

THE NATIONAL INSURANCE BOARD

COMPLAINT FORM  
(To be completed in duplicate)

PARTICULARS OF COMPLAINANT

NAME:.....

ADDRESS:.....

IDENTIFYING LANDMARKS:.....

N.I. No. (If Known) 

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TEL. NO. ....

PARTICULARS OF EMPLOYER:

NAME:.....

TRADING NAME:.....

TYPE OF BUSINESS:.....

ADDRESS:.....

REGISTRATION NO; (If known) 

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TEL. NO. ....

(N.I. 4 to be completed if necessary)

NATURE OF COMPLAINT:

DATE:.....

TIME:.....AM/PM

LOCAL OFFICE/DEPARTMENT WHERE COMPLAINT MADE:.....

RECEIVER OF COMPLAINT:.....STATUS:.....  
(Block Capitals)

2/99

**ACTION TAKEN AT LOCAL OFFICE/DEPARTMENT:**

DATE:.....

SIGNATURE OF MANAGER:.....

DATE FORWARDED TO COMPLIANCE:..... DATE OF RECEIPT AT COMPLIANCE:.....

**ACTION TAKEN AT COMPLIANCE SERVICES DEPARTMENT:**