Benefits with **added benefits**

ACHCCS
Atlantic Canada Health Care Coalition Society
Union Benefits Purchasing Power

Exciting Program News

As a member of **IBEW Local 37**, an **Atlantic Canada Health Care Coalition Society (ACHCCS)** participating group, you are eligible for the **MHCSI Preferred Supplementary Pharmacy Benefits Program.** We are pleased to offer this great savings opportunity and look forward to providing continued and enhanced value to participating members.

Start Saving

With your MHCSI drug program, you and your eligible dependents are entitled to coverage of up to **$3. 00*** per prescription processed through MHCSI's preferred provider network. Depending on your specific program type, this coverage is administered at the point of sale (i.e. on-line at the pharmacy) or back to your plan.

*dependent on achievement of annual market share targets , the coverage can be up to $5.00

You also enjoy great discounts on front store purchases at Lawtons Drugs with the Lawtons Client Group Partner Discount Card. With so many essential items to pick up at your local pharmacy, why not save* with Lawtons Drugs.

Plus you can earn valuable **Scene+ points** on your purchases.*

*Where allowed by law, some restrictions apply.

To enroll go to www.mhcsi.ca/enroll/ and enter the following:
Group Name: IBEW 37
Group Password: IBEW69115

MHCSI
Managed Health Care Services Inc.

Services administered and delivered by MHCSI.
For more information call 1-888-686-6427

Sobeys Pharmacy
FOODLAND PHARMACY
Lawtons DRUGS

Return this signed form to MHCSI by email mhcsi.groupadmin@mhcsi.ca, fax 902-481-7114
or mail to 1-535 Portland Street, Dartmouth NS B2Y 4B1

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 M | D |Y	Location (if applicable)
Male ☐ Female ☐	Family ☐ Single ☐		

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

SPOUSE COVERAGE

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

DEPENDENT COVERAGE

Last Name	First 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		
Address		
City		
Province	Postal Code	Phone #

Do you wish to receive emails pertaining to this benefit including services and exclusive offers which MHCSI believes will interest you?
☐ Yes, please provide email address _____
☐ No

Employer Name: IBEW Local 37

Group Number (Assigned at MHCSI)	Effective Date (Assigned at MHCSI)	MHCSI Client/Family #: (Assigned at MHCSI)
69115		

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 I am consenting to the collection and use by the Benefits Manager/Claims Adjudicator 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. I understand that my personal information may be disclosed by MHCSI to pharmacy providers or other health care professionals, such as prescribing physicians for the purpose of utilization review and safe and appropriate health management. I understand that the MHCSI Privacy Policy is available at any time for my review. I also hereby provide consent to the above on behalf of my dependents/children as listed above. I understand that I may withdraw my consent at any time by writing to mhcsi@mhcsi.ca and in doing so I am no longer able to submit payment for any health benefit claims to MHCSI.

Member's Signature _____ Date Signed: _____
Spouse's Signature _____ Date Signed: _____
(IF APPLYING FOR THIS BENEFIT)