



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 a Health Insurance BC 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 GENDER PERSONAL HEALTH NUMBER REQUESTED EFFECTIVE DATE
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
3. If dependent child is newly adopted, indicate date of adoption
4. Has spouse/child lived in BC since birth?
5. Spouse/child's status in Canada
PHOTOCOPIES OF DOCUMENTS ARE REQUIRED FOR ALL DEPENDENTS BEING ADDED, INCLUDING NEWBORNS. SEE NEXT PAGE.
6. Do you or any family member plan to be away from BC for more than 30 days during the next six months?
6a. Have you or any family member been outside BC for more than 30 days during the past 12 months?
7. Is dependent an active member of the Canadian Armed Forces or RCMP?
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 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 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 DATE SIGNED
SIGNATURE OF SPOUSE DATE SIGNED
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