



BENEFICIARY'S NOTICE TO MINISTER

Pursuant to section 12 of the Health Care Costs Recovery Act

Personal information on this form is collected under the authority of the Health Care Costs Recovery Act. The information will be used to identify recoverable health care costs as a result of a third party liability incident.

The beneficiary's legal counsel may complete and send this form on behalf of the beneficiary

PART A

Form with fields: Last Name of Beneficiary, Given Name(s), Date of Birth, Residential Address, Postal Code, Personal Health Number (PHN), Contact Phone Number, Email Address, Date of Incident, Name of Parent, Guardian or Litigation Guardian, Incident Location, Nature of Incident, Type of Injury/Illness.

PART B

Form with fields: Have legal proceedings been commenced relating to your injury/illness?, Registry Number, Location, Has a proposed settlement been reached?, Date(s) of any upcoming mediation or settlement meetings/conferences or trial.

PART C

Form with columns: BENEFICIARY'S COUNSEL, WRONGDOER'S REPRESENTATIVE (DEFENCE COUNSEL / ADJUSTER). Fields include Name and Address, Phone Number, Email Address, Name(s) of Wrongdoer(s).

Form with fields: Signature, Print Name, Date Signed, If signatory is not plaintiff/beneficiary, state relationship, OFFICE USE ONLY.

This form is sufficiently served if scanned and emailed to the following address: hlth.tpl@gov.bc.ca

- OR - Please send registered mail or traceable courier to: Third Party Liability, Ministry of Health, 2nd Floor - 1515 Blanshard Street, PO Box 9647 STN PROV GOVT, Victoria BC V8W 9P4