SOUTHWEST GAS CORPORATION

APPLICATION FOR ADDITIONAL BASELINE ALLOWANCE FOR QUALIFIED MEDICAL CONDITIONS

Customer hereby claims eligibility for additional baseline rates and declares that the service requested will be used for residential purposes under the provisions of Southwest Gas Corporation's (the Company) applicable rate schedules.

Customer Information:

Name _____

Service Address _____
Street *City* *State* *ZIP Code*

Mailing Address _____
(if different from service address) *Street or P.O. Box* *City* *State* *ZIP Code*

Telephone No. ( ) _____ Account Number _____

Would you like information regarding "Third Party Notification"? ☐ Yes ☐ No

Declaration of Eligibility – ***Please sign and date below and return form to Southwest Gas Corporation***

I, the undersigned, certify that _____ is a full-time resident of my household and is a: ☐ hemiplegic, ☐ paraplegic, ☐ quadriplegic, ☐ multiple sclerosis patient, ☐ scleroderma patient or ☐ person who is being treated for a life-threatening illness and has a compromised immune system with space heating/cooling needs in excess of the average residential user.

I declare that I am a customer of the Company and that the above stated individual is a permanent resident at the above service address, where gas is used for space heating/cooling, thereby qualifying me for an additional standard monthly allowance of 25 therms under the baseline rate.

I understand that if I can provide written verification by a state licensed physician, surgeon or osteopath that the standard monthly allowance of 25 therms is insufficient to meet the life-support and comfort requirements of the eligible resident, the Company shall make a determination as to the additional quantity required and round such quantity to the next higher 25 therms. Such written verification shall be made a part hereof.

I further acknowledge that eligibility is restricted to the above service address and I agree to notify the Company immediately if the disabled person no longer resides at this address or if gas is not used for heating/cooling.

I understand that I must renew this application at the request of the Company in order to maintain this additional baseline allowance.

Customer Signature _____ Date Signed _____

Letter Of Certification—***By physician, surgeon or osteopath licensed to practice medicine in the state of*** ____

I hereby certify that _____ is a: ☐ hemiplegic, ☐ paraplegic, ☐ quadriplegic, ☐ multiple sclerosis patient, ☐ scleroderma patient or ☐ person who is being treated for a life-threatening illness and has a compromised immune system with space heating and/or cooling needs in excess of the average residential user.

Name of Physician _____ Telephone No. _____

Business Address _____
Street or P.O. Box *City* *State* *ZIP Code*

Registration No. _____

Physician Signature _____ Date Signed _____

Mailing Address:
ATTN CARE
Southwest Gas Corporation
PO Box 1498
Victorville, CA 92393-1498

For additional information, please call:
Customer Assistance ..... **(877) 860-6020**
Hearing Impaired **711**
Apply online at: www.swgas.com

For Company Use Only: Date Received _____ Date Processed _____