Print Form

APPLICATION AND NOTICE OF SERVICE CESSATION AND RELINQUISHMENT OF PROVIDER OF LAST RESORT OBLIGATIONS WITHIN THE STATE OF INDIANA

State Form 52714 (7-06)
INDIANA UTILITY REGULATORY COMMISSION

Providers should file five (5) paper copies of each form with supporting documentation and one unofficial electronic copy in PDF format on disk.

Mark Type of Provider/Authority you are Relinquishing:

☐ ILEC under Alternative Regulation ☐ Rural ILEC or Coop

☐ CLEC- Facilities Based with ETC Designation

I. Contact Information

Legal Name of Company: _____

Name under which the company does business in Indiana:

_____

_____

Company Address: _____

_____

Parent Company (*if applicable*): _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Contact Person: _____

Toll Free Customer Service Number (*to facilitate the transition of customers to other providers*)

_____

11. Nature of Service Cessation

☐ Bankruptcy

Bankruptcy trustee:
Name: _____
Address: _____
_____
Phone No: _____

Attorney Representing Provider:
Name: _____
Address: _____
_____
Phone No: _____

☐ Withdrawal from or Selling Exchange(s) and Provider of Last Resort Obligations

Expected date of service cessation: _____

Has a discontinuance, reduction or impairment of service application pursuant to 47 CFR 63.61 or 63.71 been filed with the FCC? ☐Yes ☐ No

a. If yes, please indicate the FCC Docket No. and date filed: _____

Type of discontinuance application: ☐ Dominant ☐ Non-dominant

b. If no, please explain why an application was not filed or does not apply.
_____

111. Exchange Information

1. List Exchange(s), customer class[1] and corresponding rate group from which you are requesting service cessation (*add additional sheets if necessary*). Please include a street level map to identify the precise location(s) for which this request should be processed:

_____
_____
_____
_____
_____
_____

[1] Refers to Retail Residential and/or Business Customers and Wholesale Customers

2. Number of Customers affected in each Exchange (*or part thereof*):

3. How many Lifeline/LinkUp customers are affected in each Exchange (*or part thereof*):

4. Line Counts by Customer Class of affected customers in each Exchange (*or part thereof*):

5. Types of Services offered in each affected Exchange (*or part thereof*):

IV. Federal & State Support

1. Does your company receive Federal Universal Service Support? If so, please identify the specific type of support and the annual amount received (*for example, Interstate Access support, Interstate Common Line Support, LifelineILinkUP, etc.*):

2. Does your company receive Indiana High Cost Support or Transitional DEM Weighting Funds? If so, please identify the amount received for each program:

V. Facilities

1. Type of facilities deployed by subject provider in each exchange proposed for cessation:

2. Will the subject facilities continue to be owned by the applicant or will they be offered for sale? Please explain (*add additional sheets if necessary*).

3. Are there other communications service providers operating in the exchanges for which you are seeking service cessation? If so, please identify each provider, where they are operating and type of facilities they operate or the method used to provide service (i.e. CMRS, facilities-based CLEC, etc.).

VI. Other Information

1. Please add additional relevant information that you believe the Commission should take under consideration regarding this application (*add additional sheets if necessary*).

AFFIDAVIT

As an authorized corporate officer of _____ (provider name), I, _____ (print name), under penalty of perjury, hereby affirm familiarity with and understanding of the requirements of IC 8-1-32.4 and attest to the accuracy of the information provided herein. I further acknowledge that _____ (provider name) will be liable for all charges owed to other providers and is responsible for any provider change charges and will maintain a customer service telephone number to facilitate the continuation of service and the transition of customers to other providers.

_____
(Signature)

_____
(Title)

_____
(Date)

Subscribed and Sworn to before me this _____day of _____, A.D. 20____

NOTARY PUBLIC

My Commission expires _____