MHCSI MANAGED HEALTH CARE SERVICES INC.
ENROLLMENT FORM FOR SUPPLEMENTARY PHARMACY BENEFIT

PLEASE PRINT CLEARLY ☐ NEW HIRE ☐ CHANGE

Family Name	First Name	Second/Other Names

Gender	Coverage	Date of Birth M | D |Y	Location (if applicable)
Male ☐ Female ☐	Family ☐ Single ☐		

IF COVERAGE IS "FAMILY" - LIST ALL YOUR DEPENDENTS BELOW:

SPOUSE COVERAGE

Last Name	First Name	Date of Birth M|D|Y	Age	Sex Code M or F	
		| |			

DEPENDENT COVERAGE

Last Name	First Name	Date of Birth M|D|Y	Age	Sex Code M or F	Relationship Code #
		| |			
		| |			
		| |			
		| |			

RELATIONSHIP CODES: 2 - CHILD UNDERAGE; 4 - DISABLED DEPENDENT; 9 - DEPENDENT STUDENT

ADDRESS INFORMATION

Address		
Address		
City		
Province	Postal Code	Phone #
Employer Name: IBEW Local 1928 N.S. Power		

Group Number (Assigned at MHCSI)	Effective Date (Assigned at MHCSI)	MHCSI Client/Family #: (Assigned at MHCSI)
69016		

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEFS THE ABOVE ANSWERS ARE FULL AND TRUE. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I understand that I am consenting to the collection, use and disclosure by the Benefits Manager/Claims Adjudicator (MHCSI) of personal information about me that is required to maintain an eligibility file, process payment of my health benefit claims within the parameters of my benefit plan design, and to provide benefits of the Lawton's Drugs Preferred Client Discount Program.

EMPLOYEE'S SIGNATURE _____ DATE SIGNED: _____

SPOUSE'S SIGNATURE _____ DATE SIGNED: _____
(IF APPLYING FOR THIS BENEFIT)