vivanta

Bringing pharmacy +health benefits to life.

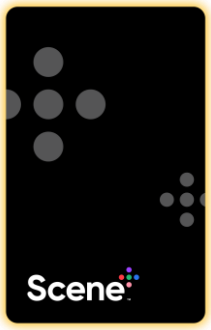
As a member of **NS Federation of Agriculture**, you are eligible for the **Vivanta Preferred Supplementary Pharmacy Benefits Program**. We are pleased to offer this great savings opportunity and look forward to providing continued and enhanced value to participating members.

Start Saving.

With your Vivanta drug program, you and your eligible dependents are entitled to coverage of up to **$2.00** per prescription processed through Vivanta's preferred network solution pharmacies.

Enjoy great savings* on most of your purchases at Lawtons Drugs with your partner discount card**

*some exclusions apply
**available to members in Atlantic Canada only



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

‡Where allowed by law, some restrictions apply.

Enroll & receive your exclusive offer at vivantahealth.ca/enroll:

GROUP NAME: **NSFA**
GROUP PASSWORD: **NSFA69142**

For more information call 1.888.686.6427

Vivanta preferred network solution pharmacies include:

360Health Pharmacy & Wellness | Sobeys Pharmacy | Pharmacy at Safeway | Thrifty Foods Pharmacy | Lawtons Drugs | FreshCo Pharmacy | Chalo! FreshCo Pharmacy | Foodland Pharmacy

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

ENROLLMENT FORM FOR VIVANTA/MHCSI SUPPLEMENTARY PHARMACY BENEFIT

PLEASE PRINT CLEARLY ☐ **NEW HIRE** ☐ **CHANGE**

Last Name	First Name	Middle Name

Sex at Birth	Coverage	Date of Birth (DD/MM/YYYY)	Location (if applicable)
Male ☐ Female ☐	Family ☐ Single ☐		

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

SPOUSE COVERAGE

First Name	Last Name	Date of Birth DD|MM|YYYY	Age	Sex at Birth	

DEPENDENT COVERAGE

First Name	Last Name	Date of Birth DD|MM|YYYY	Age	Sex at Birth	Relationship Code #

RELATIONSHIP CODES: 2 - CHILD UNDERAGE; 4 - DISABLED DEPENDENT; 9 - DEPENDENT STUDENT

ADDRESS INFORMATION

Address		
City		
Province	Postal Code	Phone #

Do you wish to receive emails pertaining to this benefit including services and exclusive offers which Vivanta/MHCSI believes will interest you?

☐ Yes, please provide email address _____

☐ No

Employer Name: **NS FEDERATION OF AGRICULTURE**

Group Number	Effective Date	MHCSI Client/Family #: (Assigned at Vivanta/MHCSI)
37523-001-002		

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 Vivanta/MHCSI believes will interest me. I understand that my personal information may be disclosed by Vivanta/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 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 admin@vivantahealth.ca and in doing so I am no longer able to submit payment for any health benefit claims to Vivanta/MHCSI.

Member's Signature _____ Date Signed: _____

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