This is not an insurance policy.

BILL ASSURE
BENEFIT CLAIM FORM

PO BOX 5370, McAllen, Texas 78502 • Ph. 325-400-1744 • Fax 866-579-7400
ATTN: Bill Assure Plan Administrator

*****Please fill out this form completely. If something does not apply, write N/A.*****

SECTION 1 - CLIENT'S INFORMATION — PLEASE PRINT

NAME OF UTILITY COMPANY		UTILITY COMPANY ACCOUNT NUMBER	
NAME ON MONTHLY BILLING STATEMENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
CLIENT'S STREET ADDRESS/APT. #	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (DAY)	TELEPHONE NUMBER (EVENING)	CLIENT'S EMAIL ADDRESS	
NAME OF PERSON(S) AFFECTED BY ELIGIBLE EVENT	PLACE OF EMPLOYMENT		
CLIENT'S JOB TITLE	DATE HIRED	HOURS WORKED PER WEEK	

TYPE OF EMPLOYMENT
☐ FULL-TIME ☐ PART-TIME ☐ SEASONAL ☐ TEMPORARY ☐ SELF-EMPLOYED ☐ RETIRED ☐ UNEMPLOYED

HAVE YOU RESUMED DUTIES ☐ YES ☐ NO IF YES: ☐ FULL-TIME ☐ PART-TIME	LAST DAY YOUR WORKED	DATE YOU RETURNED TO WORK

REASON FOR INTERRUPTION OF EMPLOYMENT OR RETIREMENT

ELIGIBLE EVENT — PLEASE SELECT

☐ INVOLUNTARY UNEMPLOYMENT ☐ DISABILITY ☐ FAMILY LEAVE OF ABSENCE ☐ LOSS OF LIFE ☐ HOSPITALIZATION ☐ OTHER

DATE OF EVENT

DETAILS OF EVENT

I hereby assign to my Utility Company, Assignee, the benefit due or to become due under Bill Assure, when issued to the extent of any indebtedness due by me to said Assignee per the Terms of Service. I specifically agree that this assignment is irrevocable.

CLIENT SIGNATURE	DATE

FOR OFFICE USE ONLY

DATE FORM RECEIVED	☐ APPROVED ☐ DENIED ☐ UNDER REVIEW ☐ INCOMPLETE ☐ CONTACT CLIENT	BENEFIT PAID DATE

BILL ASSURE REP	BENEFIT AMOUNT PAID	CHECK NUMBER

CONFIDENTIAL