Ontario Association of Osteopathy and Natural Medicine
11160 Yonge Street, Suite 12, Richmond Hill, ON, L4S 1H5. Tel. (905) 884-9141, Fax. (905) 884-5889
www.oaonm.com

CONSUMER – COMPLAINT REPORTING FORM

Mr. ☐ Last name First name
Ms. ☐ _____ _____

Address:

_____
(No) (Street) (City) (Province) (Postal code)

Phone number: (_____) - _____ - _____
Daytime contact number: (_____) - _____ - _____
e-mail:_____@_____

Name of insurance company:

_____

Describe your complaint**

_____
_____
_____
_____
_____
_____

What settlement or outcome are you seeking**
(*e.g. disability benefits, reinstatement of policy, reimbursement of premiums, etc*)

_____
_____
_____
_____

Documentation to provide**

1. Copy of the insurer's final position letter
2. Copy of correspondences to and from your insurance company
3. Copy of your policy contract, benefits booklet, insurance proposal, policy application, policy illustration, account statements, etc.

_____ _____
Signature Date

***Further details may be requested from you at a later date.*
Important note: Keep your originals, documents will not be returned