

Growth Hormone Deficiency Plan Application Form

The Growth Hormone Deficiency Plan is a provincial drug plan that provides coverage for certain growth hormone drugs for eligible New Brunswick residents under the age of 19 if they:

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

More information is available online at www.gnb.ca/NBPDP or by contacting the inquiry line at 1-800-332-3692.
Mail or fax your completed application and any supporting documentation to the address or fax number above.

Before completing this form

1. Call the number above to confirm that the drug you have been prescribed is covered under the Growth Hormone Deficiency Plan.
2. The annual premium of \$50 must be paid online, or by cheque or money order made payable to the New Brunswick Prescription Drug Program. Cash is not accepted.
3. Your coverage under the Growth Hormone Deficiency Plan must be renewed annually. Information on renewing your coverage will be mailed to you at least two months prior to the deadline of June 30th.

SECTION 1 - Applicant Information

First Name: _____ Last Name: _____
Address: _____
City/Town/Village: _____ Province: _____ Postal Code: _____
Telephone: (____) _____-____ Gender: ☐ M ☐ F ☐ X
Medicare Number: _____ Date of Birth: _____
Language Preference: ☐ English ☐ French
Name of drug prescribed: _____

SECTION 2 - Other Drug Coverage

Are you currently enrolled in another drug plan that covers any of your drugs? ☐ Yes ☐ No
This includes drug plans through an employer, spouse, parent/guardian, federal or provincial government.
If yes, you must provide a letter from your private plan confirming that you do not have coverage for any portion of the drugs you have been prescribed.
Name of Insurance Company: _____
Policy Number: _____ Identification Number: _____
Name of employer or organization that sponsors the plan (if applicable): _____
Does your insurance company require you to apply to the Growth Hormone Deficiency Plan? ☐ Yes ☐ No

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 – **Growth Hormone Deficiency 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 authorize the New Brunswick Prescription Drug Program to communicate with my third-party insurance providers, pharmacies or patient support programs and act on my behalf to facilitate the processing of my application and administer my drug coverage.

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.

X Sign here - 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.

Name of parent/guardian: _____

X Sign here - Parent/Guardian: _____ 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.