www.mediclaim.ca

Membership Registration Form

Last Name ________________________ **First Name** ___________________

Address____

City________________________________ **Postal Code** ________________

Office Telephone________________**Home / Cell Phone**________________

E-mail Address____

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Contact Person: Same ☐ or,

Name ________________________________ **Phone** __________________

Email Address____

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How did you hear about us? / Referred by____________________________

Nature Of Practice / Specialty _____________________________

MSP Practitioner Number ___________**MSP Payee Number** ____________

Credit Card Info: **Please call (604) 473-0046 to provide your Visa or MasterCard info.**

As a MediClaim Member, I authorize Phoenix Medical Systems Ltd. to charge my credit card the agreed upon amount on a monthly basis. It is my responsibility to keep my credit card information current and up-to-date. If I no longer require MediClaim services, it is my responsibility to provide 30 days written notice to MediClaim.

☐ **I have read and agree to MediClaim's Terms of Service**
(Failure to check this box may result in delaying your registration)

Signature _____________________________________

Date ___________________

Please email this document to MediClaim at info@mediclaim.ca
All details will be kept strictly confidential. Please see our privacy policy at www.mediclaim.ca/policy.jsp
For more information, call (604) 473-0046 or email us at info@mediclaim.ca

For Office Use Only

Doc Key _________ **CL** _________ **FS** ___________ **CB** ___________

Opted Status: In ☐ Out ☐