



RETURN BY MAIL TO:
SASKATCHEWAN
MINISTRY OF HEALTH
Drug Plan & Extended Benefits Branch
Operations Unit
3475 Albert Street
Regina, Saskatchewan S4S 6X6
PHONE: 1-800-667-7581 or 306-787-3317
FAX: 306-787-8679

SENIORS' DRUG PLAN ANNUAL APPLICATION

- ◆ Completing Side B means that you must apply for the program each year.
- ◆ Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax Return showing Line 150 (for both Applicant and Spouse).
- ◆ If you do not file income tax, please include a written explanation and provide all documentation from all sources of income. (some examples: cheque stubs, T4 slips)
- ◆ Incomplete applications will result in delays in processing. Please ensure you have provided all information.
- ◆ Coverage is effective the date complete information is received, subject to approval.

APPLICANT	
SURNAME	FIRST NAME
CURRENT ADDRESS	
CITY	POSTAL CODE
DATE OF BIRTH (DD / MM / YYYY)	PHONE NUMBER
HEALTH SERVICES NUMBER (HSN)	SOCIAL INSURANCE NUMBER (SIN)

DECLARATION AND CONSENT

By completing this form, I declare that my income from Line 236 is less than the eligibility amount used for the Federal Age Tax Credit.

Is the Power of Attorney (POA) signing on behalf of the applicant? YES NO
If YES, then copies of the POA documents MUST be attached. NOTE: If a Trustee, Guardian or POA is signing for the Applicant a copy of the legal document must be attached to this consent form. Due to the variety of POA documents, some may not be considered acceptable, such as POA specific to or limited to a bank or financial institution.

"I declare that all the information I have provided is complete and correct in all respects and fully discloses my total income from all sources. I further consent to the use of this information by Saskatchewan Health for the purpose of determining my entitlement for other Health Care benefits or programs but will not be disclosed to any other person or organization without my approval."

SIGNATURE OF APPLICANT _____ DATE _____

If applicable, SIGNATURE OF GUARDIAN / TRUSTEE / POWER OF ATTORNEY. _____ DATE _____
A Witness is necessary if Applicant signs with an "X" or a mark.

PLEASE PRINT YOUR NAME IF GUARDIAN / TRUSTEE / POWER OF ATTORNEY. _____ DAYTIME CONTACT NUMBER OF GUARDIAN / TRUSTEE / POWER OF ATTORNEY. _____