The New Brunswick drug plan

Change in Circumstance
Personal and Payment Information

How to complete this form

1. Section 1 and 4 are required.
2. Complete section 2 and 3 only if changes are required.
3. If you want to cancel your membership or change your address or contact information, please contact us by calling the number below.

How to reach us

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**

1 Current Information for Primary Cardholder *(required)*

Last name: _____ First name: _____ Initial: _____

Plan identification number: _____ Date of birth: DD ____ / MM ____ / YYYY _____

2 Personal Information Change

Name Change for:

◯ Primary cardholder ◯ Spouse ◯ Dependant

From:
Last name: _____ First name: _____ Initial: _____

To:
Last name: _____ First name: _____ Initial: _____

Medicare Number Change for:

◯ Primary cardholder

◯ Spouse or Dependant: Last name: _____ First name: _____ Initial: ____

Date of birth: DD ____ / MM ____ / YYYY _____

New Medicare number: _____

3 Payment Information Change

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

Effective Date of Change: DD____ / MM ____ / YYYY_____

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I authorize an official or representative or agent of the Department of Health (DH) or 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 for the full amount of services delivered will be debited to my specified account on the first business day of every month. An official or representative or agent of the DH or the New Brunswick Drug Plan will not provide pre-notification but will provide a premium statement indicating the amount of each regular debit. An official or representative or agent of the DH or the New Brunswick Drug Plan will obtain my authorization for any other one-time or sporadic debits. An official or representative or agent of the DH or the New Brunswick Drug Plan requires written notification of any changes to banking information.

This authority is to remain in effect until an official or representative or agent of the DH or 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: please attach **a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below.

Signature of bank account holder:_____ Date of signature: DD ____/ MM ____/ YYYY_____

If someone other than the primary cardholder 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:

Last name: _____ First name: _____ Initial:_____

Building number and street:_____ Apt.:_____

City/town: _____ Province: _____ Postal code:_____

Phone number: _____ Alternate (*e.g. mobile*):_____

Signature of bank account holder:_____ Date of signature: DD____/ MM____/ YYYY_____

4 Personal Declaration of Primary Cardholder *(required)*

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.

Name of primary cardholder: _____

Signature of primary cardholder:_____ Date of signature: DD____/ MM____/ YYYY_____

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.