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

MHCSI MANAGED HEALTH CARE SERVICES INC.
SUPPLEMENTARY PHARMACY BENEFIT ENROLMENT FORM - CEPACC

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

Family Name	First Name	Employee Number:

Gender	Coverage	Date of Birth	**INDICATE YOUR LOCATION**:
Male ☐ Female ☐	Family ☐ Single ☐	M | D |Y	☐ NL LOCAL 410 ☐ NS LOCAL 2289 ☐ NB LOCAL 506 ☐ PE LOCAL 401 ☐ RETIREE

Do you have a Lawtons Discount Card (used for discounts on front store purchases): ☐ Yes ☐ NO

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

SPOUSE COVERAGE

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

DEPENDENT COVERAGE

Last Name	First Name	Date of Birth M|D|Y	Age	Gender M or F	Relationship to member
		| |			
		| |			
		| |			
		| |			

RELATIONSHIP CODES: 1 - SPOUSE; 2 - CHILD UNDERAGE; 4 - DISABLED DEPENDENT; 9 - DEPENDENT STUDENT

ADDRESS INFORMATION

Address		
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

Group Name**: UNIFOR ACL**

Group Number (Assigned at MHCSI)	Effective Date	MHCSI Client/Family #: (Assigned at MHCSI)
69066		

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 SIGNATURE _____ DATE: _____

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