Return the signed form to MHCSI at: 201 Brownlow Avenue, Unit 20, Dartmouth NS B3B 1W2
Phone 1-888-686-6427 Fax 1-902-481-7114

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

PLEASE PRINT CLEARLY

First Name	Second/Other Names (Optional)	Family Name

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

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

SPOUSE COVERAGE

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

DEPENDENT COVERAGE

First Name	Last 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 #
Group Name: **New Brunswick Union**		
Group Number (Assigned at MHCSI) **69187**	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 and that I am a member of NBU and eligible for this coverage. 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, to provide information about services and offers which MHCSI believes will interest me and to provide benefits of the Lawton's Drugs Preferred Client Discount Program.

Member's Signature ______________________________ Date Signed:______________________

Spouse's Signature ______________________________ Date Signed: ______________________
(IF APPLYING FOR THIS BENEFIT)