The New Brunswick drug plan

Application for Coverage

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

Toll-Free Number: 1-855-540-7325
Fax: **1-888-455-8322**
Website: **gnb.ca/drugplan**

Prior to applying, please contact the New Brunswick Drug Plan Inquiry Line at 1-855-540-7325 to confirm that the drug you would like covered is included in the New Brunswick Drug Plan Formulary.

How to complete this form

1. **All sections must be completed.** Please print clearly. Ensure you (and your spouse if applicable) sign sections 3, 4 and 5. Any dependant (if applicable) over the age of 16 must sign section 5.
2. **Only one application form per family is necessary.** If you have a spouse and/or dependant(s), they do not need to complete a separate application.
3. If you are applying for coverage and have an existing drug plan, you must complete the **Existing Drug Coverage form** and send it along with your completed application form. The Existing Drug Coverage form is available on the New Brunswick Drug Plan website.
4. Mail or fax your completed and signed application to the address/fax number above.
5. Once your application is processed, you will receive notification of your acceptance in the New Brunswick Drug Plan with your premium and copayment details and the effective date of your coverage.

SECTION 1 - Personal information *(required)*

APPLICANT:

First name: ______________________ Last name: ______________________

Medicare number: ______________________ Date of birth: ______________________ DD/MM/YYYY

Gender: ❑ male ❑ female

Marital status: ❑ single ❑ married ❑ common-law ❑ separated ❑ divorced ❑ widowed

Mailing address: ______________________

City/town: ______________________ Province: ______________________ Postal code: ___ ___

Telephone: ______________________ Alternate *(e.g. mobile)*: ______________________

Are you currently covered under a drug plan? ❑ yes ❑ no When is your coverage ending? ______________ DD/MM/YYYY

If you have coverage from another drug plan that is not ending, please complete the Existing Drug Coverage form and send it with your completed application form.

SPOUSE: *(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: ______________________ DD/MM/YYYY

Gender: ❑ male ❑ female

Is your spouse applying for coverage as well? ❑ yes ❑ no

Is your spouse currently covered under a drug plan? ❑ yes ❑ no When is the coverage ending? ______________ DD/MM/YYYY

If your spouse has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your spouse along with your completed application form.

FORM-759E 05/18

SECTION 2 - Dependant information *(if applicable)*

Please list all eligible dependants. If more space is required, please attach a separate sheet.

Eligible 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	Gender	Disabled (as per the definition above)	*Is your dependant applying for coverage?	*Is your dependant currently covered under a drug plan?
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no

* *If your dependant has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your dependant along with your completed application form.*

SECTION 3 - 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 consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year. I/we hereby consent to the release, by the Canada Revenue Agency to an official of the **New Brunswick Department of Health** and/or its **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 entitlement for subsidy under the **New Brunswick Drug Plan**, and will not be disclosed to any other person or organization without my/our 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: ___ ___ ___ Spouse Social Insurance Number: ___ ___ ___

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

Name of Applicant: ____________________

X Sign here - Applicant: [ ] Date signed: ________ 20 ____
DD/MM YY

Name of Spouse: ____________________

X Sign here - Spouse: [ ] Date signed: ________ 20 ____
DD/MM YY

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 4 - Payment information *(required)*

Your monthly premiums will be automatically deducted from your bank account each month. Please complete the Pre-authorized Debit (PAD) plan agreement below.

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I authorize the New Brunswick Drug Plan, and the financial institution designated (or any other financial institution I may authorize at any time) to begin deductions as per my instructions for recurring payments and/or one-time payments, from time to time, for payment of insurance premiums. Regular monthly payments will be debited to my specified account on the first business day of every month. The New Brunswick Drug Plan will not provide pre-notification but will provide a premium statement indicating the amount of each regular debit. The New Brunswick Drug Plan will obtain my authorization for any other one-time or sporadic debits. The New Brunswick Drug Plan requires written notification of any changes to banking information.

This authority is to remain in effect until the New Brunswick Drug Plan has received written notification from me of its change or termination. This notification must be received at least ten (10) business days before the next debit is scheduled. This notification must be sent to the New Brunswick Drug Plan. I may obtain a sample cancellation form or more information on my right to cancel a PAD Agreement at my financial institution or by visiting **www.payments.ca**.

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

BANKING INFORMATION: Tick the box that applies.

1. ☐ Applicant or spouse will be paying the premiums.

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

   X Sign here -
   Bank account holder: ____________________ Date signed: __________ 20 ____
   DD/MM YY

2. ☐ Someone other than the applicant or their spouse will be paying the premiums. Please have them **attach a void cheque or a direct deposit/pre-authorization payment form from their financial institution** and complete the information below:

   First name: ____________________ Last name: ____________________

   Mailing address: ____________________

   City/town: ____________________ Province: ____________________ Postal code: ___ ___

   Telephone: ____________________ Alternate *(e.g. mobile)*: ____________________

   X Sign here -
   Bank account holder: ____________________ Date signed: __________ 20 ____
   DD/MM YY

SECTION 5 - Personal declaration, authorization and obligations *(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.

The signatures of your spouse and all listed dependants over the age of 16 are required even if they are not applying for coverage.

Name of Applicant: ______________________

X Sign here - Applicant: [ ] Date signed: ________ 20 ____
DD/MM YY

Name of Spouse: ______________________

X Sign here - Spouse: [ ] Date signed: ________ 20 ____
DD/MM YY

*Name of Dependant (16 or older): ______________________

X Sign here - Dependant: [ ] Date signed: ________ 20 ____
DD/MM YY

*Name of Dependant (16 or older): ______________________

X Sign here - Dependant: [ ] Date signed: ________ 20 ____
DD/MM YY

***A parent/guardian can sign on behalf of the 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 for personal care.

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. For more information regarding collection and use of personal information, visit www.gnb.ca/healthprivacy, or contact the New Brunswick Drug Plan at the address or telephone number shown on page 1 of this application.