Best Doctors®
When you need to be absolutely sure.

APPLICATION FOR BEST DOCTORS® INDIVIDUAL MEMBERSHIP

APPLICANT'S INFORMATION

Applicant's Full Name: ______________________________

Date of Birth: ____________________ (DD/MM/YYYY)

Gender: ☐ Male ☐ Female

Language: ☐ English ☐ French

Spouse's Full Name: ______________________________

Date of Birth: ____________________ (DD/MM/YYYY)

Gender: ☐ Male ☐ Female

Language: ☐ English ☐ French

Home Address: ______________________________

City: ____________________ Province: ____________________ Postal Code: ____________________

Home Telephone No: ____________________ Email: ____________________

Billing Information If Different Than Applicant's: **✓ if Gift:** ☐

Name: ______________________________

Address: ______________________________

City: ____________________ Province: ____________________ Postal Code: ____________________

Telephone No: ____________________ 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/Method of Payment:	Pre-Authorized Payment:	Invoice:
☐ Monthly Pre-authorized payment *(Please attach a VOID cheque)*	☐	not available
☐ Annually	☐	☐

☐ Cheque Enclosed Payable to: **Best Doctors, Inc**. (annual payments only): Amount: $150.00 ____ or $225.00 ____

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 new Best Doctors membership, services will not be available for the same Medical Condition(s) for twelve months following the effective date of the new Membership.

The Applicant Acknowledges, Undertakes and Agrees by applying for Best Doctors membership, I acknowledge that if I elect to use the services:
(a) I will be required to provide personal health information and I agree to permit Best Doctors to use if for that purpose.
(b) I am not a patient of Best Doctors.

Signature of Applicant: ______________________________ **Date:** _____/_____/_____ (DD/MM/YYYY)

Agent Name: ______________________________ **Best Doctors Agent Code:** ____________________

Company of Agent: ______________________________ **Agent Phone #:** ____________________

THIS SECTION MUST BE SIGNED AND DATED

Pre-Authorized Payment Authorization (PLEASE ATTACH A VOID CHEQUE)
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 Account Holder: ______________________________

Please send by mail or courier to: Best Doctors Canada
One Queen Street East, Suite 2000 • Toronto, Ontario M5C 2W5

THIS IS NOT INSURANCE