The New Brunswick drug plan

Change in Circumstance
Spouse and Dependants

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: 1-800-332-3692
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 Spouse

Current marital status of primary cardholder:
☐ single ☐ married ☐ common-law ☐ separated ☐ divorced ☐ widowed

Effective date: _____

Spouse's Information **Change requested:** ○ addition ○ removal

Last name: _____ First name: _____ Initial: _____

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

Gender: ☐ M ☐ F ☐ X

If adding a spouse, complete the following:
Is your spouse applying for coverage as well? ☐ yes ☐ no
Is your spouse currently covered under a drug plan? ☐ yes ☐ no

If "yes" to both questions, you must send a completed Supporting Application Form Other Drug Coverage available at www.gnb.ca/drugplan.

Consent to release income tax information

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

Your spouse's consent is required even if your spouse is not applying for coverage.

☐ I consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year.

Social Insurance Number: _____

I 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 income tax returns, and, if applicable, other required taxpayer information about me, whether supplied by me 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 understand that, if I wish to withdraw this authorization, I 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.

☐ 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 Spouse: _____

Signature of Spouse: _____ Date of signature: DD ____ / MM ____ / YYYY _____

FORM-970E 04/24

2 Spouse (cont.)

Personal declaration, authorization and obligations

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 the premiums must be paid each month in order to receive benefits and that if they are not paid in full by the primary cardholder or myself, benefits will not be provided and 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.

Name of Spouse: _____

Signature of Spouse: _____ Date of signature: DD ___/ MM ___/ YYYY _____

3 Eligible Dependant

(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 primary cardholder.

	Last Name	First Name	Initial	Medicare Number	Date of Birth	Gender	Disabled?	Change Requested
1.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal
2.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal
3.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal
4.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal
5.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal
6.						☐ M ☐ F ☐ X	☐ Yes ☐ No	☐ addition ☐ removal

List Dependant(s) in the same order as above

	Is your dependant applying for coverage?	Is your dependant currently covered under a drug plan?
1.	☐ Yes ☐ No	☐ Yes ☐ No
2.	☐ Yes ☐ No	☐ Yes ☐ No
3.	☐ Yes ☐ No	☐ Yes ☐ No
4.	☐ Yes ☐ No	☐ Yes ☐ No
5.	☐ Yes ☐ No	☐ Yes ☐ No
6.	☐ Yes ☐ No	☐ Yes ☐ No

If "yes" to both questions, you must send a completed Supporting Application Form Other Drug Coverage available at www.gnb.ca/drugplan.

3 Eligible Dependant (cont.)

(if more space is required, please attach a separate sheet)

Dependants who are 16 years old or older must complete the following:

By signing this form, I confirm that:

I consent to sharing personal health information with the New Brunswick Drug Plan, and 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.

	Signature of Dependant	Date of Signature		
		DD	MM	YYYY
1.				
2.				
3.				
4.				
5.				
6.				

The name and signature of a parent/guardian is required 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. If you do not have Power of Attorney, please contact the New Brunswick Drug Plan.

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*.