Replacement Check Request Form

Instructions: Please fill out, sign and return this form via fax @ 860-295-0340 or via email with a scanned signature to the following email: **eebenereim@diversifiedgb.com**. If you have problems or questions, please call 1-800-423-5573.

Employee Name: _____

Employee SSN or Member ID: _____

Employer Name: **Research Foundation for Mental Hygiene, Inc.**

Please issue a replacement check for to _____ in the amount of $_____ and void or place a stop-payment on check #_____, dated _____.

Please indicate reason for replacement check request by checking the appropriate box below:

☐ The original check was lost or stolen.
☐ The original check was destroyed.
☐ I never received the original check.

Please issue a replacement check. In the event that the original check eventually does clear the bank and it is evident that I have been reimbursed twice, I understand that I must immediately repay Research Foundation For Mental Hygiene, Inc. the amount of the original check.

_____ _____

Employee Signature Date