BRITISH COLUMBIA
Ministry of Health Services
Medical Services Plan (MSP)

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H170

GROUP CHANGE FORM

Residents of BC are required, by law, to enroll themselves and their dependents with the Medical Services Plan of BC.

Personal information on this form is collected under the authority of the *Medicare Protection Act.* The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client service representative at the address and telephone numbers shown above. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

ACCOUNT HOLDER'S LEGAL NAME **— THIS SECTION MUST BE COMPLETED**

FIRST / SECOND / SURNAME	GROUP	ACCOUNT OR PERSONAL HEALTH NO.

A. ADDITION / CHANGE

PREVIOUS DEPT. / PAYLIST ☐☐☐☐☐☐ NEW DEPT. / PAYLIST ☐☐☐☐☐☐ PREVIOUS EMPLOYEE NO. ☐☐☐☐☐☐☐☐☐ NEW EMPLOYEE NO. ☐☐☐☐☐☐☐☐☐

B. ADDITION OF DEPENDENTS **— USE LEGAL NAMES ONLY** SEE NEXT PAGE FOR DEFINITION OF RESIDENT AND DEPENDENT(S)

FIRST NAME	SECOND NAME	SURNAME	BIRTHDATE MM	BIRTHDATE DD	BIRTHDATE YYYY	GENDER M / F	PERSONAL HEALTH NUMBER	REQUESTED EFFECTIVE DATE MM	REQUESTED EFFECTIVE DATE DD	REQUESTED EFFECTIVE DATE YYYY
							9			
							9			
							9			

1. Relationship to you _____ Date of marriage and previous surname (if applicable) _____
2. If child is 19 to 24 years of age, indicate name and address of school he/she is attending on a full-time basis _____
   enrollment date_____ date studies will be completed _____.
   If school is outside BC, provide original date of departure _____ **SEE NEXT PAGE ABOUT OUT-OF-PROVINCE STUDENTS**
   Will dependent reside in BC upon completion of studies ? ❒ yes ❒ no **PROOF REQUIRED FOR OUT-OF-COUNTRY STUDENTS**
3. If dependent child is newly adopted, indicate date of adoption _____ **ENCLOSE PROOF OF ADOPTION**
4. Has spouse/child lived in BC since birth ? ❒ yes ❒ no If no, complete the following
   Spouse/child's previous place of residence _____ Most recent move to BC _____ Is this a permanent move? ❒ yes ❒ no
5. Spouse/child's status in Canada
   PHOTOCOPIES OF DOCUMENTS ARE REQUIRED FOR ALL DEPENDENTS BEING ADDED, INCLUDING NEWBORNS. SEE NEXT PAGE.
   - ❒ CANADIAN CITIZEN (Canadian Birth Certificate or Canadian Citizenship Card)
   - ❒ HOLDER OF PERMANENT RESIDENT STATUS (Record of Landing, Permanent Resident Card (front & back) or Confirmation of Permanent Residence)
   - ❒ OTHER (Work Permit, Study Permit, etc.)
6. Do you or any family member plan to be away from BC for more than 30 days during the next six months? ❒ yes ❒ no
6a. Have you or any family member been outside BC for more than 30 days during the past 12 months? ❒ yes ❒ no
} **IF YES, SEE NEXT PAGE REGARDING ABSENCES**
7. Is dependent an active member of the Canadian Armed Forces or RCMP ? ❒ yes ❒ no
   If dependent has recently been released from the Canadian Armed Forces, RCMP, or an institution, please provide date of discharge/release _____

DECLARATION MUST BE SIGNED MSP MUST HAVE YOUR CURRENT ADDRESS **— SEE NEXT PAGE**

- 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 Services 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 on this application is true and I authorize the Ministry to 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	DATE SIGNED MM	DD	YYYY

SIGNATURE OF SPOUSE	DATE SIGNED MM	DD	YYYY

AUTHORIZATION **— THIS SECTION MUST BE COMPLETED BY YOUR PAY OR PENSION OFFICE** *UNAUTHORIZED FORMS WILL BE RETURNED*

NAME OF PAYROLL / PENSION OFFICER OR EMPLOYER STAMP	ADDRESS OF PAYROLL / PENSION OFFICE

CONTINUED ON NEXT PAGE ///➡

IMPORTANT INFORMATION

Eligibility for provincial health care benefits is based on residency in British Columbia. Under the *Medicare Protection Act*, **RESIDENT** means 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.

DEPENDENT – includes a spouse and children who are residents of BC.

SPOUSE – with respect to another person means a resident who is married to or is living and cohabiting in a marriage-like relationship with the other person and, for the purposes of this definition, the marriage or marriage-like relationship may be between persons of the same gender.

CHILD – means a person who is a child of a beneficiary or a person in respect of whom a beneficiary stands in the place of a parent and who is a minor, or, is older than 18 and younger than 25 years, and is in full-time attendance at an approved educational institution, is supported by the beneficiary and does not have a spouse.

DOCUMENTS REQUIRED – PHOTOCOPIES MUST BE INCLUDED OR FORM WILL BE RETURNED

If you are adding new dependent(s) include with this form, photocopies of documents to show the legal name and to support Canadian citizenship or immigration status of all those, including newborns, to be covered. This information will be used to determine eligibility for coverage and when coverage can begin.

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 US status.

ABSENCES – If you or any family member expect to leave the province for more than 30 days, in total, during the next 6 months, a letter outlining your planned date of departure, where you will be, the reason for the absence and your expected date of return is required. If you or any family member have been outside BC for more than 30 days during the past 12 months, a letter is required giving all dates of departure from BC, your whereabouts, the reason for each absence and all dates of return to BC. If you or any family member spend part of each year outside the province you must reside in Canada at least 6 months in a calendar year and continue to maintain your home in BC, to qualify for provincial health care benefits.

OUT-OF-PROVINCE STUDENTS – If studying outside BC the absence must be temporary and solely for the purpose of attending school or university. Also, if studying outside Canada, proof of school registration as a foreign student for the current term is required. Benefits are provided for a maximum of five years while studying outside the country.

YOUR ACCOUNT OR PERSONAL HEALTH NO.

C. DELETION OF DEPENDENT(S)

FIRST NAME	SECOND NAME	SURNAME	BIRTHDATE MM	BIRTHDATE DD	BIRTHDATE YYYY	GENDER M / F	REASON FOR CANCELLATION	CANCELLATION DATE MM	CANCELLATION DATE DD	CANCELLATION DATE YYYY

CURRENT MAILING ADDRESS OF DEPENDENT

FIRST NAME	SECOND NAME	SURNAME	MM	DD	YYYY	M / F	REASON FOR CANCELLATION	MM	DD	YYYY

CURRENT MAILING ADDRESS OF DEPENDENT

FIRST NAME	SECOND NAME	SURNAME	MM	DD	YYYY	M / F	REASON FOR CANCELLATION	MM	DD	YYYY

CURRENT MAILING ADDRESS OF DEPENDENT

D. CHANGE OF PERSONAL INFORMATION

If the names or birthdate which appear on the CareCard need changing, you are asked to include a **photocopy of a legal document indicating the cardholder's correct name or birthdate,** such as one of the documents listed under B5 on the previous page or a change of name or marriage certificate.

CURRENT CARECARD SHOWS: INITIALS		SURNAME	BIRTHDATE MM	BIRTHDATE YYYY	REVISED OR CORRECT INFORMATION IS: FIRST NAME	SECOND NAME	SURNAME	BIRTHDATE MM	BIRTHDATE DD	BIRTHDATE YYYY

E. RESIDENTIAL AND MAILING ADDRESS

ALL CHANGES OF ADDRESS MUST BE REPORTED IMMEDIATELY TO MSP

As you must be a resident of British Columbia to be eligible for provincial health care benefits, your current residential address is required on this form. A form received without a residential address will be returned.

ACCOUNT HOLDER'S RESIDENTIAL AND MAILING ADDRESS

RESIDENTIAL ADDRESS	MAILING ADDRESS (if different from residential address)
POSTAL CODE / DAYTIME TELEPHONE NUMBER ( )	POSTAL CODE / TELEPHONE NUMBER ( )

F. CANCELLATION OF ENTIRE CONTRACT

To cancel an entire contract (account holder and any dependents) complete an Employer Record Card (ERC) or, if your group does not receive ERCS (for example, Federal Pay/Pension Offices), complete a Coverage Cancellation form.