Affordable Connectivity Program (ACP)
Customer Opt-In Form

Date: _____

Name			
Application ID		Date of Birth	
Address			
Phone Number			
Email Address			

Please read and *initial* each of the following to participate in the ACP Program:

_____ I hereby opt-in to the Affordable Connectivity Program (ACP).

_____I acknowledge that I am aware of the eligibility requirements for the ACP. If I can't demonstrate eligibility, I will not be enrolled in the program and/or Craigville Telephone Company, Inc dba AdamsWells Internet Telecom TV will be required to de-enroll me from the program.

_____I acknowledge the ACP is a government program that reduces my broadband internet access service bill.

_____I acknowledge that I may obtain ACP-supported broadband service from any participating provider of my choosing and that I can transfer my ACP benefit to another provider one time a month.

_____I acknowledge I may apply the ACP benefit to any broadband service offering of AdamsWells at the same terms and available to households that are not eligible for the ACP supported service.

_____I acknowledge my provider may disconnect my ACP supported service after 90 consecutive days of non-payment.

_____I acknowledge I will be subject to the AdamsWells' undiscounted rates and general terms and conditions if the ACP ends, if I transfer my benefit to another provider but continue to receive service from AdamsWells, or upon de-enrollment from the ACP.

_____I acknowledge I may file a complaint regarding an ACP supported service or any difficulty enrolling with a provider via the Commission's Consumer Complain Center at https://consumercomplaints.fcc.gov/hc/en-us or by calling 888-225-5322.

_____I acknowledge that the ACP Program is non-transferable and that the discount is limited to one ACP discount per household, and I further certify that no other member of my household is receiving a benefit under the ACP.

_____ I acknowledge that I have reviewed the available services and upload/download speeds and data caps for services offer by AdamsWells for the ACP Program.

_____I consent to applying my ACP program benefit to the broadband Internet access service I receive from AdamsWells.

_____I consent to AdamsWells disclosing and/or transmitting any information required to the program Administrator for my participation in the program including but not limited to my name, my dependent's name, date of birth, last 4 digits of social security number or Tribal Identification Number, address, telephone number, type of service, start date of service, termination of service date, ACP Program discount amount, eligible program, tribal benefit status, Lifeline Tribal Benefit, Linkup Service Date and Independent Economic Household certification date.

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_____I acknowledge that if AdamsWells has a reasonable basis to believe that I am no longer eligible to receive the ACP benefit, I will receive a notification of impending termination of my ACP benefit and will have 30 days following the date of such notice to demonstrate continued eligibility.

_____I acknowledge that my participation in the ACP does not relieve my obligations to adhere to AdamsWells' posted rates, terms and conditions, or other rules and regulations or tariffs that govern the services I receive.

_____I acknowledge that the monthly ACP Benefit will not be prorated but may be less than the full benefit during the first and final month of the program.

_____I certify that:

(1) I have confirmed my eligibility for the Affordable Connectivity Program through the National Verifier.
(2) I reviewed the above disclosures and consent to ACP program enrollment.

_____ _____
Customer Signature Date

Please read and *initial* each of the following to *transfer* to AdamsWells in the ACP Program:

_____I am transferring my ACP benefit to AdamsWells.

_____The effect of the transfer is my ACP benefit will be applied to the AdamsWells' service and will no longer be applied to service retained from the transfer-out provider.

_____I may be subject to the transfer-out provider's undiscounted rates because of the transfer if I elect to maintain service from the transfer-out provider.

_____I am limited to one ACP benefit transfer transaction per service month, with limited exceptions for situations where the subscriber seeks to reverse and unwanted transfer or is unable to receive service from a specific provider.

_____I acknowledge that I was provided and read the disclosures herein, and that I give my informed consent to transfer my benefit to the transfer-in provider on the date indicated next to my signature.

FOR OFFICIAL USE

Processing Date: _____ Employee Name: _____

Was Customer eligibility confirmed in National Verifier? Yes or No Benefit Amount: $30, $75, $100

NOTE: THIS RECORD AND ANY RELATED DOCUMENTATION OF ELIGIBILITY MUST BE MAINTAINED FOR A MINIMUM OF 6 YEARS AFTER THE LAST DATE THE ABOVE-NAMED CUSTOMER RECEIVED ACP BENEFITS.