

Priority Services Application Form

By completing this document, signing the declaration, and returning it to us you are confirming that you or the person you are registering on behalf of would like to be added to the Affinity Water Priority Services Register. You are also confirming that you are happy for Affinity Water to securely hold and process your contact information and information about the stated needs including limited medical information.

Fill in this form in CAPITAL LETTERS and black ink only. Please write only within the white boxes.

Customer Reference Number:														
Contact Details														
Title:														
Name:														
Surname:														
Supply Addres														
Line 2														
Line 3														
	Postcode:													
Contact no:	Contact no:													
Email Address														

This contact information will be used to link your needs and our services. It will be held securely on our customer system and will be accessible to Affinity Water employees and trusted partners for providing you with clean, safe water.

Registration Details

Are you a third party registering on behalf of the account holder?													
Put a cross (X) in the relevant box													
Yes please provide your name and relationship to the account holder.													
No the registration is for myself or someone else in my household.													
Title:													
Name:													
Surname:													
Relationship:													
Contact no:													
Email Address:													

Priority Services Team Affinity Water Tamblin Way Hatfield, Herts AL10 9EZ

Priority Services Requirements

Visu	al impairment												
	Partially sighted				Blind								
Plea	use indicate what service(s) you	would	l like									
	Large print bills	Audio CD bills											
	Braille bills				Not req	uired							
	Speech difficulties				Chronic	c/Serious	illne	SS					
	Mobility restrictions			Developmental condition									
	Water dependent				Pensionable age								
	Mental health condition				Dement	tia or coo	gnitiv	e im	pairı	ment			
	Hearing impairment				Living v	vith child	dren u	Indei	the	age	of 5		
	Reliant on medical equipme [Please state below]		Post ho	spital re	cover	У							
	If you would like your hou please tick the box.	ısehol	d to b	e remo	oved fror	n the Pr	iority	Ser	vice	s Re	gister		
		d sche er you like us	me, so ur pro	o you perty, se a po	can tell they mu assword	if our st st tell y	aff a ou th	re g	enui assv	ine i [.] vord	f they first.		
	please tick the box. Register for our password visit you. Before they ent Please tick if you would 1	d sche er you like us	me, so ur pro	o you perty, se a po	can tell they mu assword	if our st st tell y	aff a ou th	re g	enui assv	ine i [.] vord	f they first.		
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Supply Interruptions

Do you wish to nominate someone else to contact us on your behalf regarding Supply interruptions?												7										
If you wish to nominate a different person for Supply Interruptions , please tick here and provide details below:																						
Title:																						
Name:											Τ											Ī
Surname:																						
Address: Line 1															7							
Line 2		T																				
Line 3		T			$\frac{1}{T}$				╡	 	T	T	T	T	T	T	T	T				
2												Po	stco	bde	:	Γ	T]			
Contact no: Email Addres																						
Declaration I confirm that I or the person I am registering on behalf of would like to be added to the Priority Services Register and I understand that the information supplied will be used to make sure the right service and/or support is provided. Signature - [keep within the border]																						
										Do	te:				Day]/	M	onth	/[Y	ear	

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