Members who depend on life support systems should notify Choctaw Electric Cooperative's Billing Department before an emergency. The member's electric service will be identified as a medical account and will be given a high priority status. Medical accounts should, however, make plans for alternate sources of power or alternate lodging during a power outage.

LIFE SUPPORT DEPENDENT MEMBER

Date:_____ Account #:_____

A Life Support Dependent Member is defined as a person who because of a medical condition, or is immobile and requires use of electric powered medical equipment to sustain life.

Choctaw Electric Cooperative attempts to maintain a record of Members dependent upon electrical life support systems in order to prioritize the maintenance and restoration of electrical service to such Members as soon as the situation permits.

Persons having a need to be designated, as Life Support Dependent should complete the Member portion of this form and have their doctor complete the physician's portions and return it to the Choctaw Electric office within 30 days from the date above.

Note: A complete response to all items in both the Member Information section and the Physicians Statement is necessary.

MEMBER INFORMATION

Name:_____

Home Phone:_____Work Phone:_____Cell Phone_____

Address:_____

Members' on-site backup capabilities or other alternatives for loss of normal electrical service:

_____

_____

Other information or comments:

_____

_____

I understand that Choctaw Electric Cooperative cannot and does not guarantee uninterrupted electric service and that some interruptions of electric service are inevitable. I also understand that it is my responsibility to provide a battery or other backup power source in the event of a power outage and I am not relying on Choctaw electric cooperative for alternate or emergency electric power in the event of a power outage. I understand that being included on the Life

Support dependent Member Information list does not entitle me to special rights or preferential service.

Member Signature:_____
Date:_____

PHYSICIANS STATEMENT

PHYSICIAN: PLEASE FURNISH A COMPLETE RESPONSE TO EACH ITEM BELOW:

Physician's Name:_____

Office Address:_____

Patient Name:_____

Patient Address:_____

Need for life support equipment:_____

_____

Extent of time and use of life support equipment:_____

_____

I certify that the above information is true and correct and the above named patient qualifies for life support dependent status under the definition above.

Physician Signature:_____
Date:_____