SELECTIVE INVESTIGATIONS, INC. a professional claims investigative agency

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Assign a Case

* Denotes mandatory fields

Client Contact Information

Client *: Phone *:

Company: Fax:

Address: Email:

Claim Information

Claim Number: Insured: DOL:

Type of Claim: ☐ Auto ☐ Auto PIP ☐ Disability ☐ Home Owners

☐ Life and Health ☐ Medical Mal Practice ☐ Worker's Comp. ☐ Other

Subject Information

Subject: Phone:

Address: Cell:

SS #: DOB:

Physical Description:

Occupation: Hobbies:

Injuries/Restrictions/Work Status:

Is there a Court Date or known Medical Appointment: ☐ NO ☐ YES If yes, Date and Time:

Vehicle Info:

Doctor's Name:

Doctor's Address:

Is Claimant Represented: ☐ NO ☐ YES If yes, Attorney's Name:

Attorney's Address:

Assignment / Additional Instructions / Objectives:

Turnaround: ☐ Standard (2 Weeks) ☐ Rush If Rush, Request Date:

Updates of Case Activity: ☐ NO ☐ YES ☐ Verbal ☐ Email ☐ Both