



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
BIRTHDATE (MM / DD / YYYY)	GENDER	DAYTIME TELEPHONE NUMBER
	<input type="checkbox"/> M <input type="checkbox"/> F	
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)		
	<input type="checkbox"/> CANADIAN CITIZEN - Canadian Birth Certificate, Canadian Citizenship Card or Passport <input type="checkbox"/> HOLDER OF PERMANENT RESIDENT STATUS - Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence <input type="checkbox"/> OTHER - Work or Study Permit, etc.		
B	HAVE YOU HAD MSP COVERAGE PREVIOUSLY?	PERSONAL HEALTH NUMBER (PHN)	
	<input type="checkbox"/> YES <input type="checkbox"/> NO (IF NO, GO TO "C") IF YES, PROVIDE →		
C	HAVE YOU LIVED IN BC SINCE BIRTH?	(MM / DD / YYYY)	(MM / DD / YYYY)
	<input type="checkbox"/> YES (GO TO "D") <input type="checkbox"/> NO → MOST RECENT MOVE TO BC →		
	IS THIS A PERMANENT MOVE? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? IF YES, SEE RESIDENCY , PAGE 2.		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:
	<input type="checkbox"/> YES <input type="checkbox"/> NO		(MM / DD / YYYY)
	ARE YOU A FULL-TIME STUDENT?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
	IF YES, WILL YOU RESIDE IN BC ON COMPLETION OF YOUR STUDIES?		
	<input type="checkbox"/> YES <input type="checkbox"/> NO		

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	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
PERSONAL HEALTH NUMBER (PHN)	BIRTHDATE (MM / DD / YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	STATUS INDIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	FULL STATUS NUMBER	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
STATUS IN CANADA (MARK ONE - <input checked="" type="checkbox"/>)		MARRIAGE DATE (MM / DD / YYYY)		SPOUSE'S PREVIOUS LAST NAME (IF APPLICABLE)	
<input type="checkbox"/> CANADIAN CITIZEN - Canadian Birth Certificate, Canadian Citizenship Card or Passport		<input type="text"/>		<input type="text"/>	
<input type="checkbox"/> HOLDER OF PERMANENT RESIDENT STATUS - Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence		HAS SPOUSE LIVED IN BC SINCE BIRTH?		MM / DD / YYYY FROM (PROVINCE OR COUNTRY)	
<input type="checkbox"/> OTHER - Work or Study Permit, etc.		<input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, MOST RECENT MOVE TO BC →		<input type="text"/>	
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.		IS THIS A PERMANENT MOVE?		REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE	
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>	

CHILD LEGAL LAST NAME		CHILD LEGAL FIRST NAME		CHILD LEGAL SECOND NAME	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
PERSONAL HEALTH NUMBER (PHN)	BIRTHDATE (MM / DD / YYYY)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	STATUS INDIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	FULL STATUS NUMBER	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
STATUS IN CANADA (MARK ONE - <input checked="" type="checkbox"/>)		HAS CHILD LIVED IN BC SINCE BIRTH?		MM / DD / YYYY FROM (PROVINCE OR COUNTRY)	
<input type="checkbox"/> CANADIAN CITIZEN - Canadian Birth Certificate, Canadian Citizenship Card or Passport		<input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, MOST RECENT MOVE TO BC →		<input type="text"/>	
<input type="checkbox"/> HOLDER OF PERMANENT RESIDENT STATUS - Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence		IS THIS A PERMANENT MOVE?		REG. # OF MEDICAL PLAN IN PREVIOUS PLACE OF RESIDENCE	
<input type="checkbox"/> OTHER - Work or Study Permit, etc.		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="text"/>	
PROVIDE PHOTOCOPIES OF ALL APPLICABLE DOCUMENTS (DO NOT SEND ORIGINALS). IF LEGAL NAME DOES NOT MATCH, INCLUDE COPY OF CHANGE OF NAME CERTIFICATE, ETC.		IF CHILD IS NEWLY ADOPTED, INDICATE DATE OF ADOPTION AND ENCLOSE PROOF OF ADOPTION →		ADOPTION DATE (MM / DD / YYYY)	
				<input type="text"/>	

☐ IF YOU HAVE MORE THAN ONE CHILD, PLEASE MARK BOX (☒) , 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	
<input type="text"/>		<input type="text"/>		<input type="text"/>	
SCHOOL NAME AND FULL ADDRESS		DATE STUDIES WILL BE FINISHED (MM / DD / YYYY)		IF SCHOOL IS OUTSIDE BC, ORIGINAL DEPARTURE DATE (MM / DD / YYYY)	
<input type="text"/>		<input type="text"/>		<input type="text"/>	

☐ 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
<input type="text"/>	<input type="text"/>
MEDICAL SERVICES BRANCH REPRESENTATIVE	<input type="text"/>

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).