Medical dependency form

The purpose of this form is to either:

1. **Request to be placed on Contact Energy's Medical Dependency Register.**
2. **Request to be removed from Contact Energy's Medical Dependency Register.**

How to fill in the form:

If you are requesting to be placed on Contact's Medical Dependency Register, please do the following:

- Complete section one
- Read and tick box A within section one
- Complete section two. This part needs to be completed and signed by your medical practitioner to confirm that you have a serious medical condition and are dependent on electricity or piped gas for critical medical support. With your permission, we can contact your practitioner (for example, your GP) on your behalf if you prefer. You will then be placed on Contact's Medical Dependency Register. Please note we are unable to guarantee a 24-hour continuous supply of energy so you need to ensure you have a back-up plan in case of a power or gas outage.

If you are requesting to be removed from Contact's Medical Dependency Register, please do the following:

- Complete section one only
- Read and tick box B within section one

If you have any questions or wish to give us permission to contact your practitioner on your behalf, please call our Customer Service team on **0800 80 9000**.

Section one (to be completed by the medically dependent person or a parent/guardian or authorised representative of that person)

Account holder details

Energy account name(s) *The name(s) on your Contact Energy bill.*

> Title > First name(s) > Last name

Account number *Your account number is on your bill.*

Medically dependent person's details

Name

> Title > First name(s) > Last name

Date of birth

> Day > Month > Year

Daytime phone

> Area code > Number

Mobile phone

> Network code > Number

Work phone

> Area code > Number

Email address

Home address

> Number > Street

> Suburb > Town or city > Post code

A ☐ **Read and tick if you are requesting to be placed on Contact's Medical Dependency Register**. I confirm that Contact Energy is allowed to discuss the following personal details with the medical practitioner listed to confirm that electricity or piped gas needs to stay connected at the medically dependent person's address, and to re-confirm that information every 12 months.

1. Details of my medical condition, or
2. Details of the medical condition of the medically dependent person referred to above, and I confirm that I am authorised to act on behalf of that person.

B ☐ **Read and tick if you wish to be removed from Contact's Medical Dependency Register**. I confirm that the person listed as being medically dependant above is no longer dependent on electricity or piped gas for critical medical support and can be removed from Contact's Medical Dependency Register. If I am not the person listed, I am authorised to act on behalf of them. If anything changes in the future, I will advise Contact Energy that I (or the person listed) have critical medical electricity or piped gas equipment to prevent loss of life or serious harm and request to be put back on the Register.

Information may also be passed on to the relevant lines company.

Signature of medically dependent person

or parent/guardian or authorised representative of that person

Section two (to be completed by medical practitioner)

Medical practitioner details

Medical practitioner name

Designation *For example, General Practitioner or Specialist.*

Medical practice centre *For example, health centre or surgery.*

Daytime phone > Area code > Number

Mobile phone > Network code > Number

Email address

Medical details

Description of medical condition

Type of equipment requiring a continuous supply of electricity or piped gas

Duration for which equipment will be needed

- ◯ Permanently need equipment
- ◯ Temporarily need equipment > Needed until ☐☐ > Day ☐☐ > Month ☐☐☐☐ > Year

Declaration by medical practitioner

I > Medical practitioner state that > Medically dependent person has a serious medical condition and needs electricity or piped gas for medical reasons.

Signature of medical practitioner

Date

☐☐ > Day ☐☐ > Month ☐☐☐☐ > Year

Medical practitioner's stamp *Important: This form will not be valid unless a medical practitioner's stamp is provided in the box below.*

Please post the completed form back to us in the FreePost envelope if you have one, or post to:
Contact Energy Limited, PO Box 624, Wellington 6140.

Alternatively, you can scan and email it to us at **contact.medicalqueries@contactenergy.co.nz**