Northwest Territories Health and Social Services

Health Services Administration - Department of Health and Social Services
Bag #9, Inuvik, NT X0E 0T0
Toll-free: 1-800-661-0830 • Phone: (867) 777-7400 • Fax: (867) 777-3197

CHANGE OF ABORIGINAL STATUS

Proof required, i.e. copy of Indian Status Card or letter from Métis, Inuit, or Inuvialuit organization. (Inuit and Inuvialuit letter must include Inuit N number.)

NOTE: This personal information is being collected under the authority of the *Medical Care Act* and will be used only to update the information on your health care card. It is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, contact the Department of Health and Social Services at the address listed above.

APPLICANT INFORMATION (Please Print Clearly)

Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number

Residential Street Address	Work Phone No. ( )	Home Phone No. ( )

Old Status	Ethnicity	☐ Status Indian ☐ Métis ☐ Inuit ☐ Innuvialuit ☐ Indigenous Métis ☐ Non-Native
New Status	Aboriginal Status	☐ Status Indian ☐ Métis ☐ Inuit ☐ Innuvialuit ☐ Indigenous Métis

List family members who have also changed their status - Include spouse/common-law and any dependants (18 yrs and under):

Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number
Surname	First Name	Middle Name(s)
Birthdate (dd/mm/yyyy)	Gender ☐ Male ☐ Female	Health Care Plan Number

"I hereby certify that I am a permanent resident of the Northwest Territories and I understand that it is an offence to give false or misleading information in the application form and by signing this form I am authorizing health services administration to verify or confirm the information and documentation contained with this application."

Signature ______________________ Date (dd/mm/yyyy) ______________________

Signature ______________________ Date (dd/mm/yyyy) ______________________

NWT8266/0904