The New Brunswick drug plan

Information Changes
Personal, Income or Payment

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

Toll Free: 1-855-540-7325
Fax: 506-867-4872
Toll Free Fax: 1-888-455-8322
Website: www.gnb.ca/drugplan

How to complete this form

1. Sections 1 and 5 must be completed.
2. Only complete sections 2, 3, and/or 4 if changes are required.
3. To cancel your membership or change your address or contact information, mail/fax your changes to the address/fax number above or call the New Brunswick Drug Plan Inquiry Line at 1-855-540-7325.

SECTION 1 - Information for Primary Cardholder (required)

First Name: _____ Last Name: _____

Plan Identification Number: _____ Date of Birth: D D M M Y Y Y Y

SECTION 2 - Personal Information Change

Name Change for: ☐ Primary cardholder ☐ Spouse ☐ Dependant

From: First Name: _____ Last Name: _____

To: First Name: _____ Last Name: _____

Medicare Number Change for:

☐ Primary cardholder New Medicare Number: _____

☐ Spouse or Dependant

First Name: _____ Last Name: _____

Date of Birth: D D M M Y Y Y Y New Medicare Number: _____

SECTION 3 – Consent to Release Income Tax Information Change

☐ 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.

Primary cardholder Social Insurance Number: _____

Spouse Social Insurance Number: _____

☐ I do **not** 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.

Primary cardholder signature: _____ Date signed: D D M M Y Y Y Y

Spouse signature: _____ Date signed: D D M M Y Y Y Y

SECTION 4 - Payment Information Change

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

Effective Date of Change: D D M M Y Y Y Y

PRE-AUTHORIZED DEBIT (PAD) PLAN AGREEMENT

I authorize an official or representative or agent of the Department of Health (DH) or 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 for the full amount of services delivered will be debited to my specified account on the first business day of every month. An official or representative or agent of the DH or the New Brunswick Drug Plan will not provide pre-notification but will provide a premium statement indicating the amount of each regular debit. An official or representative or agent of the DH or the New Brunswick Drug Plan will obtain my authorization for any other one-time or sporadic debits. An official or representative or agent of the DH or the New Brunswick Drug Plan requires written notification of any changes to banking information.

This authority is to remain in effect until an official or representative or agent of the DH or 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: please attach a **void cheque** or a **direct deposit/pre-authorization payment form from your financial institution** and sign below.

Signature of bank account holder: _____ Date signed: D D M M Y Y Y Y

If someone other than the primary cardholder 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: _____

Address: _____

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

Telephone: (___)___-____

Signature of bank account holder: _____ Date signed: D D M M Y Y Y Y

SECTION 5 - Personal Declaration of Primary Cardholder (required)

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.

Signature of primary cardholder: _____ Date signed: D D M M Y Y Y Y

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.

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