Hawaiian Electric
Customer Service Department - Credit Division
P. O. Box 2750
Honolulu, HI 96840

LIFE SUPPORT PROGRAM APPLICATION

Life Support Program: The program is intended to assist HECO in identifying customers who require electricity to operate medical equipment necessary to support life.

Electric Bills Must Be Paid When Due: Electric bills must be paid on time and past due accounts will be subject to disconnection of service. In the event your electric account is subject to disconnection, the Public Utilities Commission will be notified prior to such termination of service.

Discontinuance of Service: If service is disconnected for non-payment, a fee for re-establishment of service will be charged in addition to full payment of the past-due amount. You may also be required to post a deposit.

Power Outages: Because electricity outages can and do occur, it's important for customers who are on life support to make alternate plans should the power go out at their homes.

PART I. Customer's Certification - To be completed and returned within two weeks

I hereby certify that _____ is a full-time resident of my household and regularly
(Name of individual on Life-Support)
requires the use of a life-support device for the hours indicated. I understand that I must notify HECO upon termination of use of the life support equipment.

***Name of Customer on Record*: _____** **Acct. No. _____**

***Address:* _____** ***Tel. No.* _____**

_____ _____
Signature of Customer on Record ***Date***

Part II. Doctor's Certification - To be completed by a Medical Doctor licensed to practice medicine in the State of Hawaii

Please indicate Life Support Device(s) in use:

☐ **Dialysis** ☐ **Intravenous** ☐ **Nebulizer** ☐ **Oxygen**
☐ **Respirator** ☐ **CPAP** ☐ **Other _____**

I hereby certify that _____regularly requires the use of the life support device
(Name of individual on Life-Support)
designated for _____hours per month; and I further certify that the life support device will continue to be required for approximately _____ year(s).

***Name of Doctor*: _____** ***Telephone No.*_____**

***Address*: _____** ***City & Zip* _____**

_____ _____
Signature of Doctor ***Date***