

**APPLICANT INFORMATION**

Company Name (Operating Name) \_\_\_\_\_ # of Eligible\* Employees \_\_\_\_\_

Affiliates & Subsidiaries: \_\_\_\_\_

Nature of Business: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone No: \_\_\_\_\_ Fax No: \_\_\_\_\_

Contact Name (for billing purposes): \_\_\_\_\_

Language Preference:  English  French      **SELECT ONE:** Self-Billed:       Electronic Invoice:

**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

**PLAN INFORMATION**

Plan Effective Date: \_\_\_\_\_ DD/MM/YYYY

Number of Eligible Members: \***Eligibility 18<sup>th</sup> - 65<sup>th</sup> birthday:** \_\_\_\_\_ \*\*  
(Mandatory for all eligible employees. Family coverage includes spouse and all dependent children under the age of 26)

Payment: Rate per Member per Month: \$ \_\_\_\_\_ x # of Members\*\* \_\_\_\_\_ \$ \_\_\_\_\_

Payment Mode:  Monthly  Quarterly  Semi-Annual  Annual      x \_\_\_\_\_ (# mths)

Cheque Enclosed (Payable to: Best Doctors, Inc)      Total: \$ \_\_\_\_\_

Language Preference for the Welcome Kits: English # \_\_\_\_\_ French # \_\_\_\_\_

**PLEASE READ CAREFULLY – THIS SECTION MUST BE SIGNED AND DATED**

**Membership Terms/Pre-existing Conditions:**

If the Member was diagnosed or has received treatment relating to any of the listed Medical Condition(s) during the twenty four (24) months prior to the effective date of the Best Doctors Group membership, services will not be available for the same Medical Condition(s) for twelve months following the effective date of the Group Membership (not applicable to groups with over 50 certificate holders).

**The Applicant Acknowledges, Undertakes and Agrees:**

- (a) At all times, to enroll only actively working, eligible permanent employees and their eligible dependents in the Best Doctors Group Service Card program. The employer is obligated to provide Best Doctors with updated census data as it changes (sample census data form attached).
- (b) To pay, or cause to be paid, all fees necessary to provide the services applied for herein.
- (c) To the best of the Applicant's knowledge, the statements and answers contained in this Application are full, complete and true as of the date hereof.

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (DD/MM/YYYY)

Agent Name: \_\_\_\_\_ Best Doctors Agent Code: \_\_\_\_\_

Company of Agent: \_\_\_\_\_ Agent Email: \_\_\_\_\_

Company Affiliated With: \_\_\_\_\_ Agent Telephone No: \_\_\_\_\_

