

Member Name _____
Member Account No. _____
Member Social Security No. _____
Member Date of Birth: _____

EXHIBIT "A"

**Sumter Electric Membership Corporation ("Sumter EMC")
Application for Placement on Life Support List**

I, _____, (Member) do hereby make application to Sumter EMC to be placed on Sumter EMC's Life Support List due to a medical condition requiring Life Support in my home as follows:

The patient with the medical condition is the Member. The medical condition is _____. In connection with this application, I authorize Sumter EMC to review information supplied by my medical provider which offers verification of the medical condition. The information may be requested from:

Doctor's Name: _____ (See Exhibit B, Medical Certification)

The granting of this right to review, access and disclosure includes the power to consent to disclosure of medical information for which consent is required pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA), as amended, (42, U.S.C. 1320 et seq, 45 CFR 3 164 et seq). I hereby release my medical provider and Sumter EMC from all legal responsibility or liability that may arise from the acts I have authorized herein and request that sufficient medical records and information (condition and diagnosis code) be released to verify I have a life threatening medical condition requiring Life Support.

The patient with the medical condition is other than the Member. The patient's name is _____ (See Exhibit B, Medical Certification.)

I understand that placement on Sumter EMC's Life Support List does not guarantee outage free electric service, nor does it place my service as a reconnection priority. Sumter EMC will make all reasonable efforts, within standard utility practices, to prevent a major outage and to notify me of a planned power outage. I understand some natural causes (weather, transmission outage, animals or accidents among others) are not preventable. **I further understand that it is my responsibility to have a standby plan in the event of a temporary or longer-term power outage.** I acknowledge advice that purchasing a back-up generator is a primary alternative when outages occur and that placement on a life support list does not relieve me of the obligation to make timely payments for electric service.

By my signature or the signature on my behalf below, I certify under penalty of law that the information contained herein is true and correct and not made with an intent to avoid payment of any debt due Sumter EMC.

This _____ day of _____, 20____
Member

Notary Public
My commission expires: _____

If Member is unable to sign, the foregoing is executed on behalf of the Member by the Member's Agent:

_____ Relationship: _____

By executing on behalf of Member, I agree to be financially responsible for any electric service provided for Member's benefit under the same terms and conditions of Sumter EMC's membership contract that binds Member. The required documentation to verify my authorization as the Member's Agent is attached.

Please fax this form directly to Sumter EMC, (229) 924-4982.

EXHIBIT "B"
MEDICAL EQUIPMENT NECESSARY FOR SERIOUS MEDICAL CONDITION
MEDICAL CERTIFICATION

Physician Information

NAME: _____

ADDRESS: _____

PHONE: _____

Patient Information

NAME: _____

LEGAL GUARDIAN (if minor or incapacitated adult): _____

ADDRESS: _____

PHONE: _____

Medical Condition: _____

Diagnosis: _____ Date Condition Commenced: _____ Expected Duration: _____

PLEASE DESCRIBE THE PATIENT'S CURRENT CONDITION:

PHYSICIAN CERTIFICATION

1. Is the above-referenced patient currently using medical equipment which is electrically operated to treat their medical condition?
_____ Yes _____ No

2. If the answer to #1 is yes, please specify the type of equipment.

3. Will turning off the patient's electricity, and the resulting turning off of the medical equipment, result in a life threatening situation. _____ Yes _____ No

I agree to fax and/or mail this certification directly to Sumter EMC.

Signature of Physician

Date of Signature and Certification

PATIENT AUTHORIZATION

I authorize the above-named physician to release this information to Sumter EMC. The granting of this right to review, access and disclosure includes the power to consent to disclosure of medical information for which consent is required pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPPA), as amended, (42, U.S.C. 1320 et seq, 45 CFR 3 164 et seq). I hereby release my medical provider and Sumter EMC from all legal responsibility or liability that may arise from the acts I have authorized herein and request that sufficient medical records and information (condition and diagnosis code) be released to verify I have a life threatening medical condition requiring Life Support.

Signature of Patient or Legal Guardian

Date

Notary Public

My commission expires: _____

THIS FORM IS VALID THE SHORTER OF THE LENGTH OF SUCH MEDICAL CONDITION OR
ONE HUNDRED EIGHTY (180) DAYS FROM THE DATE OF THIS CERTIFICATION.