DIRECTION TO PAY

Company ____

Policy Holder ______________________________ Claim Number __________

Date __________________________________ Date of Loss ___________

ASSIGNMENT AND DIRECTION TO PAY

I hereby assign my policy benefits for collision/comprehensive repairs and authorize________________________________ insurance company to pay **Salem Auto Body** directly for supplemental charges in the amount of $ ________________________ arising out of the accident on _________.
Date

____
Policyholder Authorized Signature

____
Repairing Authorized Signature

Salem Auto Body
25 Boston Street
Salem, MA 01970
Phone: 978-744-3927
Fax: 978-744-0952
R.S.# 1710
Tax I.D.# 04-3266584