

<b>APPLICANT'S INFORMATION</b>		
<b>Applicant's Full Name:</b> _____ <b>Date of Birth:</b> _____ <small>(DD/MM/YYYY)</small> <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> French	<i>Complete spousal information only if applying for Family Membership</i> <b>Spouse's Full Name:</b> _____ <b>Date of Birth:</b> _____ <small>(DD/MM/YYYY)</small> <b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Language:</b> <input type="checkbox"/> English <input type="checkbox"/> French	
<b>Applicant's Contact Information:</b> <b>Home Address:</b> _____ <b>City:</b> _____ <b>Province:</b> _____ <b>Postal Code:</b> _____ <b>Home Telephone No:</b> _____ <b>Email:</b> _____		
<b>Billing Information If Different Than Applicant's:</b> <b>Name:</b> _____ <b>Gift:</b> <input type="checkbox"/> <b>Address:</b> _____ <b>City:</b> _____ <b>Province:</b> _____ <b>Postal Code:</b> _____ <b>Telephone No:</b> _____ <b>Email:</b> _____		
<b>MEMBERSHIP INFORMATION</b>		
<b>Please Select Type of Membership:</b> <input type="checkbox"/> <b>Individual (\$90.00 per year or \$7.50 per month)</b> <input type="checkbox"/> <b>Family (\$180.00 per year or \$15.00 per month)</b> <small>(Immediate family includes spouse and all dependent children under the age of 18)</small>		
<b>PAYMENT INFORMATION</b>		
<b>Please Select Mode of Payment:</b> <b>Monthly</b> <b>Annually</b>	<b>Pre-authorized Payment:</b> <input type="checkbox"/> <input type="checkbox"/>	<b>Direct Bill:</b> <b>not available</b> <input type="checkbox"/>
<b>Please Select Method of Payment:</b> <input type="checkbox"/> <b>Cheque Enclosed (annual payments only)</b> <small>(Please make Cheques Payable to: Best Doctors, Inc.)</small> <b>Amount: \$90.00</b> <b>or</b> <b>\$180.00</b> <input type="checkbox"/> <b>Pre-authorized payment (Please attach a VOID cheque)</b>		

**PLEASE READ CAREFULLY**

**Membership Terms**

If you were diagnosed with any of the listed Medical Condition(s) during the twenty four (24) months prior to the effective date of the Best Doctors Service Card, Services will not be available for the same Medical Condition(s) for twelve months following the effective date of the Card.

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

By applying for the Best Doctors Service Card, I acknowledge that if I elect to use the services provided by Best Doctors:

- I will be required to provide personal health information and I agree to permit Best Doctors to use it for that purpose.
- I am not a patient of Best Doctors.

**Signature of Applicant:** \_\_\_\_\_

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

**Agent Name:** \_\_\_\_\_

**Company of Agent:** STRATA BENEFITS CONSULTING INC

**Best Doctors Agent No:** 500882

**Company Affiliated With:** \_\_\_\_\_

**Agent Telephone No:** 204-984-9450

**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:** \_\_\_\_\_

**Bank Name:** \_\_\_\_\_ **Transit/Branch Number:** \_\_\_\_\_ **Account Number:** \_\_\_\_\_