



Bluebonnet Electric Cooperative, Inc.
Tariff for Electric Service
Section III, Sheet No. 39.1

The Cooperative will make reasonable efforts to extend the discontinuance of service to a delinquent residential Member when it is established that disconnection of the Member's electric service will result in a person residing at that residence becoming seriously ill. It will be the Member's responsibility to provide the cooperative with a written statement from the physician or health care provider stating someone at that residence is either seriously ill and/or supported by an electric device. The delinquent residential Member who makes such a request and provides proper documentation may enter into a deferred payment agreement. The critical care documentation for electric service shall be valid for two years from the date shown.

If the Member's service is disconnected after failure to reach an agreement or meet the deferred payment agreement, a reconnection of the service will not be made until the amount owed is paid in full along with the disconnect fee, reconnect fee and a deposit if applicable, for each meter to be reconnected. **Full payment must be received prior to 5 p.m.** Bluebonnet will make every effort to reconnect the Member on the date full payment is received. Bluebonnet reserves the right to postpone reconnection should an emergency situation occur. **Payments will not be accepted at the Member's service location.**

Medical Form for Critical Care

DATE: _____

MEMBER NAME: _____

SERVICE ADDRESS: _____

MAILING ADDRESS (if different from service address): _____

TELEPHONE NUMBER(S): _____

ACCOUNT NUMBER: _____

SECONDARY CONTACT

NAME: _____

RELATIONSHIP: _____

PHONE NUMBER(S): _____

COMPLETED BY MEMBER'S PHYSICIAN

PATIENT'S NAME: _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE NUMBER: _____

TEXAS MEDIAL BOARD LICENSE NUMBER: _____

TYPE OF ELECTRIC, LIFE-SUSTAINING MEDICAL EQUIPMENT USED: _____

MEDICAL DIAGNOSIS: _____

IS THE PATIENT/MEMBER DEPENDENT UPON AN ELECTRIC-POWERED MEDICAL
DECVICE TO SUSTAIN LIFE? YES _____ NO _____

DOES THE PATIENT/MEMBER HAVE A SERIOUS MEDICAL CONDITION THAT
REQUIRES AN ELECTRIC-POWERED MEDICAL DEVICE FOR HEATING OF COOLING
TO PREVENT IMPAIRMENT OF A MAJOR LIFE FUNCTION THORUGH A SIGNIFICANT
DETERIORATION OR EXACERBATION OF THE PERSON'S MEDICAL CONDITION?
YES _____ NO _____

PHYSYICIAN'S SIGNATURE: _____ DATE: _____

PATIENT'S/MEMBER'S SIGNATURE: _____ DATE: _____

Qualification pursuant to this form does not guarantee uninterrupted power supply, and if electricity is a necessity, you many need to make other arrangements. This document is valid for two years from the date of document.