EXTENDED COVERAGE PLAN REGISTRATION FORM

Please complete this form and return it to our clinic. The plan begins the day you sign up and covers you for one (1) year.

1. DATE: _____
2. Patient Name(s): _____

   _____

   _____
3. Home Phone: _____

4. Select ONE of the following options:
   Individual Plan ☐ **$125**
   Couple Plan ☐ **$200**
   Family Plan ☐ **$250**

5. Please <u>circle</u> the name of your family physician

Dr. Sara Cohen-Gelfand Dr. Anita Greig Dr. Jason Klemensberg Dr. Fereshte Lalani

Dr. Elliot Lass Dr. Casey Rosen Dr. Gili Rosen Dr. Liad Salz

6. Please select <u>one</u> of the following payment options:

☐ Visa ☐ MasterCard

Name on Card: _____

Card #: _____ Expiry: _____ / _____

Month Year

CVC* #: _____ Signature: _____

*CVC # is the three-digit code located on the back of your credit card.
Or call the office with your credit card details, receipt will be given.

☐ Cheque Enclosed (Payable to Wilson Medical Group)

☐ CASH

7. Mail or bring this completed form with your payment to:
   Wilson Medical Group