Return this signed form to MHCSI by email mhcsi.groupadmin@mhcsi.ca, fax 902-481-7114
or mail to 1-535 Portland Street, Dartmouth NS B2Y 4B1

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

PLEASE PRINT CLEARLY ☐ **NEW HIRE** ☐ **CHANGE**

First Name	Second/Other Names	Last Name

Gender	Coverage	Date of Birth	**Local Union Number**
Male ☐ Female ☐	Family ☐ Single ☐	M | D |Y	CUPE Local _____

Please answer the following questions:

1) Do you have a drug card?
Yes ☐ No ☐
2) Do you have a MHCSI Supplementary Pharmacy Benefit Card?
Yes ☐ No ☐

If yes, you are already participating in the MHCSI Supplementary Pharmacy Benefits program and you do not need to complete this enrollment form. Please continue using your current card.

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		
City		
Province	Postal Code	Phone #

Do you wish to receive emails pertaining to this benefit including services and exclusive offers which MHCSI believes will interest you?
☐ Yes, please provide email address _____
☐ No

Employer Name: **CUPE PEI**

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

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 I am consenting to the collection and use 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, to provide information about services and offers which MHCSI believes will interest me. I understand that my personal information may be disclosed by MHCSI to pharmacy providers or other health care professionals, such as prescribing physicians for the purpose of utilization review and safe and appropriate health management. I understand that the MHCSI Privacy Policy is available at any time for my review. I also hereby provide consent to the above on behalf of my dependents/children as listed above. I understand that I may withdraw my consent at any time by writing to mhcsi@mhcsi.ca and in doing so I am no longer able to submit payment for any health benefit claims to MHCSI.

Member's Signature _____ Date Signed: _____
Spouse's Signature _____ Date Signed: _____
(IF APPLYING FOR THIS BENEFIT)