



WNY CLAIMS SERVICES, LLC

888 Center Road  
West Seneca, NY 14224  
Phone: 716-771-3463  
Fax: 716-771-3463  
Email to: [jmaxon@wnyclaims.com](mailto:jmaxon@wnyclaims.com)

# Surveillance Request Form

**Company/Adjuster** \_\_\_\_\_

Email Address \_\_\_\_\_

Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Number of Hours Requested \_\_\_\_\_

Over How Many Days \_\_\_\_\_

Due Date \_\_\_\_\_

## **Claimant Information**

Claimant/Subject \_\_\_\_\_

File Number \_\_\_\_\_

Phone \_\_\_\_\_

Residential Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

Date of Birth \_\_\_\_\_



WNY CLAIMS SERVICES, LLC

Employment Status \_\_\_\_\_

Employment Info. \_\_\_\_\_

Marital Status \_\_\_\_\_

## Additional Information

Date of Injury \_\_\_\_\_

Type of Injury \_\_\_\_\_

Restrictions \_\_\_\_\_

Any Scheduled I.M.E.'s \_\_\_\_\_

Any Scheduled Hearings, Depositions, Etc. \_\_\_\_\_

Would you Like Daily Updates?    YES     NO

If so, Verbal     E-mail

Please Provide any photos you have on the subject.

Provide additional information below: