conEdison

Residential Claim for Food and Medicine Spoilage

If you experienced a power outage that resulted from a failure in Con Edison's local distribution system that lasted for more than 12 hours within a 24-hour period:

- **You may file a claim, up to a maximum of $450, for actual losses of food spoiled due to lack of refrigeration.**
- **Claims for food up to $200 must include an itemized list.**
- **Claims for food over $200 must include an itemized list and proof of loss (for example: cash register tapes, store or credit card receipts, cancelled checks, or photographs of spoiled items).**

- **In addition, you may file a claim for actual losses of prescription medicine, spoiled due to lack of refrigeration.**
- **You must include an itemized list and proof of loss (for example: pharmacy prescription label or pharmacy receipt identifying the medicine).**
- **We may also request authorization to enable Con Edison to verify the loss of prescription medicine.**
- **Reimbursement for prescription medicine is not included in the $450 maximum for food spoilage.**

- **Claims must be filed within 30 days of the date of the power outage.**
- **Reimbursement is limited to food and medicine and is governed by Con Edison's electric rate schedule.**
- **Losses for damage to motors, equipment, or appliances are not reimbursable under the electric rate schedule.**

Claims for reimbursement for losses sustained as of result of power outages caused by storms or other conditions beyond our control will not be paid.

Name: _____
*(PLEASE **PRINT** CLEARLY)*

Address: _____ **Apt.:** _____

City: _____ **State:** _____ **Zip Code:** _____

Daytime Phone: (_____) _____ - _____ **E-mail:** _____

Con Edison Account Number: ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___ ___ ___ ___ - ___
(15 DIGIT NUMBER LISTED ON YOUR BILL – NOT APPLICABLE IF YOU DO NOT RECEIVE A CON EDISON BILL)

Date of Outage: **From:** _____/____, 20____ **Time:** _____ **To:** _____/____, 20____ **Time:** _____
MONTH / DAY / YEAR — AM / PM — MONTH / DAY / YEAR — AM / PM

	TYPE OF FOOD / MEDICINE	QUANTITY	COST
1			
2			
3			
4			

(CONTINUE ON A SEPARATE SHEET IF NECESSARY)

Total Amount of Loss: $ _____ . _____

Please allow 30 days for review and processing of your claim.

All of the information provided on this claim form is true and accurate to the best of my knowledge and represents my actual losses.

_____ _____
(SIGNATURE — UNSIGNED CLAIM FORMS WILL NOT BE PROCESSED) **(DATE)**

SIGN AND RETURN FORM TO:	**CON EDISON CLAIMS DEPARTMENT PO BOX 801 NEW YORK, NY 10276**
OR FAX TO:	**(212) 979-1278**

12/07
Law#282975