FORMS NEEDED TO BE COMPLETED AND TURNED IN TO
TRANSFER AND SETUP NEW SERVICE ON EXISTING WATER METER

1) Transfer Application

2) Notice of Charges and Fees

3) Debit Authorization Form

4) Careflite Application

5) Careflite Information

6) Request Personal Information

Also we will need to make a copy of Drivers License

Also we will need to make copy of
Rental/Lease Agreement or Buyers Agreement/Bill of Sale

TRANSFER APPLICATION

Bethany Special Utility District
133 S CR 810
Alvarado, TX 76009
817-790-2516
817-790-2525 (fax)
bethanysud@gmail.com

Date: _____ **Account #:** _____

Owner/Landlord Name: _____

Current (New) Occupant Name: _____
In order for the utility district to transfer service into another name, the utility district requests the information below.

New occupant will need to complete and sign a transfer application/service agreement.

Transfer fee is $75.00 due at the time papers are signed and turned in.
Deposit of $150.00 due at the time papers are signed and turned in.
Copy of the driver's license.

Current (New) Occupant Name: _____

Service Address: _____

Mailing Address: _____
Street City State Zip

Cell #: _____ Home #: _____

Employer Name _____ Work #: _____

E-mail: _____

Current Occupant Social Security # _____

Current Occupant Drivers License # _____ Date of Birth _____

_____ _____
Current (New) Occupant Signature Date

_____ _____
Current (New) Occupant Signature Date

Transfer fee is $75.00 due at the time papers are signed and turned in.
Deposit of $150.00 due at the time papers are signed and turned in.
We will need a copy of the driver's license for the person that is going to be on the account.

Payment:
Credit/Debit $_____ Type _____ Fee $_____
Cash $_____ Receipt # _____
Check $_____Check # _____
Money Order $_____Check # _____
Cashiers Check $_____ Check # _____

_____ _____
Employee Initials Date

Account # _____

Auto Draft	Yes	or	No
CareFlite	Yes	or	No

NOTICE OF CHARGES AND FEES

Bethany Special Utility District
133 S CR 810
Alvarado, TX 76009
817-790-2516
817-790-2525 (fax)
bethanysud@gmail.com

MINIMUM MONTHLY CHARGE: $29.50 per month for the first 2,000 gallons used, plus $5.95 per each 1,000 used for the next 15,000 gallons and $7.00 for anything over 15,001 gallons of water. Any customer requiring two meters will be charged $59.00 per month for the first 4,000 gallons used, plus $5.95 per each 1,000 used for the next 15,000 gallons and $7.00 for anything over 15,001 gallons of water. TWC Tax (.5%) is added to the monthly water charge on each bill.

LATE FEE: A $10.00 late charge is added to the balance if the bill is not paid by the 10th of each month. Failure to pay a bill in full by the 25th of each month will result in disconnection of water service unless prior payment arrangements have been made. A reconnection/trip fee of $30.00 will apply anytime our service drivers have to collect payment or disconnect service. All balances must be paid in full to resume service. If the meter is locked, for any reason, the minimum charge will still apply each month.

A $75.00 transfer fee is required for all new occupants at the time the transfer application is completed and turned in. Also a $150.00 deposit is required for all new occupants at the time the transfer application is completed and turned in. Service will not be turned on till all paperwork and monies are collected.

It is your responsibility to pay your monthly bill. The bills are mailed so that you should receive by the 1st of the month. If you do not receive your bill, please contact us at 817-790-2516. We cannot be responsible for the postal service. There is a $25.00 charge for returned checks. A $10.00 late fee may also apply. If at any time we receive a check back for insufficient funds then we will no longer be able to accept personal checks. Only cash, credit/debit cards (with $2.00 processing fee), money orders or cashiers check will be accepted for payment of a returned check.

Anytime you believe that your bill is incorrect, you may contact the utility office in person or by phone at 817-790-2516. If problem is not resolved informally, you may request a hearing by written notice or in person during normal business hours. The request for hearing must be registered prior to the proposed date of discontinuance. No formal hearing may be had where your sole complaint is that you are financially unable to pay the billing and there is no dispute as to accuracy of the billing. If the determination is made that the bill is correct, you will be required to pay the amount due.

Customer must contact our office in advance to suspend or cancel service. Failure to do so will result in continuing charges.

You are hereby notified that unauthorized connection of a utility meter is a violation of Sec. 31.4 of the Texas Penal Code and is subject to prosecution. If at anytime a lock is placed on a meter and that lock is removed by anyone other than a Bethany SUD Employee your account will be charged $200.00. Your account will also be charged for the water usage that occurred from the time the lock was removed at the current highest water rate per 1000 gallons of water used.

Our business office is open Monday thru Friday 8:00am to 4:00pm. For your convenience, a mail slot is located on the front door for payments during non business hours. We are able to set up an automatic draft on your bank account if you complete the Debit Authorization form and provide us with a voided check.

If you have a complaint you may contact Laura Aguirre the Office Manager, or John Daniel the General Manager. If they cannot assist you with your concern, it should be brought before the Board of Directors at the monthly board meeting held on the 3rd Tuesday of each month.

By execution hereof, the Applicant shall hold the District harmless from any and all claims for damages caused by service interruptions due to waterline breaks by utility or like contractors, tampering by other customer/users of the District, normal failures of the system, or other events beyond the District's control.

Thank you and we appreciate your business!

_____ _____

Current (New) Occupant Signature Date

_____ _____

Current (New) Occupant Signature Date

Debit Authorization Form

I (we) hereby authorize **Bethany Special Utility District** to initiate entries to my checking account at the Financial Institution listed below, if necessary initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Bethany Special Utility District is notified by me (us) in writing to cancel it in such time as to afford Bethany Special Utility District and the Financial Institution a reasonable opportunity to act on it.

_____

Name

_____

Address

_____

Phone #

_____

Name of Financial Institution

_____

Address of Financial Institution - Branch City, State & Zip

_____

Financial Institution Routing Number

_____

Account Number

TO BE DRAFTED = BILL TOTAL EACH MONTH

WILL BE DRAFTED ON THE 10TH OF EACH MONTH

_____

Signature Date

_____

Bethany Account Number

PLEASE ATTACH A VOIDED CHECK

CareFlite
Making precious minutes count since 1979

3110 S. Great Southwest Pkwy
Grand Prairie, Texas 75052
(877) 339-2273 Membership
Fax: 972-660-8821

Caring – Heart
Membership Application
Bethany SUD

Bethany Special Utility District & CareFlite have partnered together to allow all customers of the water system to become members of CareFlite for $1 per month. This includes all permanent family members of your household at no additional cost as listed below. Filling out this application is not required by the agreement but by doing so, CareFlite is able to provide you with better service if you are transported.

First Name:_____Middle Initial:_____Last Name: _____

Mailing Address: _____

City:_____Zip Code:_____Phone # (_____) _____

Date of Birth: _____ ▫ Male ▫ Female

Do you have health insurance? ▫ Yes ▫ No If you answered Yes to this question, please list your primary health insurance company:

_____

Other Family Members of Your Household:

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ ▫ Male ▫ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ ▫ Male ▫ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ ▫ Male ▫ Female

First Name:_____Middle Initial:_____Last Name: _____

Date of Birth: _____ ▫ Male ▫ Female

First Name._____Middle Initial:_____Last Name: _____

Date of Birth:_____ ▫ Male ▫ Female

(For additional household family members, please copy this page and attach to this application)

By submitting this application, I agree (on my behalf and on behalf of my family) in consideration of the benefits provided to abide by the terms of the Caring-Heart Membership Program, which are shown on the back of this application. I request payment of authorized Medicare or other insurance benefits to me, or on my behalf, to be paid to CareFlite for any emergency services and supplies furnished to me or my household family members by CareFlite. I authorize any holder of any of my medical information or that of my household family members to release that information to CMS, its agents or carriers, or CareFlite in order to determine benefits payable on my behalf or on behalf of my family members, now and in the future. This agreement and authorization is executed on my own behalf and on behalf of the other members of my household, if they are minors or otherwise unable to sign. **I understand that under Texas rule 157.11 if I or a household member is a Medicaid recipient, than I am not allowed to have them on this application.** Therefore I am stating that I have not listed on this application anyone that is a Medicaid recipient. If a household family member subsequently becomes a recipient of Medicaid, I will notify CareFlite in writing of this change immediately. I warrant that all of the information on this application is true and correct. CareFlite reserves the right to request documentation to verify the accuracy of any such information. I acknowledge that membership in CareFlite's Caring-Heart Membership Program is an EMS membership in a program sponsored by CareFlite and is not a membership in CareFlite's non-profit entity as the term "membership" is contemplated under the Texas Non-Profit Corporation Act.

_____
Signature

For CareFlite Office Use Only

Date Received: _____ Membership # Assigned: _____

3110 S. Great Southwest Pkwy.
Grand Prairie, Texas 75052
Members Services Office
Phone: (877) 339-2273
Fax: (972) 660-8821

Caring - Heart Membership Program

PERSONS COVERED: This Agreement covers the household family members listed on the application on the reverse side provided to CareFlite, so long as they remain full-time residents (including college students) of my household. New residence family members may be added, others deleted or the household location changed by written notice to CareFlite at the address shown above. Added members will be effective as of the date the information is received by CareFlite. Medicaid recipients may not enroll by law.

EFFECTIVE DATE: The program complies with the contracted terms between CareFlite and the entity named on the reverse side.

BENEFITS: Payment of the membership fee and compliance with the terms of this program/agreement entitles the member to the following benefits:

1. Emergency helicopter air ambulance services originating within 150 miles of DFW Airport for medically necessary advanced or basic life support emergency transport services from CareFlite as a result of an emergency medical condition shall pay nothing out of pocket, unless otherwise specified herein.
2. Emergency fixed wing air ambulance services for patients needing a higher level of care originating within 500 miles of DFW Airport and within the United States shall pay nothing out of pocket. For non-medically necessary fixed wing transports, CareFlite will make its best efforts to obtain an insurance pre-authorization. For fixed wing air ambulance service that are not medically necessary and/or operated for patient or family convenience, CareFlite will give members a 50% discount from its standard rates.
3. CareFlite's ground ambulance and 911/EMS service will be available with its service areas. These benefits will follow the rules of this Air Ambulance membership program.
4. If CareFlite has any agreements for the reciprocal honoring of a membership benefit with other air/ground EMS providers, all Members of CareFlite shall be covered by such agreement. A list of any such agreements can be found at www.careflite.org .

PAYMENT FOR SERVICES: I understand that I am responsible for payment for any services provided to me by CareFlite, but that my membership will assist me by discharging that part of my financial liability that is not covered by insurance for those CareFlite services specified in this Agreement. This benefit is subject to certain limitations specified in this agreement. As a condition of receiving this benefit, I hereby assign (hand over) to CareFlite all rights and benefits that I or the other family members of my residence have under any and all medical, health, supplemental, worker's compensation, liability, auto or homeowner's insurance policies or plans, or from other third party payers or sources which provide coverage or would otherwise pay for ambulance services. Such payment sources are collectively referred to in this agreement as "insurance". I authorize the payment of all insurance benefits or payments to CareFlite. I understand that CareFlite will, whenever it deems it feasible, file claims for and directly collect the benefits payable from insurance up to the amount of CareFlite's charges for its services. When requested by CareFlite, I agree to complete any forms and take any other reasonable action that may be necessary to collect such amounts. If I or anyone on my behalf receives any insurance or other third party payments for services provided by CareFlite, I will promptly forward those payments to CareFlite at the address shown at the top of this form.

LIMITATIONS and CONDITIONS: Membership benefits extend to CareFlite's critical care, advanced or basic life support helicopter and fixed wing air ambulance services staffed with nurses, paramedics and pilots, Specialty Care Transport (a ground transport staffed similarly to CareFlite's air ambulance services) as well as ground ambulances staffed with quality trained paramedics and EMTs. Member benefits are not applicable to services rendered by any other provider. As a condition of receiving the benefits of membership with respect to any air or ground ambulance transport, members with insurance agree to and must comply with all coverage conditions of their applicable insurance program for such transport. Some insurance programs require the insured person to obtain prior authorization of payment for non-emergency, yet medically necessary air ambulance services. (This requirement typically applies to fixed wing air ambulance and inter-facility ground ambulance only but not to helicopter or 911/EMS emergency services.) Non-insured household family members will automatically receive a 50% membership discount on CareFlite's standard charges for the services rendered. Some plans require certain documentation from the insured within a specified time limit or the plan(s) deny or reduce coverage for ambulance services. In the event the member with insurance forfeits coverage by failing to comply with these types of requirements for a transport that would otherwise be covered by insurance, the member will then forfeit membership benefit for failing to so comply and their membership can be revoked at CareFlite's discretion. Membership is available for sale only in those counties or jurisdictions shown on CareFlite's website www.careflite.org . Ground ambulance benefits are available to all members but only in CareFlite's ground ambulance service areas. The member must hold a membership that is in good standing at the time of service and the transport must originate in CareFlite's deemed service area with CareFlite as the transporting agency. CareFlite reserves the right to deny or revoke any membership for reasonable cause. If membership is revoked then all balances are due in full. CareFlite may terminate the membership program at any time upon notice to the members. If CareFlite terminates the program, members will have any unused, prorated portion of their membership fee returned. To protect member fees, CareFlite maintains a bond with an A rated insurance company. CareFlite's Membership benefits are honored by certain other medical transport programs. Visit www.careflite.org for complete details.

CareFlite is a 501(c)3 not for profit air & ground ambulance service sponsored by:

Baylor Scott & White Health · JPS Health Network · Methodist Health System · Parkland · Texas Health Resources

WWW.CAREFLITE.ORG MEMBERSHIP (877) DFW CARE

REQUEST PERSONAL INFORMATION CONTAINED IN OUR UTILITY RECORDS NOT BE RELEASED TO UNAUTHORIZED PERSONS

The Texas legislature enacted a bill, effective September 1, 1993 allowing special utility districts to give their customers the option of making the customer's address, telephone number, and social security number confidential.

IS THERE A CHARGE FOR THIS SERVICE?

NO. There is not a charge for this service.

HOW CAN YOU REQUEST THIS?

Simply complete the bottom of this page and return to:

Bethany Special Utility District
133 S. CR. 810
Alvarado, Texas 76009

Your response is not necessary if you do not want this service.

WE MUST STILL PROVIDE THIS INFORMATION UNDER LAW TO CERTAIN PERSONS.

We must still provide this information to (1) an official or employee of the state or a political subdivision of the state, or the federal government acting in an official capacity, (2) an employee of a utility acting in connection with the employee's duties, (3) a consumer reporting agency, (4) a contractor or subcontractor approved by and providing services to the utility or to the state, a political subdivision state, the federal government, or an agency of the state or federal government, (5) a person for whom the customer has contractually waived confidentiality for personal information, or (6) another entity that provides water, wastewater, sewer, gas, garbage, electricity, or drainage services for compensation. However, such confidentiality does not prohibit the District from disclosing the name and address of each customer on a list to be made available to the District's voting customers, or their agents or attorneys, in connection with any meeting of the District's customers.

Yes, I want to make my personal information (address, telephone number, and social security number) confidential.

_____ Name

_____ Account Number

_____ Address

_____ Telephone Number

_____ City, State, Zip Code

X _____ Signature