Disabled Protection Form

Rhode Island Energy®
a PPL company

Please complete this form in full and return it to Rhode Island Energy using one of the following methods:

Online: Visit us online at RIEnergy.com/Protections to securely upload this completed form and provide proof of other benefits.

Fax: 401-955-6617

Mail: Rhode Island Energy
PO Box 25215
Lehigh Valley, PA 18002-5215

I hereby state the following information is true and correct. **PLEASE PRINT.**

Account Holder's Name	**Electric Account Number:** **Gas Account Number:** **(Account numbers must be at the same premise)**
Service Address	**Phone Number**
	Email Address
Disabled Individual's Name	**Relationship to Account Holder**

To qualify for disabled protection, you may either have a Licensed Physician (LP), Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN) complete the below section of the Disabled Protection Form or submit proof of receiving Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI) or a Benefit Verification Letter. Note: The SSDI award letter or Benefit Verification Letter must be dated within the past 3 months. The SSI award letter or Benefit Verification Letter must be dated within the past 12 months. The Affidavit below must also be completed and submitted for SSDI and SSI.

Patient's Name	**Patient's Disability**
Physician's Name	**Physician's License Number**
Name & Address of Practice	

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The above information is necessary to conform to the Rhode Island Public Utilities Commission's regulations, as modified by court order, in establishing a Disabled protection. A "disability" shall mean, "with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual. This impairment is material, rather than transitory and minor, and is one with an actual or expected duration of more than six (6) months." For purposes of this definition, "major life activities" include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working.

I certify the above-mentioned individual, at the address above, is disabled as defined above, and all information provided regarding the patient's health is current and accurate.	**Licensed Physician's Signature & Title**
	Date **(must be dated within the past 30 days)**

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This Section Is An Affidavit And Must Be Completed By The Account Holder

Residing permanently at this address is someone who has a physical or mental impairment that substantially limits one or more of the major life activities of such individual. This disability is material, rather than transitory and minor, and is one with an actual or expected duration of more than six (6) months.	
Account Holder's Signature	**Date** (must be dated within the past 30 days)
The person whose signature above personally appeared before me and swore the statements contained herein are true.	
Notary Public's Signature	**Date** (must be dated within the past 30 days)
Notary Number	**Notary Expiration Date**

Rhode Island Energy will require you periodically to recertify the existence of the disability to maintain the protection.