

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

Please note that there is no coordination of benefits with the New Brunswick Drug Plan.

i **Personal information (required)**

* Please note: A separate Existing Drug Coverage Form is only required for applicants who have an existing drug plan. A completed form is required for each family member applying for the New Brunswick Drug Plan.

Last name: _____ First name: _____ Initial: _____

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

i **Which of the following applies to your application?**

I've reached my maximum for drug coverage under my existing plan.

Date maximum was reached: DD ____ / MM ____ / YY _____

Plan renewal date: DD ____ / MM ____ / YY _____

Please note: A letter from your insurer that confirms your maximum has been met, must accompany this application.

I've been prescribed specific drug(s) that are not covered under my existing plan.

Please note: A letter from your insurer confirming that your specific drug(s) is not covered must accompany this application. The New Brunswick Drug Plan will only consider drugs that are not included in your existing drug coverage, and are included in the New Brunswick Drug Plan formulary. The New Brunswick Drug Plan will only cover the drugs listed on this form if they are approved.

If another drug is required at a later date, you will have to submit another Existing Drug Coverage form.

Please complete for each drug not covered under your existing plan:

Drug Name	Strength	Drug Identification Number (DIN) (if available)

