REGISTRATION FORM

To set up your account with *Sobeys Pharmacy by Mail*, we require the same type of information as you would provide your local pharmacy such as your name, contact information and drug plan and/or payment information. There is no fee to register and you are under no obligation to use *Sobeys Pharmacy by Mail*. Please complete the following:

SECTION 1 PERSONAL INFORMATION

Primary Member:

Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

Home Address:

Number	Street	Apt	City	Province	Postal Code

Primary Delivery Address (if different than above):

Number/PO Box/RR#	Street	Apt	City	Province	Postal Code

Alternate Delivery Address (optional):

Number/PO Box/RR#	Street	Apt	City	Province	Postal Code

Do you have any special delivery requirements? If Yes, please describe: ☐ Yes ☐ No

Telephone Numbers:

Home : ( ) _____ - _____
Office : ( ) _____ - _____
Cell : ( ) _____ - _____

E-mail address : _____

Would you like to be contacted by e-mail for:
Your prescription related information ☐ Yes ☐ No
Other health information and promotional offers? ☐ Yes ☐ No

Spousal or Partner Information

Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

Dependant Children's Information

Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender ☐ Male ☐ Female

Send completed form to: P.O. Box 25132 Moncton NB E1C 9M9 • Fax: 1-888-343-6060 • Email: info@SobeysPharmacybyMail.ca
For any questions please call 1-866-657-MEDS (6337)

Sobeys Pharmacy by Mail

SECTION 2 INSURANCE / PAYMENT INFORMATION

Drug Plan Information

For any questions please call 1-866-657-6337

Do you and/or your family have coverage under a drug plan? ☐ Yes ☐ No

If "Yes", please provide the following:

Name of Employer/Group/or Plan providing coverage:	Name of Insurer (e.g. Medavie Blue Cross, Manulife, Sunlife, MSI, MHCSI, NBPDP, ODB, etc.):

If you have a "pay-direct" drug benefit card please provide the following information (as found on your drug card, or where applicable, provincial health card)

Group Number:	ID Number :	Carrier ID Number:

Do you and/or your family have coverage under another or secondary drug plan (such as a spouses' plan, or Workers Compensation, etc.)? ☐ Yes ☐ No

If "Yes", please provide the following :

Name of Employer /Group/ or Plan providing coverage:	Name of Insurer (e.g. Medavie Blue Cross, Manulife, Sunlife, MSI, MHCSI, NBPDP, ODB, etc.):

If your secondary plan has a "pay-direct" drug benefit card please provide the following information (as found on your drug card, or where applicable, provincial health card)

Group Number:	ID Number:	Carrier ID Number:

Credit Card Information

Sobeys Pharmacy by Mail requires credit card information to process any prescription costs that you are required to pay out-of-pocket (such as deductibles or co-pays) as well as for any additional non-prescription purchases you wish to make at *Sobeys Pharmacy by Mail*. Please complete below or have card information ready when *Sobeys Pharmacy by Mail* calls to verify your registration information.

Credit Card: ☐ Visa ☐ Mastercard ☐ American Express ☐ Diners Card

Credit Card Number	Expiry date

SECTION 3 CONSENT

Sobeys Pharmacy by Mail is committed to protecting the privacy of our customers information. All information provided on this form will be kept strictly confidential. Information is not released or shared without your consent.

I _____ PRINT NAME _____ agree that *Sobeys Pharmacy by Mail* may collect, use and disclose information about me as described in the brochure "Protecting You Personal Health Information – A Message from Your Pharmacists" (also available on our website) in order to provide me with pharmacy services in accordance with laws and regulations governing the practice of pharmacy.

☐ By checking here you are giving consent to be contacted by *Sobeys Pharmacy by Mail* to verify and complete your registration, and provide pharmacy and related services to you as described above.

Date: _____ Signature: _____

This section is for pharmacy use only

Consent recorded on Patient(s) file : ☐

CDP: _____
Store #: _____
By: _____

Send completed form to: P.O. Box 25132 Moncton NB E1C 9M9 • Fax: 1-888-343-6060 • Email: info@SobeysPharmacybyMail.ca
For any questions please call 1-866-657-MEDS (6337)