

APPLICATION FOR EQUAL PAY BILLING

I, _____ hereby apply for Equal Pay Billing with the City Of Wells for water, sewer, and sanitation service with the understanding that I adhere to the Regulations for Equal Pay Billing as established by the Wells City Code and Resolutions adopted by the Board of Councilmen.

I understand that Equal Pay Billing is a privilege offered by the City Of Wells to consumers with a minimum satisfactory payment history of one year.

I understand that to be eligible for Equal Pay Billing, I must have had service at my present location for a period of at least one year.

I understand that my monthly payment will initially be determined from time of application until November of the current year and that the monthly payment will be reviewed and adjusted each November based on the previous twelve months history or at any rate change for any service provided by the City Of Wells.

I understand that I must make the monthly payment as determined by the City Of Wells.

I understand that the Equal Pay Billing privilege will be revoked for non-payment and I will be subject to discontinuance of service. I further understand that full account balance will be due and payable upon notification.

I understand that if I terminate service with the City Of Wells, my full account balance will be due and payable at time of termination.

I understand that the Equal Pay Billing privilege offered by the City Of Wells may be rescinded at any time.

Applicant

Date

For City Use Only

Customer Account Number _____ Beginning Service Date _____

Satisfactory Customer History _____

Approval by: _____ Date: _____

Title: _____