MM/DD/YY
Complaint Date: **Producer Certification Number:** *Plan Use Only*

CALIFORNIA AUTOMOBILE ASSIGNED RISK PLAN (CAARP)
CALIFORNIA LOW COST AUTOMOBILE INSURANCE PROGRAM (LCA)
PRODUCER PERFORMANCE COMPLAINT FORM

Producer Name		Complainant Name	
Street Address		Street Address	
City State Zip Code		City State Zip Code	
Producer License Number	Producer Tax ID Number	Name of Insured	
Effective Date of Policy	Policy Number	CAARP/LCA APN Number	Company of Assignment

The above named Producer is in violation of the below indicated Performance Standard(s) or other rules of the California Automobile Assigned Risk Plan and/or the California Low Cost Automobile Insurance Program

☐ ORIGINAL APPLICATION
Application shall be fully completed and include:
- ☐ Information to rate and write a policy
- ☐ Name, Address, Tax ID, License Number of Producer
- ☐ Signatures of Applicant and Producer
- ☐ Application shall be accompanied by a legible photocopy of the valid driver license of the applicant and operator(s) and current registration for each vehicle on the application.

☐ RETURN COMMISSION
Date producer was originally billed for the return commission for the policy stated above:
☐ COMMISSION RETAINED FROM INITIAL/RENEWAL DEPOSIT

☐ FAILURE TO USE EASi RETRACTION REQUEST FORM
☐ FAILURE TO PROPERLY SEND POLICY CHANGE REQUEST
☐ CLAIM NOT REPORTED PROMPTLY
☐ REMITTANCE OF PAYMENT TO INSURER
☐ NON-ISSUANCE OF RECEIPT TO INSURED
☐ NSF PRODUCER CHECK
☐ MAINTENANCE OF RECORDS
☐ FALSE STATEMENTS OR MISREPRESENTATIONS
☐ BROKER FEE CHARGED
☐ ID CARD/BINDER ISSUED
☐ OTHER PROBLEMS (Specify in Remarks)

COMPLAINANT CONTACT NAME:	**COMPLAINANT PHONE #:**

PRODUCER RESPONSE:

☐ VALID ☐ INVALID (If invalid, a full explanation is required with complete documentation. Specify reason and all details below.)

PLAN DETERMINATION:

☐ VALID ☐ INVALID DATE ENTERED: SUSPENSE DATE: DATE RESOLVED:

COMMENTS:

☐ NO RESPONSE FROM PRODUCER PLAN STAFF INITIALS:

MAIL TO:

California Automobile Assigned Risk Plan
PO Box 6530
Providence, RI 02940-6530

NOTE TO PRODUCER: This complaint will be considered **VALID** if you do not respond to the Plan office within 20 days of receiving this form. Once completed, please retain a copy for your records.

INSTRUCTIONS ON HOW TO USE THIS FORM - Complainant completes the form and keeps one (1) copy. Complainant mails one (1) copy to the Plan office. Two (2) copies are mailed to the Producer. Producer is to respond and mail their response back to the Plan office within **20 days** from the complaint date. Producer keeps one (1) copy for their records.

AIP 1254 Rev 1/14

YOU CAN ALSO FAX THIS FORM TO (415) 421-4013 OR E-MAIL IT TO CAARP@AIPSO.COM.