



BRITISH
COLUMBIA

Ministry of
Health

**MEDICAL SERVICES PLAN (MSP)
ADDITIONAL FINANCIAL STATEMENT FOR
REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD**

This form is to be used **only in addition to HLTH 293**, on an as-needed basis.
Please refer to instruction sheet on HLTH 293 for more information.



**MEDICAL SERVICES PLAN (MSP)
ADDITIONAL FINANCIAL STATEMENT FOR
REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD**

NAME OF APPLICANT ON FORM 293 AND RELATIONSHIP TO PERSON PROVIDING FINANCIAL SUPPORT		
APPLICANT FIRST NAME	APPLICANT LAST NAME	RELATIONSHIP TO PERSON PROVIDING FINANCIAL SUPPORT

PERSON PROVIDING FINANCIAL SUPPORT TO APPLICANT				
FIRST NAME	SECOND NAME	LAST NAME		
MAILING ADDRESS		CITY	PROVINCE	POSTAL CODE
PHONE (INCLUDE AREA CODE)	MARITAL STATUS	BIRTHDATE (MM/DD/YYYY)	NO. IN HOUSEHOLD	

FINANCIAL STATEMENT

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	Self	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		\$

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			\$

ADDITIONAL FINANCIAL STATEMENT FOR REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD PAGE 2 OF 3

EMPLOYMENT STATUS	
Self	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? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain):	IF UNEMPLOYED, ARE YOU LOOKING FOR WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain):

ASSETS				
<i>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)</i>				
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			
<i>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.</i>			
Creditor Name	Creditor Address	Balance Owing	Monthly Payment
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$

ADDITIONAL FINANCIAL STATEMENT FOR REQUEST TO WAIVE THE MSP COVERAGE WAIT PERIOD PAGE 3 OF 3**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)
		\$	\$
		\$	\$
		\$	\$
		\$	\$
		\$	\$

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).

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 PERSON PROVIDING FINANCIAL SUPPORT TO APPLICANT	DATE SIGNED
SIGNATURE OF SPOUSE OF PERSON PROVIDING FINANCIAL SUPPORT TO APPLICANT	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

Personal information requested on this form is collected under the authority of the *Medicare Protection Act*. The information will be used to determine eligibility for a reduction or waiver of the wait period for provincial health care benefits. If you have any questions about the collection of this information, contact a ministry representative at the address shown. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.