



**PASCOAG**  
UTILITY DISTRICT

Pascoag Electric • Pascoag Water

253 Pascoag Main Street  
P.O. Box 107  
Pascoag, RI 02859  
Phone: 401-568-6222  
TTY via RI Relay: 711  
Fax: 401-568-0066  
www.pud-ri.org

## SERIOUS ILLNESS PROTECTION FORM - RI

Account Holder: \_\_\_\_\_

Account Number: \_\_\_\_\_

Service Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Name of Individual Who is Seriously Ill: \_\_\_\_\_

Relation to Account Holder: \_\_\_\_\_

*It is important that the account information listed above is correct. Please Print*

The Patient's Licensed Physician must complete this form in full.

Patient's Name: \_\_\_\_\_

Please specify the nature of the illness and its likely duration

\_\_\_\_\_  
\_\_\_\_\_

Thank you for your cooperation

Print Licensed Physician's Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Licensed Physician's Address: \_\_\_\_\_

Licensed Physician's Telephone Number: \_\_\_\_\_

Above information is necessary to conform to the Public Utilities Commission's regulations in establishing a Serious Illness protection

"Seriously Ill" shall mean an illness that is life threatening that will cause irreversible adverse consequences to human health or that has a significant potential to become life threatening or to cause irreversible adverse consequences to human health. We will also require the business address, telephone number, and licensed physician's signature.

I certify the above-mentioned individual, at the address listed above, is seriously ill as defined above and all information provided regarding the patient's health is current and accurate.

Licensed Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this form via Fax: 401-568-0066 or via Mail: Pascoag Utility District, PO Box 107, Pascoag RI 02859