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

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PRINT RESET