

# NOVA SCOTIA SENIORS' PHARMACARE PROGRAM

P.O. BOX 9322 HALIFAX, N.S., B3K 6A1 TELEPHONE 429-6565 or 1-800-544-6191 FAX (902)468-9402

---

## BILLING CHOICES FORM

3
---

This form tells us how you want to make payments to the Nova Scotia Seniors' Pharmacare Program. Please indicate your choice below.

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Health Card Number

---

---

### **Option 1: Pay by Cheque or Credit Card**

If you choose this option we will send you a bill with instructions.

Please choose one of the following:

- I wish to get a bill and pay each month.
  - I wish to get a bill and make one payment for the whole year.
- 
- 

### **Option 2: Have payments withdrawn directly from your bank account**

If you choose this option, payments will be withdrawn from your bank account on the same day of each month.

To set up Option 2 you must do all of the following:

- Send us a blank cheque with "VOID" written on it.
  - Choose the day of the month (from the 1<sup>st</sup> to the 28<sup>th</sup> only) that you want the money to be withdrawn: \_\_\_\_\_.
  - Complete the Pre-Authorized Debit (PAD) Plan agreement located on the reverse of this form.
- 
- 

**Pre-Authorized Debit (PAD) Plan Agreement:**

I/we authorize Nova Scotia Seniors Pharmacare, and the financial institution designated (or any other financial institution I/We may authorize at any time) to begin deductions as per my/our instructions for monthly regular recurring payments and/or one-time payments from time to time, for payment of all charges arising under my/our Seniors Pharmacare Program account(s). Regular monthly payments for the full amount of services delivered will be debited to my/our specified account on the same day of each month. Nova Scotia Seniors Pharmacare will obtain my/our authorization for any other one-time or sporadic debits. This authority is to remain in effect until Nova Scotia Seniors Pharmacare has received written notification from me/us of its change or termination. This notification must be received at least twenty (20) business days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our right to cancel a PAD Agreement at my/our financial institution or by visiting [www.cdnpay.ca](http://www.cdnpay.ca). Nova Scotia Seniors Pharmacare may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 10 days prior written notice to me/us. I/we have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any PAD that is not authorized or is not consistent with this PAD Agreement. To obtain a form for a Reimbursement Claim, or for more information on my/our recourse rights, I/we may contact my/our financial institution or visit [www.cdnpay.ca](http://www.cdnpay.ca)

**PLEASE PRINT DATE:** \_\_\_\_\_

Name(s): \_\_\_\_\_ Health Card Number: \_\_\_\_\_

Type of Service: Personal \_\_\_\_\_ Business \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number: (Bus.) \_\_\_\_\_ (Res.) \_\_\_\_\_

**Financial Institution Number :** \_\_\_\_\_

Account Number: \_\_\_\_\_ Transit Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

**Authorized Signature(s):** \_\_\_\_\_

Nova Scotia Seniors Pharmacare  
PO Box 9322  
Halifax, NS, B3K 6A1  
Tel: 1-800-544-6191  
E-mail: [SeniorsPharmacare@medavie.bluecross.ca](mailto:SeniorsPharmacare@medavie.bluecross.ca)