

DirectPay

SECONDARY PAYEE REQUEST FOR REIMBURSEMENT FORM

Group Name Imlay City Community Schools Group # BH28 Plan Year end 12/31/2009

Employee Name _____ Social Security # _____

Address _____ City _____ ST ____ ZIP _____

I authorize payment of this claim to be sent directly to the payee identified below.

Claim Information:

Payee Name: _____

Address: _____

City, State, ZIP _____

Phone: _____

Insured is covered under another health/dental/medical plan: Yes No

Employee Signature _____ Date _____