

Easy and Convenient Healthcare



FOR JUST
\$10.95
 PER MONTH
 + HST

Join Now and Start Your Health Journey

Joining Genrus Health is simple. After signing up, you'll receive a membership card by email and access to our services within two weeks.

Our Care Managers will listen to your needs and connect you with the right practitioner. Plus, enjoy the benefits of Genrus United prescription savings. Skip the long waits at clinics and get started with Genrus Health today.

Peace of Mind Anytime, Anywhere

Healthcare at Your Fingertips

Life happens, and with Genrus Health, you can have peace of mind knowing that medical advice is always available. Connect with healthcare professionals from your computer or phone, and get the care you need anytime, anywhere. With wait times of less than 15 minutes, it's like having a doctor's office in your pocket.

Genrus Health covers a wide range of healthcare needs. Our services include managing chronic diseases, renewing prescriptions, coordinating specialist appointments, and providing mental health care. Whether you're dealing with migraines, sexual health issues, or need a lab requisition, we've got you covered.

Quick and Easy Healthcare Access

✓ Always Available

Genrus Health connects you with a physician or nurse practitioner 24/7. If you don't have a family doctor or need an alternative to emergency rooms and walk-in clinics, Genrus Health is here for you!

✓ Comprehensive Telehealth Services

During your telehealth appointment, you will be assessed, diagnosed, prescribed meds or refills, and referred to specialists or other services as needed.

✓ Fast and Convenient

Enjoy average wait times of less than 15 minutes for telehealth services, all from the comfort of your home. A helpful Care Manager will connect you with a doctor or nurse practitioner.

✓ Reliable Support

Life happens, and Genrus Health provides peace of mind by offering medical advice whenever you need it. Access care anytime, anywhere from your computer or phone.

Easy Steps to Access Genrus Health

- STEP 01** **Membership Card**
 When you join, you'll receive a membership card via email.
- STEP 02** **Account Confirmation**
 Within two weeks, you'll get a second email confirming that your account is ready to use.
- STEP 03** **Login Instructions**
 The second email will include instructions on how to log in and access Genrus Health services.
- STEP 04** **24/7 Availability**
 Genrus Health is available 24/7 on your computer, tablet, or phone. Anywhere, anytime.
- STEP 05** **Personalized Support**
 A Care Manager will listen to your needs and connect you with the right health practitioner.

BONUS

Save \$6 on every RX

Genrus Health makes it easy and affordable to manage your medications with free delivery.

Benefits with added benefits

Exciting Program News

As a member of the **Restaurant Association of Nova Scotia**, you are eligible for the **MHCSI 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 **MHCSI drug program**, you and your eligible dependents are entitled to coverage of up to **\$2.00** per prescription processed through MHCSI's preferred provider network.



You also enjoy great discounts on front store purchases at Lawtons Drugs with the Lawtons Client Group Partner Discount Card. With so many essential items to pick up at your local pharmacy, why not save with Lawtons Drugs.



Plus you can earn valuable **Scene+ points** on your purchases.[‡]
[‡]Where allowed by law, some restrictions apply.

To enroll go to mhcsi.ca/enroll and enter the following:

GROUP NAME: RANS

GROUP PASSWORD: RANS69080



Services administered and delivered by MHCSI. For more information call 1.888.686.6427

MHCSI Preferred Provider Network (PPN) Pharmacies include:



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

MHCSI MANAGED HEALTH CARE SERVICES INC. ENROLLMENT FORM FOR SUPPLEMENTARY PHARMACY BENEFIT

PLEASE PRINT CLEARLY

NEW HIRE CHANGE

First Name	Family Name	Second/Other Names	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Coverage Family <input type="checkbox"/> Single <input type="checkbox"/>	Date of Birth D M Y	Location (if applicable)

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

SPOUSE COVERAGE

First Name	Last Name	Date of Birth D M Y	Age	Sex Code M or F	

DEPENDENT COVERAGE

First Name	Last Name	Date of Birth D M Y	Age	Sex Code M or F	Relationship Code #

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

ADDRESS INFORMATION

Address		
Address		
City		
Province	Postal Code	Phone #

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

- Yes, please provide email address _____
 No

Employer Name: **RESTAURANT ASSOCIATION OF N.S.**

Group Number (Assigned at MHCSI) 37478-001-002	Effective Date (Assigned at MHCSI)	MHCSI Client/Family #: (Assigned at MHCSI)
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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 MHCSI believes will interest me. I understand that my personal information may be disclosed by 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 MHCSI 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 mhcsi@mhcsi.ca and in doing so I am no longer able to submit payment for any health benefit claims to MHCSI.

Member's Signature _____

Date Signed: _____

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

Date Signed: _____