.E.M. required procedures

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 for O.E.M. required procedures, or procedures that the collision center deems necessary for a safe and proper repair. 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