ELITE PROFESSIONAL BULLRIDERS RIDER RELIEF APPLICATION FOR ASSISTANCE

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888-776-5609 (phone/fax)

EPB Rider Relief Fund - Application for Assistance

CONTACT INFORMATION

EPB Member Name: _____ Cell Phone: _____

Home Phone: _____ Email: _____

Address: _____

Street/Box City State/Province Zip/Postal Code

Age: _____ Birthdate: ___ / ___ / _____ EPB Card Number: _____

Medical Insurance Provider: _____

EVENT & INJURY INFORMATION

Date of injury: _____ Event Location: _____

Describe the incident and your resulting injury: _____

_____

_____

_____

_____

Provide evidence of your claim/need for assistance (doctor note, hospital bill, etc.).

Describe/explain the document you are providing here, and attach a copy to this application:

_____

_____

You have 4 weeks from the date of the EPB event at which your injury occurred to submit a request for assistance. You must provide evidence of need/expense with this form.

Printed Name: _____ Date: _____

Applicant Signature: _____

Note: All details contained in this form are CONFIDENTIAL. The more information you provide, the faster a decision can be made. RETURN FORM TO: 4692 Montrose Dr. Missoula, MT 59808, or fax to 888-776-5609