ATTN CLAIM REP:_____

FAX NUMBER:_____

FROM : HYNES AUTO CENTER /
TEL: 617-323-9800
FAX: 617-323-9802

DIRECTION TO PAY

I authorize the insurance company to send payments for repairs directly to Hynes Auto Center.

I also understand this DTP is required so that my vehicle may be released upon completions of repairs.

X _____ Date_____

Signature Policyholder

CLAIM INFORMATION:

COMPANY: _____
INSURED: _____
TYPE OF LOSS: _____
CLAIM #: _____
DATE OF LOSS:_____

SHOP INFORMATION:

SEND PAYMENT TO:

HYNES AUTO CENTER
331 BELGRADE AVE.
ROSLINDALE, MA 02131

Mass RS# 5005
Tax ID# 46-1580342
Hazardous Waste# MV 6173239800
Liability Insurance# S2056262
Mass Appraisers License# 12694

Attention Claim Representative

This vehicle will not be released until DTP acceptance is received by shop
Please provide proof of DTP acceptance, in writing, by one of the following:
Fax: **617-323-9802**

Claim Rep Signature:_____ Date:_____