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.

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).

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. 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).

Last Name	First Name	Date of Birth (Day/Month/Year)	Gender (M or F)	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 236 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 236 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: _____