

Slash Pine Electric Membership Corporation

PO Box 356, Homerville, GA 31634
Phone: (912) 487-5201 Fax (912) 487-2948

Qualifications: Delayed Billing for Senior Citizens

Account **MUST** be listed in the name of the applicant. If the person whose name the account is in is deceased, please contact our office.

Applicant must be age 62 or older and attach copy of drivers license or birth certificate with application.

Only residences and "residential use" type accounts qualify.

Accounts which qualify are:

Primary residence or vacation home (if not rented out)
Barns, water pumps, sheds, etc..., **ONLY** if not involved in a commercial business or active farming operation. A residence which is rented out or someone else (including a family member) lives in does **NOT** qualify.

Each account being applied for must be listed on the application and must state what account is used for. Business or active farming accounts do not qualify. Each account must have a zero balance at the start of the delayed billing program.

If you are approved for the delayed billing program, you must pay your bill on time each month. If you do not pay your bill by your due date, you will be charged penalties, removed from the program and could be disconnected without further notice.

If you are interested and qualify for the above mentioned program, please fill out the application and mail or bring in to our office.

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APPLICATION FOR SENIOR CITIZEN DELAYED BILLING

Applicant Name: _____ (please print)

Date of Birth: ____/____/19__

Please list below your account number(s) and what each account is used for.
(Ex., Primary residence, Rental House, pump, barn, vacation home, ect...)

_____	_____
_____	_____
_____	_____

Please circle the day of the month that you receive your Social Security or Retirement Income. If you receive income on more than one date, circle the date of the income that you will use to pay your electric bill.

1st of Month 3rd of Month 2nd Wednesday 4th Wednesday

Please enclose a copy of your most recent disability check or certification of disability from your medical physician. If you bring your application to our office, please bring a copy of your disability check or medical physician's certification with you.

I, _____ certify that all information listed is complete and accurate.

Applicant's Signature

Office Use Only

Approve/Deny By: _____ Date: _____ Cycle: _____