Ontario

Ministry of Health and Long-Term Care

Trillium Drug Program (TDP)

Clear Form

Application for Ontario Drug Benefits

Before you begin:

You should apply to the TDP if:

- Your household spends a large portion of its income on prescription drugs, and
- You have a valid Ontario Health Card, and
- Your household does not have a private insurance plan or an employer that covers prescription drugs, or
- Your private insurance plan or employer does not cover all the costs of your household's prescription drugs.

Your application will be returned if:

- Any household member 16 years and over has not signed section 1 (on page 4) and section 2 (on pages 4 and 5) of the application
- The Private Insurance Coverage section on page 3 of the application is not completed

Send in your application as soon as possible. *If you are applying for the previous program year that ended July 31, then your application must be delivered or postmarked by September 30 in order to be accepted. See attached Guide, point #6 for more information.*

Household Members

Print clearly.

Person 1

Last name

First name

Middle name

Health Number

Version

Sex

[X] Male [X] Female

Date of birth Y Y Y Y / M M / D D

Social Insurance Number

Language choice

[X] English [X] French

Net Income *(18 years of age and older only)*

$, .

Universal Child Care benefit amount *(if applicable)*

$, .

Home telephone number

–

Work telephone number

–

Extension

Apt. #

Mailing address (street no., street name)

City or town

Province O N

Postal Code

If the address above is a rural route, P.O. Box or General Delivery, give us your physical address.

Street number and name, lot, concession or township

City or town

Province O N

Postal Code

3693–87E (08/02)

Household Members

By law, anyone who meets the definition of a member of a household unit must become part of your household's application to the TDP, even if they do not require drug benefits.

For the purpose of the TDP, the following people are included in our definition of a household unit:

- a single person living alone
- a spouse, common-law spouse or same-sex partner;
- children, parents or grandparents who live with you and rely on you or you on them for financial support,
- children who are students, who may not live with you but rely on you for financial support.

Print clearly.

Person 2

Last name

First name | Middle name

Health Number | Version | Sex | Date of birth

Sex: X Male X Female

Date of birth: Y Y Y Y / M M / D D

Social Insurance Number | Relationship to person #1 | Net Income *(18 years of age and older only)*

Net Income: $, .

Person 3

Last name

First name | Middle name

Health Number | Version | Sex | Date of birth

Sex: X Male X Female

Date of birth: Y Y Y Y / M M / D D

Social Insurance Number | Relationship to person #1 | Net Income *(18 years of age and older only)*

Net Income: $, .

Person 4

Last name

First name | Middle name

Health Number | Version | Sex | Date of birth

Sex: X Male X Female

Date of birth: Y Y Y Y / M M / D D

Social Insurance Number | Relationship to person #1 | Net Income *(18 years of age and older only)*

Net Income: $, .

If there are more than four household members to register in the Trillium Drug Program, list their names on a separate sheet of paper. Give us the same information as you did for Persons 1, 2, 3, and 4.

Enrolment Start Date

New TDP applicants can select the date their TDP coverage will start only in the first year they register with the program. New applicants can select any date between August 1st of the current year and July 31st of the following year. If the start date selected is after August 1st, the household deductible will be pro-rated based on the number of days remaining in the program year. *See attached Guide, point #7 for more information.*

Enrolment start date

Y Y Y Y / M M / D D

Choose carefully. You cannot change your enrolment start date once you have been enrolled in the Trillium Drug Program.

3693–87E (08/02)

Private Insurance Drug Coverage

Does any household member have private insurance coverage that includes drug benefits?

☒ **Yes** ***(complete the rest of this page)***

☒ **No** If you start a new insurance plan that includes drug benefits during the program year, you must inform the TDP immediately. Please provide the same information as required on this application form.

If no one in the household pays insurance premiums write $0 in the "annual premium paid" box below. ▼

Insurance Plan #1

Name of insurance company

Annual premium paid

$, .

Policy or plan number

Identification or certificate number

Coverage start date

Y Y Y Y / M M / D D

Coverage end date

Y Y Y Y / M M / D D

Which household member has this plan?

☒ person 1 ☒ person 2 ☒ person 3 ☒ person 4 ☒ other

Which household members are covered by this plan?

☒ person 1 ☒ person 2 ☒ person 3 ☒ person 4 ☒ all of them

If no one in the household pays insurance premiums write $0 in the "annual premium paid" box below. ▼

Insurance Plan #2

Name of insurance company

Annual premium paid

$, .

Policy or plan number

Identification or certificate number

Coverage start date

Y Y Y Y / M M / D D

Coverage end date

Y Y Y Y / M M / D D

Which household member has this plan?

☒ person 1 ☒ person 2 ☒ person 3 ☒ person 4 ☒ other

Which household members are covered by this plan?

☒ person 1 ☒ person 2 ☒ person 3 ☒ person 4 ☒ all of them

You must send a letter from the Insurance company, if, during the Trillium program year:

	The letter from your private insurer must state:
■ Your insurance coverage starts	*the date coverage started*
■ Your insurance coverage ends	*the date coverage ended*
■ You reach your annual or lifetime maximum if any	*the date the coverage maximum was met and the reinstatement date*
■ Your drug plan does not cover a particular drug(s)	*the name of the drug(s) not covered*
■ You pay a premium	*the $ amount you will pay annually*

(See attached Guide, point #8 for more information.)

3693–87E (08/02)

Declaration

All adult household members 16 years and over must sign areas 1 and 2 below. *See attached Guide, point #9 for more information.* **If there are more than four household members to register in the Trillium Drug Program, a separate sheet of paper must be used for their signatures under Declaration and Consent below.**

1.

By signing this application, I confirm that:

- I am applying for Ontario drug benefits through the Trillium Drug Program and that I am providing information on this application form for this purpose,
- I understand that I can withdraw my application at anytime,
- the information provided in this application is true, correct and complete to the best of my knowledge,
- I understand that I must immediately notify the Trillium Drug Program in writing of any changes to Household Members, Private Insurance Coverage, or any changes affecting the amount of my household net income given in this application,
- the Ministry of Health and Long-Term Care or its agents may collect any information from any source to verify the information in this application,
- the address given on page 1 will be the official address to be used by the Ministry of Health and Long-Term Care for all household members listed on this application.

Person 1 Signature	Date	**Person 3** Signature	Date
X	Y Y Y Y / M M / D D	X	Y Y Y Y / M M / D D
Person 2 Signature	Date	**Person 4** Signature	Date
X	Y Y Y Y / M M / D D	X	Y Y Y Y / M M / D D

Consent for Canada Revenue Agency to Release my Income Information to the Ministry

2.

I authorize the Canada Revenue Agency to release to the Ministry of Health and Long-Term Care information from my income tax returns and other required taxpayer information whether supplied by me or a third party. The information will be relevant to, and used solely for the purpose of determining and verifying eligibility, including determining appropriate deductible amounts, and for the administration of the Trillium Drug Program of the Ontario Drug Benefit Program under the *Ontario Drug Benefit Act*, and will not be disclosed to any other person or organization without my approval, except as required or permitted by law. This authorization is valid for the most recently available of the two taxation years prior to signing this consent and each subsequent consecutive taxation year for which assistance under the *Ontario Drug Benefit Act* may be requested and determined. I understand that, if I wish to withdraw this consent, I may do so at any time by writing to the Trillium Drug Program, PO Box 337, Station D, Etobicoke ON M9A 4X3.

Signature of person 1 or representative Date

X Y Y Y Y / M M / D D

If the signature is ***not*** that of person 1, print the signatory's information below, and attach supporting documents, as appropriate

Last name First name

Identity of signatory* *(see below)*

[X] 1 [X] 2 [X] 3 [X] 4 [X] 5

[X] I decline to give Canada Revenue Agency consent. I have attached my proof of income.

Signature of person 2 or representative Date

X Y Y Y Y / M M / D D

If the signature is ***not*** that of person 2, print the signatory's information below, and attach supporting documents, as appropriate

Last name First name

Identity of signatory* *(see below)*

[X] 1 [X] 2 [X] 3 [X] 4 [X] 5

[X] I decline to give Canada Revenue Agency consent. I have attached my proof of income.

***Categories for signatory identification:**

1. Person's Guardian of property
2. Person's Guardian of the person
3. Person's Attorney under continuing power of attorney for property
4. Person's Attorney under power of attorney for personal care
5. Substitute Decision Maker

3693–87E (08/02)

Declaration

Consent for Canada Revenue Agency to Release my Income Information to the Ministry . . *continued*

Signature of person 3 or representative

Date

X

Y Y Y Y / M M / D D

If the signature is ***not*** that of person 3, print the signatory's information below, and attach supporting documents, as appropriate

Last name

First name

Identity of signatory* *(see below)*

X 1 X 2 X 3 X 4 X 5

X I decline to give Canada Revenue Agency consent. I have attached my proof of income.

Signature of person 4 or representative

Date

X

Y Y Y Y / M M / D D

If the signature is ***not*** that of person 4, print the signatory's information below, and attach supporting documents, as appropriate

Last name

First name

Identity of signatory* *(see below)*

X 1 X 2 X 3 X 4 X 5

X I decline to give Canada Revenue Agency consent. I have attached my proof of income.

***Categories for signatory identification:**

1. Person's Guardian of property
2. Person's Guardian of the person
3. Person's Attorney under continuing power of attorney for property
4. Person's Attorney under power of attorney for personal care
5. Substitute Decision Maker

Print Form

If a household member 18 years of age and older does not sign the above CRA consent, income documentation must be submitted for that member, along with this application.

The Ministry of Health and Long-Term Care collects information about prescriptions to:

- help pharmacists fill their customers' prescriptions safely and effectively
- review trends, and
- ensure that health programs meet the needs of people in Ontario.

This information is collected with the legal authority of Section 13 of the *Ontario Drug Benefit Act*, R.S.O., 1990, chap.O.10. The information will be used and disclosed to administer the Trillium Drug Program and the Ontario Drug Benefit Program. How the Ministry uses and discloses personal health information is set out in the Ministry's Statement of Information Practices available at http://www.health.gov.on.ca/english/public/legislation/bill_31/stat_info_practices.pdf. For more information, write to the Director, Individual Eligibility Review Branch, Ministry of Health and Long-Term Care, 5700 Yonge Street, 3rd Floor, Toronto ON M2M 4K5 or call 1 800 575–5386. In Toronto, call (416) 642–3038.

3693–87E (08/02)