BRITISH COLUMBIA | Ministry of Health

MEDICAL SERVICES PLAN (MSP)

REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD

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

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

A letter from your treating physician and/or hospital outlining details of your medical history, specifics surrounding your recent diagnosis, when the diagnosis was made, prognosis, the treatment plan for the wait period and, ALL copies of any supporting medical reports.

Copies of ALL invoices and/or receipts for health care received during the wait period (Hospital invoices etc.).

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

Complete all requested financial information on this form. If you are being sponsored, a completed Additional Financial Statement (HLTH 293A) for the sponsor and spouse (if applicable) **must** also be submitted.

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

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	APPLICANT SECOND NAME	APPLICANT LAST NAME	
MAILING ADDRESS	CITY	PROVINCE	POSTAL CODE
PRIMARY PHONE (INCLUDE AREA CODE)	ALTERNATE PHONE (INCLUDE AREA CODE)	FAX	
EMAIL			
MARITAL STATUS	PERSONAL HEALTH NUMBER (PHN)	BIRTHDATE (MM/DD/YYYY)	NO. IN HOUSEHOLD

PART 1 – REASON FOR REQUEST

Provide a letter outlining the medical circumstances that are prompting your request and any extenuating circumstances you would like considered.

PART 2 – MEDICAL SUBSTANTIATION AND TREATMENT COSTS

Please attach the following to your request:

- a letter from your treating physician or hospital outlining details of your medical history, specifics surrounding your recent diagnosis, when the diagnosis was made, prognosis, the treatment plan for the wait period and in addition, copies of any supporting medical reports; **and**
- copies of **ALL** health care invoices and/or receipts that pertain to care received during the wait period.

PART 3 – CURRENT HOUSEHOLD FINANCIAL INFORMATION

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 REASON THAT NO PRIVATE INSURANCE WAS SOUGHT
INSURANCE COMPANY ADDRESS	
COVERAGE PERIOD	
IMPORTANT: Please ensure you contact your private insurer regarding any medical claims before requesting a waiver. Failure to do so may result in your request being cancelled.	

CURRENT MONTHLY INCOME

Indicate the household NET monthly income (take home pay) received by source. If your income varies each month, indicate the range of fluctuation.

Attach copies of documentation to provide verification of monthly income, including but not limited to, Universal Child Tax Benefit, GST, paystubs from employer(s), etc.

PLEASE DO NOT LEAVE THIS SECTION BLANK (ENTER 0 IF NOTHING TO REPORT)

Source of Income	Applicant	Spouse
Net earnings + tips + bonuses + commissions	$	$
Employment Insurance	$	$
Social Assistance	$	$
Pension (specify):	$	$
GST + Child Tax Benefit + BC Family Bonus	$	$
Alimony/Child Support	$	$
Other (specify):	$	$
SUBTOTAL NET INCOME	$	$
	TOTAL COMBINED NET INCOME	**$**

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CURRENT MONTHLY EXPENSES

Indicate all household expenses below. Divide annual expenses, such as car insurance, by twelve and indicate the monthly rate.

Attach copies of documentation to provide verification of monthly expenses.

PLEASE DO NOT LEAVE THIS SECTION BLANK (ENTER 0 IF NOTHING TO REPORT)

Mortgage/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 MONTHLY 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. Indicate owner as **I** (for yourself) **S** (for spouse) or **J** (for joint)*

Description	**Owner (I, S, J)**	**Purchase Date (YYYY/MM/DD)**	**Purchase Price**	**Current Value**
REAL ESTATE (INCLUDE ADDRESS - IF MORE THAN ONE, ATTACH SEPARATE SHEET)			**$**	**$**
VEHICLE 1 (INCLUDE MAKE, MODEL, YEAR)			**$**	**$**
VEHICLE 2 (INCLUDE MAKE, MODEL, YEAR)			**$**	**$**
STOCKS, BONDS, RRSP, ETC			**$**	**$**
OTHER ASSETS (PLEASE LIST)			**$**	**$**

LIABILITIES

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

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 AGREEMENT

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).

PART 5 – DECLARATION AND CONSENT

I declare that all information provided is true and that I am not able to afford health care services incurred during the wait period for provincial health care coverage. I understand that withholding relevant information, or providing false information in this statement will be grounds for the Ministry of Health to revoke any approval given to waive the wait period.

I understand that the Ministry of Health may verify this information with public authorities, agencies and persons as appropriate.

SIGNATURE OF APPLICANT	DATE SIGNED
SIGNATURE OF SPOUSE	DATE SIGNED

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

PRINT

CLEAR FORM