Application for Non-Discontinuance of Electric Service

Your Touchstone Energy® Cooperative

BOTH PAGES OF APPLICATION MUST BE COMPLETED

I, the undersigned customer of United Power, do hereby request the non-discontinuance of electric service due to non-payment. In support of my request, I swear the following are true and correct statements:

1. I am unable to pay the full amount owed for electric service at this time.
2. Termination of electric service would be especially dangerous to the health or safety of the following person who is a permanent resident of my household:

Full Name of Person	Age	Relationship

Such person requires the use of the following life-sustaining medical equipment for his/her health or safety (describe equipment and its use with particularity):

I understand that electric service will be continued under this application for **60** days from the date of receipt by United Power and acceptance of a physician's certification and that said certification shall not relieve me of any indebtedness to United Power.

I UNDERSTAND THAT ANY NON-DISCONTINUANCE OF SERVICE WILL BE EFFECTIVE FOR ONLY SIXTY (60) DAYS FROM THE DATE OF ACCEPTANCE BY UNITED POWER. AFTER THAT TIME, POWER WILL BE DISCONNECTED UNLESS PAYMENT HAS BEEN MADE IN FULL AND THE ACCOUNT IS CURRENT. I UNDERSTAND THAT I MAY INVOKE THIS PROCEDURE NO MORE THAN ONCE DURING ANY PERIOD OF 12 MONTHS. SAID PERIOD TO BEGIN ON THE FIRST DATE A MEDICAL CERTIFICATION IS PRESENTED TO AND ACCEPTED BY UNITED POWER.

THE MEDICAL CERTIFICATION MUST BE SIGNED BY A LICENSED COLORADO PHYSICIAN.

Customer Name	**Customer Signature**

Street Address	**City**	**State**	**ZIP**

Cell Phone Number	**Email Address**

INTERNAL USE	Customer Account Number	Prepared By	Date Received	Received By	Cycle

SUBMIT COMPLETE FORMS AT WWW.UNITEDPOWER.COM/MEDICAL-DEVICES

Medical Certification

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This is to certify to United Power that termination of electric service would be especially dangerous to the health or safety of:

Full Name of Person

because, in my opinion said termination of electric service would create a medical emergency or aggravate an existing medical condition for said person.

Please describe the medical condition and the life-sustaining medical equipment being used by said person below. The description must be detailed and must describe with particularity how the lack of electricity would create a medical emergency or aggravate an existing medical condition for said person.

Dated this _____ day of _____ , _____.
(DAY) (MONTH) (YEAR)

Printed Physician Name	**Physician Signature**

Colorado Physician License Number	**Email Address**

Street Address	**City**	**State**	**ZIP**

Phone Number	**Fax Number**

MEDICAL CERTIFICATION DOES NOT GUARANTEE UNINTERRUPTED POWER. CUSTOMER IS ENCOURAGED TO DISCUSS BACKUP POWER PLANS WITH PHYSICIAN, MEDICAL DEVICE MANUFACTURER, AND CARE CIRCLE.

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