

PRODUCER PERFORMANCE COMPLAINT FORM

(FOR USE ONLY IF A PRODUCER HAS FAILED TO PERFORM IN ACCORDANCE WITH THE TERMS LISTED BELOW)

CENTRAL REGION AUTOMOBILE ASSIGNED RISK PLAN

SECTION 1. PLAN (Check one)

Illinois Iowa Missouri (MOAIP) Missouri (MJUA) Nebraska
 Minnesota North Dakota South Dakota

SECTION 2. COMPLAINT DATE

(mm/dd/yyyy)

SECTION 3. PRODUCER/COMPLAINANT/INSURED INFORMATION

a.	Producer Name/Agency Name	Telephone Number (include area code)	Extension	
	Mailing Address	City	State	Zip Code
	Producer License Number	Producer Tax ID Number		
b.	Complainant Name	Telephone Number (include area code)	Extension	
	Mailing Address	City	State	Zip Code
c.	Insured Name	Policy Effective Date (mm/dd/yyyy)	Policy Number	Assignment Number (APN)

SECTION 4. VIOLATIONS (Complainant should refer to the Producer Performance Standards in the applicable state Plan Manual/Plan of Operation.)

<input type="checkbox"/> ORIGINAL APPLICATION Application should be fully completed and include: <input type="checkbox"/> Producer Name, Address, Tax ID Number <input type="checkbox"/> Signatures of Applicant and Producer <input type="checkbox"/> Deposit Premiums <input type="checkbox"/> Application completed and mailed properly.	<input type="checkbox"/> CLAIMS When an Insured reports an accident or claim to the Producer, the Producer shall report it to the company within one (1) working day in accordance with the instructions of the Insurer.	<input type="checkbox"/> PAYMENTS <input type="checkbox"/> Producer shall remit all payments received from insureds to the company by the date due. <input type="checkbox"/> Dishonored checks shall be reported to the Plan. <input type="checkbox"/> RETURN COMMISSION <input type="checkbox"/> POLICY CHANGE REQUEST <input type="checkbox"/> OTHER (Specify in Section 5.)
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SECTION 5. COMPLAINANT REMARKS (If necessary, attach additional documentation.)

SECTION 6. PRODUCER RESPONSE

Producer Respondent	Telephone Number (include area code)	Extension
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VALID INVALID (If invalid, provide a full explanation and complete documentation.)

SECTION 7. PLAN DETERMINATION

<input type="checkbox"/> VALID <input type="checkbox"/> INVALID	Date Entered	Suspense Date	Date Resolved	Plan Staff Initials
<input type="checkbox"/> NO RESPONSE FROM PRODUCER				

SECTION 8. COMPLAINANT AND PRODUCER INSTRUCTIONS

Complainant: Complete Sections 1 – 5, retain a copy, mail a copy to the Plan and to the producer.

Producer: Complete Section 6, retain a copy, and mail a copy to the Plan within 20 days of the complaint date.

Mail Plan copy to: **CENTRAL REGION AUTOMOBILE INSURANCE PLANS**
P.O. BOX 6530
PROVIDENCE, RI 02940-6530
Fax: (800) 827-6260
E-mail: ilaip@aipso.com