

Elderly & Life Support Program Application

This program is intended to assist KIUC in identifying customers who require electricity to operate medical equipment necessary to support life or elderly who may require special handling.

Electric Bills Must Be Paid When Due: Electric bills must be paid on time. Past due accounts are subject to disconnection of service. In the event your electric account is subject to disconnection, the Public Utilities Commission will be notified prior to such termination of service in accordance to KIUC Tariff Rules No. 7.3.b and No. 7.3.c.1.

Discontinuance of Service: If service is disconnected for non-payment, a fee to re-establish service will be charged in addition to full payment of the past-due amount. A credit deposit may also be required.

Power Outages: Outages can and do occur, it is important for customers who are on life support to make alternate plans should the power go out at their homes.

Elderly

To Qualify:

- Account holder must be age 62 or older (Please attach Driver's License, State ID, Passport or Passport Card required for proof of age).
- Account holder can only have one account identified as Elderly, must reside in the home and must be a year-round resident on the Island of Kauai.

Signature of Customer on Record

Date

Disability or Life Support– Customer Certification

I hereby certify that _____ is a full-time resident of my household and
(Name of person with a Disability or on Life Support)

requires the use of a life-support device. I understand that I must renew this certification annually and notify KIUC upon termination of use of the life support equipment.

Name of Customer on Record: _____ Acct. No. _____

Address: _____ Telephone No. _____

Signature of Customer on Record

Date

Disability or Life Support – Physician Certification

To be completed by a medical doctor licensed to practice medicine in the State of Hawaii:

I hereby certify that _____ has a disability or regularly requires the use of a life support
(Name of person with a Disability or on Life-Support)

device and I further certify that the life support device will continue to be required for approximately _____ years.

Name of Physician: _____ Telephone No. _____

Address: _____ City & Zip _____

Signature of Physician

Date