

NOVA SCOTIA SENIORS' PHARMACARE PROGRAM

P.O. BOX 9322 HALIFAX, N.S., B3K 6A1 TELEPHONE 902-429-6565 or 1-800-544-6191 FAX 902-468-9402

Health Card Number:

Name and Address below:

REGISTRATION FORM

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I will not have other prescription drug coverage that will continue after age 65.

Please be advised that if you choose to enroll, we require a separate application for each senior applying, regardless of marital status. If you wish to have your premium assessed based on your income information, please sign, and complete the income verification consent below. If you are sharing a household with a partner or spouse, both residents must sign below to assess your premium based on household income. Please be aware that the program eligibility is not contingent on giving consent to access your Canada Revenue Agency information or providing proof of income. The inability to verify an applicant's or a beneficiary's income information will only mean that the premium payable will be based on the maximum premium.

Please return this completed form, with any other required forms, to the Nova Scotia Seniors' Pharmacare Program. A self-addressed envelope is included.

Income Verification Consent

I/we hereby consent to the release, by the Canada Revenue Agency, of information from my income tax records to the Nova Scotia Department of Health and Wellness, or its authorized representatives. This authorization is valid for two taxation years prior to my signing the application and each subsequent consecutive taxation year for which assistance is requested by me or on my behalf. This information will be relevant to and used solely for the purpose of the general administration and enrollment in the Nova Scotia Seniors' Pharmacare Program. This information will not be disclosed to any person, department, or organization without my approval. I understand if I wish to withdraw this authorization, I may do so at any time by writing to the Nova Scotia Seniors' Pharmacare Program.

Signature of Applicant

Applicant Social Insurance Number

Date

Spouse/Partner Health Card

Spouse/Partner Social Insurance

Signature of Spouse/Partner (if applicable)

Date

If you have any questions or concerns, you can contact us at the numbers above or email SeniorsPharmacare@medavie.bluecross.ca.