Approved January 29, 2014

Prairieland Energy, Inc.
100 Trade Centre Drive, Suite 304 ♦ Champaign, IL 61820
Phone: (217) 265-0855 ♦ Fax: (217) 265-0857
www.plandenergy.com ♦ plandenergy@plandenergy.com

DATE

Dear Prairieland Energy Customer:

Energy customers of Prairieland Energy are responsible for paying the electricity charges shown on the monthly billing statement in full each month. Failure to make timely payments or acceptable payment arrangements may result in disconnection of service until such time as payments are brought current.

Customers who have electrically-powered medical devices that are deemed medically necessary may qualify for Prairieland's **Critical Care Program**. Customers who qualify for this program may request that the disconnection actions be delayed or stopped.

In order to be considered for the Prairieland Energy's Critical Care Program:

- You must reside at the location where there is a potential for electricity disconnection due to non-payment.
- You must submit a *Medical Release Form* and related *Physician's Verification Form*.

Customers who qualify for the Critical Care Program will continue to receive a monthly electric bill that will be due on the date indicated on the statement. Service will not be interrupted for non-payment by such customers. The Critical Care Program does not eliminate the requirement to pay all balances due. Interest will accrue on overdue balances.

If you have questions, or if we can be of assistance in meeting your energy needs, please contact our office at (217) 265-0855, during the hours of 8:00 am to 4:00 pm, Monday through Friday.

Sincerely,

Prairieland Energy, Inc.
Enclosures

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PRAIRIELAND ENERGY, INC. — MEDICAL RELEASE FORM

I hereby authorize physicians, hospitals, and all medical attendants to furnish information necessary to complete the Physician's Verification form. This information will aid Prairieland Energy in determining the suitability for careful handling of the electric service account because a permanent resident of the home has electrically-powered medical equipment operating continuously or as specified by a physician.

Full Name of Patient _____

Relationship to Customer of Record _____

Signature of Patient
or Legal Guardian _____

Physician Name _____

Physician
Office Address _____

_____
City State Zip Code

Physician
Phone Number (_____)_____ Physician
Fax Number (_____)_____

Prairieland Energy Customer Name _____

Customer Account Number _____

Customer Address _____

_____
City State Zip Code

Customer
Phone Number (_____)_____ Alternate
Phone Number (_____)_____

I understand that (1) I am obligated to pay my monthly electric bill by the due date indicated on the monthly statement, and (2) I am fully responsible for providing appropriate safeguards or alternative arrangements for myself in the event of a prolonged power outage.

I acknowledge that I have read and understand the above conditions for receiving the Critical Care Program on my electric service account.

Prairieland Energy
Customer Signature_____

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PRAIRIELAND ENERGY, INC. — PHYSICIAN'S VERIFICATION

Prairieland Energy Customer Name_____

Prairieland Energy Account Number_____

Please complete this form and return to Prairieland Energy.

1. Patient Name_____
2. Patient must use electrically-powered equipment to avoid life-threatening conditions:
3. How long could this patient function without electricity or backup equipment without his/her survival being threatened?

_____

[Failure to complete this form in its entirety may result in disqualification for the program]

Physician's name (please print) _____

Physician's signature _____

Physician's License Number _____ **Date**_____

Physician's daytime phone number(s) _____

PLEASE RETURN THE COMPLETED MEDICAL RELEASE FORM AND PHYSICIAN'S VERIFICATION

FAX TO: (217) 265-0857
OR MAIL TO: PRAIRIELAND ENERGY, INC.
100 TRADE CENTRE DR. STE. 304, CHAMPAIGN, IL 61820