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. Please circle the name of your family physician:

   Dr. Sara Cohen-Gelfand Dr. Naomi Driman Dr. Anita Greig
   Dr. Fereshte Lalani Dr. Susan Joyce Dr. Barb Newman
   Dr. Gili Rosen

3. Patient Name(s):

   _____
   _____
   _____

4. Home Phone: _____

5. Select ONE of the following options:

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

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. Mail or bring this completed form with your payment to:

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