BRITISH COLUMBIA | Health InsuranceBC

MEDICAL SERVICES PLAN (MSP)
BABY ENROLMENT

PLEASE PRINT IN CAPITAL LETTERS ONLY 1 2 3 4 A B C D

Residents of BC are required, by law, to enrol themselves and their dependants with MSP.

The personal information you will provide will be collected for the following purposes: **Enrolment in the Medical Services Plan; and, Application for a BC Services Card and its authorized programs.** Personal information is collected under the authority of the Medicare Protection Act and section 26 (c) of the Freedom of Information and Protection of Privacy Act ("FIPPA"). Information may be disclosed pursuant to section 33 of FIPPA. If you have any questions about the collection and use of your personal information, please contact: Health Insurance BC Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

1 PARENT INFORMATION

PARENT LEGAL LAST NAME | PARENT LEGAL FIRST NAME | PARENT LEGAL SECOND NAME

ADDRESS

APT / UNIT | STREET NUMBER | STREET NAME AND CITY

PROV | POSTAL CODE | YOUR BIRTHDATE (MM / DD / YYYY) | PERSONAL HEALTH NUMBER (PHN) | DAYTIME TELEPHONE NUMBER

2 NEWBORN INFORMATION

NEWBORN LEGAL LAST NAME | NEWBORN LEGAL FIRST NAME | NEWBORN LEGAL SECOND NAME

HOSPITAL NAME | HOSPITAL LOCATION (CITY)

If a home birth, a photocopy of your baby's birth certificate or Certificate of Live Birth is required.

GENDER ☐M ☐F | BIRTHDATE (MM / DD / YYYY) | ADOPTION DATE, IF APPLICABLE (MM / DD / YYYY)

Attach a photocopy of the proof of adoption or the letter confirming adoption is in progress.

3 HOW TO ENROL YOUR BABY

If YOUR MEDICAL PREMIUMS ARE PAID:

A. through your employer or union welfare plan – *complete this form and take it to your group administrator for authorization (section 5)*
B. by the Ministry of Employment and Income Assistance – *complete this form and take it to your Worker*
C. directly by yourself – *complete this form and mail it directly to Health Insurance BC (HIBC) at the address below*
D. by First Nations Health Authority (Status Indian) – *complete this form and mail it directly to HIBC at the address below*

Please ensure that this form is completed and returned to our office within 60 days of your baby's birth.
A BC Services Card will be issued after this form is processed. Due to system limits, your baby's full name may not appear on the card.

4 SIGN AND DATE THE DECLARATION BELOW

Under the *Medicare Protection Act,* a resident is defined as "a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, makes his or her home in British Columbia, and is physically present in British Columbia at least 6 months in a calendar year, and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to British Columbia."

- I agree to abide by the terms and conditions of MSP.
- I understand the information I have given is collected under the authority of the *Medicare Protection Act* and may be used to assess eligibility for other Ministry of Health programs.
- I understand that practitioners who provide service(s) under MSP are required under the *Medicare Protection Act* to release information relative to those services to MSP to support claims for benefits.
- I declare that all information provided is true and I understand that the Ministry of Health and/or Health Insurance BC may verify this information with immigration authorities, law enforcement authorities and other public authorities, agencies and persons as appropriate.
- I declare that the above named child is a resident of British Columbia.

SIGNATURE(S) OF PARENT AND ACCOUNT HOLDER | DATE SIGNED (MM / DD / YYYY)

5 GROUP ADMINISTRATOR USE ONLY

GROUP NUMBER | ACCOUNT NUMBER | **AUTHORIZATION NAME OR STAMP**

Mailing Address: Health Insurance BC, Medical Services Plan, PO Box 9681 Stn Prov Govt, Victoria BC V8W 9P7
Tel: (Lower Mainland) 604 683-7151, (Rest of BC) 1 800 663-7100 Web: www.hibc.gov.bc.ca

HLTH 115 V2 Rev. 2013/06/24

BRITISH COLUMBIA | Health InsuranceBC

USE CAPITAL LETTERS ONLY

A B C D

MEDICAL SERVICES PLAN (MSP)
ENROLMENT APPLICATION

This application is for registered Status Indians who are assisted by First Nations Health Authority, and must be authorized by the First Nations Health Authority Benefits BC Region Office.

SUBMIT COMPLETED FORM TO THE FIRST NATIONS HEALTH AUTHORITY AT THE ADDRESS LISTED AT THE BOTTOM.

NOTE: INCOMPLETE, UNSIGNED OR UNAUTHORIZED FORMS WILL BE RETURNED.

Before completing this application, please read **IMPORTANT INFORMATION** on page 2.

Residents of BC are required, by law, to enrol themselves and to enrol their spouse and children who are residents of BC.
RESIDENT means a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, who makes his or her home in British Columbia, and is physically present in British Columbia for at least 6 months in a calendar year, or a shorter prescribed period, and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to British Columbia.

BAND NAME | FULL STATUS NUMBER | PERSONAL HEALTH NUMBER (PHN) | GROUP NUMBER

2100030

1 APPLICANT INFORMATION

APPLICANT LEGAL LAST NAME | APPLICANT LEGAL FIRST NAME | APPLICANT LEGAL SECOND NAME

As a person must be a resident of BC to qualify for provincial health care benefits, your current **residential** address is required.

BIRTHDATE (MM / DD/ YYYY) | GENDER ☐ M ☐ F | DAYTIME TELEPHONE NUMBER

RESIDENTIAL ADDRESS | CITY | PROV | POSTAL CODE

MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS) | CITY | PROV | POSTAL CODE

2 RESIDENCE AND CITIZENSHIP / IMMIGRATION INFORMATION

A STATUS IN CANADA - ***PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS FOR EACH PERSON LISTED ON THIS APPLICATION*** (DO NOT SEND ORIGINALS)

☐ CANADIAN CITIZEN – Canadian Birth Certificate, Canadian Citizenship Card or Passport ☐ HOLDER OF PERMANENT RESIDENT STATUS – Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence ☐ OTHER – Work or Study Permit, etc.

B HAVE YOU HAD MSP COVERAGE PREVIOUSLY? ☐ YES ☐ NO (IF NO, GO TO "C") IF YES, PROVIDE → PERSONAL HEALTH NUMBER (PHN)

C HAVE YOU LIVED IN BC SINCE BIRTH? ☐ YES (GO TO "D") ☐ NO →

MOST RECENT MOVE TO BC → (MM / DD / YYYY)

MOST RECENT MOVE TO CANADA → (IF DIFFERENT FROM DATE OF MOVE TO BC) (MM / DD / YYYY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO

PROVINCE OR COUNTRY MOVED FROM | PREVIOUS HEALTH NUMBER

D HAVE YOU OR ANY FAMILY MEMBER BEEN OUTSIDE BC FOR MORE THAN 30 DAYS IN TOTAL DURING THE PAST 12 MONTHS? ☐ YES ☐ NO (IF NO, GO TO "E")

DEPARTURE DATE (MM / DD / YYYY) | RETURN DATE (MM / DD / YYYY) | FAMILY MEMBER NAME, REASON FOR DEPARTURE AND LOCATION

E WILL YOU OR ANY FAMILY MEMBER BE AWAY FROM BC FOR MORE THAN 30 DAYS IN TOTAL IN THE NEXT SIX MONTHS? ☐ YES ☐ NO
IF YES, SEE **RESIDENCY**, PAGE 2.

ARE YOU A FULL-TIME STUDENT? ☐ YES ☐ NO

IF YES, WILL YOU RESIDE IN BC ON COMPLETION OF YOUR STUDIES? ☐ YES ☐ NO

IF ANYONE LISTED IS AN ACTIVE MEMBER OF, OR HAS BEEN RELEASED FROM, THE CANADIAN FORCES, RCMP OR AN INSTITUTION, PLEASE PROVIDE THE DISCHARGE DATE:
(MM / DD / YYYY)

IS THIS APPLICATION ALSO FOR A SPOUSE OR CHILD? IF YES, PLEASE COMPLETE PAGE 2.

3 AUTHORIZATION - MUST BE SIGNED (DO NOT CHANGE TEXT OF AUTHORIZATION BELOW)

I have received information about MSP and agree to abide by the terms and conditions of MSP. I understand the information I have given is collected under the authority of the *Medicare Protection Act* and may be used to assess eligibility for other Ministry of Health programs, and that practitioners who provide service(s) under MSP are required under the *Medicare Protection Act* to release information relative to those services to MSP to support claims for benefits.

I declare that all information provided is true and I understand that the Ministry and/or Health Insurance BC may verify this information with immigration authorities, law enforcement authorities and other public authorities, agencies and persons as appropriate. I declare that all persons listed are residents of British Columbia.

SIGNATURE OF APPLICANT | SIGNATURE OF SPOUSE | DATE SIGNED (MM / DD / YYYY)

SUBMIT THIS FORM, MARKED CONFIDENTIAL, TO:
First Nations Health Authority, Health Benefits Department,
#501 - 100 Park Royal South, West Vancouver BC V7T 1A2

4 SPOUSE AND CHILD INFORMATION (LIST ONLY THOSE ELIGIBLE)

SPOUSE means a resident of BC who is either married to or living and cohabiting in a marriage-like relationship with the applicant and may be of the same gender as the applicant.
CHILD means a resident of BC who is the legal ward or child of the applicant, is supported by the applicant, is neither married nor living and cohabiting in a marriage-like relationship, and is either age 18 or younger, or age 19 to 24 and attending school or university full time.

PHOTOCOPIES OF CURRENT CITIZENSHIP/IMMIGRATION DOCUMENTS MUST BE ATTACHED. USE LEGAL NAMES WHEN COMPLETING THIS FORM. IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF MARRIAGE OR CHANGE OF NAME CERTIFICATE, ETC.

SPOUSE LEGAL LAST NAME | SPOUSE LEGAL FIRST NAME | SPOUSE LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | GENDER ☐ M ☐ F | STATUS INDIAN? ☐ YES ☐ NO | FULL STATUS NUMBER

STATUS IN CANADA *(MARK ONE – [X])*

- ☐ CANADIAN CITIZEN – Canadian Birth Certificate, Canadian Citizenship Card or Passport
- ☐ HOLDER OF PERMANENT RESIDENT STATUS – Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence
- ☐ OTHER – Work or Study Permit, etc.

PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS (DO NOT SEND ORIGINALS). IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF MARRIAGE/CHANGE OF NAME CERTIFICATE, ETC.

MARRIAGE DATE (MM / DD / YYYY) | SPOUSE'S PREVIOUS LAST NAME (IF APPLICABLE)

HAS SPOUSE LIVED IN BC SINCE BIRTH? ☐ YES ☐ NO | IF NO, MOST RECENT MOVE TO BC → | MM / DD / YYYY | FROM (PROVINCE OR COUNTRY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE

CHILD LEGAL LAST NAME | CHILD LEGAL FIRST NAME | CHILD LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | GENDER ☐ M ☐ F | STATUS INDIAN? ☐ YES ☐ NO | FULL STATUS NUMBER

STATUS IN CANADA *(MARK ONE – [X])*

- ☐ CANADIAN CITIZEN – Canadian Birth Certificate, Canadian Citizenship Card or Passport
- ☐ HOLDER OF PERMANENT RESIDENT STATUS – Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence
- ☐ OTHER – Work or Study Permit, etc.

PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS (DO NOT SEND ORIGINALS). IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF CHANGE OF NAME CERTIFICATE, ETC.

HAS CHILD LIVED IN BC SINCE BIRTH? ☐ YES ☐ NO | IF NO, MOST RECENT MOVE TO BC → | MM / DD / YYYY | FROM (PROVINCE OR COUNTRY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE

IF CHILD IS NEWLY ADOPTED, INDICATE DATE OF ADOPTION AND ***ENCLOSE PROOF OF ADOPTION*** → | ADOPTION DATE (MM / DD / YYYY)

☐ **IF YOU HAVE MORE THAN ONE CHILD, PLEASE MARK BOX ([X]), ATTACH ADDITIONAL SHEET AND PROVIDE ALL INFORMATION**

IF ANY OF THE CHILDREN ARE 19 TO 24 YEARS OF AGE AND ATTENDING SCHOOL ON A FULL-TIME BASIS, PLEASE COMPLETE THE SECTION BELOW.

STUDENT LEGAL LAST NAME | STUDENT LEGAL FIRST NAME | STUDENT LEGAL SECOND NAME

SCHOOL NAME AND FULL ADDRESS | DATE STUDIES WILL BE FINISHED (MM / DD / YYYY) | IF SCHOOL IS OUTSIDE BC, ORIGINAL DEPARTURE DATE (MM / DD / YYYY)

☐ **IF YOU HAVE MORE CHILDREN 19 TO 24 YEARS OF AGE THAT ARE FULL-TIME STUDENTS, PLEASE CHECK BOX, ATTACH ADDITIONAL SHEET AND PROVIDE ALL INFORMATION**

5 FIRST NATIONS HEALTH AUTHORITY AUTHORIZATION – *MUST BE SIGNED BY A FIRST NATIONS HEALTH AUTHORITY REPRESENTATIVE*

FIRST NATIONS HEALTH AUTHORITY AUTHORIZATION	**THE ABOVE INFORMATION IS SUPPORTED BY**
MEDICAL SERVICES BRANCH REPRESENTATIVE	

6 IMPORTANT INFORMATION

- **IDENTIFICATION:** You must send with your application: photocopies of documents that support the name and Canadian citizenship or immigration status for all persons listed. Eligibility cannot be determined without this documentation. Canadian citizens and holders of permanent resident status (landed immigrants) returning from the USA may also be asked to provide evidence of having established residence in BC and/or having abandoned their status in the USA.

  If any person is not enrolling under the name shown on his/her citizenship or immigration document, please also submit a photocopy of a legal document (for example, a marriage or name change certificate) that indicates the name shown on this application.
- **RESIDENCY:** If you or any family member listed on this application expect to leave the province for more than 30 days in total during the next 6 months, a letter outlining your planned dates of departure and return, destination and the reason for your absence is required with this application. Failure to provide this information may affect eligibility for benefits.
- **EFFECTIVE DATE OF BENEFITS:** New and returning residents must complete a waiting period before health care benefits begin. Generally, this period is the balance of the month of arrival in BC, plus two months. If absences from Canada exceed a total of 30 days during the waiting period, eligibility may be affected. Applications should be submitted immediately on arrival in BC, not at the end of the waiting period. If you apply late, the effective date of benefits will be determined by MSP and may result in premiums being charged retroactively.
- **OUT-OF-PROVINCE STUDENTS:** Residents who leave BC temporarily to attend school or university may be eligible for MSP coverage for the duration of studies, provided they are in full-time attendance at a recognized educational facility.
- **CANCELLATION OF BENEFITS:** Failure to remit premiums does not constitute notification to cancel benefits. If you will no longer be a resident of BC, you must notify Health Insurance BC that this is the case, and provide your date of departure from the province and your new address; otherwise, premium invoicing may occur.
- **CHANGE OF NAME OR ADDRESS:** Health Insurance BC must be notified immediately of any change of name or address.
- **LEGISLATION:** All information is subject to change in accordance with the *Medicare Protection Act* and Health Care Services Regulations and the *Hospital Insurance Act* and Regulations. If a discrepancy exists between the information Health Insurance BC has provided on this application and the legislation, the legislation will prevail.

The personal information you will provide will be collected for the following purposes: **Enrolment in the Medical Services Plan; and, Application for a BC Services Card and its authorized programs.** Personal information is collected under the authority of the Medicare Protection Act and section 26 (c) of the Freedom of Information and Protection of Privacy Act ("FIPPA"). Information may be disclosed pursuant to section 33 of FIPPA. If you have any questions about the collection and use of your personal information, please contact: Health Insurance BC Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

BRITISH COLUMBIA | Health InsuranceBC

PLEASE USE CAPITAL LETTERS ONLY

A B C D

MEDICAL SERVICES PLAN (MSP) CHANGE REQUEST

This application is for registered Status Indians who are assisted by First Nations Health Authority, and must be authorized by the First Nations Health Authority Benefits BC Region Office.

SUBMIT COMPLETED FORM TO THE FIRST NATIONS HEALTH AUTHORITY AT THE ADDRESS LISTED AT THE BOTTOM.

Residents of BC are required, by law, to enrol themselves and to enrol their spouse and children who are residents of BC.

RESIDENT means a person who is a citizen of Canada or is lawfully admitted to Canada for permanent residence, who makes his or her home in British Columbia, and is physically present in British Columbia for at least 6 months in a calendar year, or a shorter prescribed period, and includes a person who is deemed under the regulations to be a resident but does not include a tourist or visitor to British Columbia.

WAIT PERIOD: New and returning residents must complete a wait period before benefits begin. Generally, this is the balance of the month of arrival in BC plus two months. If absences from Canada exceed a total of 30 days in this period, eligibility may be affected.

1 CHANGE REQUEST

I AM SUBMITTING THIS FORM TO (PLEASE MARK (☒) ALL BOXES THAT APPLY):

☐ CHANGE/CORRECT ACCOUNT HOLDER'S INFORMATION – Complete sections 2 (with new/correct information) and 4, and submit form to the First Nations Health Authority to authorize (section 5). Legal documents are required for Health Insurance BC to confirm a change or correction. **For example, provide a photocopy of your proof of Status in Canada** (see examples on page 2) **or marriage/change of name certificate.**

☐ CHANGE ADDRESS INFORMATION – Complete sections 2, 3, 4 and submit form to the First Nations Health Authority to authorize (section 5).

☐ ADD, REMOVE OR CHANGE/CORRECT INFORMATION FOR A SPOUSE – On page 2, complete section 6 and, if you are adding a spouse, section 8. On this page complete sections 2, 4 and submit form to the First Nations Health Authority to authorize (section 5). **Provide photocopies of all applicable documents** as explained in section 6 on page 2.

☐ ADD, REMOVE OR CHANGE/CORRECT INFORMATION FOR A CHILD – On page 2, complete section 7 and, if you are adding a child, section 8. On this page complete sections 2, 4 and submit form to the First Nations Health Authority to authorize (section 5). **Provide photocopies of all applicable documents** as explained in section 7 on page 2.

2 ACCOUNT HOLDER INFORMATION – *THIS SECTION MUST BE COMPLETED*

ACCOUNT HOLDER LEGAL LAST NAME | ACCOUNT HOLDER LEGAL FIRST NAME | ACCOUNT HOLDER LEGAL SECOND NAME

GROUP NUMBER: 2100030 | PERSONAL HEALTH NUMBER (PHN) | FULL STATUS NUMBER | BIRTHDATE (MM / DD / YYYY) | GENDER ☐ M ☐ F

TELEPHONE NUMBER

3 ADDRESS CHANGE – *PLEASE PROVIDE NEW ADDRESS INFORMATION*

RESIDENTIAL ADDRESS | CITY | PROV | POSTAL CODE

MAILING ADDRESS (IF DIFFERENT FROM RESIDENTIAL ADDRESS) | CITY | PROV | POSTAL CODE

4 AUTHORIZATION – *MUST BE SIGNED (DO NOT CHANGE TEXT OF AUTHORIZATION BELOW)*

I understand the information I have given is collected under the authority of the *Medicare Protection Act* and may be used to assess eligibility for other Ministry of Health programs, and that practitioners who provide service(s) under MSP are required under the *Medicare Protection Act* to release information relative to those services to MSP to support claims for benefits.

I declare that all information provided is true and I understand that the Ministry and/or Health Insurance BC may verify this information with immigration authorities, law enforcement authorities and other public authorities, agencies and persons as appropriate. I declare that all persons listed are residents of British Columbia.

SIGNATURE OF ACCOUNT HOLDER | SIGNATURE OF ACCOUNT HOLDER'S SPOUSE | DATE SIGNED (MM / DD / YYYY)

5 FIRST NATIONS HEALTH AUTHORITY AUTHORIZATION – *MUST BE SIGNED BY A FIRST NATIONS HEALTH AUTHORITY REPRESENTATIVE*

FIRST NATIONS HEALTH AUTHORITY AUTHORIZATION

MEDICAL SERVICES BRANCH REPRESENTATIVE

THE ABOVE INFORMATION IS SUPPORTED BY

The personal information you will provide will be collected for the following purposes: **Enrolment in the Medical Services Plan; and, Application for a BC Services Card and its authorized programs.** Personal information is collected under the authority of the Medicare Protection Act and section 26 (c) of the Freedom of Information and Protection of Privacy Act ("FIPPA"). Information may be disclosed pursuant to section 33 of FIPPA. If you have any questions about the collection and use of your personal information, please contact: Health Insurance BC Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

SUBMIT THIS FORM, MARKED CONFIDENTIAL, TO:

First Nations Health Authority, Health Benefits Department,
#501 - 100 Park Royal South, West Vancouver BC V7T 1A2

SPOUSE means a resident of BC who is either married to or living and cohabiting in a marriage-like relationship with the applicant and may be of the same gender as the applicant.
CHILD means a resident of BC who is the legal ward or child of the applicant, is supported by the applicant, is neither married nor living and cohabiting in a marriage-like relationship, and is either age 18 or younger, or age 19 to 24 and attending school or university full time.

6 SPOUSE

SPOUSE LEGAL LAST NAME | SPOUSE LEGAL FIRST NAME | SPOUSE LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | GENDER ☐ M ☐ F | STATUS INDIAN? ☐ YES ☐ NO | FULL STATUS NUMBER

☐ **CHANGE/CORRECT SPOUSE'S INFORMATION** LEGAL DOCUMENTS ARE REQUIRED FOR MSP TO CONFIRM A CHANGE OR CORRECTION. ***PROVIDE PHOTOCOPY OF APPLICABLE DOCUMENT;*** E.G. PROOF OF STATUS IN CANADA (SEE BELOW) OR MARRIAGE/CHANGE OF NAME CERTIFICATE

☐ **REMOVE SPOUSE FROM PLAN** CANCELLATION DATE (MM / DD / YYYY) | REASON FOR CANCELLATION

SPOUSE'S CURRENT MAILING ADDRESS | CITY | PROV | POSTAL CODE

☐ **ADD SPOUSE TO PLAN**

STATUS IN CANADA *(MARK ONE – X)*

- ☐ CANADIAN CITIZEN – Canadian Birth Certificate, Canadian Citizenship Card or Passport
- ☐ HOLDER OF PERMANENT RESIDENT STATUS – Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence
- ☐ OTHER – Work or Study Permit, etc.

PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS (DO NOT SEND ORIGINALS). IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF MARRIAGE/CHANGE OF NAME CERTIFICATE, ETC.

MARRIAGE DATE (MM / DD / YYYY) | SPOUSE'S PREVIOUS LAST NAME (IF APPLICABLE)

HAS SPOUSE LIVED IN BC SINCE BIRTH? ☐ YES ☐ NO IF NO, MOST RECENT MOVE TO BC → | MM / DD / YYYY | FROM (PROVINCE OR COUNTRY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE

7 CHILD

☐ **IF YOU ARE ADDING, REMOVING OR CHANGING INFORMATION FOR MORE THAN ONE CHILD, PLEASE MARK BOX (X), ATTACH ADDITIONAL SHEET AND PROVIDE ALL INFORMATION.**

CHILD LEGAL LAST NAME | CHILD LEGAL FIRST NAME | CHILD LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | GENDER ☐ M ☐ F | FULL STATUS NUMBER

☐ **CHANGE/CORRECT CHILD'S INFORMATION** LEGAL DOCUMENTS ARE REQUIRED FOR MSP TO CONFIRM A CHANGE OR CORRECTION. ***PROVIDE PHOTOCOPY OF APPLICABLE DOCUMENT;*** E.G. PROOF OF STATUS IN CANADA (SEE BELOW) OR CHANGE OF NAME CERTIFICATE

☐ **REMOVE CHILD FROM PLAN** CANCELLATION DATE (MM / DD / YYYY) | REASON FOR CANCELLATION

CHILD'S CURRENT MAILING ADDRESS | CITY | PROV | POSTAL CODE

☐ **ADD CHILD TO PLAN**

STATUS IN CANADA *(MARK ONE – X)*

- ☐ CANADIAN CITIZEN – Canadian Birth Certificate, Canadian Citizenship Card or Passport
- ☐ HOLDER OF PERMANENT RESIDENT STATUS – Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence
- ☐ OTHER – Work or Study Permit, etc.

PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS (DO NOT SEND ORIGINALS). IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF CHANGE OF NAME CERTIFICATE, ETC.

HAS CHILD LIVED IN BC SINCE BIRTH? ☐ YES ☐ NO IF NO, MOST RECENT MOVE TO BC → | MM / DD / YYYY | FROM (PROVINCE OR COUNTRY)

IS THIS A PERMANENT MOVE? ☐ YES ☐ NO | REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE

IF CHILD IS NEWLY ADOPTED, INDICATE DATE OF ADOPTION AND ***ENCLOSE PROOF OF ADOPTION*** → ADOPTION DATE (MM / DD / YYYY)

IF THE ABOVE CHILD IS 19 TO 24 YEARS OF AGE AND ATTENDING SCHOOL ON A FULL-TIME BASIS, PLEASE ALSO COMPLETE THE SECTION BELOW.

SCHOOL NAME AND FULL ADDRESS

DATE STUDIES WILL BEGIN (MM / DD / YYYY) | DATE STUDIES WILL BE FINISHED (MM / DD / YYYY) | IF SCHOOL IS OUTSIDE BC, ORIGINAL DEPARTURE DATE (MM / DD / YYYY)

Residents who leave BC temporarily to attend school or university may be eligible for MSP coverage for the duration of studies, provided they are in full-time attendance at a recognized educational facility.

8 ADDITIONAL REQUIRED INFORMATION – *FAILURE TO PROVIDE THIS INFORMATION MAY AFFECT ELIGIBILITY FOR BENEFITS*

HAVE YOU OR ANY FAMILY MEMBER BEEN OUTSIDE BC FOR MORE THAN 30 DAYS IN TOTAL IN THE PAST 12 MONTHS? ☐ YES ☐ NO IF YES, PROVIDE DETAILS BELOW.

WILL YOU OR ANY FAMILY MEMBER BE OUTSIDE BC FOR MORE THAN 30 DAYS IN TOTAL IN THE NEXT 6 MONTHS? ☐ YES ☐ NO IF YES, PROVIDE DETAILS BELOW.

DEPARTURE DATE (MM / DD / YYYY) | RETURN DATE (MM / DD / YYYY) | FAMILY MEMBER NAME, REASON FOR DEPARTURE AND LOCATION

IF ANYONE LISTED IS AN ACTIVE MEMBER OF, OR HAS BEEN RELEASED FROM, THE CANADIAN ARMED FORCES, RCMP OR AN INSTITUTION, PROVIDE NAME AND, IF APPLICABLE, DISCHARGE DATE:

NAME | (MM / DD / YYYY)