

INVESTIGATIVE CLAIMS BUREAU  
P.O. BOX 390007  
DELTONA, FLORIDA 32739  
WWW.INVESTIGATIVECLAIMSBUREAU.COM  
386-804-3222

Date: \_\_\_\_\_

Client: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Requestor: \_\_\_\_\_ File Number: \_\_\_\_\_

Insured: \_\_\_\_\_ Date Of Loss: \_\_\_\_\_

Subject/Claimant: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

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

Address Number 2: \_\_\_\_\_ City: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Drivers License Number: \_\_\_\_\_ License Tag: \_\_\_\_\_

Vehicle Description: \_\_\_\_\_

Spouse: \_\_\_\_\_ Kids: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

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

Injury: \_\_\_\_\_ Restrictions: \_\_\_\_\_

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

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

Authorized \$ Amount: \_\_\_\_\_ Number S/V Days: \_\_\_\_\_

Special Instructions:

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