



**APPLICATION FOR NEW DRUG PLAN ACCOUNT**  
**(Subject to approved credit)**

Subscriber's full name: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Phone number: \_\_\_\_\_

List first name and BIRTH DATE of SUBSCRIBER and ALL FAMILY MEMBERS covered on the plan.  
Month / Day / Year

Subscriber: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

: \_\_\_\_\_

: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Number of years employed: \_\_\_\_\_

Work number: \_\_\_\_\_

Name of drug plan: \_\_\_\_\_ Deductible: \_\_\_\_\_

I.D. numbers: \_\_\_\_\_

Subscriber's S.I.N. number (Optional): \_\_\_\_\_

**Does your plan pay for Over The Counter Drugs?**

**Does your spouse have a drug plan?**

**Name of spouse's plan and I.D. numbers:** \_\_\_\_\_

Daytime contact number: \_\_\_\_\_ Email Address: \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING OFF MY ACCOUNT AS SOON AS I RECEIVE A CHEQUE FROM THE DRUG COMPANY ALONG WITH ANY REJECTED PRESCRIPTIONS OR DEDUCTIBLES THAT ARE DELETED FROM MY CLAIMS. I AGREE TO PAY INTEREST ON ANY OUTSTANDING BALANCE AT A RATE OF **1½%** PER MONTH. ON DEFAULT I AGREE THAT ALL LAWYER'S FEES AND/OR AGENTS COSTS OF RECOVERING THE DEBT ARE ALSO PAYABLE BY ME. I AGREE TO THE OBTAINING OF CREDIT AND/OR PERSONAL INFORMATION REQUIRED AT ANY TIME IN CONNECTION WITH THIS AGREEMENT AND TO THE DISCLOSURE OF ANY CREDIT INFORMATION TO ANY CREDIT REPORTING AGENCY. THE UNDERSIGNED HEREBY CONSENTS TO THE COLLECTION AND USE OF PERSONAL INFORMATION ABOUT ME IN ACCORDANCE WITH THE PERSONAL INFORMATION PROTECTION AND ELECTRONIC DOCUMENTS ACT ( PIPEDA).  
**IF MY ACCOUNT IS IN ARREARS, I AUTHORIZE YOU TO CHARGE MY CREDIT CARD.**

CARD: \_\_\_\_\_ ACCOUNT #: \_\_\_\_\_ EXPIRY DATE: \_\_\_\_\_

**SIGNED CLAIM FORMS MUST ACCOMPANY THIS APPLICATION**

**SUBSCRIBER'S SIGNATURE:** \_\_\_\_\_

**Internal Use only:**

**Store Location:** \_\_\_\_\_