MARYLAND CLAIMS INVESTIGATION

ROBERT H. JONES, President | P.O. Box 99 | Perry Hall, Maryland 21128 | 410-256-6161 PHONE | 410-256-7520 FAX | www.mdclaims.com

CUSTOMER REQUEST FORM	Date Assigned:
Adjuster	**Defense Attorney/Insurance Company**
Name:	Name:
Firm:	Firm:
Address:	Address:
City:	City:
State: Zip:	State: Zip:
Phone:	Phone:
File No:	File No:

Claimant Information

Name:	Date of Accident:
	WCC ☐ Auto Lia. ☐ Gen Lia. ☐
Current Address:	Insured:
City:	Insured Address:
State: Zip:	City:
Phone:	State: Zip:
Prior Address:	Phone:
City:	Job Description:
State: Zip:	Limitations:
Phone:	Features:
Type of Injury:	SS#:

Race/Sex:	Age:	D.O.B.:	HT:	WT:	Hair:

T/T: Yes ☐ No ☐	Amount:	Date of Last T/T Payment:

Budget/Days:	Hearing/Trial Date:	Location:

Instructions: