

# COMPLAINT REGISTRATION FORM

800-PETRA  
Clarity@insurewithpetra.com

  
Bringing Clarity To Life

- Please complete in BLOCK CAPITALS and give a definite answer to each question
- Use a separate paper if the space provided for the answer is not enough

Insured Details			
Please provide contact details.			
Name of Complainant:			
Name of patient (where applicable):			
Date of complaint			
Contact Information:	PO Box:	City:	Country:
	Tel:		Mob:
	Email ID:		

Policy Details			
Please provide the policy detail. Please ensure correctness of the details provided.			
Policy No:		Certificate / Member No:	
Policy Type:			
Insurance Company Name:			

Detail of the complaint		
Please give exact description of the complaint. If there are any documents supporting the complaint, please provide as attachments		
Description of the complaint		
For Office Use Only		
Complaint Ref No :		
Signature	Date	Place
***PLEASE SEND THIS FORM TO:		



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