

CONSUMER COMPLAINT FORM

Name		
Company Name (if applicable)		
Postal Address		
Town/City		
Telephone (Home)		
Telephone (Work)		
Email Address		
Name of IBANZ Member Firm		
Postal Address		
Town/City		
Telephone Number		
Email Address		
Name of person/s Contacted		
Detail of any other parties Involved (e.g. Insurance Company)		
Name		
Postal Address		
Telephone Number		

FULL DETAILS OF COMPLAINT (Please ensure you attach copies of any relevant information/documentation e.g. cover notes, renewal notices, policies, etc. which might help in investigating your complaint).		
Please	e continue on a separate sheet if required	
I/We declare that, to the best of my /our knowledge, accurate. I/We agree to The Insurance Brokers Association of N	ew Zealand Inc. (IBANZ) releasing to the other	
parties listed below, personal information relating to this	complaint.	
I/We hereby authorise the IBANZ Complaints Commappropriate in relation to my/our complaint and I/We approached by the Committee disclose to them all relevand material related to the complaint, which are held by	hereby authorise and request that any party ant information about me/us, and all documents	
Please Note: Pursuant to the Privacy Act, the following is broad	ught to your attention	
The intended recipients of the information are: a) IBANZ Disciplinary & Complaints (b) IBANZ Member Firm and/or other process.		
The information is being collected and held by the Ins New Zealand Inc.		
 You have the rights to access to, and correction of, the Privacy Act. 	is information subject to the provisions of the	
Signature:	Date Signed:	
·	For	
Name of person signing	For Name of Company (where appropriate)	
Places return this form to		

Please return this form to: The CEO, IBANZ PO Box 302504 North Harbour, Auckland info@ibanz.co.nz