Life Support / Special Medical Needs 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): _____

Hawaiian Electric has created the Special Medical Needs Program discounted rate to help customers who depend on life support equipment at home and/or have increased heating or cooling needs due to a medical condition. Enrollment for the discounted rate is open for up to 2,000 residential customers. If you qualify for the Special Medical Needs Program but capacity is reached, you will be placed on a wait list and notified as space becomes available. While on the wait list, you will be automatically enrolled in the Life Support Program which offers special consideration if a billing issue arises[1].

I certify this application is for the Life Support / 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 Hawaiian Electric if the eligible resident moves or no longer requires life support equipment. I agree to allow Hawaiian Electric to confirm this information, if necessary.

Pursuant to Decision and Order No. 38164 (Docket No. 2020-0056), Hawaiian Electric will be providing Hawai`i Energy with your name and account number so that Hawai`i Energy may reach out to you to offer energy-efficiency opportunities to lower your bill. To opt-out, please check the following box:

☐ I opt-out of being referred to Hawai`i Energy for energy cost saving measures.

ACCOUNT HOLDER SIGNATURE: _____ DATE: _____

Customers under the Life Support / Special Medical Needs 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 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.

[1]https://www.hawaiianelectric.com/billing-and-payment/payment-assistance/life-support

Hawaiian Electric

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

For Company Use Only:

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