

Protections Application Form

Account Holder Name: _____ Contact Phone No: _____

Service Address: _____

Gas Account: _____ Electric Account: _____

PLEASE SELECT WHICH PROTECTION PROGRAM YOU ARE APPLYING FOR:

- ☐ **Medical Protection- Serious or Chronic Illness:** A letter submitted with your form signed by a medical professional indicates there is a serious or chronic illness present in your household.
- ☐ **Infant Protection** - an official qualifying document submitted with this form indicates a child under 12 months of age resides at this premise.

You must submit proof along with this application to be approved for a protection claim.

Required are as follows:

For Medical Protection: the letter must be on Medical Professionals Letterhead, include a signature of a Doctor, Nurse Practitioner, Physician's Assistant, or local Board of Health signature. It must state the name and address of seriously ill person and whether the illness is serious (90 day protection) or chronic (180 day protection).

For Infant Protection: you must submit a valid birth certificate, or a letter or official documents issued by a registered physician, physician's assistant, nurse practitioner, local board of health, hospital or government official, Dept of Transitional Assistance, clergyman, or Religious institution

NOTE: If your account is not already on a Discount Rate, or you are unsure, please fill out the **Financial Hardship Form located on the back of this application.** You must list all members of your household (including children) and their incomes (even if \$0).

Return this form and proof required to:

Mail: National Grid
Attn: Protections D-1
300 Erie Blvd West
Syracuse, NY 13202

Email: NEProtections@nationalgrid.com

Fax: 1-866-460-8549



Financial Hardship Statement

for our Massachusetts and Nantucket Customers

Customer Name: _____ Phone number: _____

Service Address: _____ City: _____ Zip: _____

National Grid Electric Account: _____ - _____ National Grid Gas Account: _____ - _____

Please list ALL people living in your household (including children). If they receive income, list the income source and amount. (If needed, use the other side of this form to list additional people.)

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

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Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

I do certify that the information provided above is complete and true to the best of my knowledge.
(National Grid reserves the right to request documents to support this information.)

Signature: _____ **Date:** _____

National Grid offers Discount Rates to customers who receive certain public benefits. Call the Customer Service number on your bill to learn more and to ask for an application.

Financial Hardship Statement

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Please use this space to provide information on any additional household members:

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Name: _____ Date of Birth: _____ \$ Amount: _____

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Name: _____ Date of Birth: _____ \$ Amount: _____

Income Source: _____ Received: ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Yearly

Please use this space to provide any additional information: