

MEDICAL SERVICES PLAN (MSP) REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD

Complete this Action	Information Only	Documentation to Include with your Request
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General Information

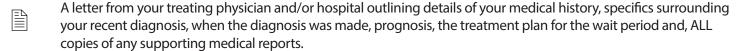
Complete this form IN FULL. Failure to provide ALL required documentation will delay your request for a decision.

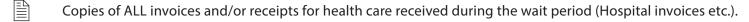
PART 1 - Reason for Request



A letter outlining the medical circumstances that are prompting your request and any extenuating circumstances you would like considered upon review.

PART 2 – Medical Documentation and Treatment Costs

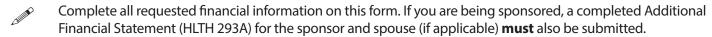




Please note, costs for routine, scheduled prenatal/delivery services are NOT eligible for a waiver request.

Examples of ineligible costs include, but not limited to: ultrasounds, laboratory tests, and clinic/doctor/midwife appointments.

PART 3 - Current Household Financial Information



Verification of monthly income for complete household; including but not limited to, Universal Child Tax Benefit, GST, paystubs from employer(s), etc.

 $\stackrel{\square}{=}$ Verification of monthly expenses for complete household.

Confirmation of all bank balances (inside and outside Canada- if applicable), RRSP Investment balances, Non-RRSP Investment balance, and any other assets.

If you have purchased travel insurance, please make a claim with the company first. If you received a denial, please include a copy of the decision.

If your income is less than expenses (or if you currently do not have an income), please attach a separate sheet of paper explaining how you are meeting your expenses AND how you plan to pay for your health care during the wait period.

PART 4 – Sponsorship Information



If you are sponsored, or are submitting a waiver of the wait period request on behalf of a family member you are sponsoring for permanent resident status, please include the signed copy of the *Application to Sponsor*, *Sponsorship Agreement and Undertaking* (IMM 1344) and a completed Additional Financial Statement (HLTH 293A) for the sponsor and spouse (if applicable).

PART 5 – Declaration and Consent



Signature of requester and spouse (if applicable), sponsor and spouse (If applicable).

Personal information is collected under the authority of the *Medicare Protection Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administration of the Medical Services Plan. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at 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).



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APPLICANT INFORMATION									
APPLICANT FIRST NAME	APPL	APPLICANT SECOND NAME APPLICANT LAST NAI			Г NAME	ME			
MAILING ADDRESS	1		CITY				PROVINCE	POSTAL CODE	
PRIMARY PHONE (INCLUDE AREA CODE)	PRIMARY PHONE (INCLUDE AREA CODE) ALTERNATE PHONE (INCLUDE			AREA CODE) FAX					
EMAIL									
MARITAL STATUS	PERSO	DNAL HEALTH NUMBE	BER (PHN) BIRTHDATE (MM/DD.				/DD/YYYY)	YYYY) NO. IN HOUSEHOLD	
PART 1 – REASON FOR REQUEST									
Provide a letter outlining the medical circumstar	nces th	at are prompting	your rec	quest and any extenuati	ng circ	umstan	ces you would	like considered.	
PART 2 – MEDICAL SUBSTANTIATION AND	TREA	TMENT COSTS							
Please attach the following to your request: a letter from your treating physician or hosy diagnosis was made, prognosis, the treatmeter copies of ALL health care invoices and/or records.	ent pla	an for the wait per	riod and	in addition, copies of ar	ny supp				
PART 3 – CURRENT HOUSEHOLD FINANCIA	L INF	ORMATION							
FINANCIAL STATEMENT WAS PRIVATE INSURANCE SOUGHT BEFORE OR ON ARRIVAL	. IN BC?								
☐ Yes (if yes, fill out section (A) below)				☐ No (if no, fill out section (B) below)					
A. INSURANCE COMPANY NAME				B. PLEASE PROVIDE REASO	N THAT N	NO PRIVAT	TE INSURANCE WA	S SOUGHT	
INSURANCE COMPANY ADDRESS									
COVERAGE PERIOD									
IMPORTANT: Please ensure you contact your private in before requesting a waiver. Failure to do so may result CURRENT MONTHLY INCOME									
Indicate the household NET monthly income (tal	ka har	ma may) racaiyad k	014 6 0 1 1 1 6	. If your income varies	aach m	anth in	dicata tha ran	go of fluctuation	
Attach copies of documentation to provide verif employer(s), etc.	icatior	n of monthly inco	me, inclu						
PLEASE DO NOT LEAVE THIS SECTION BLANK (ENTER Source of Income	0 IF NO	OTHING TO REPORT)		Applicant			Spouse		
Net earnings + tips + bonuses + commissions				\$	\$ Spouse				
Employment Insurance				\$			\$		
Social Assistance	ocial Assistance			\$	\$			i	
Pension (specify):	ension (specify):		\$		\$				
GST + Child Tax Benefit + BC Family Bonus	GST + Child Tax Benefit + BC Family Bonus			\$			\$		
Alimony/Child Support				\$			\$		
Other (specify):				\$			\$		
SUBTOTAL NET INCOME				\$			\$		
				TOTAL COMBI	NED NE	T INCOM	ΛE \$		

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CURRENT MONTHLY EXPENSES								
Indicate all household expenses below. Divide a	nnual expenses, suc	h as car insu	rance, by twelve and indicate	the monthly rate.				
Attach copies of documentation to provide verif			ance, by there and marcate	tire morning rate.				
PLEASE DO NOT LEAVE THIS SECTION BLANK (ENTER								
PLEASE DO NOT LEAVE THIS SECTION BLANK (ENTER	TO IF NOTHING TO KEPC	JN1)						
Nortgage/Rent \$			Alimony/Child Support \$					
House/Tenant Insurance	\$		Child Care		\$			
Food	\$		Life Insurance		\$			
Telephone	\$		Personal Loan(s)		\$			
Cable	\$		Credit Card(s) Payment		\$			
Other Utilities	\$		Other (Please explain)		\$			
Car Loan	\$							
Car Operating Expenses	\$							
			TOTAL N	ONTHLY EXPENSES	\$			
EMPLOYMENT STATUS								
Applicant			Spouse					
EMPLOYER NAME			EMPLOYER NAME					
OCCUPATION			OCCUPATION					
EMPLOYER ADDRESS (INCLUDE CITY, PROVINCE AND POSTAL CODE)			EMPLOYER ADDRESS (INCLUDE CITY, PROVINCE AND POSTAL CODE)					
SELF-EMPLOYED - DOING BUSINESS AS			SELF-EMPLOYED - DOING BUSINESS AS					
IF UNEMPLOYED, ARE YOU LOOKING FOR WORK? Yes No (Please explain):			IF UNEMPLOYED, ARE YOU LOOKING FOR WORK? ☐ Yes ☐ No (Please explain):					
ASSETS								
Provide details of all assets owned whether or not they are	completely paid for. Inc	dicate owner as	(for yourself) S (for spouse) or J	for joint)				
Description		Owner (I, S, J	Purchase Date (YYYY/MM/DD)	Purchase Price	C	urrent Value		
REAL ESTATE (INCLUDE ADDRESS - IF MORE THAN ONE, ATT	TACH SEPARATE SHEET)			\$	\$			
VEHICLE 1 (INCLUDE MAKE, MODEL, YEAR)				s				
VEHICLE 2 (INCLUDE MAKE, MODEL, YEAR)				\$	\$			
STOCKS, BONDS, RRSP, ETC				\$	\$			
OTHER ASSETS (PLEASE LIST)				\$	\$			

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student loans, and bank loans.	acata merating those miles, you are carrently repays		io. igages, ereait earas,	
Creditor Name	Creditor Address	Balance Owing	Monthly Payment	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
BANKING INFORMATION				
Provide the name and address of	the financial institution for each account type.			
Financial Institution Name	Financial Institution Address	Balance (Applicant/Joint)	Balance (Spouse)	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
		\$	\$	
PART 4 – SPONSORSHIP AGRE	EMENT			
	itting a waiver of the wait period request on behalf of plication to Sponsor, Sponsorship Agreement and Under		manent resident status, pleas	
PART 5 – DECLARATION AND	CONSENT			
	ovided is true and that I am not able to afford health c hholding relevant information, or providing false infor aive the wait period.			
I understand that the Ministry o	of Health may verify this information with public autho	orities, agencies and persons as appropriate.		
SIGNATURE OF APPLICANT		DATE SIGNED		
SIGNATURE OF SPOUSE		DATE SIGNED		

DATE SIGNED

Provide details of all outstanding debts including those which you are currently repaying on a monthly basis. These debts include mortgages, credit cards,

Please send request and all corresponding documents to:

Director **Beneficiary Services Branch** Ministry of Health PO Box 9649 Stn Prov Govt Victoria, BC V8W 9P4

Fax: 250 952-3268

LIABILITIES