

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

PLEASE PRINT CLEARLY

NEW HIRE     CHANGE

Family Name		First Name	Second/Other Names	
Gender	Coverage	Date of Birth		Location (if applicable)
Male <input type="checkbox"/> Female <input type="checkbox"/>	Family <input type="checkbox"/> Single <input type="checkbox"/>	M   D   Y		

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

### SPOUSE COVERAGE

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

### DEPENDENT COVERAGE

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

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

### ADDRESS INFORMATION

Address		
Address		
City		
Province	Postal Code	Phone #

Employer Name CUPE GROUP BENEFIT TRUST

Group Number (Assigned at MHCSI) 12400	Effective Date (Assigned at MHCSI)	MHCSI Client/Family #: (Assigned at MHCSI)
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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 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.

EMPLOYEE'S SIGNATURE \_\_\_\_\_

DATE SIGNED: \_\_\_\_\_

SPOUSE'S SIGNATURE \_\_\_\_\_  
(IF APPLYING FOR THIS BENEFIT)

DATE SIGNED: \_\_\_\_\_