

ADDRESS CHANGE FORM

NOTE: This personal information is being collected under the authority of the *Medical Care Act* and will be used only to update the information on your health care card. It 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 at the address listed above.

APPLICANT INFORMATION (Please Print Clearly)

Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Old Address		Mailing Address		City/Town/Village	
Residential Street Address				Postal Code	
New Address		Mailing Address		City/Town/Village	
Residential Street Address				Postal Code	
		Work Phone No. ()		Home Phone No. ()	

List family members who have moved to the same new address - Include spouse/common-law and any dependants (19 yrs and under):

Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	
Surname		First Name		Middle Name(s)	
Birthdate (dd/mm/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Health Care Plan Number	

"I hereby certify that I am a permanent resident of the Northwest Territories and I understand that it is an offence to give false or misleading information in the application form and by signing this form I am authorizing health services administration to verify or confirm the information and documentation contained with this application."

Signature _____ Date (dd/mm/yyyy) _____

Signature _____ Date (dd/mm/yyyy) _____