

Infinity Cover Solutions is a registered and authorised Financial Services Provider
with FSP number 55840, Licensed by the Financial Sector Conduct Authority.

COMPLAINTS LODGEMENT FORM

SECTION 1: COMPLAINANT DETAILS

Full Name _____

ID / Passport Number _____

Contact Number _____

Email Address _____

Postal Address _____

Preferred Method of Communication

☐ Email ☐ Phone ☐ Postal

SECTION 2: COMPLAINT DETAILS

Date of Incident _____

Complaint Reference Number (if applicable) _____

Person / Department the Complaint Relates To _____

SECTION 3: CATEGORY OF COMPLAINT (please select the applicable category)

- ☐ Product / Service Design Issues (fees, premiums, charges, product structure)
- ☐ Information Provided (misleading or insufficient disclosure)
- ☐ Advice-Related Complaint (incorrect or inappropriate advice)
- ☐ Financial Product / Service Performance
- ☐ Client Servicing Issues (premium collection, policy lapses)
- ☐ Product Accessibility Issues (switching, redemptions, changes)
- ☐ Complaints Handling Process
- ☐ Insurance Claims (claim rejection, non-payment)
- ☐ Third-Party Service Provider Issues (insurer, asset manager)
- ☐ Other (please specify): _____

SECTION 4: COMPLAINT DESCRIPTION

Please provide a detailed description of the complaint, including dates, amounts and any relevant information.

(Attach supporting documents if applicable.)

SECTION 5: DESIRED OUTCOME

Please specify the resolution or outcome you seek.

SECTION 6: DECLARATION

I, _____, confirm that the information provided in this form is true and correct to the best of my knowledge. I understand that my complaint will be handled in accordance with the company's Complaints Management Framework.

Signature _____

Date _____

FOR OFFICE USE ONLY

Complaint Received By	
Date Received	
Complaint Reference Number Assigned	
Category of Complaint	
Investigation Officer Assigned	
Date Resolved	
Resolution Outcome	

This form should be submitted via email, post, or in person. You will receive an acknowledgment within 24 hours of submission.