



Every companies

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Please Return Within 30 Days

KCP&L: 1-(888) 471-5275  
Westar Energy: 1-(800) 383-1183

## MEDICAL CUSTOMER APPLICATION

IF APPROVED FOR THE MEDICAL CUSTOMER PROGRAM, A DEDICATED PHONE NUMBER WILL BE PROVIDED TO REPORT OUTAGES AND ALL ATTEMPTS WILL BE MADE TO PROVIDE UPDATES ON EXTENDED OUTAGE RESTORATION. ACCEPTANCE INTO THE PROGRAM DOES NOT GUARANTEE CONTINUOUS ELECTRICAL SERVICE NOR DOES IT PREVENT COLLECTION ACTIVITY FOR UNPAID ELECTRIC BILLS. A CUSTOMER WHOSE SERVICE IS CRITICAL FOR LIFE SUPPORT SHOULD MAKE PRIOR EMERGENCY ARRANGEMENTS TO ACCOMMODATE THE MEDICAL PATIENT DURING POWER INTERRUPTIONS. IF APPROVED FOR THE PROGRAM, RENEWAL OCCURS ANNUALLY.

### TO BE FILLED IN BY CUSTOMER

Customer Name					Account Number					
Street Address			City & State		Zip Code		Home Phone		Work Phone	
Patient's Name						Birth Date				
<p>Authorization: I hereby authorize release of any medical information including direct consultation with any physicians that is pertinent to my qualifying as a medical customer with KCP&amp;L or Westar Energy Company. By signing below, applicant acknowledges the accuracy and truth of the information provided. <b>For your protection, the law requires you to be advised of the following:</b> It is a criminal act to make a false or fraudulent claim, or assist in the preparation or presentation of a false or fraudulent claim. Violators of this provision may be subject to criminal prosecution.</p>										
Signature of Patient or Legal Guardian								Date		

### TO BE FILLED IN BY PHYSICIAN – PLEASE ANSWER ALL QUESTIONS

Diagnosis		Is the patient homebound? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Is electrically-powered medical equipment required to sustain life? YES <input type="checkbox"/> NO <input type="checkbox"/>		What type of equipment is in use? _____			
Will the absence of electricity result in an immediate life-threatening situation? YES <input type="checkbox"/> NO <input type="checkbox"/>		If so, how? _____			
Is the medical equipment <b>capable</b> of being operated by battery-supplied electricity for at least 12 hours? YES <input type="checkbox"/> NO <input type="checkbox"/>					
How often is the medical equipment used? _____					
Have you advised your patient of the action to take in case his or her medical equipment fails to operate for any reason? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If so, what is the plan of action? _____					
Is the condition expected to last longer than 6 months? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Additional Comments: _____					
Physician's Name (Please Print)		Office Address		State, Zip Code	
Physician's Signature		(_____) Phone		Date	

### FOR KCP&L & WESTAR ENERGY USE ONLY

APPROVED: <input type="checkbox"/>	REJECTED: <input type="checkbox"/>	BY: _____	DATE: _____
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Revised: October 2018

Mail to: KCP&L  
Attn: Medical Department  
4400 East Front Street  
Kansas City, MO 64120

Fax to: 816-245-3930

Public