

APPLICATION FOR BEST DOCTORS® INDIVIDUAL MEMBERSHIP

Complete application form below and send by mail or courier to:
Best Doctors Canada **One Queen Street East, Suite 2000**
Toronto, Ontario M5C 2W5

APPLICANT'S INFORMATION

Applicant's Full Name

Date of Birth (mmddyy) Male Female Language Preference English French

Spouse's Full Name

Date of Birth (mmddyy) Male Female Language Preference English French

Home Address

City

Province

Postal Code

Telephone

Email

Billing address if different than Applicants

Name

Home Address

City

Province

Postal Code

Telephone

Email

COVERED CONDITIONS: AIDS, Alzheimer's disease, blindness, benign brain tumour, cancer, cardiovascular conditions, coma, deafness, kidney failure, loss of speech, multiple sclerosis, major organ transplant, major trauma, motor neuron disease, Parkinson's disease, paralysis, severe burns, stroke

MEMBERSHIP INFORMATION

Please Select Type of Membership: (eligibility 18th - 65th birthday)

Individual \$150.00 per year / \$12.50 per month

Family \$225.00 per year / \$18.75 per month (immediate family includes spouse and all dependent children under the age of 18)

PAYMENT INFORMATION

Please Select Mode of Payment

Monthly Pre-authorized payment (Please attach a VOID cheque)

Annual Pre-authorized payment (Please attach a VOID cheque)

Annual Payment by Cheque (Please enclose cheque made payable to Best Doctors Inc.)

THIS SECTION MUST BE SIGNED AND DATED Please read carefully

Membership Terms/Pre-existing Conditions: If the Member has been diagnosed with, or there is a suspicion of any of the listed Medical Condition(s) during the twenty four (24) months prior to the effective date of the Best Doctors membership, services will not be available for the same Medical Condition(s) for twelve (12) months following the effective date of the membership. Also, if the Member has received treatment or medical care relating to any of the listed Medical Condition(s) during the twenty four (24) months prior to the effective date of the Best Doctors membership, services will not be available for the same Medical Condition(s) for twelve (12) months following the effective date of the membership.

Signature of Applicant

Date (mmddyy)

Agent Name

Best Doctors Agent Code

Agent Company

Agent Telephone

THIS SECTION MUST BE SIGNED AND DATED Please read carefully

Pre-Authorized Payment Authorization I authorize and direct Best Doctors to debit the account at the Financial Institution which is identified on the attached void cheque for the purpose of paying membership fees. I further authorize such Financial Institution and any of its branches to deal with these debits as if authorized by me. I will notify Best Doctors in writing of any changes in the account information or termination of this authorization prior to the next withdrawal date of the pre-authorized debit. I also understand that should any withdrawal not clear my account for reason of insufficient funds, Best Doctors will automatically attempt to withdraw these funds within 5 days of the returned item without prior notification. I acknowledge that delivery of this authorization to Best Doctors constitutes delivery by me to the noted Financial Institution. This agreement may be cancelled, in writing, by either Best Doctors or me.

Signature of Applicant

Date (mmddyy)