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

PLEASE PRINT CLEARLY		\square New Hire \square Change			
Family Name	First Name	Second/Other	Names		
		**			
Gender	Coverage	Date of Birth	Location (if applicable)		
 	₋	M D Y			
Male Female					
IF COVERAGE IS "FAMILY" - LI	Single L	tow.	akai dina 44. J		
IF COVERAGE IS FAMILY - LA	Dyna (1926), posta i fili i dan Naragi di Africa di Light y telepa di territori di mantino di la	E COVERAGE			
Last Name	First Name	Date of Birth	Age	Sex Code	
		M D Y		M or F	
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našas) suorik ir štoralogos os raketa vštoritorija Vigas tuo os Asio je krališkoji sištori kirilistiki ir kirilistika	DEPENDE	NT COVERAGE	Single Perlands S Light State of Figure		
Last Name	First Name	Date of Birth	Age	Sex Code	Relationship
		M D Y	· · · ·	M or F	Code #
		1 1			
RELATIONSHIP CODES: 2 - CHILD UN	vderage; 4 - Disabled Dependen	r; 9 - Dependent Student			i Mirodensini Waliofati
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	ADDRESS	Information			
Address					·
Address			***************************************		·········
City	V.V		 		
Province	Postal Code	I Pho	ne #		
	1 00001				
THE ACTION AND THE COLUMN COLU	CEXES ALTERIOR POST FOUR CONTRACTOR	na de la la la la compania de la co	jatowejska, kiej mis	for switch difficulties to	411405 (4145 hall harren)
Employer Name CUPE GROUP Group Number (Assigned at M	refragalist in discriptions of the contract of the contract of the filter	ioned at MEICST MEICST I	"lient/Ea	milw#+ (Assim	ned at MHCSI)
12400	inest, Enceive Date (Ass		JICHUE A	шшу л., (лоогді	
I DECLARE THAT TO THE BEST OF MY R	ZNOWI EDGE AND DELIEF THE ABOV	CANCELLE AND EDITION AND TRUE	A BLIOTOC	ODV OF THIS ALTER	ODIZATION
SHALL BE AS VALID AS THE ORIGINAL.	I understand that I am consenting	to the collection, use and disclo	sure by th	e Benefits Manag	ger/Claims
Adjudicator (MHCSI) of personal in claims within the parameters of my	nformation about me that is requir	ed to maintain an eligibility file, formation about services and offe	process p	ayment of my hea MHCSI believes	alth benefit will interest me
and to provide benefits of the Lawto	on's Drugs Preferred Client Discou	unt Program.	is Willow	WIIICOI 00110VC3	will intorost mo
EMPLOYEE'S SIGNATURE		DATE SICILIED			2
LAM LOTEE B ORMATORE		DATE DIQUED	*		
SPOUSE'S SIGNATURE		מארים פוריאוים			
(IF APPLYING FOR THIS BENEFIT)		DATE SIGNED	•		