Serious Illness Protection Form

Rhode Island Energy™
a PPL company

Please complete the information on both sides of this form and return it to Rhode Island Energy using one of the following methods.

Fax: 401-955-6617

Mail: Rhode Island Energy
PO Box 25215
Lehigh Valley, PA 18002-5215

I hereby state under oath the following information is true and correct. **PLEASE PRINT.**

Account Holder's Name	**Electric Account Number:** **Gas Account Number:** **(Account numbers must be at the same premise)**
Service Address	**Phone Number**
	Email Address
Seriously Ill Individual's Name	**Relationship to Account Holder**

This Section to Be Completed By A Licensed Physician (LP), Medical Doctor (MD) Or Doctor Of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) only. Specify the nature of the illness and the duration of the illness. PLEASE PRINT.

Patient's Name	**Patient's Illness & Duration of Illness**
Physician's Name	**Physician's License Number**
Name & Address of Practice	

The above information is necessary to conform to the Rhode Island Public Utilities Commission's regulations, as modified by court order, in establishing a Serious Illness protection. "Seriously ill" shall mean a condition that carries a high risk of mortality, negatively affects quality of life and daily function, and/or is burdensome in symptoms, treatments, or caregiver stress; provided, however, for purposes of this definition, a serious illness may not exceed six (6) months in duration. A serious illness that exceeds six (6) months in duration is deemed a "disability." We also require the business address, telephone number and licensed physician's signature.

I certify the above-mentioned individual, at the address above, is seriously ill as defined above, and all information provided regarding the patient's health is current and accurate.	**Licensed Physician's Signature & Title**
	Date (must be dated within the past 30 days)

Disabled Protection Form

Rhode Island Energy™
a PPL company

Please complete the information on both sides of this form and return it to Rhode Island Energy using one of the following methods.

Fax: 401-955-6617

Mail: Rhode Island Energy
PO Box 25215
Lehigh Valley, PA 18002-5215

I hereby state the following information is true and correct. **PLEASE PRINT.**

Account Holder's Name	**Electric Account Number:** **Gas Account Number:** **(Account numbers must be at the same premise)**
Service Address	**Phone Number**
	Email Address
Disabled Individual's Name	**Relationship to Account Holder**

To qualify for disabled protection, you may either have a Licensed Physician (LP), Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) complete the below section of the Disabled Protection Form or submit proof of receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). The customer affidavit below must be completed to receive protection. The SSDI or SSI award letter must be dated within the past 3 months.

Patient's Name	**Patient's Disability**
Physician's Name	**Physician's License Number**
Name & Address of Practice	

The above information is necessary to conform to the Rhode Island Public Utilities Commission's regulations, as modified by court order, in establishing a Disabled protection. A "disability" shall mean, "with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual. This impairment is material, rather than transitory and minor, and is one with an actual or expected duration of more than six (6) months." For purposes of this definition, "major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

I certify the above-mentioned individual, at the address above, is disabled as defined above, and all information provided regarding the patient's health is current and accurate.	**Licensed Physician's Signature & Title**
	Date **(must be dated within the past 30 days)**

This Section Is An Affidavit And Must Be Completed By The Account Holder

Residing permanently at this address is someone who has a physical or mental impairment that substantially limits one or more of the major life activities of such individual. This disability is material, rather than transitory and minor, and is one with an actual or expected duration of more than six (6) months.	
Account Holder's Signature	**Date** (must be dated within the past 30 days)
The person whose signature above personally appeared before me and swore the statements contained herein are true.	
Notary Public's Signature	**Date** (must be dated within the past 30 days)
Notary Number	**Notary Expiration Date**

Rhode Island Energy will require you periodically to recertify the existence of the disability to maintain the protection.