Reset

New Nouveau Brunswick

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

Healthy Smiles, Clear Vision
Application Form

How to reach us

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

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

Plan Information

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	Family Size	Income
2 people.....	$26,928	5 people.....	$42,577	7 people……....	$50,378
3 people.....	$32,980	6 people……....	$46,641	8 people……....	$53,856
4 people.....	$38,082				

Note: Children 19 years of age or older are not included when determining family size.

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.

Document to be provided:

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

1 Parent/Guardian Information (please print)

Last Name: _____ First Name: _____ Middle Name: _____

Social Insurance Number: _____ Medicare Number: _____

Telephone Number: _____ Alternate Telephone Number: _____

Residency - Are you a resident of New Brunswick? Yes No

ADDRESS

Building number and street: _____ Apt.: _____

City/town: _____ Province: _____ Postal code: ⌊_⌊_⌊_⌋ ⌊_⌊_⌊_⌋

Dependents: Please include all dependent children 18 years or under residing with you.
(If more space is required, please attach separate sheet).

Last Name	First Name	Date of Birth (Day/Month/Year)	New Brunswick Medicare Number

2 Health Insurance Coverage*

Do your dependent children currently have health insurance coverage through a government program or private insurer?

○ Yes Name of Insurer: _____ Policy Number: _____
○ No

Does the 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.

3 Total Annual Net Income

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

Are you living with a spouse or common-law partner?

○ Yes Name of spouse or common-law partner: _____ Spouse/Common-law partner's Social Insurance Number: _____
○ No

Parent/Guardian's Income		← (Line 23600 of Notice of Assessment or Income Tax Return from previous year). Please include a copy.
Spouse or common-law partner's income (If applicable)		← (Line 23600 of spouse's or common-law partner's Notice of Assessment or Income Tax Return from previous year). Please include a copy.
Total combined net income from previous year		← Add Lines 1 and 2.

4 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): _____

Signature of Applicant: _____ Date: _____

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

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