The New Brunswick drug plan

Information Changes
Personal, Income or Payment

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

Toll Free: 1-800-332-3692
Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322
Website: www.gnb.ca/drugplan

How to complete this form

1. Sections 1 and 5 must be completed.
2. Only complete sections 2, 3, and/or 4 if changes are required.
3. To cancel your membership or change your address or contact information, mail/fax your changes to the address/fax number above or call the New Brunswick Drug Plan Inquiry Line at 1-800-332-3692.

SECTION 1 - Information for Primary Cardholder (required)

First Name: _____ Last Name: _____

Plan Identification Number: _____ Date of Birth: D D M M Y Y Y Y

SECTION 2 - Personal Information Change

Name Change for: ☐ Primary cardholder ☐ Spouse ☐ Dependant

From: First Name: _____ Last Name: _____

To: First Name: _____ Last Name: _____

Medicare Number Change for:

☐ Primary cardholder New Medicare Number: _____

☐ Spouse or Dependant

First Name: _____ Last Name: _____

Date of Birth: D D M M Y Y Y Y New Medicare Number: _____

SECTION 3 – Consent to Release Income Tax Information Change

☐ 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 co-payments 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.

Primary cardholder Social Insurance Number: _____

Spouse Social Insurance Number: _____

☐ 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.

Primary cardholder signature: _____ Date signed: D D M M Y Y Y Y

Spouse signature: _____ Date signed: D D M M Y Y Y Y

SECTION 4 - Payment Information Change

Please complete the Pre-authorized Debit (PAD) plan agreement below.

Effective Date of Change: D D M M Y Y Y Y

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: please attach 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)

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** 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 5 - 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.

Signature of primary cardholder: _____ Date signed: D D M M Y Y Y Y

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.