You will need Acrobat Reader 6.0 or higher in order to complete this form online.

Alberta

alberta works

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 1-877-469-5437.

- **Complete this form in BLACK ink. Please PRINT clearly.**
- **Your application will be sent back to you if information is missing.**
- **Your application will be processed within 15 days if:**
  - **You fill in the required blanks.**
  - **You sign and date the "My Declaration" and "Consent" sections.**

- **Send your completed form to:**
  Alberta Human Resources and Employment
  Alberta Child Health Benefit
  P.O. Box 2222 Station Main
  Edmonton, AB T5J 5H3

My Personal Information

Last name	First name	Middle initial	Birth date (yyyy/mm/dd)	Social Insurance Number

Mailing address			Work phone number/Extension

City/Town/Municipality	Province	Postal code	Home phone number

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

Spouse/Partner's birth date (yyyy/mm/dd)	Spouse/Partner's Social Insurance Number	Work phone number

Spouse/Partner's last name	First name	Middle initial

My Child(ren) (List all children up to age 19 who are attending Kindergarten to Grade 12.)

	Child's last name	First name	Sex
1			-
2			-
3			-
4			-

Birth date (yyyy/mm/dd)	**Alberta** Personal Health Number	Does this child have health coverage other than standard Alberta Health Care Insurance? -	Does this child have Indian or Inuit status? -

If you have more than four children, double click on the paperclip.

Reset form

Form continues on Page 2

Save Form

Print

Applicant's Last name	Social Insurance Number

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

1

Type(s) of coverage provided in policy	☐ Dental ☐ Prescription Drugs ☐ Optical ☐ Ambulance	*Name of Insurer (i.e. Clarica, Alberta Blue Cross)*
Name of Policy Holder *(if different from you)*		Policy Number/Identification Number

2

Type(s) of coverage provided in policy	☐ Dental ☐ Prescription Drugs ☐ Optical ☐ Ambulance	*Name of Insurer (i.e. Clarica, Alberta Blue Cross)*
Name of Policy Holder *(if different from you)*		Policy Number/Identification Number

▶ If you have more than two other health insurers, please attach another sheet providing the same information for that coverage and which children are covered under each plan.

My Declaration

- 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 this information 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 my children's health benefits being suspended or terminated, or criminal charges. I could also be ordered to repay 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 my information, to confirm whether my children qualify for this program.
- I understand that to be eligible for this program I must consent to Canada Revenue Agency providing tax information to AHRE.

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

Consent for Canada Revenue Agency (Revenue Canada) to verify income

I consent to the release, by Canada 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

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

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