

SECTION C DEPENDENT INFORMATION - Include all dependent children living with you under the age of 18 or aged 18 to 20 and still attending high school. Please attach a confirmation letter from the school. Dependents living with you aged 18 or older but not attending high school, must complete their own application form. (If more space is required, please attach a separate sheet)

Surname	First Name	Initial	Gender		Date of Birth			MCP Number															
			M	F	Year	Month	Day																

SECTION D PRIVATE DRUG INSURANCE/COVERAGE

Do you, your spouse or dependent children have drug insurance coverage with a private insurer? Yes No (If no, go to Section E)

Name of Insurance Company (e.g. Blue Cross)

Policy Number

Family Members Covered

Terms of Coverage (e.g. insurance pays 80% of costs of prescription drugs)

SECTION E DECLARATION AND CONSENT

I declare that the information provided on this application is true and correct to the best of my knowledge. I understand that this information will be used to determine eligibility for a drug card with the Newfoundland and Labrador Prescription Drug Program (NLPDP) as well as eligibility for the Dental Health Program and may be subject to verification by officials of the Department of Health and Community Services.

For the purpose of verifying my eligibility for the drug program or dental program, and of auditing use of the drug card or dental coverage, I authorize the Department of Health and Community Services to obtain information from:

- My Employer regarding private insurance coverage.
- The Medical Care Plan (MCP) regarding my eligibility for provincial health benefits and release of my MCP number to be used for identification purposes on my drug card.
- Pharmacies, to access copies of prescriptions in order to verify claims billed to the NLPDP.
- Dentists, to verify claims billed to the Newfoundland and Labrador Dental Health Plan.

I agree to notify the Newfoundland and Labrador Prescription Drug Program of any change in my financial circumstances so that my level of coverage can be adjusted accordingly.

In order to verify financial information provided, I hereby consent to the release, by the Canada Revenue Agency to an official of the Department of Health and Community Services, of information from my income tax returns, and, if applicable, other required taxpayer information about me, including my dependent children, to be used solely for the purpose of determining and verifying my eligibility, entitlement for and the general administration and enforcement of the Newfoundland and Labrador Prescription Drug Program and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the current taxation year and each subsequent consecutive taxation year for which I will be in receipt of assistance under the Newfoundland and Labrador Prescription Drug Program. I understand that if I wish to withdraw this consent, I may do so at any time by writing to the Regional Director at the address identified below.

Printed Name of Applicant

Printed Name of Spouse

Signature of Applicant

Signature of Spouse

Social Insurance Number

Social Insurance Number

Date

Date

Please mail completed applications to:
Newfoundland and Labrador Prescription Drug Program
Assessment Office
P.O. Box 510
Stephenville, NL, A2N 3B4

Contact Information:
Toll free: 1-888-859-3535
Toll free fax: 1-888-272-2444
E-mail: LIDPinfo@gov.nl.ca