Hawaiian Electric
Maui Electric
Hawai'i Electric Light

Special Medical Needs Pilot Program Application

TO BE COMPLETED BY CUSTOMER:

NAME OF ACCOUNT HOLDER: _____

ACCOUNT NUMBER: _____

SERVICE ADDRESS: _____

PHONE NUMBER: _____ ☐ Home ☐ Mobile

SPECIAL MEDICAL NEEDS PATIENT (if different): _____

The Hawaiian Electric Companies have created the Special Medical Needs Pilot Program discounted rate to help our customers who depend on life support equipment at home and/or have increased heating or cooling needs due to a medical condition.

I certify this application is for the Special Medical Needs resident's primary residence and no other application is being made for this resident at another address. I agree to promptly notify the Hawaiian Electric Companies if the eligible resident moves or no longer requires life support equipment. I agree to allow the Hawaiian Electric Companies to confirm this information, if necessary.

☐ I would like to participate in a voluntary survey requested by the Hawaii Public Utilities Commission ("PUC") and the State of Hawaii Division of Consumer Advocacy ("CA") seeking relevant information regarding my participation in this Special Medical Needs Pilot Program. By checking the box, I agree to be contacted by the Hawaiian Electric Companies to participate in this survey and further give my express consent to the Hawaiian Electric Companies to share such information obtained with the PUC and the CA. Please note that participation in this survey is completely voluntary and is not a condition to your application or participation in the Special Medical Needs Pilot Program.

CUSTOMER SIGNATURE: _____ DATE: _____

Customers under the Special Medical Needs Pilot Program, please note:

- Electric bills must be paid on time. Past due accounts are subject to disconnection of service. If electric service must be disconnected, the Public Utilities Commission will be notified prior to such termination.
- If service is disconnected for non-payment, before we can reconnect, the past-due amount, payment for re-establishing service and any deposit required must be paid.
- The information you and your doctor provide is protected by our Privacy Policy. The policy may be viewed by visiting www.hawaiianelectric.com and clicking on Privacy Policy in the lower left corner of the home page or entering Privacy Policy in the search box.

Important: Electricity outages can occur unexpectedly. It's essential for customers who depend on medical life support equipment to make alternate plans should the power at their homes go out.

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TO BE COMPLETED BY A STATE OF HAWAII LICENSED MEDICAL DOCTOR (M.D.) OR DOCTOR OF OSTEOPATHY (D.O.)

I certify the medical condition and needs of my patient listed below:

Patient's First Name: _____ Patient's Last Name: _____

1. Requires the use of any of the following life support devices*:

☐ **Dialysis** ☐ **Intravenous** ☐ **Nebulizer** ☐ **Oxygen**

☐ **Respirator** ☐ **CPAP** ☐ **Other** _____

The above-referenced patient regularly requires the use of the life support device designated for approximately _____ hours per month and that the life support device will continue to be required for approximately _____ year(s).

* A qualifying life-support device is any medical device used to sustain life or relied upon for mobility. This device must run on electricity supplied by the Hawaiian Electric Companies. It may include, but is not limited to, respirators (oxygen concentrators), iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPPB machines, kidney dialysis machines, and motorized wheelchairs. Devices used for therapy/comfort rather than life-support do not qualify.

2. Requires heating and/or cooling (check one): ☐ Heating ☐ Cooling

The Special Medical Needs Pilot Program is available for heating and/or cooling if the patient has a compromised immune system, life threatening illness, or any other condition for which additional heating or cooling is medically necessary to sustain the patient's life or prevent deterioration of the patient's medical condition.

DOCTOR'S NAME (please print): _____ PHONE: _____

OFFICE ADDRESS: _____ SOH MD / DO STATE LICENSE NUMBER: _____

_____

DOCTOR'S SIGNATURE: _____ DATE: _____

Please return the completed form to:

Hawaiian Electric Company
Attn: Credit Division
P.O. Box 2750
Honolulu, HI 96840

Maui Electric Company
P.O. Box 398
Kahului HI, 96733

Hawai'i Electric Light Company
P.O. Box 1027
Hilo, HI 96721

For Company Use Only:

Date Form Received:_____ Processed:_____ Certification Date:_____