

# BIONIC EAR SERVICE AGREEMENT ENROLLMENT FORM (CANADA)



Please complete the Bionic Ear Service Agreement Enrollment Form ("Enrollment Form") and fax or mail it to us in the enclosed envelope. The warranty extension requested in this Enrollment Form will extend the limited warranty coverage for your sound processors and headpieces (excluding batteries, earhooks, and cables) from the date of expiration of your current warranty or service contract and will last for one (1) year. You have sixty (60) days from the expiration date of your current warranty or service contract to submit this Enrollment Form. Please select your choices below (all prices are in U.S. Dollars), including your choice for payment option and the number of systems you would like to cover. If your insurance policy covers Durable Medical Equipment (DME) repair or replacement if damaged, you will not need this coverage.

Number of Systems*	Single Payment Option	Monthly Payment Option**
One System	<input type="checkbox"/> \$599	<input type="checkbox"/> \$56
Two Systems	<input type="checkbox"/> \$1,050	<input type="checkbox"/> \$96
Each Additional System (Please specify how many: _____)	<input type="checkbox"/> \$185	<input type="checkbox"/> \$17

\* Note: A "system" is defined as one (1) speech processor and one (1) headpiece.

\*\* Financing authorization required. Monthly payment reflects a special 9.9% Annual Percentage Rate.

Last Name		First name		Middle Initial	Date of Birth
Mailing Address					
City		State or Province		Country	Zip or Postal Code
Delivery Address for Federal Express (if different from above)					
City		State or Province		Country	Zip or Postal Code
Telephone Home Voice		Home TDD		Work Voice	Work TDD
Fax		Email Address			
Name of Current Clinic, City and State					Clinic's Telephone
Current Audiologist's Name		Sound Processor Serial Number:			Headpiece Serial Number/ Lot Number:

My signature acknowledges that I have read, understood and accepted the terms and conditions of the service contract option chosen above.

\_\_\_\_\_  
Signature Date

**PAYMENT OPTION:**  Single Payment  Monthly Payment (Not available for implant clinics)

Payment Method:  Check or money order in US dollars made out to Advanced Bionics enclosed

Please bill my credit card. Type of card:  Visa  MasterCard  Discover  American Express

Account #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Card holder's Name (if different from above): \_\_\_\_\_

Card holder address: \_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_

*My signature above authorizes Advanced Bionics, LLC to bill my credit card, if listed, for the amount of the Service Agreement option chosen.*

Purchase Order # (For Implant Clinics Only): \_\_\_\_\_