Zorg en Jeugd Caribisch Nederland
Ministerie van Volksgezondheid, Welzijn en Sport

Complaints form Health Insurance

You can use this form to submit a complaint if you are dissatisfied with the actions or functioning of the Health Insurance Office. You cannot use it to submit an objection or appeal.

The Health Insurance Office will process your complaint as quickly as possible. Our aim is to send you a response by the statutory deadline of a maximum of 6 weeks. If it transpires that a detailed investigation needs to be carried out, the processing may take more time and the Health Insurance Office will then contact you.

It is important that you clearly indicate what your complaint relates to. You should, for example, indicate when you wrote a particular letter, or what happened on a particular date. If you have a complaint about an employee, please state the name of the employee in question.

Do you have any documents which are important for your complaint, for example letters which have been sent out by the Health Insurance Office? If so, please send them to us. That will help us to process your complaint quicker.

Please note!
Any documents you send with your complaint will not be returned.
You should therefore only submitcopies.

1 I have a complaint. My details are:

Gender: ☐ male ☐ female

First name: (in full)

Surname

ID number (sedula)

Date of birth (mm/dd/yyyy)

Address

Town/city

Email address

Daytime telephone number

I am being represented/my interests are being represented by, if applicable:

Gender: ☐ male ☐ female

First name: (in full)

Surname

ID number (sedula)

Date of birth (mm/dd/yyyy)

Address

Town/city

Email address

Daytime telephone number

2 My complaint relates to:

☐ A medical referral
☐ The daily reimbursement/airline company
☐ Claims and payments
☐ Health insurance claims
☐ Information
☐ Treatment by the Health Insurance
☐ Other, namely:

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3 Description of the complaint:

4 My expectations are/my complaint will have been resolved if:

☐ Discussion with employee responsible for handling objections and complaints

☐ Action

☐ Other, namely:

5 Signature

I declare that I have completed this form accurately, fully and truthfully.

Place

Date (mm/dd/yyyy)

Number of enclosures

Signature

To be filled in by the Health Insurance Office:

Received on: (mm/dd/yyyy)

Received by: