

APPLICATION FOR MÉTIS HEALTH BENEFITS

PLEASE PRINT



IMPORTANT INFORMATION

The personal information being collected on this form is protected by the Access to Information and Protection of Privacy Act, and will be used only to determine your eligibility for the Métis Health Benefits Program.

In order to apply for the Métis Health Benefits Program, you must have a valid NWT Health Care Plan No.

NOTE: If more space is required, enter additional information on a separate sheet of paper and attach it to this application.

You must access employer or similar plans first. Métis Health Benefits is a payer of last resort

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						Benefits, Health Services Admi 3197, Tel (867) 777-7402, Toll	
						alth Services Administration, De 3197, Tel (867) 777-7402, Toll	
	e responsible for providing th Registration, (b) Marriag					vide the following:	
REASON FO	OR APPLICATION						
New	☐ Change	Other (specify):					
Please							
Indicate:	OR I make this appl	ication as guardian on	on as guardian on behalf of the applicant who is under the age of 18 or is incapacitated.				apacitated.
APPLICANT	'S INFORMATION						
Family Name (Given Name(s)						Sex M F
Mailing Addres	es						Postal Code
Telephone No.	N/	WT Health Care Plan No.	Date of Birth	(dd/mm/yyyy)		Place of Birth	
Indigenous De Métis ar	scendent of which NWT Group nd: Cree Hare	☐ Slavey ☐ Chipe	wyan 🔲	Dogrib 🔲	Gwio	ch'in Other (specify):	
Name of Fathe	er and Ethnic Origin	· · ·		Maiden Name o	of Moth	her and Ethnic Origin	
Date of Birth (dd/mm/yyyy) Place of Bir	th		Date of Birth (dd/mm/yyyy) Place of Birth			
Name of Pater	nal Grandfather and Ethnic Origin			Name of Maternal Grandfather and Ethnic Origin			
Name of Pater	nal Grandmother and Ethnic Origi	in		Name of Maternal Grandmother and Ethnic Origin			
SPOUSE'S	INFORMATION (Note: If s	oouse is non-aborigina	ıl he/she is	not required	to fill	out this section)	
Family Name (· · · · · · · · · · · · · · · · · · ·	3		•		,	Sex M F
Mailing Addres	ss						Postal Code
Telephone No.	NV NV	WT Health Care Plan No	Date of Birth	ı (dd/mm/yyyy)		Place of Birth	
Indigenous De Métis ar	scendent of which NWT Group nd: Cree Hare	☐ Slavey ☐ Chipe	wyan \square	Dogrib \Box	Gwic	ch'in Other (specify):	
LIST OF AL						ete their own application form.)	
LIST OF AL	Family Name	1	Name(s)	er ro musi co	Sex		NWT Health Care Plan No.
OTHER INF	ORMATION	1		I		1	
Please indicate	e if you are: ous Métis Non-indig		mmunity A	cceptance Me nmunity:	embe	er,	☐ Métis Bill C-31
	e if you are: General Membership List, f Community:			A Member o	f a M	Métis Local,	

	On the General Membership List,	
ч	Name of Community:	

		,

Please indicate if you qualify as a Land Claims Beneficiary in:							
☐ Gwich'in Region	Sahtu Region	Deh Cho Region					

	Nlovth	Clavia	Region
_	IMOULL	Siave	Region

South	Slave	Region	

EMPLOYMENT STATUS Applicant Spouse Description or parent or guardian if applicant is a dependant or second parent or quardian if applicant is a dependant Are you Employed? Yes ☐ No Yes ☐ No Is your Employment seasonal? Yes ☐ No Yes ☐ No From То From То If 'Yes', Specify: Employer's Name and Department: Employer's Address: Employer's Phone Number: Are you eligible for any Benefits under Yes ☐ No Yes ☐ No your Employer's Insurance Plan? Name of Employer's Insurance Plan Name of Employer's Insurance Plan Medical Plan No. Medical Plan No. If 'Yes', Specify: Dental Plan No. Dental Plan No. Are you eligible for any Benefits under ☐ No Yes Yes ☐ No a Private Insurance Plan? Name of Private Insurance Plan Name of Private Insurance Plan Medical Plan No. Medical Plan No. If 'Yes', Specify: Dental Plan No. Dental Plan No. CERTIFICATION I hereby certify that the information given on BOTH sides of this application is true, correct and complete to the best of my knowledge. Signature: Date: Applicant, Parent, Guardian dd/mm/vvvv SHADED AREAS ARE FOR HEALTH SERVICES ADMINISTRATION OFFICE USE ONLY - NORTHWEST TERRITORIES -☐ No Verification of Form: Is the form completed? Yes Are they on the 1988 Comprehensive Verification of Applicant: Yes ☐ No Lands Claim Agreement Listing? (Y = Step 11, N = Step 3) 3. Verification of Parents: Is (are) the parent(s)/grandparent(s) of the applicant listed on the 1988 Comprehensive Lands Claim Agreement Listing? Yes ☐ No (Y = Step 11, N = Step 4) Verification of Community Acceptance: Are they listed on any Community ☐ No Yes Acceptance Listing? (Y = Step 11, N = Step 5) Verification of Gwich'in Enrolment: Are they on that listing? Yes ☐ No (Y = Step 11, N = Step 6) Is (are) the parent(s)/grandparent(s) of Verification of Parents: 6. the applicant listed on the Gwich'in ☐ No **Enrolment Listing?** Yes (Y = Step 11, N = Step 7) ☐ Yes ☐ No Verification of Sahtu Enrolment: Are they on that listing? (Y = Step 11, N = Step 8) Verification of Parents: Is (are) the parent(s)/grandparent(s) of 8. the applicant listed on the Sahtu Enrolment ☐ No Yes Listing? (Y = Step 11, N = Step 9)Verification of Adoption: Is the registrant adopted as a minor under the laws of any jurisdiction or any Métis custom, by a person qualified under Step 2 ☐ Yes □ No to Step 6? (Y = Step 11, N = Step 10) 10. Verification as a Descendant: Is the registrant a descendant of a person ☐ Yes ☐ No qualified under Step 2 to Step 7? (Y = Step 11, N = Step 12) Employer Name: Group Insurance: 11. Approved Group Insurance: ☐ No 12. Not Approved ☐ Yes Health Benefits Specialist's Signature Date - dd/mm/yyyy Health Benefits Coordinator's Signature Date - dd/mm/yyyy Client was entered into NIHM on (dd/mm/yyyy) Registered an ABC on (dd/mm/yyyy) ABC ID Number MBH Cancelled on (dd/mm/yyyy) Reason for Cancellation