New Nouveau Brunswick

Prescription Drug Program
P.O. 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

Organ Transplant Plan Application Form

Please indicate if you have had your transplant:
☐ Yes ☐ No

What you should know before completing this form

1. Prior to completing this form please call us at the number above to confirm that the anti-rejection drug(s) that you are prescribed is/are covered under the Organ Transplant Plan.
2. If you are applying for coverage and have existing drug coverage but your plan does not cover anti-rejection drugs, a letter from your insurer is required. This letter must accompany this application and confirm you do not have coverage for anti-rejection drugs.
3. Enclose the registration fee of $50.00 with this application. Cheque is made payable to: **New Brunswick Prescription Drug Program.**
4. Mail or fax your completed application and any supporting documentation to the address/fax number above.

Personal Information

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

Name of Parent/Guardian (if Applicant is under the age of 16): _____

Address: _____

_____ Postal Code: _____

Telephone Number: _____ Medicare Number: _____

Gender: ☐ Male ☐ Female Language of Preference: ☐ English ☐ French

Please answer **Yes** or **No** to the following questions: **Yes** **No**

1. Do you have drug coverage through a Private or a Federal Government Drug Plan? ☐ ☐

   If "Yes", does this plan cover any portion of the cost of anti-rejection drugs? ☐ ☐
   If your plan does not cover any portion of the cost of anti-rejection drugs, a letter from your insurer confirming this must accompany this application.

2. Do you have drug coverage through a Provincial Government Plan? (e.g. Social Development, New Brunswick Prescription Drug Program, New Brunswick Drug Plan). ☐ ☐

   ID Number: _____

   If "Yes", please call the telephone number above for further instructions and provide your identification number.

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 – **Organ Transplant 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, the New Brunswick Organ Procurement Office, and other sources to verify the information on this form and to verify eligibility for the New Brunswick Prescription Drug Program.

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.

Name of Applicant: _____ Date: DD / MM / YYYY

Signature of Applicant: _____

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.

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, or contact the New Brunswick Prescription Drug Program at the address or telephone number shown on page 1.