

CUSTOMER HOSPITALIZATION PROGRAM APPLICATION



I will be hospitalized for more than 3 days. I am requesting an extension on my utility bill.

Please send me an application for the following programs

- The Third Party Notification Life Support Protection
 Extra Security Plan

Customer Name _____

CHG&E Account Number _____

Patient Name _____

Patient Address _____

Mailing Address _____

Patient Telephone No. _____

Doctor's Name _____

Doctor or Hospital Official's Signature _____

Doctor's Telephone No. _____

Name of Hospital _____

Address of Hospital _____

Date of patient admission _____ Expected date of hospital discharge _____

Customer Signature _____ Date _____

Both you and your doctor or hospital official must sign this application form.

