BUDGET BILLING PROGRAM APPLICATION

Date:	
Customer Name:	
Customer Account No.:	
Location Code:	
Address:	
Initial:	I hereby request participation in the Budget Billing Program and agree to the terms and conditions of the program. I understand and agree to the following:
Initial:	I am either 65 years of age, 100 percent Military disabled or on permannet or total social security disability; proof of age and disability are required to participate in the program.
Initial:	I may voluntarily terminate the program but may not participate in the budget billing program again for 36 months and must meet all the required criteria at that time.
Initial:	I certify that my account has not been deliquent or disconnected for non-payment in last 12 months.
Initial:	I will automatically be removed from the budget billing program if at any time my account is paid after the due date.
Initial:	I will automatically be removed from the budget billing program if my payment is returned.
Initial:	I agree to pay in full the agreed upon monthly payment.
Initial:	I agree to pay in full the settlement balance during the settlement month of December.
Initial:	I agree to pay any differential at the time I terminate from the program.
Start Date:	
Phone Number:	
e-mail address:	
Customer Signature:	