SOBERLINK HEALTHCARE LLC ARBITRATION OPT OUT FORM

Please complete all blanks to submit your request to opt out of the arbitration process. If information is incomplete or inaccurate, your opt out request will not be valid. The information provided must be for the specific Soberlink Device or line of service, activated within the last 30 days, for which you want to opt out.

Account Holder's Name:
(you must be the account holder to submit an opt out request)

Billing Address on Account:

Phone Number:

____________________ ____

Date Signature