Best Doctors®
Information When It Matters Most

MFS 2004

APPLICATION FOR BEST DOCTORS® SERVICE CARD

APPLICANT'S INFORMATION

Applicant's Full Name: _____

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

Gender: ☐ **Male** ☐ **Female**

Language: ☐ **English** ☐ **French**

Complete spousal information only if applying for Family Membership

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: _____ **Fax No:** _____ **Email:** _____

MEMBERSHIP INFORMATION

Please Select Type of Membership:

- ❑ **Individual ($90.00 per year)**
- ❑ **Family ($180.00 per year)**
  (Immediate family includes spouse and all dependent children under the age of 18)

PAYMENT INFORMATION

Please Select Mode of Payment:	**Pre-authorized payment**	**Direct Bill**
Monthly	☐	**not available**
Annually	☐	☐

Please Select Method of Payment:

- ❑ **Cheque Enclosed (annual payments only)** **Amount**: $90.00_____ or $180.00 _____
  (Please make Cheques Payable to: Best Doctors, Inc.)
- ❑ **Pre-authorized payment** *(Please attach a VOID cheque)*

PLEASE READ CAREFULLY – THIS SECTION MUST BE SIGNED AND DATED

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.

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, if not the Applicant: _____

Bank Name: _____ Transit/Branch Number: _____ Account Number: _____

Signature of Applicant: _____ **Date:** _____/_____/_____

Agent Name: McGill Financial Services **Life or Mutual Fund Licence # 03077490**

Please either send the application to:
Best Doctors, PO Box 993, Station F, 50 Charles St. E, Toronto, ON. M4Y 2N9 or
fax to (905) 257-2016

THIS IS NOT INSURANCE