MEDAVIE BLUE CROSS™
SENIORS' HEALTH PROGRAM

644 MAIN ST
PO BOX 220
MONCTON NB
E1C 8L3

APPLICATION FOR SPOUSE

Toll-Free Number: **1-800-332-3692**
Fax: **1-888-455-8322**
E-mail: **info@nbdrugs-medicamentsnb.ca**

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 covered by a Prescription Drug Plan? ❑ Yes ❑ No

If Yes, when will this benefit terminate? DD/MM/YYYY _____

Requested effective date of policy: Please begin my coverage on the 1st day of MM/YYYY _____

DRUG COVERAGE

$115.00 per month Medavie Blue Cross Seniors' Prescription Drug Program

$15 co-pay per prescription

Please complete the attached medical questionnaire.

INFORMATION ON SPOUSE AGED 65 OR OVER

Name of Spouse: _____ Date of Birth: DD/MM/YYYY _____

Medicare No.: _____ Social Insurance No.: _____

If you are applying for Drug Coverage, indicate the drug program under which your spouse is covered.

❑ New Brunswick Prescription Drug Program
❑ Medavie Blue Cross Senior's Prescription Drug Program

I hereby apply for the benefit indicated above.

Applicant's signature _____ Date of signature DD/MM/YYYY _____

CONTINUED ON REVERSE

BILLING INFORMATION

❑ **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.

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 _____