New Nouveau Brunswick

New Brunswick
Prescription Drug Program
PO 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
Website: www.gnb.ca/NBPDP

Cystic Fibrosis Plan Application Form

The Cystic Fibrosis Plan is a provincial drug plan that provides coverage for certain cystic fibrosis drugs for eligible New Brunswick residents if they:

- have a valid New Brunswick Medicare card, and
- do not have coverage for any portion of the cost of cystic fibrosis drugs from any other drug plan.

Before completing this form

1. Call the number above to confirm that the drug you have been prescribed is covered under the Cystic Fibrosis Plan **prior** to completing this form.
2. If you have other drug coverage, you must complete and return the Other Drug Coverage form and any supporting documentation along with this completed application form.
3. The annual premium of $50 must be received before the application is processed. Cheques or money orders should be made payable to the **New Brunswick Prescription Drug Program**. Payments may also be made online. Cash is not accepted.
4. Mail or fax your completed application and any supporting documentation to the address or fax number above.

SECTION 1 - Applicant Information

○ New application ○ Re-enrolment Language Preference: ○ English ○ French

First Name: _____ Last Name: _____

Address: _____

City/Town/Village: _____ Province: _____ Postal Code: |_|_|_| |_|_|_|

Telephone: (|_|_|_|) |_|_|_|-|_|_|_|_| Gender: ○ Male ○ Female

Medicare Number: |_|_|_| |_|_|_| |_|_|_| Date of Birth: |_|_| |_|_| |_|_|_|_| D D M M Y Y Y Y

Name of drug prescribed: _____

SECTION 2 - Other Drug Coverage

Do you have other drug coverage? ○ Yes ○ No

If yes, you must complete and return the Other Drug Coverage form and any supporting documentation along with this completed application form.

SECTION 3 - Personal Declaration and Authorization

By signing this application form, I confirm that:

I am applying to become a member of the New Brunswick Prescription Drug Program – **Cystic Fibrosis 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 Prescription Drug Program to collect my 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.

Signature of applicant: _____ Date signed: D D M M Y Y Y Y

The name and signature of a parent/guardian is required if:

- The applicant is under the age of 16; or
- The applicant is between the ages of 16 and 18 (inclusive) and does not have the capacity to sign the personal declaration and authorization; or
- The applicant 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 Prescription Drug Program.

Name of parent/guardian: _____

Signature: _____ Date signed: D D M M Y Y Y Y

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 the 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.