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	☐ **$100**
Couple Plan	☐ **$160**
Family Plan	☐ **$225**

5. Please circle the name of your family physician

Dr. Sara Cohen-Gelfand	Dr. Naomi Driman	Dr. Anita Greig	Dr. Fereshte Lalani
Dr. Jason Klemensberg	Dr. Gili Rosen	Dr. Elliot Lass	Dr. Liad Salz

6. Please select one 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. Please mail this completed form with your payment to:

Wilson Medical Group
343 Wilson Avenue, Suite 303
North York, ON M3H 1T1