

## 2018 Winter Storms Quinn and Riley Residential Reimbursement for Food and Prescription Medicine Spoilage

If you experienced a power outage that lasted for more than 72 consecutive hours from 3/2/18 through 3/12/18 due to Winter Storms Quinn or Riley, you may file a reimbursement request:

- For actual losses of food spoiled due to lack of refrigeration up to a maximum of \$515.
  - Food spoilage up to \$225 must include an itemized list.
  - Food spoilage over \$225 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 reimbursement request for actual losses of prescription medicine spoiled due to lack of refrigeration.
  - You must include an itemized list and proof of loss for prescription medicine (for example: pharmacy prescription label or pharmacy receipt identifying the medicine).
  - We may also request authorization to enable O&R to verify the loss of prescription medicine.
  - Reimbursement for prescription medicine is not included in the \$515 maximum for food spoilage.

Reimbursement is limited to spoiled food and medicine ONLY.

Requests for reimbursement must be filed on or before 4/15/18.

Name: \_\_\_\_\_  
(PLEASE PRINT CLEARLY)

Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail: \_\_\_\_\_

O&R Account Number: \_\_\_\_\_  
(10 DIGIT NUMBER LISTED ON YOUR BILL – NOT APPLICABLE IF YOU DO NOT RECEIVE A O&R BILL)

Dates of your outage: From: March \_\_\_\_\_, 2018 To: March \_\_\_\_\_, 2018

	TYPE OF FOOD / MEDICINE	QUANTITY	COST
1			
2			
3			
4			

(CONTINUE ON A SEPARATE SHEET IF NECESSARY)

Total Amount of Loss: \$ \_\_\_\_\_ . \_\_\_\_\_

Please allow at least 30 days for review and processing of your request for reimbursement.

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

\_\_\_\_\_  
(SIGNATURE — UNSIGNED FORMS WILL NOT BE PROCESSED)

\_\_\_\_\_  
(DATE)

<b>SIGN AND RETURN FORM TO ONE OF THE FOLLOWING:</b>	
EMAIL	<a href="mailto:newclaims@coned.com">newclaims@coned.com</a>
FAX	(212) 979-1278
MAIL	CON EDISON CLAIMS DEPARTMENT PO BOX 801 NEW YORK, NY 10276