YOUR RIGHTS AND RESPONSIBILITIES

It is your responsibility to notify Washington Gas before the termination date if any of the following conditions apply to your account:

- -1. -- If you or an occupant of the service address listed is elderly, the certificate provided below must be-- filled in and returned by the termination date. Upon receiving the certificate, you must contact Washington Gas to make payment arrangements to pay your bill and to discuss possible sources of financial aid.

2. If you or an occupant of the service address listed is dependent on life support, or is seriously ill, the certificate provided below must be completed by a licensed physician, psychiatrist or registered psychologist and returned by the termination date. Upon receiving the certificate, Washington Gas will postpone cutting off service for 30 days beyond the scheduled termination date. During the 30-day extension, you must make payment arrangements to pay your gas bill.

3. If the past due amount does not agree with your records, call 703-750-1000. Washington Gas will investigate the bill and report the findings to you.

CERTIFICATE

THIS CERTIFICATE MUST BE RETURNED ON OR BEFORE THE DATE OF TERMINATION

Part I (to be completed by account holder) **Date:** ____________________

The account holder or an occupant at the service address listed is:

65 or older (give date of birth) _________________________
Dependent on life-support
Seriously ill, physically disabled or mentally impaired } **Physician must complete Part II of form**

Account Holder's Name (Print) ________________________________ **Account#:** _______________________________

Occupant's Name (Print) ____

Address ____

Telephone# (Daytime) __________________ **Account Holder's Signature** _____________________________________

Part II (to be completed by licensed physician or a public health official)

Doctor's Name (Print) ____

Office Address ____

Telephone# (Daytime) ____

Nature of illness, handicap and/or need for life-support equipment of person named in Part I

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Date first consulted for this condition _________________________

Termination of gas service at the address given in Part I will aggravate this illness or prevent the use of natural gas for life-support.

________________________________ ______________________________________

Date **Physician's Signature**