Return this signed form to MHCSI at: 201 Brownlow Ave, Unit 20, Dartmouth Nova Scotia B3B 1W2

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 ☐ Female ☐	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 ☐ Female ☐

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	Effective Date	MHCSI Client #: (Assigned at MHCSI)
75016		

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 (IF APPLYING FOR THIS BENEFIT) _____ DATE: _____

Phone 1-888-686-6427 Fax 1-902-481-7114