Pharmacy PARTNER
PREFERRED NETWORK

Enjoy exclusive pharmacy savings, support and more!

GROUP APPLICATION

SECTION 1 – COMPANY INFORMATION

Company Name Company Contact Person Telephone Number Email Address	

SECTION 2 – PLAN DESIGN SELECTED

EFFECTIVE DATE OF PROGRAM: ____

☐NEW GROUP
☐EXISTING GROUP

POLICY NUMBER(S): ____

☐ OPTION #1 – Member Savings – Copay Incentive at certain Pharmacy Partners

☐ OPTION #2 – Plan Savings – In/Out of Network Coinsurance

In Network Coinsurance Applies at all Pharmacy Partner pharmacies	
Out of Network Coinsurance Applies at all other pharmacies	

Pharmacy Partner: A pharmacy confirmed by Medavie Blue Cross to be part of the **Pharmacy Partner - Preferred Network** program. Due to legislative requirements this program is not available at pharmacies in the province of Quebec.

SECTION 3 – COMMUNICATION MATERIALS

The following **Communication Toolkit** materials are included in the program cost:

- ✓ Email & Newsletter Text for Members
- ✓ Member Video
- ✓ Poster for the workplace
- ✓ Frequently Asked Questions (FAQ)
- ✓ Pharmacy Partners Website - medavie.bluecross.ca/healthysavings
- ✓ Lawtons Member Reward Card - Mailed to Member's home address

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SECTION 4 – COMPANY SIGN OFF

(Company Name) hereby applies to MEDAVIE BLUE CROSS for the **Pharmacy Partners - Preferred Network** program described in this application. This application shall form part of our group contract with MEDAVIE BLUE CROSS, and our contract and member benefit booklets will be updated accordingly.

On behalf of the organization, I consent that the aggregate results of our program may be used to determine whether other products or services may benefit my organization or in the integration of data through group reporting. I acknowledge that the MEDAVIE BLUE CROSS team of professionals may be made aware of these results for the purposes of reviewing and analyzing the program. I understand that MEDAVIE BLUE CROSS will be providing the names and addresses of all eligible participants to MANAGED HEALTH CARE SERVICES INC. (MHCSI) in order for the **Lawtons Member Reward Card** to be mailed directly to eligible members.

We declare that all statements, representations and answers made in this application are consideration for and a basis of the contract between us and MEDAVIE BLUE CROSS. We declare these statements, representations and answers to be true, full and complete. We agree that no other statement, representation or information will be binding upon or affect the rights of MEDAVIE BLUE CROSS.

Signature of Authorized Officer:	
Name of Authorized Officer:	
Date:	