

ESCO is the early pioneer and the longstanding leader of independent loss and damage coverage for hearing aids.

As an advocate, ESCO partners with your hearing care professional, family, and friends to help you protect and make the best use of your investment in better hearing.

Adding ESCO coverage to your hearing aids may save you from any costly and unexpected expenses caused by repair or replacement.

ESCO has comprehensive insurance coverage for most manufacturers, models, and styles of hearing aids available.

PROTECTION PLUS - Loss & Damage

- Replacement of your hearing aid(s) if accidentally lost or permanently misplaced.
- Replacement or Repair of your hearing aid(s) if accidentally damaged.

For exact coverage costs visit:
www.escogetaquote.com

To enroll for ESCO coverage, complete the enclosed application.

FOR MORE INFORMATION:

1-800-992-3726
www.ESCO.com



CONTACT ESCO:

MAIL: ESCO

3215 Fernbrook Lane North
Plymouth, MN 55447

CALL: 1-800-992-3726

EMAIL: info@ESCO.com

ONLINE: www.ESCO.com

RENEWAL & AUTO-RENEWAL

Renewals - ESCO policies are renewed annually. You will be mailed a notification before your coverage expires.

Auto-Renewals - Save a step and automatically renew your coverage by selecting Auto-Renewal online or on the application. Once renewed a confirmation for your records will be mailed to you.

HOW TO SUBMIT A CLAIM

Obtain a claim form at: www.earserv.com, by contacting ESCO at 1-800-992-3726, or from your hearing care practitioner.

WHAT HAPPENS AFTER A CLAIM?

Single Replacement – If your hearing aid is replaced, an ESCO representative will contact you to select new coverage for your replacement instruments.

This brochure provides a summary of items regarding coverage. Please refer to your policy for a complete listing of definitions, terms, and limitations.

- Accidental damage means unintentional physical damage sustained by your hearing aids.
- Gradual deterioration, normal wear and tear, and electronic failure are NOT covered by this policy.



HEARING AID LOSS & DAMAGE COVERAGE

A COMMITMENT TO BETTER HEARING
IS WORTH PROTECTING.



ESCO coverage pricing is based on specific hearing aid manufacturer, model, and type.

For exact coverage costs, visit:

www.ESCO.com

TO ENROLL FOR COVERAGE

1. Complete the enclosed application.
2. Send the completed application and payment to **ESCO**. Note: BTE and RIC devices look similar, please double check your hearing aid style.
3. Once your application is processed, confirmation of your coverage will be mailed within 15 business days.
4. **ESCO** coverage begins the date of postmark on your application, providing all required information is received. If your application is incomplete, coverage will be effective once all necessary information is received.

Want coverage today?

Apply online at www.ESCO.com/enroll

ESCO DOES NOT CHARGE YOU A DEDUCTIBLE FOR CLAIMS

However, you may be charged a fee for professional services performed by your practitioner in the event of a loss or damage claim. Your **ESCO** policy does not cover any fees for professional service.

FOR MORE INFORMATION:

1-800-992-3726

www.ESCO.com

APPLICATION FOR HEARING AID PROTECTION

Wearer Name	POLICY HOLDER INFORMATION
Mailing Address	Guardian Name (If applicable)
City/State/Zip	E-Mail Address
Daytime Phone Number () -	Wearer Date of Birth

I elect coverage on the instruments listed.	WEARER OR GUARDIAN'S SIGNATURE
<input type="checkbox"/> The hearing device(s) I am applying for coverage on is/are in good working order. I understand, making false statements invalidates my coverage.	
Wearer or Guardian Signature (Mandatory)	
These people are authorized to discuss my coverage	

Confirm the style of your hearing instrument	COVERAGE OPTIONS				
Style: <input type="checkbox"/> BTE <input type="checkbox"/> RIC (RITE) <input type="checkbox"/> ITC <input type="checkbox"/> HS <input type="checkbox"/> ITE <input type="checkbox"/> CIC <input type="checkbox"/> MC <input type="checkbox"/> Other					
Manufacturer	Model	Serial #	Date of Purchase or Replacement	Exp. Date of Mfg. Warranty	Premium (per device)
Right Aid			Month/Day/Year	Loss Repair	\$
Left Aid			Month/Day/Year	Loss Repair	\$
Other			Month/Day/Year	Loss Repair	\$
Total Amount Due					\$

Does your patient wear another instrument that is still under mfg. warranty?

Manufacturer	Model	Serial #	Date of Purchase	Loss Mfg. Warranty Expiration Date

Select **Auto-Renewal** (You will be reminded before your policy is Auto-Renewed.) Yes No **AUTO-RENEWAL**

Practitioner Information	I WISH TO PAY BY:
Office Name _____	<input type="checkbox"/> Check made payable to ESCO
Address _____	<input type="checkbox"/> Credit Cards accepted: (Visa, MasterCard, American Express and Discover)
City/State/Zip _____	Name on Card: _____
Phone Number _____	Card #: _____
ESCO Customer Number: _____	Expiration Date _____
(Please call ESCO 800-992-3726 to obtain customer number)	Mail this completed application and payment to: ESCO, 3215 Fernbrook Lane N, Plymouth MN 55447 or FAX this form with your credit card information to ESCO at 763-559-4247 or Enroll Online at www.ESCO.com/enroll
Practitioner Signature _____	Date _____
I have examined the listed devices and certify they are in good working condition on the date shown above. Inspection valid for 30 days.	