

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 <input type="checkbox"/> Male <input type="checkbox"/> Female
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Home Address:

Number	Street	Apt	City	Province	Postal Code
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Primary Delivery Address (if different than above):

Number/PO Box/RR#	Street	Apt	City	Province	Postal Code
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Alternate Delivery Address (optional):

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

AIR MILES®

Please provide your collector number as found on your AIR MILES® card:	Card Number	To become an AIR MILES® collector please visit www.airmiles.ca
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Spousal or Partner Information

Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Dependant Children's Information

Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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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)

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.):
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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:
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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.):
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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:
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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
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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

CDP: _____
Store #: _____
By: _____

Consent recorded on Patient(s) file :

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