



SENIORS'
HEALTH PROGRAM



644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

APPLICATION FORM

Toll-Free Number: **1-800-332-3692**

Fax: **1-888-455-8322**

PLEASE COMPLETE THE FOLLOWING TO APPLY FOR BENEFITS

Name: _____

Address: _____

_____ Postal Code: _____

Telephone: _____ Date of Birth: _____

DD/MM/YYYY

Medicare No.: _____ Social Insurance No.: _____

Language preference for correspondence: ☐ English ☐ French

Are you currently or have you recently been covered by a Prescription Drug Plan? ☐ Yes ☐ No

If Yes, when will/did this benefit terminate? _____

DD/MM/YYYY

Please select when you would like your coverage to start:

- ☐ The month of your 65th birthday
- ☐ The month following your 65th birthday
- ☐ The month following the termination of your current/previous coverage
- ☐ *Other. Specify: _____

* A completed medical questionnaire is required.

DRUG COVERAGE RATES

\$140.00 per month Medavie Blue Cross Seniors' Prescription Drug Program

\$15 co-pay per prescription

AGREEMENT AND CONSENT

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used or disclosed to administer the terms of my policy, to recommend suitable products and services to me and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

A photocopy of this authorization shall be as valid as the original. This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit medaviebc.ca or call 1-888-919-7378.

Signature _____ Date of signature _____

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.

BANKING INFORMATION: please **attach a void cheque or a direct deposit/pre-authorization payment form from your financial institution** and sign below. Please attach the void cheque to a separate sheet.

Signature of bank account holder: _____ Date of signature: _____
DD/MM/YYYY

If someone other than the applicant 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:

Last name: _____ First name: _____ Initial: _____

Address: _____ Apt.: _____

City/town: _____ Province: _____ Postal code: _____

Telephone number: _____ Alternate (e.g. mobile): _____

Signature of bank account holder: _____ Date of signature: _____
DD/MM/YYYY