



# PET HEALTH CARE PLAN

## Treatment and Services Covered

**Marina Pet Hospital**  
2024 Lombard Street  
San Francisco, CA 94123  
415-921-0410  
www.marinapet.com

**Valley Veterinary Hospital**  
1780 Ygnacio Valley Road  
Walnut Creek, CA 94598  
925-932-2420  
www.valleyvethosp.com

**Danville Veterinary Hospital**  
812 Camino Ramon Road  
Danville, CA 94526  
925-837-4264  
www.danvillevett.com

### Vaccinations

Puppy/kitten vaccination series	FREE
*Rabies (annual)	FREE
*DHLPP (Dogs-annual)	FREE
*Bordetella (Dogs-annual)	FREE
*Corona (Dogs-annual)	FREE
*Parvo (Dogs-annual)	FREE
*Lyme (Dogs-annual)	FREE
*FVRCP (Cats-annual)	FREE
*FELV (Cats-annual)	FREE
*Fip (Cats-annual)	FREE

### Professional Services

Office visits	50% off
Follow-up exams	50% off
Dentistry	50% off
Radiology and Ultrasound	50% off
Hospitalization	50% off
Minor/Major Surgery	50% off
Laboratory	25% off
Medications & Injections	25% off
Treatment/Surgical Supplies	25% off
Prescription Medication (dispensed by hospital)	25% off

### Additional Services

Flea and medicated baths	10% off
Retail products sold at hospital	10% off
Prescription Rx Diets	5% off
Premium pet foods	5% off

### Exclusions

\*This plan covers only one full set of vaccines per membership premium.  
Boarding \* Emergency or veterinary care other than that at our facilities \* Cosmetic surgery \* Current illness or injury  
Emergency or veterinary care performed by non-staff members and facilities. Elective rattlesnake or giardia vaccines.

All accounts must be paid in full at time of service or discharge and a 50% deposit is required on all animals hospitalized. If you cannot pay your account at the time of service or discharge, you will not receive this discount.

**This plan covers treatment and services for your pet(s) described in this application for a period of one year, beginning seven (7) days after you execute this agreement.**

All enrollment premiums are non-refundable for any condition or reason. Prices and discounts are subject to change without notice.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ ZIP \_\_\_\_\_

Pet's Name	Breed	Colors	Sex	Weight	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

I hereby become a member of the Pet Health Care Plan and enroll my pet(s) described in this application, and I certify that all statements therein are true and correct. I hereby agree to pay the plan year coverage.

### Annual fee per pet:

1 Month through 11 years	\$209.00 = _____	Annual Renewal Fee Per Pet
12 years and older	\$425.00 = _____	All ages \$179.00 = _____

Applicant's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Applicant's representative: \_\_\_\_\_

Date: \_\_\_\_\_