New Nouveau Brunswick

Turning 65?

YOU CAN RECEIVE
DRUG AND HEALTH COVERAGE

NB Drug Plans

&

Medavie Blue Cross Seniors' Health Program

MEDAVIE BLUE CROSS™
SENIORS' HEALTH PROGRAM

MISC-425B 10/20

January 2021

Getting Started

You are receiving this package because you are turning 65 and you now have more options available for health and drug coverage.

This package details **different ways** you can receive prescription drug coverage. You can also add hospital coverage and choose between two health benefit plans. Read through the different plans to determine the coverage that is best for you.

In the centre of this package you will find application forms and return envelopes to sign up for the coverage you want.

Who is eligible?

New Brunswick seniors are eligible to apply for drug coverage if they:

- are 65 years of age or older;
- are a permanent resident of New Brunswick;
- have a valid NB Medicare Card, and
- do not have prescription drug coverage from another plan.

Privacy

The Government of New Brunswick is committed to safeguarding your privacy. Visit our privacy web page (www.gnb.ca/healthprivacy) for more information on our privacy practices and your rights regarding this issue.

Medavie Blue Cross is committed to safeguarding your privacy. Visit our privacy web page (medaviebc.ca/legal/privacy) for more information on our privacy practices and your rights regarding this issue.

Available Coverage

Prescription Drug Coverage

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New Brunswick Prescription Drug Program

You qualify for the New Brunswick Prescription Drug Program if you receive the federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada. Each senior (65 years of age or older) in a family applies for the Prescription Drug Program individually.

Annual Premium	Co-pay per Prescription
None	**$9.05 up to an annual co-pay ceiling of $500 per person**

To enrol in this program:

- Complete the Guaranteed Income Supplement Confirmation Form
- Mail or fax us your form

For more information, visit our website: **www.gnb.ca/NBPDP**

CONFIRMATION FORM:

Guaranteed Income Supplement Confirmation Form

Telephone: **1-800-332-3692**

Fax: **1-888-455-8322**

Email: **info@nbdrugs-medicamentsnb.ca**
(email is not intended to send confidential information)

If you do not receive the Guaranteed Income Supplement, please contact us if you are:

- a single person (65 years of age or older) with an annual income of $17,198 or less
- a couple (with both persons 65 years of age or older) with an annual income of $26,955 or less
- a couple (with one person 65 years of age or older, and the other person under 65 years of age) with an annual income of $32,390 or less

New Brunswick Drug Plan

Uninsured New Brunswickers, including seniors, may enrol in the New Brunswick Drug Plan. Members in this plan pay a premium and a 30 % copayment, up to a maximum amount per prescription. Premiums and copayments are based on income.

Gross Income Levels		Premiums	Co-pay
Individual	Individual with children / Couple with or without children	Monthly Premium (per adult)	30% Co-pay to a Maximum per Prescription
$17,884 or less	$26,826 or less	$16.67	$5
$17,885 to $22,346	$26,827 to $33,519	$33.33	$10
$22,347 to $26,360	$33,520 to $49,389	$66.67	$15
$26,361 to $50,000	$49,390 to $75,000	$116.67	$20
$50,001 to $75,000	$75,001 to $100,000	$133.33	$25
Over $75,000	Over $100,000	$166.67	$30

To enrol in this plan:

- Complete the New Brunswick Drug Plan Application Form
- Mail or fax us your form

For more information, visit our website: **www.gnb.ca/drugplan**

APPLICATION FORM:

New Brunswick Drug Plan Application for Coverage

Telephone: **1-855-540-7325**
Fax: **1-888-455-8322**
Email: **info@nbdrugs-medicamentsnb.ca**
(email is not intended to send confidential information)

New Nouveau Brunswick

Medavie Blue Cross Seniors' Prescription Drug Program

Uninsured New Brunswickers (65 years of age or older) may enrol in the Medavie Blue Cross Seniors' Prescription Drug Program.

Monthly Premium	Co-Pay per Prescription
$135	$15

When should I apply for the Medavie Blue Cross Seniors' Prescription Drug Program?

Knowing when you should apply is very important. You will be accepted into the Medavie Blue Cross Seniors' Prescription Drug Program if:

- you apply within 60 days following your 65th birthday, or
- you are older than age 65 and you apply within 60 days following the cancellation of a previous prescription drug plan, or
- you are older than age 65 and you apply within 60 days following gaining eligibility for NB Medicare as a new resident.

Missed the dates or forgot to apply within the 60-day limit?

If you did not apply within the 60-day limit, you may apply as a late applicant but are required to complete a medical questionnaire. You may or may NOT be accepted, based on your medical history. To begin this process, call toll free 1-800-332-3692.

To enrol in this program:

- Complete the Medavie Blue Cross Seniors' Prescription Drug Program Application Form
- Mail, email or fax us your form

APPLICATION FORM:

Medavie Blue Cross Seniors' Prescription Drug Program Application Form

Telephone: **1-800-332-3692**

Fax: **1-888-455-8322**

Email: **info@nbdrugs-medicamentsnb.ca**

(email is not intended to send confidential information)

Hospital and Health Benefits

All the previous plans cover prescription drugs only. To complement your drug coverage, consider adding hospital coverage and health benefits to design a plan to best suit your needs.

Hospital Benefits	$31.50 per month

Hospital benefits cover 80% up to $50 per day up to a maximum of 90 days per year towards a semi-private or private hospital room. This plan does not provide hospitalization coverage for the first three months following enrolment.

Basic Health Benefits	$14 per month
Enhanced Health Benefits	$24 per month

View the Comparison Chart on page 6, to see which benefits are right for you.

***Late Applicant Provision**: There is a one year waiting period for certain benefits under Health Benefits (Basic and Enhanced) if you do not apply within 60 days following your 65th birthday, or within 60 days following the termination date of other health benefits, or within 60 days of obtaining NB Medicare as a new resident.

What if I want more coverage?

Medavie Blue Cross offers a wide range of benefits that may meet your needs including health, dental, travel and life insurance.

Individual Dental Benefits	$40.28 per month (billed separately)

Dental benefits are covered at 70% and include: recall exam, polishing, scaling, fillings, root canal treatment, extractions, minor denture repair, denture reline and rebase. Frequency limits may apply. This plan does not provide dental coverage for the first six months following enrolment.

To discuss further, call toll free 1-844-209-7599.

To add hospital, health or dental benefits:

- Complete the Medavie Blue Cross Seniors' Health Program Application Form
- Mail, email or fax us your form

APPLICATION FORM:

Medavie Blue Cross Seniors' Health Program Application Form

Telephone: **1-844-209-7599**
Fax: **1-855-551-9984**
Email: **individual.sales@medavie.bluecross.ca**

Health Benefits Comparison Chart

Health Benefits	Basic Health Benefits 80%	Enhanced Health Benefits 80%
Diabetic Test Strips and Lancets*	$320 per year	$320 per year
Diabetic Needles and Syringes*	$180 per year	$180 per year
Gradient Pressure Supports	2 per year	2 per year
Hearing Aids*	$320 every 5 years	$320 every 5 years
Braces, Splints, Orthotics	$200 per year	$400 per year
Custom-made Ankle Foot Brace	$300 per year	$400 per year
Ostomy Supplies*	Covered	Covered
Prosthetic Limb*	Maximums and frequency limits apply	Maximums and frequency limits apply
Breast Prosthesis*	$160 every 2 years	$160 every 2 years
Hair Prosthesis*	$240 per lifetime	$240 per lifetime
Tracheotomy Supplies	Covered	Covered
Vision Care*	$64 every 2 years	$100 every 2 years
X-ray	$20 per year combined with Chiropractor maximum	$20 per year combined with health practitioners maximum
Health Practitioners		
Chiropractor	$12 per visit up to $100 per year combined with X-ray	$200 per year per health practitioner up to a combined maximum of $400 per year
Podiatrist	$16 per visit up to 5 visits per year	
Psychologist	▲	
Massage Therapist	▲	
Osteopath	▲	
Physiotherapist	▲	
Speech Therapist	▲	
Respiratory Devices	▲	$400 every 3 years
Catheter Products	▲	Covered
Accidental Dental	▲	$7,000 per lifetime
Ambulance	▲	$400 per year
Emergency Drugs out of Province but within Canada	▲	Covered
Equipment Rental*	▲	Covered
Nursing	▲	$250 per year
Oxygen Equipment*	▲	$1,600 every 3 years
Oxygen*	▲	$1,200 per year
Blood Glucose Monitor*	▲	$80 every 5 years
Orthopedic Shoes and Supplies	▲	$100 per year
Eye Prosthesis*	▲	$300 every 3 years
Contact lenses due to disease*	▲	$200 every 2 years

▲ Benefit not covered. * Late applicant provision *(see page 5)*

Frequently Asked Questions

Which drugs are covered?

- To view the list of drugs eligible under the New Brunswick Drug Plan, visit **www.gnb.ca/drugplan** and follow the link entitled "New Brunswick Drug Plan Formulary".
- To view the list of drugs eligible under the New Brunswick Prescription Drug Program and the Medavie Blue Cross Seniors' Prescription Drug Program, visit **www.gnb.ca/nbpdp** and follow the link entitled "Formulary".
- Most drugs listed are regular benefits that are reimbursed with no criteria or prior approval requirements. Some drugs require special authorization and have specific criteria that must be met in order to be reimbursed.

Do the drug plans cover more than prescription drugs?

No, the drug plans cover prescription drugs only. If you desire coverage for additional benefits including vision care, hearing aids, nursing, oxygen, diabetic supplies and medical equipment, you can purchase health benefits through the Medavie Blue Cross Seniors' Health Program. Call toll free at 1-844-209-7599.

Can my spouse also be covered if he/she is under 65 years of age?

Yes, if your spouse is uninsured, he/she can apply for drug coverage under the New Brunswick Drug Plan or with Medavie Blue Cross.

Can my spouse and I be covered under different plans?

Yes, you and your spouse may be covered under different plans presented in this document, depending on your situation.

Frequently Asked Questions

How do I qualify for drug coverage if I am moving to New Brunswick?

- The first step is to apply for New Brunswick Medicare coverage. When you receive your Medicare card, check the date that your Medicare coverage becomes effective.
- Then call the telephone number corresponding to the coverage you wish to apply for.
- To guarantee your acceptance for the Medavie Blue Cross Seniors' Prescription Drug Program, you must apply within 60 days of your Medicare effective date. If you do NOT apply within 60 days following your Medicare effective date, you will be considered a late applicant and may or may NOT be accepted, based on your medical history.

If I'm moving outside New Brunswick, can I still get my drugs covered?

- All the drug plans are for New Brunswick residents only. If you are planning to move outside New Brunswick, you must advise Medicare and your drug plan of your moving date and your coverage will be cancelled accordingly.
- Although you can't take your drug plan with you, for most drugs you can obtain a 90-day supply of your medication before leaving New Brunswick, to cover the period until you can obtain coverage in your new province of residence.
- You should find out as soon as possible what your coverage options are in your new home province.

New Brunswick
Prescription Drug Program

New Nouveau Brunswick

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.

NB Drug Plan

The New Brunswick drug plan

Application for Coverage

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**

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

How to complete this form

1. **All sections must be completed.** Please print clearly. Ensure you (and your spouse if applicable) sign sections 3, 4 and 5. Any dependant (if applicable) over the age of 16 must sign section 5.
2. **Only one application form per family is necessary.** If you have a spouse and/or dependant(s), they do not need to complete a separate application.
3. If you are applying for coverage and have an existing drug plan, you must complete the **Existing Drug Coverage form** and send it along with your completed application form. The Existing Drug Coverage form is available on the New Brunswick Drug Plan website.
4. Mail or fax your completed and signed application to the address/fax number above.
5. Once your application is processed, you will receive notification of your acceptance in the New Brunswick Drug Plan with your premium and copayment details and the effective date of your coverage.

SECTION 1 - Personal information *(required)*

APPLICANT:

First name: _____ Last name: _____

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

Gender: ❑ male ❑ female

Marital status: ❑ single ❑ married ❑ common-law ❑ separated ❑ divorced ❑ widowed

Mailing address: _____

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

Telephone: _____ Alternate *(e.g. mobile)*: _____

Are you currently covered under a drug plan? ❑ yes ❑ no When is your coverage ending? _____ DD/MM/YYYY

If you have coverage from another drug plan that is not ending, please complete the Existing Drug Coverage form and send it with your completed application form.

SPOUSE: *(Your spouse's information is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.)*

First name: _____ Last name: _____

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

Gender: ❑ male ❑ female

Is your spouse applying for coverage as well? ❑ yes ❑ no

Is your spouse currently covered under a drug plan? ❑ yes ❑ no When is the coverage ending? _____ DD/MM/YYYY

If your spouse has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your spouse along with your completed application form.

FORM-759KIT-E 05/18

SECTION 2 - Dependant information *(if applicable)*

Please list all eligible dependants. 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 applicant

First name	Last name	Date of birth (DD/MM/YYYY)	Medicare number	Gender	Disabled (as per the definition above)	*Is your dependant applying for coverage?	*Is your dependant currently covered under a drug plan?
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no
				❑ male ❑ female	❑ yes ❑ no	❑ yes ❑ no	❑ yes ❑ no

* *If your dependant has coverage from another drug plan that is not ending, you must send a completed Existing Drug Coverage form for your dependant along with your completed application form.*

SECTION 3 - Consent to release income tax information *(required)*

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

Please choose one of the following options:

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

Applicant Social Insurance Number: ⌊⌊⌊ ⌊⌊⌊ ⌊⌊⌊ Spouse Social Insurance Number: ⌊⌊⌊ ⌊⌊⌊ ⌊⌊⌊

❑ I do <u>not</u> 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 Applicant: _____

X Sign here - Applicant: _____ Date signed: _____ 20 _____ (DD/MM) (YY)

Name of Spouse: _____

X Sign here - Spouse: _____ Date signed: _____ 20 _____ (DD/MM) (YY)

Your spouse's consent is required even if your spouse is not applying for coverage. The premiums and copayments are based on your family income.

SECTION 4 - Payment information *(required)*

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

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I authorize 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 will be debited to my specified account on the first business day of every month. The New Brunswick Drug Plan will not provide pre-notification but will provide a premium statement indicating the amount of each regular debit. The New Brunswick Drug Plan will obtain my authorization for any other one-time or sporadic debits. The New Brunswick Drug Plan requires written notification of any changes to banking information.

This authority is to remain in effect until 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: Tick the box that applies.

1. ❑ Applicant or spouse will be paying the premiums.

   Please **attach a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below.

   X Sign here -
   Bank account holder: _____ Date signed: _____ 20 _____
   DD/MM YY

2. ❑ Someone other than the applicant 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:

   First name: _____ Last name: _____

   Mailing address: _____

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

   Telephone: _____ Alternate *(e.g. mobile)*: _____

   X Sign here -
   Bank account holder: _____ Date signed: _____ 20 _____
   DD/MM YY

SECTION 5 - Personal declaration, authorization and obligations *(required)*

By signing this application form, I confirm that:

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 I must pay my premiums each month in order to receive benefits, and that if I do not pay my premiums in full, benefits will not be provided and my 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.

The signatures of your spouse and all listed dependants over the age of 16 are required even if they are not applying for coverage.

Name of Applicant: _____

X Sign here - Applicant: _____ Date signed: _____ 20 _____
DD/MM YY

Name of Spouse: _____

X Sign here - Spouse: _____ Date signed: _____ 20 _____
DD/MM YY

*Name of Dependant (16 or older): _____

X Sign here - Dependant: _____ Date signed: _____ 20 _____
DD/MM YY

*Name of Dependant (16 or older): _____

X Sign here - Dependant: _____ Date signed: _____ 20 _____
DD/MM YY

***A parent/guardian can sign on behalf of the dependant 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.

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 of this application.

Medavie Blue Cross
Seniors' Prescription Drug Program

MEDAVIE BLUE CROSS™
SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

APPLICATION FORM

Toll-Free Number: **1-800-332-3692**
Fax: **1-888-455-8322**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: _____
DD/MM/YYYY

Medicare No.: _____ Social Insurance No.: _____

Language preference for correspondence: ❑ English ❑ French

Are you currently or have you recently been covered by a Prescription Drug Plan? ❑ Yes ❑ No

If Yes, when will/did this benefit terminate? _____
DD/MM/YYYY

Please select when you would like your coverage to start:

❑ The month of your 65th birthday
❑ The month following your 65th birthday
❑ The month following the termination of your current/previous coverage
❑ *Other. Specify: _____

* A completed medical questionnaire is required.

DRUG COVERAGE RATES
$135.00 per month Medavie Blue Cross Seniors' Prescription Drug Program
$15 co-pay per prescription

AGREEMENT AND CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-888-919-7378.

Signature _____ Date of signature _____
DD/MM/YYYY

CONTINUED ON REVERSE

FORM-4079KIT-E 05/19

BILLING SELECTION

❑ **Monthly Pre-authorized Debit (PAD)** (Please complete the Pre-authorized Debit (PAD) plan agreement below, sign, date and attach void cheque).

I authorize Medavie Blue Cross, 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 will be debited from my specified account on the first business day of every month. *Medavie Blue Cross will not provide monthly pre-notification but will provide 30-days notice if the deduction is subject to change.* Medavie Blue Cross will obtain my authorization for any other one-time or sporadic debits. Medavie Blue Cross requires written notification of any changes to banking information.

This authority is to remain in effect until Medavie Blue Cross has received written notification from me of its change or termination. This notification must be received at least 30 business days before the next debit is scheduled. This notification must be sent to the Seniors' Health Program at Medavie Blue Cross. 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. Please attach the void cheque to a separate sheet.

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

If someone other than the applicant 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: _____

Address: _____ Apt.: _____

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

Telephone number: _____ Alternate (e.g. mobile): _____

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

Medavie Blue Cross Seniors' Health Program

MEDAVIE BLUE CROSS™ SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 9N7

APPLICATION FORM

Toll-Free Number: **1-844-209-7599**
Fax: **1-855-551-9984**
Sales e-mail: **individual.sales@medavie.bluecross.ca**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Email: _____

Medicare No.: _____ Date of Birth: DD/MM/YY

Language preference for correspondence: ❑ English ❑ French Sex: ❑ Male ❑ Female

BENEFIT SELECTION - Please refer to the Medavie Blue Cross Seniors' Health Program booklet for a complete description of the benefits. The amounts shown below are monthly rates.

Waiting periods apply for Hospital and Dental benefits. There may also be a one year waiting period on some health benefits if you do not apply within 60 days of your 65th birthday.

Please check all benefits you wish to include in your plan.

HEALTH COVERAGE

The following options do not include coverage for prescription drugs.

- ❑ $14.00 Basic Health Benefits
- ❑ $24.00 Enhanced Health Benefits (includes the benefits under Basic)
- ❑ $31.50 Hospital Reimbursement Plan
- ❑ $40.28 Individual Dental Benefits (billed separately)

Have you recently been covered for other health benefits, such as Vision or Physiotherapy? ❑ Yes ❑ No

Have you been covered for dental benefits in the last three months? ❑ Yes ❑ No

If Yes, when will these benefits terminate? DD/MM/YY

Your coverage becomes effective on the first day of the month of your 65th birthday unless you are a late applicant or request a different effective date.

Requested Effective Date of Policy: Please begin my coverage on the 1st day of Month/Year

AGREEMENT AND CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-888-919-7378.

Signature _____ Date DD/MM/YY

CONTINUED ON REVERSE

FORM-070KIT-E 05/20

BILLING SELECTION

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Authorized Signature: _____

DATE: _____ DD/MM/YY Type of Service: ❑ Personal ❑ Business

Please attach a void cheque. (Credit card payments are not accepted.)
(PLEASE PRINT)

Financial Institution (FI): _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

FI Transit Number: |_|_|_|_|_| |_|_|_| FI Account Number: |_|_|_|_|_|_|_|_|_|_|_|_|
(transit-5 digits; FI-3 digits)

Would you like your claim reimbursements automatically deposited in the same account? ❑ Yes ❑ No

If someone other than the policy owner will be paying the premiums, please have them sign, date and complete their financial information above and complete their personal information below:

Name: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Phone Number: (Bus.) ____ - ____ - _____ (Res.) ____ - ____ - _____

FOR OFFICE USE ONLY

I hereby certify that, as an agent for Medavie Blue Cross, I have informed the applicant of the importance of making full and accurate disclosure of the matters covered in this application and that any misrepresentations or omissions may give Medavie Blue Cross the right to cancel the contract of insurance and refuse coverage under the policy. I have disclosed the company or companies I represent and any conflicts of interest they may have with respect to this transaction and that I may receive a salary, commissions or other forms of compensation for the sale of insurance company products.

Agent's Name: _____ Agent's Number: _____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____

Agent's Signature: _____