

Certification by Physician, Board of Health Official, Nurse Practitioner, or Physician Assistant

Form for WMECO Customers

Dear WMECO Customer:

You have requested protection under WMECO's Medical Protection Plan. Please complete all the information requested below and have your physician, Board of Health official, nurse practitioner or physician assistant complete the reverse side. Return the completed form to WMECO.

Thank you for your cooperation.



**Western Massachusetts
Electric**

The Northeast Utilities System

To be completed by CUSTOMER:

Date _____

Customer Name: _____

Customer Mailing Address: _____

City: _____ State: _____ Zip: _____

Account Number (11 digits): ___/___/___/___/___/___/___/___/___/___/___/___

Telephone Number: () _____

*Name of Person with Illness: _____

Address of Person with Illness:

Street: _____

Building Number: _____ Apartment Number: _____

City: _____ State: _____ Zip: _____

*Provide if different from the named customer of record.

Please complete (front and back) and return this form
to WMECO within seven (7) days of receipt.

Mail to:

Western Massachusetts Electric Company
Credit and Collections Administration Office
P.O. Box 270
Hartford, CT 06141-0270

Telephone: **781-4300** (within the Springfield calling area)
or **1-800-286-2828** (outside the Springfield calling area)
Fax: **1-800-558-5946**

To be Completed by a Physician, Board of Health Official, Nurse Practitioner, or Physician Assistant

Our customer has applied to WMECO for protection against the termination of his or her electric service because he or she or someone within their household is suffering from a serious illness or a serious chronic illness. In compliance with M.G.L. Chapter 164 Section 124A, WMECO will enroll your patient in our Medical Protection Plan provided you, as a registered physician, Board of Health official, nurse practitioner or physician assistant, certify in writing that he or she is suffering from a serious illness or a serious chronic illness. Your certification of this condition shall be conclusive evidence of the existence of the serious illness or serious chronic illness claimed unless, after review, the Massachusetts Department of Public Utilities determines otherwise. It is necessary that you provide WMECO with the following information.

Date: _____

Patient's Name: _____

Nature of Illness: _____

Date of last appointment (mm/dd/yy): ____ / ____ / ____

Is your patient's condition considered a:

*Serious Illness: _____ or **Serious Chronic Illness: _____

*If serious illness, this form must be filled out and mailed to WMECO every 90 days.

** If serious chronic illness, this form must be filled out and mailed to WMECO every 180 days.

Certifying Person's Name (please print): _____

Certifying Person's Title/Position: _____

Certifying Person's Address: _____

City: _____ State: _____ Zip: _____

Certifying Person's Telephone Number: () _____

Certifying Person's Signature: _____ Date: ____ / ____ / ____