

# MARYLAND CLAIMS INVESTIGATION

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<b>CUSTOMER REQUEST FORM</b>			<b>Date Assigned:</b>		
<b>Adjuster</b>			<b>Defense Attorney/Insurance Company</b>		
Name:			Name:		
Firm:			Firm:		
Address:			Address:		
City:			City:		
State:		Zip:	State:		Zip:
Phone:			Phone:		
File No:			File No:		
<b>Claimant Information</b>					
Name:			Date of Accident:		
Current Address:			WCC <input type="checkbox"/> Auto Lia. <input type="checkbox"/> Gen Lia. <input type="checkbox"/>		
City:			Insured:		
State:		Zip:	Insured Address:		
Phone:			City:		
Prior Address:			State:		
City:		Zip:	Phone:		
State:		Zip:	Job Description:		
Phone:			Limitations:		
Type of Injury:			Features:		
SS#:			Race/Sex:		
Age:		D.O.B.:	HT:	WT:	Hair:
T/T: Yes <input type="checkbox"/> No <input type="checkbox"/>		Amount:	Date of Last T/T Payment:		
Budget/Days:		Hearing/Trial Date:		Location:	
Instructions:					