REQUEST FOR PLAN REVIEW OF COMPANY PERFORMANCE
MIDATLANTIC REGION AUTOMOBILE INSURANCE PLANS

☐ DISTRICT OF COLUMBIA ☐ DELAWARE ☐ VIRGINIA ☐ WEST VIRGINIA

INSTRUCTIONS:

COMPLAINANT:

1. Before completing this form, contact the Company to attempt to resolve the issue.
2. If the issue is not resolved, use this form to request a review and determination by the Plan. Complete Sections 1 – 5. Mail one copy to the Company. Fax or Email one copy to the Plan and retain a copy for your records.
3. If you disagree with the Plan's determination, you can request a review by the Plan's governing body/board of governors as set forth in the Plan's rules.

COMPANY:

Complete Section 6. Mail one copy to the Complainant. Fax or Email one copy to the Plan **within 20 days of the date provided in Sec. 2** and retain a copy for your records.

SECTION 1. NAME OF THE PLAN:	**SECTION 2. TODAY'S DATE:**

SECTION 3. REQUIRED INFORMATION:

Company Name			
Mailing Address	City	State	Zip Code

Insured Name	Policy Effective Date	Policy Number	Assignment Number (APN)

SECTION 4. COMPLAINANT

Name (Include Agency or Company name if applicable)	Email Address		
Telephone Number (include area code)	Fax Number (include area code)		
Mailing Address	City	State	Zip Code

SECTION 5. IDENTIFY PERFORMANCE STANDARDS WHICH WERE ALLEGEDLY VIOLATED AND EXPLAIN

☐ ISSUANCE OF ORIGINAL POLICY	☐ RETURN PREMIUMS	☐ CLAIM HANDLING
☐ RENEWAL POLICIES OR CERTIFICATES	☐ COLLECTION OF PREMIUM	☐ SURCHARGES
☐ ENDORSEMENTS	☐ COMMISSIONS	☐ OTHER

EXPLANATION (If necessary, attach additional documentation.)

SECTION 6. COMPANY RESPONSE (must be completed by the Company who is the subject of this review)

Company Respondent	Telephone Number (include area code)	Extension

Email Address

Company Response: Is the basis of the request for review valid or invalid? Select box and provide brief explanation. If additional space is needed, include that information in a letter. Submit the letter and supporting documentation with this form.

☐ VALID ☐ INVALID

SECTION 7. PLAN DETERMINATION (the Plan will provide a written response if necessary)

☐ VALID ☐ INVALID ☐ NO RESPONSE FROM COMPANY	Date Received	Date Responded	Date Resolved	Plan Staff Initials

SECTION 8. CONTACT INFORMATION

Forward a copy of this form (and any supporting documents) to the Plan using the Fax number or Email address below:

MIDATLANTIC REGION AUTOMOBILE INSURANCE PLANS
Fax: (800) 516-1923
Email: daip@aipso.com
dcaip@aipso.com
vaip@aipso.com
wvaip@aipso.com