Please complete and return this form. If the information below is outdated, you can use the space provided to update. You can also update the information by contacting our call center at 1-800-808-2837 or in your account at BVESInc.com.

Customer Name: _____

Account ID: _____

Billing Address: _____

Mobile Phone: _____

Home Phone: _____

Email Address: _____

Please mark your selection:

1. Are you or anyone in your household dependent on gas or electricity for medical needs? This could involve needing electricity to power a medical device. Having a medical condition that could become life threatening if the power is shut off also qualifies.
   ◯ Yes ◯ No

2. Do you or anyone in your household rely on assistive technology? *I.e., a screen reader or specialized meal device.*
   ◯ Yes ◯ No

3. Do you or anyone in your household rely on medical equipment? *I.e., a CPAP, respirator, motorized wheelchair/ scooter or hospital bed.*
   ◯ Yes ◯ No

4. Do you or anyone in your household identify with any of the following? *Check all that apply.*
   ☐ Blind ☐ Deaf or Hard of Hearing ☐ Disabled (Cognitive and/or Physical)

5. Do you prefer to receive your billing statement in large print or Braille? *If yes, please check one selection.*
   ◯ Large Print ◯ Braille

6. What is your primary language?
   ◯ English ◯ Spanish ◯ Other

   If "Other", please list: _____

☐ By checking this box and signing below, I certify that the information above is accurate.

Name _____

Date _____

Signature _____