

PART 1 TO BE COMPLETED BY CUSTOMER (please print)

Liberty Account #:		
Customer Name (as it appears on your bill):		
Medical Baseline Resident's Name (if different):		
Service Address:		
Customer Mailing Address (if different):		
Home Phone: () Work Phone: ()	
For Customers Billed by Someone other than Liberty		
Name of Mobile Home Park or Apartment Complex:		
Complex Address:		
Complex Manager's Name:	Complex Phone: ()
Name of Tenant:	Tenant's Phone: ()
I understand that:		

- 1. If the qualified medical professional certifies the resident's medical condition is permanent, Liberty will require completion of a form self-certifying that the resident continues to be eligible for Medical Baseline every two years.
 - 2. If the qualified medical professional certifies the resident's medical condition is not permanent, Liberty will require the completion of a form self-certifying the resident's eligibility for Medical Baseline each year and completion of a new application with a qualified medical professional's certification every two years.
- 3. Liberty cannot guarantee uninterrupted electric service and I am responsible for making alternate arrangements in the event of an electric outage.

I certify that the above information is correct. I also certify that the Medical Baseline Resident lives full-time at this address and requires or continues to require the Medical Baseline Allowance. I agree to allow Liberty to verify this information.

I also agree to promptly notify Liberty if the qualified Resident moves or Medical Baseline Allowance is no longer needed by the resident.

Customer Signature: Date:
