*SFDCT*

**Failure to Receive Payment Form**

*Return to- SF-DCT P.O. Box 52429 Houston Texas 77052 ATTN- Payment Dept.*

Claimant Name _____

SS No: _____

SID No: _____

Original Check Number _____ Orig, Check Mail Date_____

Check Amount_____

Î Lost in the Mail - Up-dated Address

Original Address

_____

_____

_____

New Updated Address

_____

_____

_____

Reason for address change

**ALL PAYEE(S) MUST SIGN THE FORM**

**If I should later receive the lost check, I agree to mark it "void" and return it to the above address. I swear under penalty of perjury that I will not negotiate or cash the check**.

_____

Signature of Claimant, Executor, or Administrator Date

_____ _____

Signature of Attorney of Record, if represented Date

_____

Printed Name of Claimant