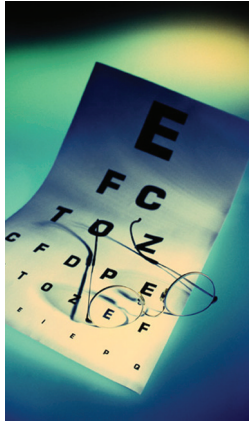


**With Medicaid®, everyone can afford the very best in elective care.**



**Simple**

Applying for Medicaid financing is as simple as filling out the application form enclosed. You can choose a credit card or our simple, fixed monthly payment plan, or both (check box on application).

**Fast**

Just complete the short application form and fax it to our toll-free number (1-888-689-9862). Approval should be confirmed within minutes.

**Convenient**

Medicaid's professional and experienced staff are committed to helping you obtain financing for elective medical treatments. Call if you have any questions or if we can be of assistance at 1-888-689-9876.

- No down payment
- No collateral
- High approval
- Competitive interest rates
- Easy monthly payments
- And more...

MEDICARD®

**Medicaid®** is available to you because your doctor cares about making health care affordable.



Toll-free telephone:  
1-888-689-9876

Toll-free facsimile:  
1-888-689-9862

Website:  
[www.medicard.com](http://www.medicard.com)



**Patient Financing**  
**Medicaid®**



**Your choice...**  
**Fixed, equal monthly payments**  
**or Credit Card.**  
**...So easy!**

**More people throughout Canada prefer Medicaid® to finance their procedures.**

**Why wait?**

With Medicaid you can get the procedure you need or want now.



**Medicaid® is accepted across Canada for:**

- **Cosmetic Treatments**
- **Plastic Surgery**
- **Laser Eye Surgery**
- **Hair Restoration**
- **Orthodontics**
- **Dentistry**
- **Infertility**
- **Diagnostic**
- **Veterinary Treatments**
- **and more...**



# MEDICARD® APPLICATION FOR CREDIT

Tel: 1-888-689-9876

Fax: 1-888-689-9862

www.medicard.com

## APPLICANT'S INFORMATION

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> First Name & Initial(s):		Last Name:	
Ms. <input type="checkbox"/> Miss <input type="checkbox"/>			
Home Phone Number:		Other Phone Number (Day):	
Present Address:		Email:	
Apt #:	City:	Postal Code:	How Long At This Address?
Own <input type="checkbox"/> Monthly Rent or Mortgage:	Mortgage Lender:	Social Insurance # (Optional in Québec):	Driver's License # + Province (Optional in Québec):
Rent <input type="checkbox"/> \$			Date of Birth: (DDMMYY)
Occupation:	Present Employer (Company Name):	Contact Name:	Employer's Phone Number:
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/>	Gross Monthly Income: \$	Net Monthly Income: \$	Other Income (Specify):
Self Employed <input type="checkbox"/> Student <input type="checkbox"/>		Accountant's Phone Number:	Contact before faxing? Yes <input type="checkbox"/> No <input type="checkbox"/>
If Self Employed, State Name of Source of Income / Accountant:		Account Number:	
Name of Bank:		Branch Address:	
		Phone Number:	

## CO-APPLICANT'S INFORMATION (If any)

Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> First Name & Initial(s):		Last Name:	
Ms. <input type="checkbox"/> Miss <input type="checkbox"/>			
Home Phone Number:		Other Phone Number (Day):	
Present Address:		Email:	
Apt #:	City:	Postal Code:	How Long At This Address?
Own <input type="checkbox"/> Monthly Rent or Mortgage:	Mortgage Lender:	Social Insurance # (Optional in Québec):	Driver's License # + Province (Optional in Québec):
Rent <input type="checkbox"/> \$			Date of Birth: (DDMMYY)
Occupation:	Present Employer (Company Name):	Contact Name:	Employer's Phone Number:
Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Retired <input type="checkbox"/>	Gross Monthly Income: \$	Net Monthly Income: \$	Other Income (Specify):
Self Employed <input type="checkbox"/> Student <input type="checkbox"/>		Accountant's Phone Number:	Accountant's Phone Number:
If Self Employed, State Name of Source of Income / Accountant:		Account Number:	
Name of Bank:		Branch Address:	
		Phone Number:	

I/we are interested in the Optional Creditors Life & Accidental Disability Insurance Program. I/we understand that it is not required in order to obtain credit. The Creditor's Life Insurance Program protects my/our account for the balance of the loan, to be paid in full, if the borrower(s) should die. The Accidental Disability Program protects my/our account for the monthly payment if the borrower(s) should become totally disabled due to injury. The cost of the insurance will be added to my fixed monthly payments at a cost of \$1.50 per \$100.00 per year for single and \$2.70 per \$100.00 per annum for joint insurance. For further information, contact Medicard®. Underwritten by subsidiaries of The Canada Life Assurance Company. \*Applicable to the fixed monthly payments program only.

**If you are a business owner and interested in deducting 100% of your medical expenses, check here for more information.**

## TERMS AND CONDITIONS

I/we understand that the above information (the "Collected Information") is being collected for the purpose of obtaining credit from Medicard Finance Inc. ("Medicard") and is warranted to be true and complete. I/we hereby authorize and consent to the collection of the Collected Information and to the making by Medicard, its successors and assigns of whatever credit investigations and/or employment and income confirmations Medicard or its successors and assigns may deem appropriate from time to time, and to the disclosure, sharing or exchange of the Collected Information and any report or information based thereon for these purposes with credit reporting agencies, and amongst Medicard, its successors and assigns or any company with whom I/we have or propose to have a financial relationship.

**READ ADDITIONAL TERMS AND CONDITIONS BELOW AND SIGN WHERE INDICATED IF YOU ACCEPT THESE TERMS.**

If approved, Medicard will contact your provider or medical facility.

**X** Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_ **X** Signature of Co-Applicant (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Approximate Date of Procedure \_\_\_\_\_

Medical Treatment Centre / Doctor's Name \_\_\_\_\_

Amount of Financing Required \$ \_\_\_\_\_

Emergency or rush? - Please check here.

Please Detach Here

Visit our website and complete

our **online** application:

**www.medicard.com**

Apply by **phone** to:

**1-888-689-9876**

**Fax** your completed application to:

**1-888-689-9862**

## AGREEMENT & CONSENT to USE of PERSONAL INFORMATION

For application of the Medicard Credit Card

I/we accept this as written notice of Medicard, its affiliates, service providers and professional advisors (collectively Medicard) receiving, disclosing, exchanging and using any Collected Information and any other personal information (collectively the "Personal Information") about me/us for the purposes set out below.

MEDICARD, its affiliates and service providers may use any Information relating to me/us:

- to establish, maintain and administer my/our Credit Card;
- to determine my/our eligibility for products, goods and services offered by MEDICARD including monitoring my/our purchase history as well as evaluating my/our credit standing;
- to determine the suitability of benefits, services or enhancements, and/or which other product or service offers may be of interest to me/us;
- to promote and market additional products, goods and services offered by MEDICARD including by means of direct marketing, &
- to comply with legal and regulatory requirements.

I/we hereby also authorize any person who is contacted in this regard to provide such information.

I/we acknowledge that my/our consent to "Use of Personal Information" includes:

- MEDICARD providing the service provider who accepts the Credit Card for which I/we am applying (the "Retailer") with MEDICARD's decision with respect to this application and if my/our Card application is accepted, my/our Account number and any other information which the Retailer may reasonably require;
- The Retailer providing MEDICARD with information related to any loyalty or reward program offered by that retailer where such loyalty or reward programs is administered by MEDICARD and MEDICARD's receipt, exchange and use of such information.

Credit will be extended by MEDICARD upon approval of this application and I/we request an account card be issued to me/us and any renewal or replacements thereof. All information provided by me/us in connection with this application is true, accurate and complete in all respects.

I/we consent to the creation of a Personal Information file containing credit and other personal information. Only those employees of MEDICARD whose job functions involve assessment of creditworthiness, credit applications, monitoring, processing of payments and matters relating to the purpose of the file, will have access to my/our file.

I/we understand I/we can tell you to stop using Personal Information about me/us in order to promote and market additional products, goods and services offered by MEDICARD. I agree that my/our Social Insurance Number may be used as an aid to identify me/us with credit bureaus and others for credit history file matching and other administrative purposes.

I/we also consent to the retention of Personal Information about me/us for as long as is needed for the purposes described above, even after I/we cease to be a customer. In order to ensure the accuracy, completeness and integrity of the credit reporting system, I/we specifically consent to the continued disclosure of my/our Personal Information to credit bureaus even after the loan or credit facility has been retired.

