AEC Form 261
Rev: 05-20-2014

APPALACHIAN ELECTRIC COOPERATIVE
NECESSARY SERVICES PROGRAM ENROLLMENT

This enrollment form is to be completed by the member of record and a registered attending physician. Once enrolled, Appalachian Electric will attempt notification prior to scheduled interruptions in electric service affecting the member due to repairs or upgrades to our electric system. *Completion of this form does NOT prevent disconnection for non-payment.* If the individual requiring necessary electric service for medical equipment or other reasons cannot be without power for any reason, Appalachian Electric recommends developing alternative plans. Please consult with your physician and/or medical equipment supplier regarding your particular medical needs.

Appalachian Electric exercises reasonable diligence in supplying continuous electrical services. Under no circumstance is Appalachian Electric a guarantor or insurer of uninterruptible service. For example, there are numerous situations where conditions beyond our control can result in power outages. All service is restored as soon as possible, with consideration given to safety first. Appalachian Electric will not be liable for any injury, loss or damage resulting from interruption, shortage or insufficiency of electric service or irregularities of electric service.

This enrollment is valid for up to two (2) years. Afterwards, it is the responsibility of the member to renew the necessary services request by submitting a new enrollment form. Member is responsible to notify AEC if status changes.

TO BE COMPLETED BY MEMBER:

Appalachian Electric Account Number:_____(where necessary service required)

Name of Member:_____ Name of Patient:_____

Relationship of Patient to Member of Record:_____

Physical Address:_____
Street City State Zip Code

Phone Number:_____(where notification message can be delivered)

Emergency Contact Name:_____ Phone Number:_____
(person NOT residing at the residence)

Does patient have electric/battery backup equipment available? □ yes □ no Is it a generator? □ yes □ no
(Please note: a generator requires double throw safety switch and must be connected per National Electric Code)

Does patient: □ live alone OR □ live with someone who can provide needed assistance?

Member's Signature:_____ Date:_____

TO BE COMPLETED BY PHYSICIAN:

Physician's Name:_____ Phone Number_____

Address:_____
Street/P.O. Box City State Zip Code

Is the equipment expected to be needed: Short Term (less than 6 months) Long Term (up to two years or longer)

I acknowledge that the patient listed above requires medical equipment that must have necessary electric service to support the life of this patient with the understanding and conditions of this program as stated above.

Signature:_____ Date:_____

TO BE COMPLETED BY APPALACHIAN ELECTRIC COOPERATIVE: Date:_____

Line Section:_____ Sub Brkr_____ Location I.D.:_____ Posted By:_____

When completed, please return to AEC @ P. O Box 400, New Market, TN 37820-0400; Attention: E&O Secretary

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