PAY DIRECT PHARMACY CARD APPLICATION

PLAN HOLDER:

Company Name: _____

Address: _____

City, Province: _____   Postal Code: _____

Effective Date: _____
                     yyyy/mm/dd

ANNUAL MAXIMUM PRESCRIPTION DRUG CARD LIMIT:

(please check one) $500   ☐

                            $1,000   ☐

                            $2,000   ☐

            Other: _____   ☐

If you would like to customize your plan further, please contact our office

TYPE OF COVERAGE:

(please check one)   Family Unit   ☐

                            Individual   ☐

DRUG CARD REIMBURSEMENT:
(please enter reimbursement %)   _____ %

Notes: _____

We use Formulary A to distinguish allowable prescriptions. For details please contact Pacific Rim Administration Services Ltd.

* If you are a non-incorporated company, professional or sole proprietor, this limit will be part of your annual allowable limit established each year by the CRA (Canada Revenue Agency). If you require clarification, please contact our office.

I have been made aware of the above conditions and agree to them. I understand that coverage will be terminated if these conditions are not met. I also understand that there must be funds in my Private Health Services Plan at all times to cover these fees.

Authorized Signature: _____   Date: _____
                                                              yyyy/mm/dd