INVESTIGATION REQUEST FORM

CLIENT INFORMATION

Claim #:		ISN File #:	Date received:
Company name:		Name of Contact:	
Company address:			
Telephone:		Email address:	
Fax:	Date of Loss:	Insured:	
Company represented:			
Nature of disability:			

SUBJECT INFORMATION

First name, LAST NAME:					
Alternate names:					
Home address:					
Email address:		DOB:		Gender:	
Telephone:		Alternate telephone:			
Physical Description (incl. hair colour, eye colour, tattoos etc.):					
Relationship Status:	Married ☐	Single ☐	Divorced ☐	Common Law ☐	Separated ☐
Name of Spouse:		Telephone:		Email address:	
Children (incl. ages):					
Driver's Licence:					
Vehicle 1:		Plate 1:			
Vehicle 2:		Plate 2:			

PROFESSIONAL SUBJECT INFORMATION

Employer:
Position:
Physician:
Physio:
Lawyer:
Other known places frequented:

SURVEILLANCE INSTRUCTIONS				
Was previous surveillance conducted? Yes ☐ No ☐			Is the subject aware of previous surveillance? Yes ☐ No ☐	
Budget: + HST Yes ☐ No ☐			Number of days/hours:	
Maximum hours:			Preferred due date:	
Other services needed:	Locate: ☐	Social Media: ☐	OSINT: ☐	Financial Background: ☐
Specific surveillance instructions:				

COMMENTS & REQUESTS

Please provide any additional information and/or requests in this section