

## DRUG CARD ENROLLMENT FORM

(For electronic processing of drug and dental claims)

*(Do not complete the shaded areas.)*

POLICY NO: \_\_\_\_\_ IDENTIFIER/BILLING DIVISION: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

### SECTION 1 - EMPLOYEE DETAILS

Last Name: \_\_\_\_\_ SIN: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial(s): \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year 19\_\_\_\_

### SECTION 2 - SPOUSE DETAILS

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial(s): \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year 19\_\_\_\_

Is spouse insured with another employer's plan? \*

FOR MEDICAL NO  YES  SINGLE OR FAMILY \_\_\_\_\_  
FOR DENTAL NO  YES  SINGLE OR FAMILY \_\_\_\_\_

\* **NOTE:** Canadian Life & Health Association regulations stipulate:

1. A spouse must claim from his/her employer's plan FIRST.
2. Insured children first claim from the plan insuring the spouse with the earlier date of birth in the year.

### SECTION 3 - DEPENDENT CHILDREN DETAILS

Last Name	First Name	Sex	Date of Birth	** D/S
			Day Month Year	
1.				
2.				
3.				
4.				

\*\* If child is age 21 or over, indicate D if permanently disabled, or S if a full-time student under age 25.

EMPLOYEE SIGNATURE: \_\_\_\_\_

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