Application to be added to medical dependency register

PLEASE NOTE:
This form is to be completed by the Slingshot Homeline Account Holder or their Representative. It requires proof to be attached from a Medical Practitioner confirming that someone who lives at the address is dependent on telephone access for critical medical support. Once the completed form is received together with a medical certificate and assuming it is deemed by us to fit our criteria of when a customer should be placed on the Medical Dependency register the person will be placed on the register for 1 year maximum.

Please email the completed form and medical certificate to customersupport@team.slingshot.co.nz or post to Private Bag 108-109 Symonds Street, Auckland Attention: Collections Team.

To be filled in by the person who is dependent on a home telephone service or their representative.

Homeline account number .....

Account holder first name .....

Account holder surname .....

Residential address .....

Homeline phone number (required for medical purposes) .....

Contact phone number (If different from above) .....

Mobile number (if you don't provide a mobile number we will be limited in our ability able to make contact to warn of any changes to service) .....

Is the account holder is medically dependent or is it someone else in the household: Is the account holder medically dependent? ..... **YES / NO** (PLEASE CIRCLE)

Medical dependent first name .....

Medical dependent surname .....

Please provide an alternative contact not living at the same address .....

.....

.....

Alternative contact person name .....

Alternative contact relationship to you .....

To be filled in by your medical practitioner .....

Designation (I.e. GP, Specialist etc..) .....

Medical practitioner first name .....

Medical practitioner surname .....

Business address .....

Phone number .....

Mobile number .....

After hour's number .....

Official stamp of professional registration .....

Certificate of membership number .....

Name of patient requiring continued access to telephone service .....

.....

Confirm patient has a condition which requires

continuous access to a telephone service ..... **YES / NO** (PLEASE CIRCLE)

I have attached a medical certificate signed by a

Medical Practitioner to support this ..... **YES / NO** (PLEASE CIRCLE)

SUBMITTING YOUR APPLICATION MEANS YOU ACKNOWLEDGE THE FOLLOWING:

I understand that Slingshot cannot guarantee continuous or fault free services.I have thought about what I would do in case of an unexpected outage. I understand that Slingshot will not always be able to inform me in advance if services will be unavailable. I understand that Slingshot strongly recommends that customers who have a medical dependency on their phone line have a mobile phone as well as a Home phone. I understand that a cordless phone may rely on mains power and may not work if there is a power outage even if the services I receive from Slingshot still work.

I have provided the contact details for an alternative contact who lives nearby and who has agreed to act as my alternative contact. I understand that Slingshot may contact my alternative contact about me and my services as required for the purposes of the register.

I understand that being on the Medical Dependency Register does not exclude me from collection action if my account is overdue. I confirm that all of the information I have provided on this form is correct. I confirm that I fulfil the eligibility criteria for Medical Dependency Registration, as I or someone living at the nominated address has a diagnosed life-threatening medical condition that leaves me/someone living at this address at a high risk of a rapid deterioration to a life-threatening situation and where access to a telephone would assist to remedy the lifethreatening situation. I acknowledge that Slingshot has the right to refuse my application if I do not meet the eligibility criteria (which may be subject to review). I consent to Slingshot collecting the information provided with this form and to use this information for the purposes of:

- assessing the patient's eligibility to be included on that Slingshot Medical Dependency Register;
- providing, administering and managing such register; and
- Providing, administering and managing the services provided to the above-mentioned customer

Please read and sign

I have read and understood the terms and conditions outlined above and understand fully the provisions of being included on the Medical Dependency Register.

Signed: ..... Date:.....