Private Health Services Plan Application

BUSINESS

NAME OF BUSINESS APPLICANT	
☐ SELF-EMPLOYED ☐ PROFESSIONAL PRACTICE ☐ CORPORATION	
NATURE OF BUSINESS	NUMBER OF EMPLOYEES (*NOT* including BUSINESS OWNER)

INDIVIDUAL TO BE COVERED

☐ SAME AS ABOVE	NAME (if different from BUSINESS APPLICANT)	
DATE OF BIRTH / / dd mm yyyy	SEX ☐ M ☐ F	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW(ER)

NAME OF SPOUSE	SPOUSE'S DATE OF BIRTH / / dd mm yyyy	NO. OF ADDITIONAL DEPENDENTS

CONTACT INFORMATION

BUSINESS			PERSONAL		
ADDRESS			ADDRESS		
City	Prov	Postal Code	City	Prov	Postal Code
PHONE	FAX		PHONE	FAX	
E-MAIL			E-MAIL		

PREFERRED COMMUNICATION: ☐ MAIL ☐ FAX ☐ E-MAIL ☐ PHONE

PLAN SETUP

PREMIUM CONTRIBUTION:

PAYMENT BY:

☐ CHEQUE

payable to MCGILL HEALTH SERVICES:

1 ST. CLAIR AVE W, SUITE 303
TORONTO, ON
M4V 1K7

☐ CREDIT CARD

☐ VISA ☐ MASTERCARD ☐ AMEX	ACCT. NO.	EXPIRY DATE mm yy
SIGNATURE		
NAME OF CARDHOLDER (Please Print)		TODAY'S DATE dd mm yyyy

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