LIFELINE APPLICATION

FOR ADDITIONAL BASELINE ALLOWANCE FOR QUALIFIED MEDICAL CONDITIONS

PART 1: TO BE COMPLETED BY CUSTOMER (PLEASE PRINT)

Customer Name (as it appears on your bill): _____

Medical Baseline Resident's Name (if different): _____

Service Address: _____
Street *City* *State* *Zip Code*

Mailing Address: _____
(If different from service address) *Street or P.O. Box* *City* *State* *Zip Code*

Customer's Phone Number: _____ Account Number: _____

Declaration of Eligibility – *Customer please complete, sign, and date below*

I declare that (Medical Baseline Resident's Name): _____ (the "Qualified Resident") is a full-time resident at the service address listed above. Additional space heating needs in excess of the average residential user are required because the stated individual is one of the following: relies on life support equipment[1] that runs on gas supplied by Alpine, has a life-threatening illness, paraplegic, quadriplegic, hemiplegic, is afflicted with multiple sclerosis or scleroderma, or has a compromised immune system.

I acknowledge that an additional standard medical allowance of 6.8/Therms per month will be received. I agree to notify Alpine Natural Gas immediately if the Qualified Resident no longer resides at the service address listed above, or if gas is not being used for heating the household.

Customer Signature: _____ Date: _____

[1] "Life support equipment" includes the following equipment: All types of respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPBB machines, motorized wheelchairs.

PART 2: TO BE COMPLETED BY A MEDICAL PROVIDER (LICENSED MEDICAL DOCTOR [M.D.], DOCTOR OF OSTEOPATHY [D.O.], NURSE PRACTITIONER [N.P.], OR PHYSICIAN'S ASSISTANT [P.A.]) (PLEASE PRINT)

Medical Provider Certification – Medical Provider, please complete, sign, and date below

I certify that my patient identified below needs additional heating in excess of the average residential user because my patient meets one of the following conditions: relies on life support equipment[2] that runs of gas supplied by Alpine, has a life-threatening illness, is paraplegic, is quadriplegic, is hemiplegic, is afflicted with multiple sclerosis or scleroderma, or has a compromised immune system.

Patient's Name: _____

Medical Provider's Name: _____

Business Address: _____
Street *City* *State* *Zip Code*

Medical Provider's Phone Number: _____

M.D./D.O./N.P./P.A. State License or Military License Number: _____

Medical Provider's Signature: _____ Date:_____

PART 3: SUBMIT COMPLETED AND SIGNED APPLICATION VIA US MAIL OR EMAIL:

US Mail: Alpine Natural Gas
15 St. Andrews Road
Suite 7
Valley Springs, CA 95252

or

Email: customerservice@alpinenaturalgas.com

[2] "Life support equipment" includes the following equipment: All types of respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPBB machines, motorized wheelchairs.