



The National Prescription Drug Plan Registration Form (DP-1)

ELIGIBILITY REQUIREMENTS

To register for the National Prescription Drug Plan a person must:

- Have a valid National Insurance number.
Belong to one of the covered groups.
Complete a Drug Plan Registration Form (DP-1).
Be diagnosed with one or more of the covered chronic diseases by a licensed physician.
Bring NIB card and valid government-issued ID when registering and collecting ACE Rx Card.

- Be receiving ante-natal care, care connected with childbirth, post-natal care or any other medical care associated with pregnancy.
Complete a Drug Plan Registration Form (DP-1) which must be accompanied by the Ante-natal/Post-natal Certificate (DP-6).
Have your physician complete an Ante-natal/Post-natal Certificate (DP-6).

IMPORTANT NOTE: Coverage is extended for only six months beyond the delivery date, after which benefits will cease.

NOTES:

General Note:

Where a person is unable to register or collect a card in person due to incapacity, a written authorization is required for an appointed person to act on behalf of the incapacitated individual.

Children/Students:

- A parent or guardian must sign the registration form for children under the age of 18.
Students age 18 – 24 years must provide a letter from their school indicating full time status. This status must be verified every six months to remain eligible for the Plan.

Pregnant Women:

In order to apply for the National Prescription Drug Plan in this group, one must:

Indigents:

In order to apply for the National Prescription Drug Plan as an Indigent, one must:

- Have an income of \$210 or less per week (\$10,920 or less per annum).
Complete a Drug Plan Registration Form (DP-1) which must be accompanied by the Indigent Certification Form (DP-7).
Have the Social Services Department complete an Indigent Certification Form (DP-7) on their behalf.

Addition of New Conditions

In cases where new conditions develop after receiving the membership card, a registered NPDP member must complete an Information Change Form (DP-2) to add the new condition(s). The same procedure for registration is completed and condition(s) are added to the member's ACE Rx Card for use at any participating pharmacy.

SECTION I - TO BE COMPLETED BY APPLICANT

NI#: [grid]

NAME: Mr. Mrs. Ms. Surname First Name Middle

SEX: Male Female Date of Birth: dd/mm/yyyy P. O. Box:

Address: Island:

Mother's Name: Father's Name:

Phone Contact: Home: Work: Cell:

Email Address: Occupation:

Employer Name:

Name of Private Health Insurer: Policy Number:

Does your private health insurance cover prescription drugs? Yes No

I certify that the information contained in this form is true and correct to the best of my knowledge and belief. I undertake that if this benefit is awarded I shall inform the National Prescription Drug Plan Office of any change in my condition, which may affect my entitlement to this Benefit.

Signature of Applicant/Guardian

Date

COMPLETE THIS SECTION ONLY IF YOU ARE A GUARDIAN

Guardian Name: Guardian NI#

Relationship to Client: ID Type & No

SECTION 2 - TO BE COMPLETED BY A REGISTERED MEDICAL PRACTITIONER

I certify that has the following medical condition(s):
Client's Name

CONDITION	<input checked="" type="checkbox"/>	CODE	DATE OF DIAGNOSIS
Arthritis			
Asthma			
Benign Prostate Hypertrophy			
Breast Cancer*			
Diabetes			
Epilepsy			
Glaucoma*			
High Cholesterol			
Hypertension			
Ischaemic Disease			
Prostate Cancer*			
Psychiatric Illness			
Sickle Cell Anemia			
Thyroid Disease			

* Diagnosis must be made by Specialist.

Home-Care Patient? Yes No

DOCTOR'S INFORMATION

Name: _____

Office Address: _____

P. O. Box: _____

Phone Number: _____

E-mail Address: _____

Medical Registration #: _____

Signature: _____

PLACE STAMP HERE

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SECTION 3 - FOR OFFICIAL USE ONLY

ID Type: Passport Drivers License Other: _____ ID Number: _____

Is claimant in receipt of NIB Benefit/Assistance? Yes No Type: _____

Application Received by: _____ Date: _____