Peninsula Light Co.
a mutual corporation
13315 GOODNOUGH DR NW • GIG HARBOR • WA • 98332-8640
PHONE (253) 857-5950 • FAX (253) 857-1558 • www.penlight.org

Application for Permanently Disabled Rate Discount

1. Applicant must be a member of Peninsula Light Company with an established account in his/her name during the previous six months.

2. Applicant must complete the income worksheet on page 2.

3. Applicant must provide proof of disability (letter from doctor or Social Security Administration).

4. Applicant must reapply annually in the month of April to ensure they continue to meet the program criteria.

5. Applicant must be a permanent, year-round resident in Peninsula Light Company's service territory, as opposed to a seasonal, part-time, or vacation resident. To qualify as a permanent resident, the applicant must reside at the service address for a minimum of 300 days per year and receive mail locally all year.

6. Only the applicant's primary meter will qualify for the discount. Pump services and rental houses shown in the applicant's name do not qualify.

I swear, under the penalties of either civil or criminal perjury, that I have READ, UNDERSTAND AND MEET ALL OF THE ABOVE CRITERIA. I understand that if at any future date I no longer meet the criteria, it is my obligation to let Peninsula Light Company know. I consent and agree that Peninsula Light Company may verify and confirm the above if deemed necessary. The Social Security Administration and the Internal Revenue Service are authorized to release any income information from their files.

Name (print) _____ Drivers License No: _____

Address_____ Phone No: _____

City, Zip_____ Cell Phone No: _____

PLC Account #:Customer NumberAccount Number

Social Security No: _____DOB: _____

Email Address: _____

Signature: _____ Date_____

Identification confirmed by Peninsula Light Company:

_____

Peninsula Light Company Employee

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Electric Rate Discount for Permanently Disabled Members
Annual income must include all individuals who live at residence

Number in household _____

TOTAL MONTHLY GROSS INCOME: _____

YOU MAY DEDUCT HEALTH CARE PREMIUMS _____

TOTAL ADJUSTED MONTHLY INCOME _____

The applicants **MUST** submit copies of the following:

-Social Security Card
-Past three (3) months income verification
-Proof of disability
-Proof of Health Care Premiums paid

Social Security Card:
We must have a copy of the Social Security card or other official document showing the social security number (not hand printed), for **ALL** individuals who live within the household.

Income verification:
Verification of **ALL** income received over the past three months is required. (Copies of retirement statements, social security payments, medical coupons, or any source of income received over the previous three months. For example, if you are applying during the month of December, copies of income are needed for September, October, and November)

Proof of disability:
Documentation from either your doctor or the Social Security Administration stating you are permanently disabled.

Proof of health care premiums paid:
Examples may be paid receipt from insurance provider, cleared check, bank statement or policy information.

Any questions please contact our Customer Service Department at (253) 857-5950.