The New Brunswick drug plan

New Brunswick Drug Plan Application Form

New Brunswick Drug Plan
PO Box 690
Moncton, NB E1C 8M7

Telephone: 506-867-4515 or 1-800-332-3692
Fax: 506-867-4872 or 1-888-455-8322
Email: info@nbdrugs-medicamentsnb.ca
Website: www.gnb.ca/drugplan

How to complete this form

Prior to applying, review the premiums and copayments at www.gnb.ca/drugplan and check that the drug for which you need coverage is listed in the New Brunswick Drug Plan Formulary at www.gnb.ca/drugplansformulary.

1. **Only one application form per family is necessary**. Ensure you (and your spouse, if applicable) sign sections 4, 5 and 6. Any dependant over the age of 16 (if applicable) must sign section 6.
2. If you are applying for coverage and have another drug plan, you must complete the **Supporting Application Form Other Drug Coverage** and send it with your completed application form. The Supporting Application Form Other Drug Coverage is online at www.gnb.ca/drugplan.
3. Mail or fax your completed and signed application. Once your application is processed, you will receive notification of your acceptance in the New Brunswick Drug Plan, your premium and copayment details and the effective date of your coverage.

SECTION 1 - Applicant Information (required)

First Name: _____ Last Name: _____

Address: _____

City/Town/Village: _____ Province: ____ Postal Code: | | | | | |

Telephone: | | | - | | | | - | | | | Language Preference: ☐ English ☐ French

Email: _____

Medicare Number: | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | | |
D D M M Y Y Y Y

Marital Status: ☐ Single, Widowed or Separated ☐ Married or Common-law Gender: ☐ M ☐ F ☐ X

Are you currently enrolled in another drug plan that covers any of your drugs? This includes drug plans through an employer, spouse, parent/guardian, federal or provincial government. ☐ Yes ☐ No

If you are enrolled in another drug plan, is your coverage ending?

☐ Yes When is your coverage ending? | | | | | | | | | |
D D M M Y Y Y Y

☐ No If you have coverage from another drug plan that is not ending, please complete the Supporting Application Form Other Drug Coverage and send it with your completed application form.

SECTION 2 - Spouse Information (if applicable)

Your spouse's information is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.

First Name: _____ Last Name: _____

Medicare Number: | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | | |
D D M M Y Y Y Y

Is your spouse applying for coverage as well? ☐ Yes ☐ No

Is your spouse currently enrolled in another drug plan that covers any of their drugs? ☐ Yes ☐ No

If your spouse is enrolled in another drug plan, is their coverage ending?

☐ Yes When is the coverage ending? | | | | | | | | | |
D D M M Y Y Y Y

☐ No If your spouse has coverage from another drug plan that is not ending and they are applying for coverage, please complete the Supporting Application Form Other Drug Coverage for your spouse and send it with your completed application form.

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SECTION 3 – Dependant Information (if applicable)

Please list all dependants. If more space is required, please attach a separate sheet. Children 18 and younger do not pay premiums but a parent /guardian must be enrolled in the plan.

Dependants are defined as:

- all dependent children under the age of 19
- all dependants age 19 or older who are eligible for a Disability Tax Credit under the federal Income Tax Act, **AND** were eligible for the tax credit as a minor, **AND** reside with the applicant

First Name	Last Name	Date of Birth (DD/MM/YYYY)	Medicare Number	Disabled (as per the definition above)	Does your dependant require coverage?	Is your dependant currently covered under a drug plan?
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If your dependant(s) is enrolled in another drug plan, is their coverage ending?

☐ Yes When is the coverage ending? D D M M Y Y Y Y

☐ No If your dependant has coverage from another drug plan that is not ending and they require coverage, you must send a completed Supporting Application Form Other Drug Coverage for your dependant with your completed application form.

SECTION 4 – Consent to Release Income Tax Information (required)

Your annual premium and maximum copayment will be calculated based on your annual family income, as indicated on your Canada Revenue Agency (CRA) tax return for the most recent tax year.

Please choose one of the following options:

☐ I/we do **not** consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year. **I/we will be charged the maximum annual premium and the maximum copayment per prescription**.

☐ I/we hereby consent to the release, by the Canada Revenue Agency to an official of the ***New Brunswick Department of Health's Delivery Agent***, of information from my/our income tax returns, and, if applicable, other required taxpayer information about me/us, whether supplied by me/us or by a third party. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility for benefits, required premiums and copayments under the New Brunswick Drug Plan, and will not be disclosed to any other person or organization without my approval. I/we understand that, if I/we wish to withdraw this authorization, I/we may do so at any time by writing to the New Brunswick Drug Plan. This authorization is valid for the current taxation year and each subsequent consecutive taxation year for which benefits under the New Brunswick Drug Plan may be requested and determined.

Applicant Social Insurance Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Applicant

Spouse Social Insurance Number (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Spouse (if applicable)

Your spouse's consent is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.

SECTION 5 – Payment Information (required)

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I/We, the undersigned, authorize the New Brunswick Drug Plan, and the financial institution designated (or any other financial institution I/we may authorize) to begin deductions as per my/our instructions for recurring payments, for payment of insurance premiums and any other related charges, each of which are incurred for personal purposes. Regular monthly payments for the full amount owing will be debited from the specified account (or any other designated account) on the first business day of every month. I/We agree to promptly notify the New Brunswick Drug Plan, in writing at the address above, of any changes to the bank account information provided. I/We acknowledge that this PAD Agreement shall remain in full force and effect with the updated bank account details. I/We confirm authority under the terms of the bank account agreement with my/our financial institution to authorize the debits under this PAD Agreement and that all persons whose signatures are required to sign on the bank account have signed or otherwise authorized this PAD Agreement.

The New Brunswick Drug Plan will obtain my/our authorization for any sporadic debits. Medavie Blue Cross is a third party administering the PAD Agreement for amounts owing by me/us under the New Brunswick Drug Plan.

This authority is to remain in effect until the New Brunswick Drug Plan has received written notification from me/us of its change or termination. This notification must be sent to the New Brunswick Drug Plan and received at least ten (10) calendar days before the next debit is scheduled.

I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca. I/We understand that this PAD Agreement applies only to the method of payment for my/our insurance premiums and related charges, and its revocation does not terminate, cancel, reduce, or otherwise affect my/our obligations to the New Brunswick Drug Plan. I/We acknowledge that I/we will have to make alternate payment arrangements acceptable to the New Brunswick Drug Plan if I/we revoke authorization for PAD but continue to have amounts owing to the New Brunswick Drug Plan. The New Brunswick Drug Plan may also cancel this PAD Agreement on not less than 5 calendar days' notice to me/us in accordance with the Rules of Payments Canada.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca.

I/We waive the right to receive pre-notification of the amount of any PAD and agree that I/we do not require advance notice of the amount of the PADs before the debit is processed. I/We also agree that a confirmation will be provided to me/us within 5 calendar days after the first PAD.

BANKING INFORMATION: Only complete the one that applies.

1. Applicant or spouse will be paying the premiums

Please **include a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below.

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Bank Account Holder

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Other Bank Account Holder (if joint bank account)

2. Someone other than the applicant or their spouse will be paying the premiums

Please **include a void cheque or a direct deposit/pre-authorization payment form from their financial institution**, review the PAD Agreement terms above, and complete the information below to acknowledge their acceptance of those terms.

By providing a void cheque or a direct deposit/pre-authorization payment form, completing and signing below, the undersigned agrees to the PAD Agreement terms and conditions.

First Name: _____ Last Name: _____

Address: _____

City/Town/Village: _____ Province: ____ Postal Code: _____

Telephone: ___-___-____

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Bank Account Holder

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Other Bank Account Holder (if joint bank account)

SECTION 6 – Personal Declaration and Authorization (required)

By signing this application form, I confirm that:

I am applying to become a member of the New Brunswick Drug Plan, and I am providing information on this form for this purpose.

I understand that I can withdraw my application and cancel my membership at any time.

The information provided on this form is true to the best of my knowledge. I understand that knowingly providing false or incomplete information is an offence.

I authorize the New Brunswick Drug Plan to collect my information from Medicare and other sources to verify the information on this form and to verify eligibility for the New Brunswick Drug Plan.

I agree to notify the New Brunswick Drug Plan immediately of any changes that may affect my coverage.

I understand that the personal information I provide, as well as any other personal information currently held or collected in the future, may be collected, used or disclosed to administer the New Brunswick Drug Plan.

I authorize the New Brunswick Drug Plan to collect, use and disclose my personal information as described above for as long as I remain a member of the New Brunswick Drug Plan.

I understand that I can revoke my consent at any time. In some instances, revoking my consent may prevent the New Brunswick Drug Plan from providing me with the requested coverage or benefits.

I understand that I must pay my premiums each month in order to receive benefits, and that if I do not pay my premiums in full, benefits will not be provided and my coverage will be suspended or cancelled.

I understand that failure to pay premiums does not mean that I have cancelled my New Brunswick Drug Plan coverage and that I must contact the administrator in order to do so. I understand that action will be taken to collect any outstanding premiums owed.

Your signature along with the signatures of your spouse and all listed dependants over the age of 16 are required even if they are not applying for coverage. If you are signing on behalf of the applicant, attach a copy of the Power of Attorney.

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Applicant

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Spouse

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Dependant*

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Dependant*

*A parent/guardian can only sign on behalf of a dependant if:

- The dependant is between the ages of 16 and 18 (inclusive) and does not have the capacity to sign the personal declaration and authorization; or
- The dependant is 19 years of age or older and does not have the capacity to sign the personal declaration and authorization, or has given legal authority for another person to act on their behalf. Please attach a copy of the Power of Attorney.

This information is collected under the authority of the *Prescription and Catastrophic Drug Insurance Act,* SNB 2014, c 4, s 12 and s 13. This information will be used and disclosed to administer the New Brunswick Drug Plan. It may be used and disclosed in accordance with the *Personal Health Information Privacy and Access Act*, SNB 2009, c P-7.05. More information regarding the collection and use of personal information is available online at www.gnb.ca/healthprivacy.