

**MHCSI SUPPLEMENTARY PHARMACY BENEFIT ENROLLMENT FORM
FOR
RETIRED ATLANTIC CANADA HEALTH CARE COALITION SOCIETY MEMBERS**

PLEASE PRINT CLEARLY

First Name	Middle Name	Last Name
Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth: Month Day Year
		Union Local NSGREA

Have you registered for Provincial Pharmacare? No Yes

Do you have coverage under another drug plan other than Provincial Pharmacare?

If yes, what plan is it? _____

YOUR SPOUSE MAY ALSO BE ELIGIBLE TO PARTICIPATE IN THIS PROGRAM.

Spouse First Name	Spouse Last Name	Date of Birth: Month Day Year	Male <input type="checkbox"/>
			Female <input type="checkbox"/>

Has your spouse registered for Provincial Pharmacare? No Yes

Do they have coverage under another drug plan other than Provincial Pharmacare?

If yes, what plan is it? _____

ADDRESS INFORMATION

Address		
Address		
City		
Province	Postal Code	Phone #
Retired ACHCCS Member 75016	Effective Date	MHCSI Client #: (Assigned at MHCSI)

I DECLARE THAT TO THE BEST OF MY KNOWLEDGE AND BELIEFS THE ABOVE ANSWERS ARE FULL AND TRUE. I UNDERSTAND THAT BY SIGNING BELOW, I AM CONSENTING TO THE COLLECTION AND USE BY MHCSI OF PERSONAL INFORMATION ABOUT ME THAT IS REQUIRED TO ADMINISTER THIS BENEFIT. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

MEMBER SIGNATURE _____ DATE: _____

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