30 WALNUT GROVE . CRANSTON. RHODE ISLAND 02920
401 223 1111 PHONE . 401 943 6840 FACSIMILE
WWW.CRANSTONCOLLISION.COM

Tax ID 050426133

DIRECTION TO PAY

Vehicle Owner:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home: _____ Work: _____ Other: _____

Vehicle:

Year: _____ Make: _____ Model: _____

License Plate #: _____ State: _____

Claim #: _____ Date of Loss: _____

Insured: _____

Claimant: _____

INSURED'S/CLAIMANT'S DIRECTION OF PAYMENT GUARANTEE

The undersigned hereby authorize the above named insurance company to pay Cranston Collision Center directly for all repairs and supplement invoices for the above mentioned vehicle/claim. Please note: payment must first be received in full prior to delivery of the vehicle. Any payment inadvertently sent to the insured must be forwarded to Cranston Collision Center immediately upon receipt. In addition, the undersigned authorized Cranston Collision Center to sign their name to the insurance check for repairs that have been complete to this vehicle.

Vehicle Owner Signature/Assignor: _____

Witness: _____ Date: _____

INSURANCE COMPANY'S DIRECTION TO PAY GUARANTEE

The undersigned hereby acknowledges receipt and acceptance of said Direction of payment. Please note: any company not honoring the Direction of Payment accepts responsibility for delay in delivery of said vehicle until payment of all work orders and supplements have been paid in full.

Claims Hander: _____ Date: _____