TRILLIUM DRUG PROGRAM

DRAFT

Ontario

Application

This form is your application for the Trillium Drug Program. For help in completing it, please read *A guide to your Trillium Drug Program application* and follow the examples in it.

Be sure to send your prescription drug receipts with your application. See page 2 of the guide for a list of the other documents you need.

Simplified Communications Group Inc.
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1. Tell us about your family

Start with an adult family member as Person 1. Include all members of your family even if they are not applying to this program. You must include their incomes when you calculate your family's annual net income.

See page 3 of the guide for help with this section.

Person 1

Last name | First name | Middle name

Health number | Version | Sex ☐ male ☐ female | Date of birth (y/m/d)

Social insurance number | Net income $

Person 2

Last name | First name | Middle name

Health number | Version | Sex ☐ male ☐ female | Date of birth (y/m/d)

Relationship to Person 1 | Social insurance number | Net income $

Person 3

Last name | First name | Middle name

Health number | Version | Sex ☐ male ☐ female | Date of birth (y/m/d)

Relationship to Person 1 | Social insurance number | Net income $

Person 4

Last name | First name | Middle name

Health number | Version | Sex ☐ male ☐ female | Date of birth (y/m/d)

Relationship to Person 1 | Social insurance number | Net income $

Person 5

Last name | First name | Middle name

Health number | Version | Sex ☐ male ☐ female | Date of birth (y/m/d)

Relationship to Person 1 | Social insurance number | Net income $

Your family's total annual net income $ A

2. Tell us who to write to or call about your application

You must choose someone we can write to or call about your application. You can choose one of the family members listed in Section 1. Or you can choose someone else, such as a neighbour or your lawyer. If your family qualifies for the program, we'll continue to communicate with the person you have chosen.

See page 5 of the guide for help with this section.

Are you choosing one of the family members listed in Section 1? ☐ yes ☐ no

If yes, which family member? ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ Person 5

Last name | First name | Middle name

Telephone number | When is the best time to call? ☐ days ☐ evenings | Which language does the person prefer? ☐ English ☐ French

Mailing address (street name and number)

City or town | Province | Postal code

Complete this section if the person you have chosen does not live at the mailing address above or if the mailing address is a rural route, P.O. Box or General Delivery.

Street name and number, lot, concession or township

City or town | Province | Postal code

3. Determine your family's deductible

The deductible is the amount your family must spend on prescription drugs before you apply to the program. Use the table on the green pages in the centre of the guide to determine your family's deductible.

See page 7 of the guide for help with this section.

Here's how to use the table.

- find your family's total annual net income (from Box A in Section 1) in the left-hand column of the table.
- move across that row until you come to the correct number of people in your family.

Put this amount in Box B.

$ B

4. Calculate how much your family has spent on prescription drugs

Use the receipt envelope in this package to calculate how much your family has spent on prescription drugs since April 1, 1995. See page 9 of the guide for help.

After you've filled in the prescription information we need, add up the last column on the envelope, *Amount paid by family member*.

Put this amount in Box D.

$ D

5. Tell us about your family's insurance coverage

Tell us about your family's insurance coverage that includes drug benefits. Be sure to include all insurance plans. These may be plans that family members have through work or buy themselves.

See page 11 of the guide for help with this section.

Does any family member have insurance coverage that includes drug benefits? ☐ yes ☐ no

If *no*, skip to Section 6.
If *yes*, complete this section.

Insurance plan #1

Name of insurance company | Policy or plan number

Identification or certificate number | Coverage start date (y/m/d) | Coverage end date (y/m/d)

Which family member has this plan? ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ Person 5

Which family members are covered by this plan? ☐ All of them ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ Person 5

Does an employer pay for some or all of this plan? ☐ yes ☐ no

If yes, who is the employer?

Insurance plan #2

Name of insurance company | Policy or plan number

Identification or certificate number | Coverage start date (y/m/d) | Coverage end date (y/m/d)

Which family member has this plan? ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ Person 5

Which family members are covered by this plan? ☐ All of them ☐ Person 1 ☐ Person 2 ☐ Person 3 ☐ Person 4 ☐ Person 5

Does an employer pay for some or all of this plan? ☐ yes ☐ no

If yes, who is the employer?

Does a family member pay for any part of the insurance plans above? ☐ yes ☐ no

If *no*, put Ø in Box E and skip to Section 6.
If *yes*, figure out your credit amount below.

If a family member pays for any part of the insurance plans above, you'll receive a credit for the payments. If you are a single person, write $100 in Box E. If you are a family of two or more, write $200 in Box E.

$ **E**

6. Fill in your calculations

Write your amounts from Boxes B, D and E here. See page 14 of the guide for help.

Your family's deductible
Use the amount from Box B in Section 3.

$ **B**

Amount your family has spent on prescription drugs
Use the amount from Box D in Section 4.

$ **D**

Your family's credit for insurance plan payments
Use the amount from Box E in Section 5.

+ $ **E**

Add Boxes D and E together.
Write the total in Box F.

Total = $ **F**

If Box F is larger than or the same as Box B, your family should apply to the program. Send us your application immediately.

If Box F is smaller than Box B, your family shouldn't apply to the program yet. So hold on to your application and keep adding up your receipts. Send us your application when the amount you've spent (Box F) is the same as or larger than your deductible (Box B).

7. Please read and sign this agreement

Each member of your family who is listed in Section 1 and who is 16 years or older must sign this application.

By signing this application, you confirm that:

- you are applying for the Trillium Drug Program
- the information given on this application is true, correct and complete to the best of your knowledge
- the Ministry of Health or its agents may collect any information from any source for the purpose of verifying the information contained in this application
- you authorize the District Taxation Office of Revenue Canada to verify your net taxable income
- the mailing address you gave us in Section 2 of this application will be the official address used by the Ministry of Health for the purpose of the Trillium Drug Program.

Please sign here.

Person 1

Signature	Date

Person 2

Signature	Date

Person 3

Signature	Date

Person 4

Signature	Date

Person 5

Signature	Date

Use the return envelope in this package and mail your application and documents to:

Trillium Drug Program
Drug Programs Branch
Ministry of Health
5700 Yonge Street, 15th Floor
North York, Ontario M2M 4K5

The Ministry of Health is collecting prescription information for claims payment and drug use review. The information will be used to:
- help pharmacists prevent medication-related problems e.g. harmful drug interactions before dispensing your prescriptions
- review medication use trends and implement programs to promote optimal drug therapy.

This information is collected under the legal authority of the *Ministry of Health Act*, R.S.O. 1990, Chap. M.26 and the *Ontario Drug Benefit Act*, R.S.O. 1990, M.26 0.10. The information will be used for the purpose of administering the Trillium Drug Program and the Ontario Drug Benefit Program.
For more information, write to the Director, Drug Programs Branch, 3rd Floor, 5700 Yonge Street, North York, Ontario M2M 4K5 or telephone 1-800-268-1154.