Eagle, Globe & Anchor Investigations A1000131

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☐ Surveillance	Date Assigned:		# of Days
☐ Activity Check	Due Date:		# of Days
☐ Background	Other		
☐ AOE/COE	MA&A Internal #		

INVESTIGATION ORDER FORM

Claimant:	D.O.B.	Age:	SSN:

Address:

City:	State:	Zip:	Home Phone:	Cell Phone:

Vehicle Year:	Vehicle Make:	Model:	Lic. Plate:	Drivers Lic.:

☐ Are benefit checks mailed to the above address?	If no; Where are they sent:

Physical Description:	Physical Marks:

☐ Sex	Hair Color:	Eye Color:	Race:	Height:	Weight:

Injury/Illness:	Physical Restrictions:

Date of injury:	Occupation:	Employer Phone:	Contact Person:

Employer:	Employer Address:

☐ Is it acceptable for our investigator to contact the employer's contact person or representative in this matter?

☐ Are there any photographs available of the claimant?	☐ Does the claimant have a doctor's appointment in the near future?

If yes; Please provide the name of the doctor and the date of the next appointment below

Doctor's Name:	Doctor's Address:
City:	Date/Time Appointment:

Special Instructions:

Claims Agent:	Company:	Claim # for case:
Email:	Phone:	Fax:

[Print Form]   [Submit by Email]