



**APPLICATION FOR NEW RESIDENTIAL CUSTOMERS**

**Use this form to start new residential service.**

**Two forms of identification required at least one must be a photo ID**

Date service to start (Monday thru Friday) \_\_\_\_\_ Move in date \_\_\_\_\_

Legal Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_

Service Address \_\_\_\_\_

Billing Address, if different \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Social Security # \_\_\_\_\_ DL # \_\_\_\_\_ State \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse/Co-Occupant Full Legal Name \_\_\_\_\_

Their cell \_\_\_\_\_ Their SS# \_\_\_\_\_ Their Date of Birth \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Their Phone \_\_\_\_\_

Own Home \_\_\_\_\_ Rent Home \_\_\_\_\_ Landlord Name \_\_\_\_\_ Phone \_\_\_\_\_

Please list a password for your account \_\_\_\_\_

Please list a reminder, in case you forget your password \_\_\_\_\_

Do you want a \$3.65 per month ambulance membership? Yes \_\_\_\_\_ No \_\_\_\_\_

I hereby certify that the foregoing information is truthful and accurate. I understand that a \$25.00 connection fee will be added to my first monthly bill. I further understand that failure to pay my bills by the due date will result in late fees being added to my account and my service could be terminated. I understand that failure to pay my final account balance will result in my account being turned over to a collection agency. I understand that I will be responsible for any additional collection agency charges and/or legal fees incurred in the collection of my delinquent balance as allowed by law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

For Office use only:  
Deposit Paid \$ \_\_\_\_\_ Cash/Check # \_\_\_\_\_ Receipt # \_\_\_\_\_ Account # \_\_\_\_\_