



# Orthotic Insurance Program

**Protection against loss and outgrowth for patients 18 years of age and younger.**

The coverage period extends for 24 months from the day Northwest Podiatric Laboratory ships your orthotics. This program provides one replacement pair of orthotics, identical to the original pair, for orthotics that have been outgrown, lost or stolen.

Upon enrollment in the program, your original casts will be returned to you, postage paid. In case of outgrowth, new casts must be provided by your doctor. This insurance program does not include casting fees or any of your doctor’s professional fees.

Claims must be presented to Northwest Podiatric Laboratory by the prescribing doctor, along with a note of explanation. Inbound shipping charges are the responsibility of the patient. Outbound shipping will be paid by Northwest Podiatric Laboratory, Inc.

**This insurance program runs concurrently with our Standard Guarantee which states:**

Northwest Podiatric Laboratory, Inc. guarantees all orthotic shells and extrinsic posts against breakage or defects in materials or workmanship for a period of two years from the date the orthotics are shipped, with the exception of medial and lateral flanges which are guaranteed for six months. Top covers and pads are guaranteed for one year.

This guarantee is rendered null and void if the orthotics have been subject to unusual or abusive treatment, intentional damage or alterations made by anyone other than Northwest Podiatric Laboratory, Inc.

**Important**

Please return your enrollment form within 6 weeks of the date Northwest Podiatric Lab ships your orthotics. Your doctor has this information.

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### Enrollment Form

Please fill out and mail this portion with your payment of \$65.00 USD  
Payable to: Northwest Podiatric Laboratory  
1091 Fir Avenue, Blaine, WA 98230

Patient’s Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Doctor’s Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Payment MUST accompany this form for coverage to begin.  
You will receive confirmation within three weeks.**