FORM A

Department of Health
Regulatory Services
Cayman Islands Government

Health Insurance
Commission
Cayman Islands

FOR HIC USE ONLY

FILE #	☐FE&C ☐UIMED ☐ULD ☐CP ☐PTBLY ☐Other

HEALTH INSURANCE COMMISSION
Complaint Intake Form

Remain Anonymous Y N Resident Y N

INFORMANT: ☐ IP ☐HCP/F ☐ER ☐AI ☐Other

Last Name: *	First Name: *	Middle Initial:	Date of Birth:	Gender:
				F M
Facility Name (If Applicable):				

Physical Address: *	Postal Address : *	Telephone Contact: *	Email address:

Employment Start Date:	Employment End Date:	Occupation:

Approved Insurer & ID Number:	Policy Start Date: (If Applicable)	Policy End Date: (If Applicable)	Reason for Policy Termination:(If Applicable)

RESPONDENT: ☐ IP ☐HCP/F ☐ER ☐AI ☐Other

Name	T/A	Contact Person

Physical Address	Telephone Contact	Postal Address	Email Address

Briefly describe your complaint. Please attach copies of all relevant documents.

After fully understanding the following, please sign and date this form below: *To the best of my knowledge, the above statements are correct. I understand that a copy of this form and any attachments that are needed may be shared with necessary organizations or individuals. I authorize the approved insurer, healthcare facility/practitioner or employer to release all necessary records relating to this complaint to the Health Insurance Commission (HIC) and I authorize the HIC to release only essential information, relating to this complaint to required persons in order to assist with the investigation. I also give authorization to the HIC to obtain records from healthcare facilities/practitioners (private or public) and employers on my behalf. I represent that I have the proper authority to execute this release.*

Signature *	Print Name *	Date *

KEY:
IP – INSURED PERSON
HCP/F – HEALTHCARE PRACTITIONER/FACILITY
ER – EMPLOYER
AI – APPROVED INSURER

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