



PEI Drug Cost Assistance Program Application

Generic Drug Program applications can be done online at: healthpei.ca/genericdrugs

Personal Information (please print)

| Applicant | | | | Spouse (if applicable) | | | |
|-----------------------------------|--|-------------|-------------|-----------------------------------|--|---------|--|
| Surname | | | | Surname | | | |
| First Name | | Initial | | First Name | | Initial | |
| PEI Health Care Card number (PHN) | | | | PEI Health Care Card number (PHN) | | | |
| Date of Birth (yyyy-mm-dd) | | | | Date of Birth (yyyy-mm-dd) | | | |
| Street/PO Box | | | | Building/Apt Number | | | |
| City/Town | | Province PE | Postal Code | Telephone Number | | | |
| Email address | | | | Mobile Number | | | |

Dependent Information - Include all dependent children living with you under the age of 18 or aged 18 to 25 and attending a post secondary institution on a full time basis. Dependents living with you aged 18 or older but NOT attending school must complete their own application form. (If more space is required, please attach a separate sheet)

| Surname | First Name | Initial | Date of Birth | | | Provincial Health Card Number |
|---------|------------|---------|---------------|-------|-----|-------------------------------|
| | | | Year | Month | Day | |
| | | | | | | |
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Private Drug Insurance/Coverage – I certify by signing below that I do NOT have private drug insurance- that the information given on this application and in any documents attached is correct, complete, and fully discloses my household conditions. I understand that a false statement constitutes fraud and may result in recovery of any benefits paid. I acknowledge that it is my responsibility to report any change to the information provided within 30 days of the change coming into effect.

I/We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge. I/We, the undersigned, understand that refusing to submit information or knowingly furnishing false or incomplete information is an offence under the *Drug Cost Assistance Act*.

For the purpose of verifying program eligibility, I/we authorize the Department of Health and Wellness or Health PEI to obtain information from:

- The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN
- Retail pharmacies, to access data in order to verify claims billed to the Drug Cost Assistance Program

Personal information on this form is collected under section 31(c) of Prince Edward Island's *Freedom of Information and Protection of Privacy (FOIPP) Act* as it relates directly to and is necessary for providing services under the PEI Drug Cost Assistance Act. If you have any questions about this collection of personal information, you may contact the program office at (902) 368-4947 or 1-877-577-3737 or at the address on this form.

| | | |
|-------------------|-----------|------|
| Name of Applicant | Signature | Date |
| Name of Spouse | Signature | Date |

Return by fax to: 902-368-4905 or to : PEI Pharmacare, PO Box 2000, Charlottetown, PE, C1A 7N8 or drugprograms@gov.pe.ca

Please allow 5 business days for processing. No benefits are payable until the application is processed and eligibility approved. MARCH 2024/CM