STATE OF DELAWARE
DEPARTMENT OF JUSTICE
CONSUMER PROTECTION UNIT
820 N. French Street, Fifth Floor
Wilmington, Delaware 19801

REQUEST FOR PAYMENT FROM HEALTH SPA GUARANTY FUND

In accordance with Title 6, Chapter 4203 (e) of the Delaware Code

SECTION 1 **YOUR INFORMATION**	LAST NAME	FIRST NAME	MID. INITIAL
MAILING ADDRESS			APT. OR SUITE NUMBER
CITY		STATE	ZIP CODE
HOME NUMBER, ( )		WORK NUMBER ( )	
CITY OR COUNTY OF RESIDENCE	SOCIAL SECURITY NUMBER (REQUIRED FOR PAYMENT FROM THE HEALTH SPA GUARANTY FUND)___________________________	YOUR E-MAIL ADDRESS	

SECTION 2 **HEALTH SPA INFORMATION**	LAST NAME	FIRST NAME	MID. INITIAL
MAILING ADDRESS			APT. OR SUITE NUMBER
CITY		STATE	ZIP CODE
HOME NUMBER ( )		WORK NUMBER ( )	
CITY OR COUNTY OF RESIDENCE		E-MAIL ADDRESS	

SECTION 3 **COMPLAINT INFORMATION**	CONTRACT START DATE	CONTRACT EXPIRATION DATE
TOTAL AMOUNT PAID $	AMOUNT IN DISPUTE $	
DATE OF CLOSING OF HEALTH SPA		

SEE REVERSE

SECTION 4 – ATTACHMENTS

- COPY OF YOUR CONTRACT
- COPIES OF PROOF OF PAYMENT, SUCH AS CANCELED CHECKS, CREDIT CARD STATEMENTS, ETC.

SECTION 5 – DISCLAIMERS AND AFFIDAVIT

- NO APPLICATION FOR A PAYMENT FROM THE GUARANTY FUND SHALL BE ACCEPTED BY THE DIRECTOR MORE THAN 6 MONTHS AFTER THE DATE OF THE CLOSING OF THE LOCATION OF THE HEALTH SPA WHERE THE BUYER ENTERED INTO THE CONTRACT.

- BY SIGNING THIS FORM, YOU CERTIFY THAT THE STATEMENTS MADE HEREIN OR ON ANY ATTACHED DOCUMENTATION ARE TRUE AND COMPLETE TO THE BEST OF YOUR KNOWLEDGE, INFORMATION AND BELIEF.

Signature: ____________________________________ **Date:** _____/_____/______