



The Alberta Child Health Benefit

Your application will be processed within 15 days of receipt if:

-  you fill in all required blanks. If information is missing, the application will be returned to you.
- and**
-  you and your spouse/cohabiting partner (if applicable) **sign and date** the Declaration and the Consent for Canada Customs and Revenue Agency to Verify Income.

Send the completed application to:

Alberta Human Resources and Employment
Alberta Child Health Benefit
PO Box 2222
Edmonton AB T5J 5H3

If you have questions about the form, call 427-6848 in Edmonton or 1-877-4MY-KIDS (1-877-469-5437), toll-free outside of Edmonton.

ALBERTA CHILD HEALTH BENEFIT APPLICATION

The information you have provided on this application is collected under the authority of the Income and Employment Supports Act, and is in compliance with the Freedom of Information and Protection of Privacy Act. The information will be used solely for the purpose of determining and verifying eligibility for benefits under the Alberta Child Health Benefit (ACHB) program, and will be matched and shared with any agency, institution, government department (federal or provincial), or other sources for this purpose. If you have questions about the collection of this information, contact Alberta Human Resources and Employment, ACHB program at 427-6848 or toll-free outside of Edmonton at 1-877-4MY-KIDS (1-877-469-5437).

- The Application will be returned to you if information is missing.
- Ensure that you read all the information on the previous page and the declaration(s) below.

Applicant's Personal Information

		Birth date (yyyy/mm/dd)	Social Insurance Number
Last name	First name	Middle initial	
Mailing address			Work phone number/Extension
City/Town/Municipality	Province	Postal code	Home phone number

Spouse/Cohabiting Partner's Information *(If you are divorced or separated from your spouse, do not complete this section.)*

Spouse/Cohabiting Partner's birth date (yyyy/mm/dd)	Spouse/Cohabiting Partner's Social Insurance Number	Work phone number
Spouse/Cohabiting Partner's last name	First name	Middle initial

Child Information (List all children under 18 years, and 18 and 19 year olds attending high school.)

1	Child's last name	First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?
2	Child's last name	First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?
3	Child's last name	First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?
4	Child's last name	First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?

Child Information (continued)

Applicant's Last name	Social Insurance Number
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5	Child's last name	First name	Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status? Does this child have health benefit coverage (other than standard Alberta health care)?
6	Child's last name	First name	Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status? Does this child have health benefit coverage (other than standard Alberta health care)?
7	Child's last name	First name	Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status? Does this child have health benefit coverage (other than standard Alberta health care)?

If your children have other health benefit coverage (*other than standard Alberta Health Care Insurance*) please provide:

1	Type(s) of coverage provided in policy <input type="checkbox"/> Dental <input type="checkbox"/> Optical <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Ambulance	Name of Insurer (i.e. Clarica, Alberta Blue Cross)
	Name of Policy Holder (if different from applicant)	Policy Number/Identification Number
2	Type(s) of coverage provided in policy <input type="checkbox"/> Dental <input type="checkbox"/> Optical <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Ambulance	Name of Insurer (i.e. Clarica, Alberta Blue Cross)
	Name of Policy Holder (if different from applicant)	Policy Number/Identification Number

Declaration of Applicant

- I declare that I am a resident of Alberta and that the information on this application is true and complete to the best of my knowledge.
- I will report any changes in the information I have provided to the Alberta Child Health Benefit program.
- I understand that giving false or incomplete information, or not advising of changes in my situation may result in termination or suspension of benefits, criminal charges and repayment of benefits I have received.
- I understand that Alberta Human Resources and Employment (AHRE) may contact any agency, institution, government department (provincial or federal), or other sources to verify the information provided, to confirm eligibility for the benefit, or to conduct an investigation relating to eligibility for this program.
- I understand that to be eligible for this program I must consent to Canada Customs and Revenue Agency providing tax information to AHRE.

Applicant's signature	Date (yyyy/mm/dd)	Spouse/Cohabiting Partner's signature (if applicable)	Date (yyyy/mm/dd)
X		X	

Consent for Canada Customs and Revenue Agency (Revenue Canada) to Verify Income

I consent to the release, by Canada Customs and Revenue Agency to Alberta Human Resources and Employment, of information from my income tax returns and other taxpayer information about me whether supplied by me or a third party. The information will be relevant to, and will be used solely for the purpose of determining, verifying and/or auditing my/our eligibility, and for the general administration and enforcement of the Alberta Child Health Benefit under the *Income and Employment Supports Act*. This consent is valid for the taxation year in which I sign this consent, the previous tax year, and for each taxation year that I ask for this benefit.

For Office Use Only
Date application received

Applicant's signature	Date	Spouse/Cohabiting Partner's signature (if applicable)	Date
X		X	

Applicant's Last name	Social Insurance Number
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Additional Child Information (List those children under 18 years only.)

8	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
9	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
10	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
11	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
12	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
13	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
14	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
15	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
16	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
17	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	
18	Child's last name		First name		Sex
	Birth date (yyyy/mm/dd)	Alberta Personal Health Number	Does this child have Treaty Indian or Inuit status?	Does this child have health benefit coverage (other than standard Alberta health care)?	