Appendix F

Kentucky Attorney General Complaint Form

CONSUMER COMPLAINT FORM

JACK CONWAY ATTORNEY GENERAL



RETURN TO:

RE I URN I U:
Office of Attorney General
Consumer Protection Division
310 Whittington Parkway, Suite 101
Louisville, KY 40222
Phone: (502) 429-7134
Fax: (502) 429-7129
Hotline: (888) 432-9257
www.ag.ky.gov/cp

			S OF ANY DOCUMENTS SUBMITTED.
OUR NAME ☐ Mr ☐ Mrs ☐ Ms _			
DDRESS			
ITY	STATE	ZIP CODE	COUNTY
OME PHONE		WORK/CELL PHONE	
MAIL ADDRESS:			
COMPANY OR PERSON(S) YOUR COM	DI AINT IS AGAINST		
ADDRESS			
CITY	STATE		ZIP CODE
PHONE:		_	
Please fill in this section completely.			
VAS A CONTRACT SIGNED? ☐ YES	□ NO (If Yes, Please Attach a Copy	of Your Contract.)	
WHERE WAS CONTRACT SIGNED?	IN YOUR HOME AT THE BUSIN	ESS □OTHER	
DATE(S) OF TRANSACTION	PRODU	ICT OR SERVICE INVOLVE	ED
TOTAL PRICE	_ AMOUNT PAID	WAS PRODUC	CT/SERVICE ADVERTISED?
HOW WAS SERVICE ADVERTISED? []Newspaper □TV □Radio □]Mail □Phone □Emai	il □ Internet □ Other
WITH WHAT OTHER AGENCIES HAVE	YOU FILED THIS COMPLAINT?		
WHAT ACTION WAS TAKEN?			
HAVE YOU HIRED OR RETAINED A PRI	VATE ATTORNEY? ☐ YES ☐ NO	HAVE YOU STARTED (COURT ACTION? YES NO
WHAT ACTION WILL RESOLVE YOUR O	OMPLAINT?		

Below briefly state the facts of you	r complaint (if necessa	rv. use additional na	per). Please attach copies of any papers involved (o	rder blanks warranties credi
card receipts or statements, contra may be shared with the party again	ncts, advertisements, car nst which you have comp	nceled checks, etc.). T plained. It may also be	the information you provide will be used in our effort to used to enforce applicable state laws. Under Kentuc tion such as account numbers are not subject to the	to resolve your problem and cky's Open Records Act, this
If Your Co	omplaint is Regard	ding a Health Cl	ub Membership, Also Complete this Se	ection.
WAS CONTRACT SIGNED? 🖵 YI	ES NO DATE C	OF CONTRACT	LENGTH OF CONTRACT: YEARS	MONTHS
TIME LEFT BEFORE CONTRACT	EXPIRES: YEARS_		MONTHS	
TOTAL AMOUNT OF YOUR CON	TRACT: \$		AMOUNT PAID TO DATE: \$	
HOW WERE YOUR PAYMENTS T	O BE MADE? IMO	NTHLY YEARL	Y 🗖 OTHER	
AMOUNT OF EACH PAYMENT?	\$		EN WAS YOUR LAST PAYMENT?	
	*	<u> </u>		
HAVE YOU MADE PAYMENTS TO If yes, please provide the following		ER THAN THIS HEAL	TH CLUB? YES NO	
NAME:				
ADDRESS:				
CITY, STATE, ZIP:				
The above information is true and	accurate to the best of m	ny knowledge.		
TODAY'S DATE		YOUR SIGNAT	URE	
	OPTIONAL- (COMPLETION OF	THIS SECTION IS VOLUNTARY	
AGE OF THE PERSON INVOLVE			25 26-39 40-59 60-75 76-over	
The Office of the Attorney Gener	ral does not discrimina	te on the basis of ra	ce, color, national origin, sex, religion, age or disa	
disabilities an equal opportunity			ons including auxiliary aids and services necessa s.	ny to antoru muividuais Witt

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CONSUMER COMPLAINT FORM

JACK CONWAY ATTORNEY GENERAL



RETURN TO: Office of Attorney General Consumer Protection Division 1024 Capital Center Drive Frankfort, KY 40601 Hotline: 1-888-432-9257

www.ag.ky.gov/cp Fax: 502-573-7151

TYPE OR PRINT N	NEATLY. SUBMIT TWO COPIES OF	THE COMPLAINT AND TWO COP	IES OF ANY DOCUMENTS SUBMITTED.
YOUR NAME	[]] Ms		
CITY	STATE	ZIP CODE	COUNTY
HOME PHONE		WORK/CELL PHONE	
EMAIL ADDRESS:			
COMPANY OF PERSON(S) VOI	JR COMPLAINT IS AGAINST		
, ,	SK OOM EANT TO AGAINST		
<u> </u>	STATE		ZIP CODE
PHONE:			
Please fill in this section complete			
•	YES NO (If Yes, Please Attac	ch a Copy of Your Contract.)	
WHERE WAS CONTRACT SIGN	IED2 D IN YOUR HOME D AT TH	HE BUSINESS OTHER	
		·	VED_
			UCT/SERVICE ADVERTISED? YES NO
TOTAL PRICE	AMOUNT PAID	WAS PROD	OCT/SERVICE ADVERTISED? TES TINO
HOW WAS SERVICE ADVERTIS	SED? 🗖 Newspaper 🗖 TV 🗖 R	Radio 🗖 Mail 🗖 Phone 🗖 En	nail 🗖 Internet 🗖 Other
WITH WHAT OTHER AGENCIES	S HAVE YOU FILED THIS COMPLAIN	IT?	
HAVE YOU HIRED OR RETAINE	ED A PRIVATE ATTORNEY?	S NO HAVE YOU STARTE	D COURT ACTION? ☐ YES ☐ NO
WHAT ACTION WILL RESOLVE	YOUR COMPLAINT?		

card receipts or statements, contracts, adv may be shared with the party against whic	rertisements, canceled checks, etc.). h you have complained. It may also b	aper). Please attach copies of any papers involved (ord The information you provide will be used in our effort to be used to enforce applicable state laws. Under Kentuck nation such as account numbers are not subject to the Commentary.	resolve your problem and y's Open Records Act, this
	_		_
	_		_
If Your Compla	int is Regarding a Health C	lub Membership, Also Complete this Sec	ction.
	DATE OF CONTRACT	LENGTH OF CONTRACT, VEADS	MONTHS
WAS CONTRACT SIGNED? YES I	·	LENGTH OF CONTRACT: YEARS	MONTHS
TIME LEFT BEFORE CONTRACT EXPIR	ES: YEARS	MONTHS	
TOTAL AMOUNT OF YOUR CONTRACT:	\$ <u> </u>	_ AMOUNT PAID TO DATE: \$	
HOW WERE YOUR PAYMENTS TO BE M	IADE? IMONTHLY I YEARI	LY 🗖 OTHER	
AMOUNT OF EACH PAYMENT? \$_	W!	HEN WAS YOUR LAST PAYMENT?	
HAVE YOU MADE PAYMENTS TO ANY (COMPANY OTHER THAN THE HEA	LTH CHIP2 DVEC DNO	
If yes, please provide the following information		LINCLOB! TES TNO	
NAME:			
ADDRESS:			
CITY, STATE, ZIP:			
The above information in two and account	to the best of my browning		
The above information is true and accurate	, ,		
TODAY'S DATE	YOUR SIGNA	TURE	
C	PTIONAL- COMPLETION OF	F THIS SECTION IS VOLUNTARY	
AGE OF THE PERSON INVOLVED IN TH	E TRANSACTION: 0 -15 16	6-25 26-39 40-59 60-75 76-over	
The Office of the Attorney General does	not discriminate on the basis of ra	ace, color, national origin, sex, religion, age or disab	ility in employment or the
provision of service and provides, upor disabilities an equal opportunity to part		tions including auxiliary aids and services necessar es.	, to amord individuals with