MED PAY REIMBURSEMENT

THE BELOW NAMED INSURANCE COMPANY DOES HEREBY ASSIGN
TO JOHNSON & ROUNTREE THE FOLLOWING CLAIM FOR RECOVERY.

ASSIGNMENT DATE:_____ **CLIENT CODE:**_____

YOUR NAME:_____**COMPANY:**_____

INSURED:_____

ADDRESS:_____CITY:_____

STATE:_____ZIP CODE:_____PHONE(S)_____

NAME OF PARTY TO PURSUE:_____

ADDITIONAL INJURED PARTY(IES)_____

ATTORNEY:_____PHONE_____

SETTLEMENT DATE_____AMT:_____CLAIM #:_____

LOSS DATE:_____ TOTAL MEDICALS PAID:$_____

PLEASE CHECK ONE:

_____FIRST PLACEMENT_____SECOND PLACEMENT

SPECIAL INSTRUCTIONS:_____

_____

_____

_____

PLEASE MAIL OR FAX TO:

JOHNSON & ROUNTREE PREMIUM
PO BOX 2625
DEL MAR, CA 92014
(800) 578-3300 FAX (800) 815-7445

ONLINE ASSIGNMENT FORM AVAILABLE AT:

WWW.JRPREMIUM.COM