Drug Plans for Seniors

The Government of New Brunswick offers drug coverage to seniors who:

- are 65 years of age or older;
- are a resident of New Brunswick;
- have a valid New Brunswick Medicare card, and
- do not have prescription drug coverage through any other plan.

Seniors who receive the federal Guaranteed Income Supplement (GIS) are eligible for the New Brunswick Prescription Drug Program (NBPDP).

Seniors who do not receive the GIS may apply for the New Brunswick Drug Plan.

Information on each of the plans and the application forms are provided in this package. Information on the Medavie Blue Cross Seniors' Health Program is also included.

Seniors who receive GIS

Seniors who receive the federal Guaranteed Income Supplement (GIS) from Employment and Social Development Canada and do not have drug coverage through any other plan are eligible for the New Brunswick Prescription Drug Program (NBPDP) Seniors Drug Plan.

This plan does not have a premium. There is a co-payment of $9.05 per prescription to a maximum of $500 per person in each calendar year (January 1st to December 31st).

To enroll in this Plan:

- Each senior must apply individually.
- Complete the enclosed NBPDP Seniors Drug Plan Application Form. A fillable and printable form is also available online at www.gnb.ca/seniorsdrugplan.
- Mail or fax the completed and signed form, along with documentation that confirms the senior is receiving the GIS.

For more information:

Online: www.gnb.ca/NBPDP

Call: 1-800-332-3692

Email: info@nbdrugs-medicamentsnb.ca
(Please do not send confidential information by email.)

Seniors who do not receive GIS

Seniors who do not receive the federal Guaranteed Income Supplement (GIS) and do not have drug coverage through any other plan may apply for the New Brunswick Drug Plan.

This plan has a monthly premium and co-payment per prescription that are based on annual family income. The premium and maximum co-payment amounts are available online at www.gnb.ca/drugplan.

To enroll in this Plan:

- Complete the enclosed New Brunswick Drug Plan Application Form. A fillable and printable form is also available online at www.gnb.ca/drugplan.
- Mail or fax the completed and signed form.

For more information:

Online: www.gnb.ca/drugplan

Call: 1-800-332-3692

Email: info@nbdrugs-medicamentsnb.ca
(Please do not send confidential information by email.)

Frequently Asked Questions

Which drugs are covered?

The drugs eligible for coverage are listed in the New Brunswick Drug Plans Formulary. Most drugs listed are regular benefits which have no criteria or prior approval requirements. Some drugs are special authorization benefits and have specific criteria that must be met for coverage to be approved.

Do the drug plans cover more than prescription drugs?

No, the drug plans cover prescription drugs only. Vaccines, medical devices, supplies and equipment (e.g., diabetic supplies, ostomy supplies, oxygen) are not eligible benefits. Some private insurers offer extended health benefit plans that cover these products.

Is my spouse eligible for coverage if they are under 65 years of age?

If your spouse is uninsured, they may apply for drug coverage under the New Brunswick Drug Plan.

How do I know if I qualify for the Guaranteed Income Supplement (GIS)?

People who are 65 or older and receiving the Old Age Security pension may also qualify for the GIS. If you are eligible, you may be notified by Employment and Social Development Canada that you will be receiving the GIS. In some cases, you may need to apply. Information is available online at Guaranteed Income Supplement - Canada.ca or by calling 1-800-277-9914.

Privacy: The Government of New Brunswick is committed to safeguarding your privacy. More information on our privacy practices is available online at www.gnb.ca/healthprivacy.

MISC-425 E 06/24

New Nouveau Brunswick

New Brunswick
Prescription Drug Program
PO Box 690
Moncton, NB E1C 8M7

Telephone: 506-867-4515 or 1-800-332-3692
Fax: 506-867-4872 or 1-888-455-8322
Email: info@nbdrugs-medicamentsnb.ca
Website: www.gnb.ca/NBPDP

NB Prescription Drug Program
Seniors Drug Plan Application Form

This drug plan is for New Brunswick residents who are 65 years of age or older, receive the **Federal Guaranteed Income Supplement (GIS)**, have a valid NB Medicare card, and have no other drug coverage.

When sending this form, please ensure that:

- One of the following documents is included:
  - A letter from Service Canada that confirms you are currently receiving the GIS. You can obtain this letter from Service Canada by calling 1-800-277-9914.

  OR

  - A printout from the Canada Revenue Agency online portal "My Account" that confirms your most recent GIS payment date and amount.
- The personal declaration and authorization on page 2 is signed and dated.

SECTION 1 - Contact Information

First Name: _____ Last Name: _____

Address: _____

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

Telephone: |_|_|_|-|_|_|_|-|_|_|_|_| Language Preference: ☐ English ☐ French

Email: _____

SECTION 2 - Personal Information

Date of Birth: |_|_| |_|_| |_|_|_|_| (D D M M Y Y Y Y) Gender: ☐ M ☐ F ☐ X

Medicare Number: |_|_|_| |_|_|_| |_|_|_|

Social Insurance Number: |_|_|_| |_|_|_| |_|_|_|

Are you currently enrolled in another drug plan that covers any of your drugs?

☐ Yes ☐ No

If yes, when will this coverage end? |_|_| |_|_| |_|_|_|_| (D D M M Y Y Y Y)

FORM-892E 05/24

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 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 Employment and Social Development Canada to release to an official of the New Brunswick Department of Health and/or its Delivery Agent, information about my eligibility and entitlement to the Guaranteed Income Supplement, and, if applicable, other required administrative information about me, whether supplied by me or by a third party.

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.

Sign Here X: _____

Date Signed: D D M M Y Y Y Y

Other Information

- Send your completed and signed form along with the required documentation by:

Mail

New Brunswick Prescription Drug Program
PO Box 690
Moncton, NB E1C 8M7

Fax

Moncton Area: 506-867-4872
Toll Free: 1-888-455-8322

- You will receive a letter once your form is reviewed and your eligibility is confirmed.
- If you have questions, please email info@nbdrugs-medicamentsnb.ca or call 1-800-332-3692.

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. More information regarding the collection and use of personal information is available online at www.gnb.ca/healthprivacy.

FORM-892E 05/24

The New Brunswick drug plan

New Brunswick Drug Plan Application Form

New Brunswick Drug Plan
PO Box 690
Moncton, NB E1C 8M7

Telephone: 506-867-4515 or 1-800-332-3692
Fax: 506-867-4872 or 1-888-455-8322
Email: info@nbdrugs-medicamentsnb.ca
Website: www.gnb.ca/drugplan

How to complete this form

Prior to applying, review the premiums and copayments at www.gnb.ca/drugplan and check that the drug for which you need coverage is listed in the New Brunswick Drug Plan Formulary at www.gnb.ca/drugplansformulary.

1. **Only one application form per family is necessary**. Ensure you (and your spouse, if applicable) sign sections 4, 5 and 6. Any dependant over the age of 16 (if applicable) must sign section 6.
2. If you are applying for coverage and have another drug plan, you must complete the **Supporting Application Form Other Drug Coverage** and send it with your completed application form. The Supporting Application Form Other Drug Coverage is online at www.gnb.ca/drugplan.
3. Mail or fax your completed and signed application. Once your application is processed, you will receive notification of your acceptance in the New Brunswick Drug Plan, your premium and copayment details and the effective date of your coverage.

SECTION 1 - Applicant Information (required)

First Name: _____ Last Name: _____

Address: _____

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

Telephone: | | | - | | | | - | | | | Language Preference: ☐ English ☐ French

Email: _____

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

Marital Status: ☐ Single, Widowed or Separated ☐ Married or Common-law Gender: ☐ M ☐ F ☐ X

Are you currently enrolled in another drug plan that covers any of your drugs? This includes drug plans through an employer, spouse, parent/guardian, federal or provincial government. ☐ Yes ☐ No

If you are enrolled in another drug plan, is your coverage ending?

☐ Yes When is your coverage ending? | | | | | | | | | |
D D M M Y Y Y Y

☐ No If you have coverage from another drug plan that is not ending, please complete the Supporting Application Form Other Drug Coverage and send it with your completed application form.

SECTION 2 - Spouse Information (if applicable)

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: | | | | | | | | | | | | | |
D D M M Y Y Y Y

Is your spouse applying for coverage as well? ☐ Yes ☐ No

Is your spouse currently enrolled in another drug plan that covers any of their drugs? ☐ Yes ☐ No

If your spouse is enrolled in another drug plan, is their coverage ending?

☐ Yes When is the coverage ending? | | | | | | | | | |
D D M M Y Y Y Y

☐ No If your spouse has coverage from another drug plan that is not ending and they are applying for coverage, please complete the Supporting Application Form Other Drug Coverage for your spouse and send it with your completed application form.

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SECTION 3 – Dependant Information (if applicable)

Please list all dependants. If more space is required, please attach a separate sheet. Children 18 and younger do not pay premiums but a parent /guardian must be enrolled in the plan.

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	Disabled (as per the definition above)	Does your dependant require coverage?	Is your dependant currently covered under a drug plan?
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
				☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If your dependant(s) is enrolled in another drug plan, is their coverage ending?

☐ Yes When is the coverage ending? D D M M Y Y Y Y

☐ No If your dependant has coverage from another drug plan that is not ending and they require coverage, you must send a completed Supporting Application Form Other Drug Coverage for your dependant with your completed application form.

SECTION 4 – 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/we do **not** consent to the release of our family income, as indicated on our CRA tax returns for the most recent tax year. **I/we will be charged the maximum annual premium and the maximum copayment per prescription**.

☐ I/we hereby consent to the release, by the Canada Revenue Agency to an official of the ***New Brunswick Department of Health's 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 copayments under the New Brunswick Drug Plan, and will not be disclosed to any other person or organization without my 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: ___ ___ ___ ___ ___ ___ ___ ___ ___

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Applicant

Spouse Social Insurance Number (if applicable): ___ ___ ___ ___ ___ ___ ___ ___ ___

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Spouse (if applicable)

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 5 – Payment Information (required)

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I/We, the undersigned, authorize the New Brunswick Drug Plan, and the financial institution designated (or any other financial institution I/we may authorize) to begin deductions as per my/our instructions for recurring payments, for payment of insurance premiums and any other related charges, each of which are incurred for personal purposes. Regular monthly payments for the full amount owing will be debited from the specified account (or any other designated account) on the first business day of every month. I/We agree to promptly notify the New Brunswick Drug Plan, in writing at the address above, of any changes to the bank account information provided. I/We acknowledge that this PAD Agreement shall remain in full force and effect with the updated bank account details. I/We confirm authority under the terms of the bank account agreement with my/our financial institution to authorize the debits under this PAD Agreement and that all persons whose signatures are required to sign on the bank account have signed or otherwise authorized this PAD Agreement.

The New Brunswick Drug Plan will obtain my/our authorization for any sporadic debits. Medavie Blue Cross is a third party administering the PAD Agreement for amounts owing by me/us under the New Brunswick Drug Plan.

This authority is to remain in effect until the New Brunswick Drug Plan has received written notification from me/us of its change or termination. This notification must be sent to the New Brunswick Drug Plan and received at least ten (10) calendar days before the next debit is scheduled.

I/We may obtain a sample cancellation form or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca. I/We understand that this PAD Agreement applies only to the method of payment for my/our insurance premiums and related charges, and its revocation does not terminate, cancel, reduce, or otherwise affect my/our obligations to the New Brunswick Drug Plan. I/We acknowledge that I/we will have to make alternate payment arrangements acceptable to the New Brunswick Drug Plan if I/we revoke authorization for PAD but continue to have amounts owing to the New Brunswick Drug Plan. The New Brunswick Drug Plan may also cancel this PAD Agreement on not less than 5 calendar days' notice to me/us in accordance with the Rules of Payments Canada.

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca.

I/We waive the right to receive pre-notification of the amount of any PAD and agree that I/we do not require advance notice of the amount of the PADs before the debit is processed. I/We also agree that a confirmation will be provided to me/us within 5 calendar days after the first PAD.

BANKING INFORMATION: Only complete the one that applies.

1. Applicant or spouse will be paying the premiums

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

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Bank Account Holder

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Other Bank Account Holder (if joint bank account)

2. Someone other than the applicant or their spouse will be paying the premiums

Please **include a void cheque or a direct deposit/pre-authorization payment form from their financial institution**, review the PAD Agreement terms above, and complete the information below to acknowledge their acceptance of those terms.

By providing a void cheque or a direct deposit/pre-authorization payment form, completing and signing below, the undersigned agrees to the PAD Agreement terms and conditions.

First Name: _____ Last Name: _____

Address: _____

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

Telephone: ___-___-____

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Bank Account Holder

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Other Bank Account Holder (if joint bank account)

SECTION 6 – Personal Declaration and Authorization (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.

Your signature along with the signatures of your spouse and all listed dependants over the age of 16 are required even if they are not applying for coverage. If you are signing on behalf of the applicant, attach a copy of the Power of Attorney.

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Applicant

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Spouse

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Dependant*

Sign Here X: _____ Date Signed: D D M M Y Y Y Y
Dependant*

*A parent/guardian can only sign on behalf of a 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.

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. More information regarding the collection and use of personal information is available online at www.gnb.ca/healthprivacy.

Medavie Blue Cross Seniors' Health Program

To complement your New Brunswick provincial coverage, consider adding hospital coverage and health benefits to design a plan to best suit your needs.

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.

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.

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.

HOSPITAL BENEFITS
$31.50 per month

BASIC HEALTH BENEFITS
$20 per month

ENHANCED HEALTH BENEFITS
$30 per month

INDIVIDUAL DENTAL BENEFITS
$57.26 per month (billed separately)

Rates are subject to change. View the Comparison Chart on page 2, to see which benefits are right for you.

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

To add hospital, health or dental benefits:

- Complete the application online at medaviebc.ca/en/plans/seniors-health-program
- Or complete the enclosed Medavie Blue Cross Seniors' Health Program Application Form and return by mail, email or fax

MEDAVIE BLUE CROSS SENIORS' HEALTH PROGRAM APPLICATION FORM
Telephone: 1-844-209-7599 | Fax: 1-855-551-9984
Email: individual.sales@medavie.bluecross.ca

MEDAVIE BLUE CROSS™

HEALTH BENEFITS COMPARISON CHART

HEALTH BENEFITS	BASIC HEALTH BENEFITS	ENHANCED HEALTH BENEFITS
Accidental Death	$5,000	$5,000
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
Respiratory Devices	Benefit not covered.	$400 every 3 years
Catheter Products	Benefit not covered.	Covered
Accidental Dental	Benefit not covered.	$7,000 per lifetime
Ambulance	Benefit not covered.	$400 per year
Emergency Drugs out of Province but within Canada	Benefit not covered.	Covered
Equipment Rental*	Benefit not covered.	Covered
Nursing	Benefit not covered.	$250 per year
Oxygen Equipment*	Benefit not covered.	$1,600 every 3 years
Oxygen*	Benefit not covered.	$1,200 per year
Blood Glucose Monitor*	Benefit not covered.	$80 every 5 years
Orthopedic Shoes and Supplies	Benefit not covered.	$100 per year
Eye Prosthesis*	Benefit not covered.	$300 every 3 years
Contact lenses due to disease*	Benefit not covered.	$200 every 2 years

HEALTH PRACTITIONERS	BASIC HEALTH BENEFITS	ENHANCED HEALTH BENEFITS
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	Benefit not covered.	
Massage Therapist	Benefit not covered.	
Osteopath	Benefit not covered.	
Physiotherapist	Benefit not covered.	
Speech Therapist	Benefit not covered.	

**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.*

MEDAVIE BLUE CROSS™

MEDAVIE BLUE CROSS™ SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

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: _____ E-Mail: _____

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

Medicare Number: _____

Language preference for correspondence: ○ English ○ French

Sex*: ○ Male ○ Female ○ Intersex ○ Undisclosed

**Why do we ask?* Some health conditions are more likely to occur based on sex. As a result, sex is used to assess your coverage. We recognize that your sex may differ from your gender identity.

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.

- ☐ $20.00 Basic Health Benefits
- ☐ $30.00 Enhanced Health Benefits (includes the benefits under Basic)
- ☐ $31.50 Hospital Reimbursement Plan
- ☐ $57.26 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/YYYY) _____

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 I have provided herein is collected and used by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada (Blue Cross Life) to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511. A photocopy of this authorization shall be as valid as the original.

Signature _____ Date (DD/MM/YYYY) _____

CONTINUED ON REVERSE

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.

Authorized Signature: _____ **DATE (DD/MM/YYYY):** _____

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

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: _____

TEN DAY RIGHT TO EXAMINE POLICY

You have 10 days from the receipt of the policy to examine and return it for a full refund of monies paid, if you are not entirely satisfied. Accidental death benefits will be underwritten by Blue Cross Life Insurance Company of Canada. All other benefits will be underwritten by Medavie Inc., operating under the business name Medavie Blue Cross.