

BILLING APPEAL REQUEST FORM

Billing Appeal under Water District Policy #16-06 WD / Sanitary District Policy #16-04 SD

Date Accou	unt Number
Name on account.	
Property Account Address:	
f different: Your Name	Address
Contact Info (phone/email)	
Date leak discovered / loss noticed	Date leak / loss repaired
Describe the water loss	Describe the repairs to your system, if any
Name of person or entity discovering leak / loss	Name of person or entity repairing leak / loss
value of person of entity discovering reak / 1033	reame of person of entity repairing reak / 1033
Amount being appealed: \$ Date(s) of	charges being appealed:
Basis of appeal:Water District Water	Leak Policy #23-09 WD
Sanitary District Wa	iter Leak Policy #24-07 SD
Water District Extraord	inary Water Usage Appeal Policy #2024-1017 WD
Other (Specify)	

NOTE: Leak and Billing Appeal Policies for the Water and Sanitary Districts may be obtained at District offices and found on-line at https://www.archcapewater.org/

THE UNDERSIGNED HEREBY CERTIFIES:

- that I have read the District Policies above indicated and this Appeal conforms to them.
- that the contents of this Request are true and correct.
- that the customer has complied with all requirements for relief under those Policies; and
- that the attached are true and correct copies of the invoice(s) paid for repairs.

Signature:	Date:	