

Appendix F

Kentucky Attorney General Complaint Form

CONSUMER COMPLAINT FORM

JACK CONWAY
ATTORNEY GENERAL



RETURN TO:
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

TYPE OR PRINT NEATLY. SUBMIT TWO COPIES OF THE COMPLAINT AND TWO COPIES OF ANY DOCUMENTS SUBMITTED.

YOUR NAME Mr Mrs Ms _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____ COUNTY _____
HOME PHONE _____ WORK/CELL PHONE _____
EMAIL ADDRESS: _____

COMPANY OR PERSON(S) YOUR COMPLAINT IS AGAINST _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
PHONE: _____

Please fill in this section completely.

WAS A CONTRACT SIGNED? YES NO (If Yes, Please Attach a **Copy** of Your Contract.)
WHERE WAS CONTRACT SIGNED? IN YOUR HOME AT THE BUSINESS OTHER _____
DATE(S) OF TRANSACTION _____ PRODUCT OR SERVICE INVOLVED _____
TOTAL PRICE _____ AMOUNT PAID _____ WAS PRODUCT/SERVICE ADVERTISED? YES NO
HOW WAS SERVICE ADVERTISED? Newspaper TV Radio Mail Phone Email Internet Other _____
WITH WHAT OTHER AGENCIES HAVE YOU FILED THIS COMPLAINT? _____
WHAT ACTION WAS TAKEN? _____

HAVE YOU HIRED OR RETAINED A PRIVATE ATTORNEY? YES NO HAVE YOU STARTED COURT ACTION? YES NO
WHAT ACTION WILL RESOLVE YOUR COMPLAINT? _____

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 NEATLY. SUBMIT TWO COPIES OF THE COMPLAINT AND TWO COPIES OF ANY DOCUMENTS SUBMITTED.

YOUR NAME Mr Mrs Ms _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____ COUNTY _____

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EMAIL ADDRESS: _____

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WHAT ACTION WILL RESOLVE YOUR COMPLAINT? _____

Below, briefly state the facts of your complaint (if necessary, use additional paper). Please attach copies of any papers involved (order blanks, warranties, credit card receipts or statements, contracts, advertisements, canceled checks, etc.). The information you provide will be used in our effort to resolve your problem and may be shared with the party against which you have complained. It may also be used to enforce applicable state laws. Under Kentucky's Open Records Act, this complaint will be available for public view upon request. Certain personal information such as account numbers are not subject to the Open Records Act.

If Your Complaint is Regarding a Health Club Membership, Also Complete this Section.

WAS CONTRACT SIGNED? YES NO DATE OF CONTRACT _____ LENGTH OF CONTRACT: YEARS _____ MONTHS _____

TIME LEFT BEFORE CONTRACT EXPIRES: YEARS _____ MONTHS _____

TOTAL AMOUNT OF YOUR CONTRACT: \$ _____ AMOUNT PAID TO DATE: \$ _____

HOW WERE YOUR PAYMENTS TO BE MADE? MONTHLY YEARLY OTHER

AMOUNT OF EACH PAYMENT? \$ _____ WHEN WAS YOUR LAST PAYMENT? _____

HAVE YOU MADE PAYMENTS TO ANY COMPANY OTHER THAN THIS HEALTH CLUB? YES NO

If yes, please provide the following information:

NAME: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

The above information is true and accurate to the best of my knowledge.

TODAY'S DATE _____ YOUR SIGNATURE _____

OPTIONAL- COMPLETION OF THIS SECTION IS VOLUNTARY

AGE OF THE PERSON INVOLVED IN THE TRANSACTION: 0-15 16-25 26-39 40-59 60-75 76-over

The Office of the Attorney General does not discriminate on the basis of race, color, national origin, sex, religion, age or disability in employment or the provision of service and provides, upon request, reasonable accommodations including auxiliary aids and services necessary to afford individuals with disabilities an equal opportunity to participate in all programs and activities.