

## **Insurance Complaint Form Steering**

	Steering	<u>Date</u>	
Person Filing the Com	plaint		
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	e (Day)	
Vehicle Owner is: Claimar	nt Insured		
Vehicle/Insurance			
Make	Model	Year	
VIN		Date of Loss	
Insurance Company	Clai	m #	
Insurance Contact Name_			
E-mail	Phone		

## **Details of Complaint**

632.375 Motor vehicle repair practices; restriction on specifying a vendor.

(2)(a) No insurer may require that...repairs to a motor vehicle must be made by a particular contractor or repair facility. For purposes of this section, a consumer has the right to select the motor vehicle repair facility of his or her choice.

(2)(b) No insurer may fail to initiate and conclude with due dispatch an investigation of a claim for repairs to a motor vehicle on the basis of whether the repairs will be made by a particular contractor or repair facility.		
Attach any Supporting documents that you feel are pertinent)		
he information that I have given above is true and accurate to the best of my knowledge nd belief. The information may be forwarded to the insurance company involved.		
ignatureDate		
Send to: wcrpinfo@gmail.com Or mail to: Wisconsin Collision Repair Professionals Inc - WCRP		

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