

# AMAX INVESTIGATIONS, LLC

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## **SURVEILLANCE AND ACTIVITY REQUEST**

**Firm:** \_\_\_\_\_ **Attention:** \_\_\_\_\_  
**Address:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**City, State Zip:** \_\_\_\_\_ **Court:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_ **Case No.:** \_\_\_\_\_  
**Direct Line:** \_\_\_\_\_ **Case Title:** \_\_\_\_\_  
**You're Fax No.:** \_\_\_\_\_ **Claim/File No.:** \_\_\_\_\_  
**You're Email:** \_\_\_\_\_ **Date of Loss:** \_\_\_\_\_

### **PLEASE NOTE ANY SPECIFIC OR TIMELY FILING OR SERVICE REQUIREMENTS**

Please check the services required:  Video Surveillance  Activities Check  other

TYPE:  Individual  Business

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Completion Deadline: \_\_\_\_/\_\_\_\_/\_\_\_\_ Trial or Hearing Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subject: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

If two crews are needed (i.e., rural cases), is permission granted to proceed?  Yes  No

Physical Description: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Subject's Vehicles: \_\_\_\_\_

Alleged Injury: \_\_\_\_\_

Physical Restrictions: \_\_\_\_\_

Claim#: \_\_\_\_\_ Date of Loss: \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured: \_\_\_\_\_

Type of Claim: \_\_\_\_\_ Previous Surveillance Performed?  Yes  No (If "Yes", attach report)

what is the purpose of this investigation? \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Are there specific days for the surveillance to be conducted?  Yes  No (If "Yes," What Days)? \_\_\_\_\_

Restrictions: Day or \$ Limit: \_\_\_\_\_

Client: \_\_\_\_\_ Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

FAX: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Is there a secondary contact for this case?  Yes  No (If "Yes," please fill in the form below)

Client: \_\_\_\_\_ Phone#: \_\_\_\_\_

FAX: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Referred by: \_\_\_\_\_