

SENIORS' DRUG PLAN APPLICATION CRA CONSENT

- ◆ If you do not file income tax, please complete FORM B.
- ◆ Please ensure you have provided all information. Incomplete applications will result in delays in processing.
- ◆ 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 Provincial Age Tax Credit. YES NO If NO, please indicate reason for applying.

This consent authorizes Canada Revenue Agency (CRA) to provide Saskatchewan Ministry of Health with Line 236 for this and future years as long as you file income tax.

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 for CRA, such as POA specific to or limited to a bank or financial institution.

I hereby consent to the release, by the Canada Revenue Agency to an official of the Saskatchewan Ministry of Health, of information from my income tax returns, and, if applicable, other required taxpayer information about me. The information will be relevant to, and used solely for the purpose of determining and verifying my eligibility and the general administration and enforcement of: the Seniors' Drug Plan pursuant to *The Prescription Drugs Act* and regulations made thereunder, and will not be disclosed to any other person or organization without my approval.

This authorization is valid for the most relevant of the two taxation years prior to the year of signature. It is also valid for each subsequent consecutive taxation year during which my family unit seeks coverage under the Seniors' Drug Plan requested by me or on my behalf. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to Saskatchewan Ministry of Health, Drug Plan and Extended Benefits Branch.

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