

Declaration of Hospital Insurance Coverage

In-Patient Interprovincial Agreement

Patient Identification (P	Provide information	as shown on Hea	alth Insurance	Card)	Province of Coverage
Surname	Given Name(s) Init		Date of Birth		
			Year	Month Day	
					Health Insurance Number
Address registered with Province of Co	overage (R.R #, Number an	d Street, Apartment No.) Gender		
			□ Male □	Famala	Date of Effectiveness
City, Town, Village)	Postal Code				Year Month Da
(oity, rown, vinage)			Current relep	hone Number	Date of Expiry
					Year Month Da
Го Be Completed if Pat	iont is Tompor	arily Procent	in Host Pro	vinco	
•	<u> </u>				
Temporary Address in Host Province if av	railable (R.R #, Number and Street, A	Apt. No., City, Town, Village)	Province	Postal Code	Telephone Number
leason for entitlement to insured in-patie	ent hospital services from I	Province of Coverage:		Anticipated	Duration of Stay
☐ Vacation/In Transit	☐ Study		From Year	Month Day	To Year Month Da
_	Name of Educati	ional Institution			<u> </u>
☑ Medical Referral	_				
Temporary Employment/Business	OtherPlease Specify				
	ricase opecity				
Awaiting Eligibility for Coverage in the	Province (other than Host I	Province) of	Date	e registered with new H	
					Year Month
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address registered with Province of Cover	rage (R.R #, Number and S	treet, Apt. No., City, Tow	n, village)	Postal Code	Telephone Number
To Be Completed if Pat	ient has Made	a Permanent	Move to Ho	ost Province	
Permanent Address in Host Province (F	R R # Number and Street A	Ant No. City Town Villa	age) Province	Postal Code	Telephone Number
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ast Address in former Province (R.R#	Number and Street Ant N	Jo City Town Village)	Province	Postal Code	Former Telephone Number
ast Address in former 1 former (18.18 #	, reamber and offect, rept. I	vo., oity, fown, village)	Fiovince	- Ostai Code	Tomer receptione Number
Date of Departure from Province of Cov	/erage Year	Month Day D	Date of Arrival		Year Month Da
bate of Departure from 1 formice of cov	real real			Residence in Host Pro	
		Ц	Date of Establishing	Residence in Host Pro	vince
Leavitel.					Han Mal New John
-lospital					Hospital Number
lame			Location		
Additional Information					Admission/Separation Number
					·
					Date of Admission
					Year Month Da
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Declaration of Patient of	or Kepresentati	ve			
hereby declare, conscientiously believing	g it to be true and knowing it	t to have the same effec	t as if it were made	under oath and by virtu	e of the Canada Evidence Act, that I am
ntitled (or I declare on behalf of the patie	nt that he/she is entitled) to	insured hospital service	s from the Province	of Coverage.	
(X			
		^			
Signature of Person making Declaration		Witness (Si	gnature of Authorize	ed Hospital Representa	tive) Date
-		`		-	
Name of Declarant if other than Patient (P	Please Print)	Relationship to Pat	ient (Please specify	if other than Parent/Gu	uardian)
	- 7	☐ Parent/Guardiar			,
ddress of Declarant if other than Patient	(R R # Number and Street			Postal Code	Telephone Number
adices of Decidiant II office than Patient	(1 T, Number and Otteet,	r spartinioni 140., Oity, 10W	in, vinago, i iovilloe)	i ostai oode	Totophone Humber
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