

# Special Support Program Application

## SIDE B: Annual Application



**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

- Completing Side B means that you must apply for the program each year.
- Provide a copy of your Notice of Assessment OR pages 1 to 4 of your Income Tax and Benefit Return showing Line 15000 (for both Applicant and Spouse).
- If you do not file income tax, include a written explanation and provide documentation from all sources of annual income (examples: cheque stubs, T4 slips).
- 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.**

Applicant		Spouse	
Name:		Name:	
Address:		Address:	
City:	Postal Code:	Phone Number:	
Date of Birth (dd/mm/yyyy):		Date of Birth (dd/mm/yyyy):	
Health Services Number:		Health Services Number:	
Social Insurance Number:		Social Insurance Number:	

DECLARATION and CONSENT	
<p>Is the Power of Attorney (POA) signing on behalf of the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If YES, then copies of the POA documents <u>MUST be attached</u>. 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.</b></p>	
<p>"I declare that all the information I have provided is complete and correct in all respects and fully discloses my total income from all sources. I further consent to the use of this information by Saskatchewan Ministry of Health for the purpose of determining my entitlement for other Health Care benefits or programs but will not be disclosed to any other person or organization without my approval."</p>	
<p>Date: _____</p> <p><b>Signature of APPLICANT</b>, or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark.</p>	<p>Date: _____</p> <p><b>Signature of SPOUSE</b>, or if applicable, GUARDIAN / TRUSTEE / POWER OF ATTORNEY. A witness is necessary if Applicant signs with an "X" or a mark.</p>
<p>Print name if GUARDIAN / TRUSTEE / POWER OF ATTORNEY _____</p>	<p>Print name if GUARDIAN / TRUSTEE / POWER OF ATTORNEY _____</p>

**ADDITIONAL INFORMATION:** Attach a written explanation and provide income documentation if you have changes in medication or income. For example, if you had capital gains – attach schedule 3.