

Seniors' Drug Plan Application

FORM A: CRA Consent

- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax and Benefit Return showing Line 23600.
- If you do not file income tax, complete FORM B and provide all sources of income.
- Ensure you have provided all information. Incomplete applications will result in delays.
- Coverage is effective the date complete information is received, subject to approval.
- **Please print the form and sign.** Written signatures are required by CRA.

Please return to:
Drug Plan and Extended Benefits
3475 Albert Street
Regina, SK S4S 6X6
Phone: 306-787-3317
Fax: 306-787-8679
Email: DPEB@health.gov.sk.ca

Applicant

Name:

Address:

City:

Postal Code:

Phone Number:

Date of Birth (dd/mm/yyyy):

Health Services Number:

Social Insurance Number:

DECLARATION and CONSENT

This consent authorizes Canada Revenue Agency (CRA) to provide Saskatchewan Ministry of Health with Line 23600 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 a POA 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/our 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 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.

Date:

Signature of APPLICANT

Date:

If applicable, signature of **GUARDIAN / TRUSTEE / POWER OF ATTORNEY**.

A witness is necessary if Applicant signs with an "X" or a mark.

Print name if **GUARDIAN / TRUSTEE / POWER OF ATTORNEY**

Daytime contact number of **GUARDIAN / TRUSTEE / POWER OF ATTORNEY**

08/2023