EXTENDED HEALTH CARE INSURANCE FORM

PLEASE FILL OUT THIS FORM AND BRING IT TO OUR OFFICE ON YOUR NEXT VISIT

410 6th St. south, Lethbridge, AB. T1J-2C9 • Phone: 403-394-1177 • Fax: 403-394-1171 **www.mcleodfamilychiro.ca**

PATIENTS NAME _____

Insurance Company Name: _____

Name of the policy holder: _____Date of Birth_____
(dd/mm/yyyy)

Employer _____

Group/Contract/Policy # _____ID #_____

CALL YOUR INSURANCE COMPANY

Date you called the Insurance company : _____

Name of person who gave you the information: _____

Contact # of person who gave you the information:_____

ASK THE FOLLOWING QUESTIONS

1. Does my policy cover chiropractic care? ☐ Yes ☐ No *(If no : Then you do not have to complete the rest of this form)*

2. Amount of coverage allowed per year per person ? $_____

3. What is my benefit year ? (*Example: Jan1—Dec 31*) _____

4. Is there a maximum amount per visit ? _____ (*is it a dollar amount or a percentage amount?)*

5. Do I have to pay a deductible ? ☐ Yes ☐ No If yes: How much is it ? _____
   Is the deductible yearly? ☐ Yes ☐ No
   Has it been paid ? ☐ Yes ☐ No

6. Does my policy cover X-rays at a chiropractic office ? ☐ Yes (What is the amount?_____) ☐ No

7. Is my yearly limit exclusively for chiropractic or is it included with a group of services? *(i.e. physiotherapy,massage, acupuncture, orthotics etc ?)* _____

FURTHER INFORMATION

Do you have dependants, spouse , or children who are covered by this insurance ? ☐ Yes ☐ No

We can photocopy your benefit card to record all the names and insurance ID # . OR you can write them down in the space provided

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Name :_____Birthdate(dd/mm/yyyy)_____#ID_____

Are you covered by any other insurance plan? ☐ YES ☐ NO If yes: *(please fill out another extended health insurance form)*