New Brunswick / 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

Multiple Sclerosis Plan Application Form

The Multiple Sclerosis (MS) Plan is a provincial drug plan that provides coverage for certain multiple sclerosis drugs for eligible New Brunswick residents if they:

- have a valid New Brunswick Medicare card, and
- a prescription written by a neurologist for one of the drugs that are covered under the MS 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 Multiple Sclerosis 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 Multiple Sclerosis 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: |_|_| |_|_| |_|_|_|_|
D D M M Y Y Y Y

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.

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 Multiple Sclerosis Plan? ☐ Yes ☐ No

FORM-905E 11/23

SECTION 3 - Financial Information (Family Unit)

This information is required to calculate your copayment amount. The copayment is the portion of the prescription cost that you pay each time you have a prescription filled. The copayment is based on your family discretionary income. **Family unit** is defined as the applicant, the applicant's spouse, and dependants of the applicant and the spouse.

You must provide supporting information regarding liquid assets held by each family member. **Liquid assets** are defined as cash in bank and the fair market value of life insurance and financial investments. Liquid assets include but are not limited to paid-up insurance, stocks, bonds, guaranteed income certificates, income distribution from funds held in trust, tax free savings accounts, etc. Exempt are funds held in trust for children in the family unit, registered retirement savings plans, registered education savings plans and registered disability savings plans. Only total liquid assets in excess of $5,000 for your family unit will be used to calculate your copayment.

Complete for all that are applicable.

	First Name	Last Name	Date of Birth (DD MM YYYY)	Liquid Assets ($)
Applicant				$
Spouse				$
Dependant(s)				$

The monthly copayment contribution table and calculation sheet used to determine the copayment are available on our website at www.gnb.ca/NBPDP.

A copy of the most recent Income Tax Notice of Assessment or Re-assessment or an acceptable verification of income from the Canada Revenue Agency for each member of the family unit must be included. If the Joint Election to Split Pension Income form (form T1032) was used when filing your Income Tax return, please submit a copy with your application.

SECTION 4 - 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 – **Multiple Sclerosis 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; 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: _____

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.