Reset

# *Healthy Smiles, Clear Vision*
## Application Form

☐ **New Application**
☐ **Renewal**
☐ **Change Request**
(please indicate changes in applicable section of the form)

***Healthy Smiles, Clear Vision*** is a dental and vision plan that provides coverage for **specified dental and vision benefits** to children who are 18 years of age and under in families with a total annual net income (after taxes) less than the limits listed below:

| Family Size | Income | Family Size | Income |
|---|---|---|---|
| 2 people | $22,020 | 5 people | $34,817 |
| 3 people | $26,969 | 6 people | $38,141 |
| 4 people | $31,142 | 7 people | $41,196 |

## PART I – ELIGIBILITY CRITERIA

**To be eligible you must:**
- currently reside in New Brunswick.
- have dependent child(ren) aged 18 years or under.
- not have dental and vision coverage through any other government program or private insurance plan.

**Documents to be provided:**
- copies of 2 pieces of identification for each child (**NB Medicare card** plus an additional piece of identification for each child).
- copy of New Brunswick Income Tax return(s) or Notice of Assessment(s) for parent/guardian and spouse or common-law partner (if applicable).

## PART II – HEALTH INSURANCE COVERAGE*

**Do you, your spouse/common-law partner, or dependent children currently have health insurance coverage through a government program or private insurer?**

☐ Yes Name of Insurer: _____ Policy number: _____
☐ No

**Does your policy include coverage for dental and/or vision benefits?**

☐ Yes If yes, please indicate: ☐ Dental coverage ☐ Vision coverage ☐ Both
☐ No

***Please note: For children with dental and vision coverage through the Department of Social Development, coverage will automatically be transferred to the *Healthy Smiles, Clear Vision* plan and, as such, there is no need for Social Development clients to make application to this plan.**

## PART III – PARENT/GUARDIAN INFORMATION (PLEASE PRINT)

| **Last Name:** | **First Name:** | **Middle Name:** | **Social Insurance Number** |
|---|---|---|---|
| | | | |
| **Telephone Number :** | **Alternate Telephone Number :** | | **Medicare Number** |
| | | | |

**Residency** – Are you a resident of New Brunswick? ☐ **Yes** ☐ **No**

**Mailing address** (P.O. Box #, Street, Rural Route, City, Province, Postal Code):

**Home Address** (If different from mailing address) at the time of application (Street, Apartment #, Rural Route, City, Province, Postal Code) :

**Dependents:** Please include all dependent children 18 years or under residing with you. Please attach copies of 2 pieces of identification **(one must be NB Medicare card)** for each child listed. (If more space is required, please attach separate sheet).

| Name | Date of Birth (Day/Month/Year) | Gender (M or F) | NB Medicare Number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
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*Healthy Smiles, Clear Vision* is administered by Medavie Blue Cross on behalf of the Government of New Brunswick.

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## PART IV – TOTAL ANNUAL NET INCOME

**Please provide copy of New Brunswick Income Tax return(s) or Notice of Assessment(s) for parent/guardian** (and spouse or common-law partner if applicable).

| Are you living with a spouse or common-law partner?<br>☐ Yes Name of spouse or common-law partner: _____<br>☐ No | **Spouse/Common-law partner's Social Insurance Number**<br>☐☐☐☐☐☐☐☐☐ |
|---|---|

| | | |
|---|---|---|
| 1. Parent/Guardian's income | | **← (Line 236 of Notice of Assessment or Income Tax Return from previous year)** |
| 2. Spouse or common-law partner's income (If applicable) | | **← (Line 236 of spouse's or common-law partner's Notice of Assessment or Income Tax Return from previous year)** |
| **Total combined net income from previous year** | | **← Add lines 1+2** |

## PART V – DECLARATION AND CONSENT

I/We declare that the information provided on this application is accurate and true to the best of my/our knowledge.

I/We understand that giving false or incomplete information may result in termination or suspension of benefits.

I/We understand that this information will be used to determine eligibility for dental and vision coverage under the *Healthy Smiles, Clear Vision* plan and may be subject to verification by officials of Medavie Blue Cross.

I/We understand that eligibility for the *Healthy Smiles, Clear Vision* plan is based on annual net income and, therefore, I/we must reapply on a yearly basis.

I/We consent to Medavie Blue Cross using the information provided on this application, including my/our social insurance number(s) and on any document attached, for the purpose of verifying eligibility for the *Healthy Smiles, Clear Vision* plan. This includes sharing the information with the Canada Revenue Agency and any other entity identified by Medavie Blue Cross and collecting information from those entities.

_____
Name of Applicant (Please print)

_____
Name of Spouse/Common-law partner (Please print) (if applicable)

_____
Signature of Applicant

_____
Signature of Spouse/Common-law partner (if applicable)

_____
Date

_____
Date

**For office use only:**

**Please mail or fax completed application to:**
*Healthy Smiles, Clear Vision*
644 Main Street
P.O. Box 220
Moncton, NB, E1C 8L3
Fax: 1-506-867-4651

**Contact information:**
Telephone number: 1-506-867-6026
Toll free number: 1-855-839-9229

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