New Nouveau Brunswick

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

Healthy Smiles, Clear Vision Four Year Old Vision Benefit Application Form

? How to reach us

Please mail or fax completed application to:
Healthy Smiles, Clear Vision
Four Year Old Vision Benefit
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

? Benefit Information

Healthy Smiles, Clear Vision Four Year Old Vision Benefit provides coverage for **specified vision benefits** to children who are four years old. This benefit covers one major eye exam and one pair of corrective lenses, if required. (Coverage equal to *Healthy Smiles, Clear Vision* Program)

? Eligibility Criteria

To be eligible the child must:
- currently reside in New Brunswick;
- be four years old; and
- not be already registered with the *Healthy Smiles, Clear Vision Program.*

Documents to be provided:
- A copy of the NB Medicare card for each child

1 Parent/Guardian Information (please print)

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

Medicare Number: _____ **Residency -** Are you a resident of New Brunswick? ◯ Yes ◯ No

Telephone Number: _____ Alternate Telephone Number: _____

ADDRESS

Building number and street: _____ Apt.: _____

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

Dependant(s): Please include all dependent children that are four years old residing with you. Please attach a copy of the **NB Medicare card** for each child listed. (If more space is required, please attach a 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 vision benefits through a government program or private insurer? ◯ Yes ◯ No

List all policyholders:

Policyholder: _____ Date of Birth: _____

Policyholder: _____ Date of Birth: _____

3 Declaration and Consent

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

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

I understand that this information will be used to determine eligibility for vision benefits under the program and may be subject to verification by officials of Medavie Blue Cross.

I consent to Medavie Blue Cross using the information provided on this application and on any document attached, for the purpose of verifying eligibility for the ***Healthy Smiles, Clear Vision Four Year Old Vision Benefit***. This includes sharing the information with any other entity identified by Medavie Blue Cross and collecting information from those entities.

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____ Date: _____

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Healthy Smiles, Clear Vision is administered by Medavie Blue Cross on behalf of the Government of New Brunswick