

EXTENDED HEALTH BENEFITS ADDITIONAL ASSISTANCE CLAIM

IMPORTANT INFORMATION

This personal information is being collected under the authority of the Government of the Northwest Territories Extended Health Benefits Policy and Directive and will be used to determine program benefit entitlement. This information is protected by the privacy provisions of the Access to Information and Protection of Privacy Act. If you have any questions about the collection of this information, contact the Department of Health and Social Services (see contact information provided on this form).

NOTE: If more space is required, enter additional information on a separate sheet of paper and attach it to this application.

1. You must access employer or similar plans first.

PATIENT

Surname	Given Name(s)	Init.	Birthdate (y/m/d)	H.C.P. Number
Mailing Address	City/Community	Postal Code	Home Phone Number ()	
				Work Phone Number ()

CLAIMANT

Surname	Given Name(s)	Init.	Birthdate (y/m/d)	H.C.P. Number
Mailing Address	City/Community	Postal Code	Home Phone Number ()	
Relationship to patient				Work Phone Number ()

DESCRIPTION

DATE OF (y/m/d)	TYPE OF SERVICE	AMOUNT SUBMITTED TO INSURANCE	AMOUNT PAID BY INSURANCE	OUTSTANDING BALANCE	OFFICE USE ONLY	
					AMOUNT ELIGIBLE	AMOUNT INELIGIBLE
TOTAL						

APPLICANT'S DECLARATION

I consent to the release of my personal information to the Extended Health Benefits program for the purposes of determining mine, my spouse and/or my family's initial and continued eligibility for extended health benefits coverage.

PLEASE PAY

- Patient
 Claimant

 X

Patient's Signature (Claimant may sign if patient is under 18 or otherwise unable to sign)

Date (y/m/d)

RETURN COMPLETED FORM TO:

Department of Health and Social Services
HEALTH BENEFIT PROGRAMS
BAG #9, INUVIK NT X0E 0T0

Phone: (867) 777-7400
Toll Free: 1-800-661-0830