PASCOAG UTILITY DISTRICT

Please mail to:
Pascoag Utility District
PO Box 107, Pascoag, RI 02859

Serious Illness Protection Form

Please note: This is not a rate reduction.

I hereby state under oath that the following information is true and correct.

Customer Information:

(Please print.)

Account Holder Name: _____ Electric Account Number:_____

Address: _____ City/Town: _____

Email Address: _____ Phone Number:_____

Name of Individual Who is Seriously Ill: _____ Relation to Account Holder:_____

TO BE COMPLETED BY LICENSED PHYSICIAN:

Print Patient Name: _____

Please specify the nature of the illness and its likely duration:

_____

_____

Print Licensed Physician's Name: _____

Physician's License Number:_____

Licensed Physician's Address: _____

Licensed Physician's Phone Number: _____

The above information is necessary to conform to the RI Public Utilities Commission's regulations in establishing a Serious Illness Protection. We require the business address, telephone number and licensed physician's signature.

"Seriously Ill" shall mean an illness that is life threatening that will cause irreversible adverse consequences to human health or that has a significant potential to become life threatening or to cause irreversible adverse consequences to human health.

I certify the above-mentioned individual at the address listed above, is seriously ill as defined above and all information provided regarding the patient's health is current and accurate.

Licensed Physician's Signature: _____ Date: _____

Pascoag Utility District requires this form to be submitted annually to recertify the existence of the serious illness in order to maintain the protection.