Department of Health and Wellness

Fertility Treatment Program: Application Form

Personal Information (please print)		
APPLICANT		
Surname	**First Name**	**Initial**
Date of Birth (month/day/year)	**PEI Health Care Number (PHN)**	**Social Insurance Number (SIN) REQUIRED**
ADDRESS		
Street # and Name	**Apt. #**	
City/Town	**Province** PE	**Postal Code**
Home Telephone	**Cell**	
Email address		
Spouse Information (if applicable)		
Surname	**First Name**	**Initial**
Date of Birth (month/day/year)	**Social Insurance Number (SIN) REQUIRED**	

Private Insurance/Coverage	
Are you eligible for coverage from: **Yes** ◯ **No** ◯ Federal Program (including Veterans Affairs, NIHB, RCMP, Department of National Defense) **Yes** ◯ **No** ◯ Your employer	
Do you or your spouse have access to private health insurance? **Yes** ◯ **No** ◯ **If "Yes", please provide the following information:**	
Health Insurance Company Name/Third-Party Insurance Provider Name	
Plan Number	**Terms of Coverage** (e.g. insurance pays 80% of the cost of medications or IVF/IUI Procedure)
If there is more than one plan that covers your IVF/IUI treatment or medications, please provide information to the additional plan:	
Health Insurance Company Name/Third-Party Insurance Provider Name	
Plan Number	**Terms of Coverage** (e.g. insurance pays 80% of the medications or IVF/IUI Procedure)

The personal health information and personal information on this application collected under section 17 of the *Health Information Act* R.S.P.E.I. 1988, Cap. H-1.41, section 7 of the Health and Dental Services Cost Assistance Act R.S.P.E.I. 1988, Cap. H-1.21, and under the Freedom of Information and Privacy Protection Act and is necessary to assess eligibility. If you have any questions about this collection of personal health information, you may contact the program office at (902) 368 5290.

I/We confirm that I/we have read and understand all program criteria viewed on-line at: www.princeedwardisland.ca/en/information/health-and-wellness/fertility-treatment-program-a-funding-support-program and program policies obtained on-line at: www.princeedwardisland.ca/sites/default/files/legislation/h01-21-health_and_dental_services_cost_assistance_regulations.pdf .

*I/We shall indemnify and hold harmless the Government of Prince Edward Island and Health PEI, their agents, representatives and employees from and against all claims, demands, losses, costs, damages, actions, suits or proceedings of every nature and kind whatsoever arising out of or resulting from a benefit(s) received under the Fertility Treatment Program or from the fertility treatments (herein called the "Claim") provided that any such Claim is caused in whole or in part by any act, error or omission, including, but not limited to, those of negligence, of the **Applicant(s)** or anyone directly or indirectly contracted by the **Applicant(s)** to provide the fertility treatments or anyone for whom anyone contracted to perform the fertility treatments may be liable.*

For further information, contact:
Email: fertilitysupportprogram@gov.pe.ca
Tel: 902-218-0241
The Department has an email address for general inquiries, but is not accepting applications or claims by email. If I send a general inquiry to this email address, I am requesting that the Department of Health and Wellness respond by email. I understand that if I send an email to the general inquiries address, I accept any risks associated with sending or receiving sensitive information by email, including a risk that my information could be accessed by someone else in transit.

Application Checklist:

- Applicants must meet the eligibility criteria set out under the *Health and Dental Services Cost Assistance Act* R.S.P.E.I. 1988, Cap. H-1.21., Health and Dental Services Cost Assistance Regulations, and Fertility Treatment Program requirements, including the following:
  - You are a **permanent resident of PEI** defined as follows:
    - As per the *Health and Dental Services Cost Assistance Act*, "resident" means a resident as defined in the regulations under the *Health Services Payment Act* R.S.P.E.I. 1988, Cap. H-2, but does not include persons who are resident pursuant to a temporary resident visa, study permit, work permit or other similar visa or permit issued by the Government of Canada;
    - As per the regulations of the *Health Services Payment Act*, "resident" means a person legally entitled to remain in Canada and who makes his or her home in and is ordinarily present in Prince Edward Island, but does not include a tourist, a visitor to the province, a member of the Canadian Armed Forces, students ordinarily resident in another jurisdiction, or a person serving a term of imprisonment in a penitentiary as defined in the Penitentiary Act (Canada) R.S.C. 1985, Chap. P-5;
  - Have a **valid PEI Health Card**; and
  - Have filed your **income tax return** for the most recent income tax year.
- For those with private insurance, provide a letter from the insurer confirming coverage available for IVF/IUI fertility treatments, including medications.

Declaration and Consent

I /We, the undersigned, declare that the information provided on this application is true and correct to the best of my/our knowledge.

I/We, the undersigned, understand that knowingly providing false or misleading information or records is an offence under the Health and Dental Services Cost Assistance Act.

For the purpose of verifying program eligibility, I/we authorize the Department of Health and Wellness or Health PEI to obtain information from:

- *My employer, my insurer, and my plan administrator regarding private insurance coverage;*
- *The Provincial Health Plan (the Plan) regarding my eligibility for health services and release of my PHN:*
- *Retail pharmacies, to access prescription drug cost data in order to verify claims billed to the Health and Dental Services Cost Assistance Program;*

I/We, the undersigned, agree to notify the Department of Health and Wellness or Health PEI of any changes to the household, insurance coverage, or any other factor which may affect my/our level or eligibility of coverage.

I/We, the undersigned, hereby consent to the release by the Canada Revenue Agency (CRA), of income, expense and identifying information from income tax returns or from other sources, copies of notices of assessment or reassessment, and copies of information slips (for example, T2202A), T3, T4 and T5 slips) filed with CRA. The information will be relevant to, and used solely for the purpose of determining and verifying my/our eligibility and entitlement for assistance under the Health and Dental Services Cost Assistance Act, and collecting overpayments of assistance under the Freedom of Information and Privacy Protection Act identified above.

This authorization is valid for the most recent filed with and verified taxation year by the CRA for which the filing deadline has passed, and for which I/We apply for assistance under the Health and Dental Services Cost Assistance Program identified above.

I/We understand that I/We may withdraw my/our consent from the Department to collect, use and disclose my/our information by providing written notice, but that my/our right to withdraw consent may be subject to limited exceptions I/We may contact the Department of Health and Wellness for further information about how to withdraw consent, and the potential impacts if I/We withdraw my/our consent.

Applicant Name (Print)	*Signature*	*Date*
Spouse Name (Print)	*Signature*	*Date*

- *By signing above, I/We certify that the information given on this application and in any documents attached is correct and complete.*
- *I/We understand that a false statement constitutes fraud and may result in recovery of any benefits paid.*
- *I/We acknowledge that it is my/our responsibility to report any change to the information provided within 30 days of the change coming into effect.*

Mail completed application to:
Fertility Treatment Program
Department of Health and Wellness
Government of Prince Edward Island
P.O. Box 2000
Charlottetown, PE C1A 7N8