PWI INSURANCE SERVICES (Agency) Ltd.
The Employee Benefit Specialists

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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 Day Month Year	** D/S
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:**