

YOUR 4C LOGO

123 Any Street, City State Zip

Endorsement

<<First>> <<Last>>
<<Street 1>>, <<Street 2>>
<<City>>, <<State_Province>> <<Zip_Postal Code>>
Barcode

FIND US ONLINE AT:
www.YourWebsite.com



Dr. Smith, Au.D.
Doctor of Audiology



Dr. Johnson, Au.D.
Doctor of Audiology



Dr. Doctor, Au.D.
Doctor of Audiology

CLEAN AND CHECK APPOINTMENT REMINDER

Dear <<First>>,

Our records show the warranty on your hearing aid(s) will expire on 12/31/2023.

It's time again to thoroughly clean and check your hearing aids to ensure proper performance.

We've heard all kinds of stories about how aids have been lost or broken. Having partnered with ESCO for years to provide accidental loss & damage coverage for our patients, we recommend you consider the offer included with this letter.

To apply warranty coverage to your current hearing aids, simply complete the below application and **return it to ESCO**.

Questions regarding extending your warranty, please contact us at (YourPhone#).

Sincerely,

Dr. Provider signature, Au.D.,

Dr. Provider Signature 2, Au.D.,

Dr. Provider Signature 3, Au.D.

Detach here and return with payment in the enclosed postage paid envelope

Patient First, enroll for coverage online: www.escocrc.com with this Reminder Care Id#: **12345**

Extended coverage is recommended for the following hearing devices:

LEFT: <<Manufacturer Left>> - <<Model Left>> - <<Serial Number Left>>

RIGHT: <<Manufacturer Right>> - <<Model Right>> - <<Serial Number Right>>



INDICATE THE COVERAGE YOU WANT TO ADD TO YOUR DEVICE(S)

- PROTECTION PLUS**
LOSS AND DAMAGE
- ANNUAL PREMIUM**
\$<<ECPRPLUSPANNUAL>> One-time payment
- 12 MONTHLY PAYMENTS**
\$<<ECPRPLUSPPAYM>> per month

- PLATINUM PLAN**
LOSS, DAMAGE, & REPAIR
- ANNUAL PREMIUM**
\$<<ECPLANANNUAL>> One-time
- 12 MONTHLY PAYMENTS**
\$<<ECPLANPAYM>> per month

By signing below, I declare, the hearing devices I am applying coverage for is/are in good working order. I understand, making false statements invalidates my coverage.

Wearer or Guardian Signature _____

Date: _____

IMPORTANT CLAIM AND PAYMENT INFORMATION

NEED TO SUBMIT A CLAIM?

ESCO and your practitioner work together to provide you with the best possible solution should a replacement device or repair be required. Note: This policy does not cover any co-payments charged for professional services performed by your practitioner in the event of a claim.

YOUR HEARING CARE PROVIDER INFORMATION

Your Hearing Center
123 Any Street
City, State Zip
(865) 555-5555
www.YOur Website.com

PROFESSIONAL FEES

YOU WILL PAY YOUR PRACTITIONER FOR THE BELOW PROFESSIONAL FEES ON ANY CLAIMS MADE TO YOUR ESCO POLICY:

COPAYMENT WHEN DEVICE IS REPLACED: <<REPLACED COPAY>>

COPAYMENT WHEN DEVICE IS REPAIRED: <<REPAIRED COPAY>>
(Platinum Coverage)

OFFICE VISIT COPAYMENT: <<Office Visit Copay>>
Copayment related to office visit charges

PAYMENT OPTIONS EXPLAINED

ANNUAL PREMIUM – Payment in full may be made by check or credit card.

MONTHLY PAY – Payment by credit card is required, as your ESCO payment will be charged automatically to the credit card provided. Monthly payment option allows you to pay for coverage over the twelve month period of your policy.

Monthly Payment Terms: By selecting the monthly payment option, you agree to the following terms: ESCO reserves the right to terminate the policy and the protection of hearing device(s) enrolled in the monthly payment program, due to non-payment or insufficient funds. The balance of the premium is required before a loss replacement can be processed. ESCO will notify you before terminating protection.

Once processing of your enrollment is complete, confirmation of your coverage will be mailed to you within 10-15 business days.

ESCO CONTACT INFORMATION

ESCO - Ear Service Agency
3215 Fernbrook Lane N,
Plymouth, MN 55447
1-800-825-3726
www.ESCO.com
Email: info@ESCO.com
Fax: 800-894-6056

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I CHOOSE TO PAY FOR MY COVERAGE WITH:

- Annual payment with a Check made payable to: **ESCO**
- Annual credit card payment. I authorize a one-time charge of: \$ _____
- Monthly credit card payment. I authorize a reoccurring charge of: \$ _____

Name on Card: _____

Card #: _____

Expiration Date: _____

(We accept: Visa, MasterCard, American Express, and Discover)

<<Invitation Code>>

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