# Guaranteed Income Supplement Confirmation Form

**Prescription Drug Program**
P.O. Box 690
Moncton NB
E1C 8M7

Telephone: 506-867-4515
Toll Free: 1-800-332-3692
Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322

## How to complete this form

1. If you are receiving the Guaranteed Income Supplement (GIS), please complete all sections. Please print clearly. **Incomplete information may delay processing.** If you have any questions, please call us at the number above.
2. Mail or fax your completed and signed form along with the required documentation that confirms you are receiving the GIS (see below for details) to the address/fax number above.
3. Once this form is processed, you will receive a letter confirming if you qualify. The copayment for this plan is $9.05 per prescription, to a maximum of $500.00 annually.

## Who is eligible to apply

- New Brunswick residents with a valid Medicare card, who are 65 years old or older, and who receive the federal Guaranteed Income Supplement are eligible for the New Brunswick Prescription Drug Program (NBPDP).

## Section 1 - Personal information *(required)*

Name of Applicant: _____ Date of Birth: DD / MM / YYYY

Social Insurance Number: _____ Medicare Number: _____

Address: _____

_____ Postal Code: _____

Telephone Number: _____

Gender: ❑ Male ❑ Female Language of Preference: ❑ English ❑ French

Have you had drug coverage through another health insurance plan within the last 12 months?
❑ Yes ❑ No

**If "Yes"**, when did this coverage end or will be ending? DD / MM / YYYY _____

## Section 2 - Documentation *(required)*

Please enclose the following document with this form.

☐ A letter from Service Canada that indicates the month the GIS was added to your Old Age Pension. You can obtain this letter by calling toll-free 1-800-277-9914.

CONTINUED ON REVERSE

## Section 3 - Consent to release Guaranteed Income Supplement information *(required)*

I hereby consent to the release, by Employment and Social Development Canada to an official of the New Brunswick Department of Health and/or its Delivery Agent, of information about my eligibility and entitlement for the Guaranteed Income Supplement, and, if applicable, other required administrative 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 eligibility for benefits under the New Brunswick Prescription Drug Program, and will not be disclosed to any other person or organization without my approval. I understand that, if I wish to withdraw this authorization, I may do so at any time by writing to the New Brunswick Prescription Drug Program. This authorization is valid for the current year and each subsequent consecutive year for which benefits under the New Brunswick Prescription Drug Program may be requested and determined.

Name of Applicant: _____

Signature: _____ Date Signed: DD / MM / YYYY

## Section 4 - Personal declaration and authorization *(required)*

**By signing this confirmation form, I confirm that:**

I am applying to become a member of the New Brunswick Prescription Drug Program 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 Prescription Drug Program to collect my Social Insurance Number, as well as information from Medicare and other sources to verify the information on this form and to verify eligibility for the New Brunswick Prescription Drug Program.

I agree to notify the New Brunswick Prescription Drug Program 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 Prescription Drug Program.

I authorize the New Brunswick Prescription Drug Program to collect, use and disclose my personal information as described above for as long as I remain a member of the New Brunswick Prescription Drug Program.

I understand that I can revoke my consent at any time. In some instances, revoking my consent may prevent the New Brunswick Prescription Drug Program from providing me with the requested coverage or benefits.

Name of Applicant: _____

Signature: _____ Date Signed: DD / MM / YYYY

This information is collected under the authority of the Prescription Drug Payment Act, SNB 1975, c P-15.01, s 2. This information will be used and disclosed to administer the New Brunswick Prescription Drug Program. 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 Prescription Drug Program at the address or telephone number shown on page 1 of this application.