Date_____

Dear Member,

Marlboro Electric has developed a Special Needs Policy to notify our members before the termination of their electric service where the loss of power would be dangerous to their health or a person residing in the member's household.

The policy does not relieve the member from their obligation to pay their bill. It does add additional notifications to the member before the disconnection of power for non-payment of their power bill.

To be added to our Special Needs customer listing we must receive the attached form completed by your health care provider, the form is to be renewed annually to remain on our list. You cannot be added to the Special Needs list without properly submitting this form. If you have any questions concerning this policy please contact one of our Customer Service Representatives at (843) 479-3855.

Occasionally we experience severe weather that could cause a loss of power for an extended amount of time. If you or someone in your household is on a life support system we suggest you purchase an inexpensive generator.

This would keep the support system operating during this time. Marlboro Electric restores power as quickly as possible but has no way of knowing how extensive the outage could be.

Sincerely,

Michelle Odom
Customer Service Supervisor

Marlboro Electric Cooperative, Inc.
Special Needs Account Member Certification

Member Name (as it appears on bill)_____

Member Address _____

_____

Member Account #_____

Member Telephone Number _____

I hereby certify that termination of residential electric service to the above-referenced member of Marlboro Electric Cooperative, Inc., would be dangerous to the health of the member or a person residing in the member's household at the premises to which electric service is rendered.

I understand that this certification expires twelve (12) months from the date of my signature below.

Licensed Health Care Provider's Signature _____

Today's Date _____

Licensed Health Care Provider's Name (Please print)_____

_____

Licensed Health Care Provider's Address _____

_____

Licensed Health Care Provider's Telephone Number_____

Members Signature_____

Adopted 09/27/06