Newfoundland Labrador
Health and Community Services

CARD REPLACEMENT / INFORMATION UPDATE

mcp
Medical Care Plan

PLEASE INDICATE YOUR REASON FOR COMPLETING THIS FORM (check all that apply)

☐ LOST / STOLEN CARD ☐ NAME CHANGE ☐ RENEWAL OF COVERAGE ☐ ADDRESS CHANGE ☐ TERMINATION OF COVERAGE
☐ EXTENSION OF COVERAGE FOR NON-CANADIANS ☐ INTENT FOR ORGAN/TISSUE DONATION

DOCUMENTS YOU MUST SUBMIT WITH THIS FORM

- For name change due to marriage, a clear copy of the marriage certificate is required.
- For other legal name changes, a clear copy of the legal name change document or Government issued Birth Certificate in the new legal name is required.
- For correction to date of birth, a Government issued Birth Certificate is required. Baptismal Certificates are not acceptable.
- For gender change, a Government issued Birth Certificate in the new gender is required.
- For extension of coverage for non-Canadians, updated immigration documents are required as well as a recent letter from University or Employer verifying full-time enrolment or employment for at least one year.

SECTIONS 1, 2 and 5 MUST BE COMPLETED BY ALL APPLICANTS

SECTION 1 GENERAL INFORMATION (please print)

MCP Card Number	Surname	All Given Names (in full) (First Name)	(Middle Name)	Sex (M / F)	Birth Date (YYYY)	(MM)	(DD)

SECTION 2 HOME MAILING ADDRESS

Street / P.O. Box	City / Town	Province NL	Postal Code

Home Telephone Number	Cell Number	E-mail Address

SECTION 3 NAME CHANGE

Reason for Change	New Surname (if applicable)	New Given Name(s) (if applicable)

SECTION 4 TERMINATION OF COVERAGE

Reason for Termination	Date of Termination/Departure	Country/Province of Relocation

SECTION 5 DECLARATION (to be signed by parent/legal guardian if applicant(s) under 16 years of age)

IT IS AN OFFENCE TO GIVE FALSE INFORMATION FOR THE PURPOSE OF OBTAINING COVERAGE UNDER THE NEWFOUNDLAND & LABRADOR MEDICAL CARE PLAN

I hereby declare that the information given is correct and the person(s) listed on this form are residents of Newfoundland & Labrador.

Signature of Applicant: _____ Date: _____

INTENT FOR ORGAN/TISSUE DONATION - If anyone named on this form wishes to become an organ/tissue donor, please sign in one of the spaces below. Your intent to donate is supported by the *Human Tissue Act.*

Printed Name	Signature	Printed Name	Signature
Printed Name	Signature	Printed Name	Signature

PRIVACY NOTICE
The Newfoundland and Labrador Medical Care Plan (MCP) collects personal health information under the authority of the *Medical Care Insurance Act, 1999*. Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.

Grand Falls-Windsor Office:
MCP, 22 High Street, PO Box 5000, Grand Falls-Windsor, NL, A2A 2Y4
Telephone: 709-292-4000 Toll Free: 1-800-563-1557 Facsimile: 709-292-4052

St. John's Office:
MCP, 45 Major's Path, PO Box 8700, St. John's, NL, A1B 4J6
Telephone: 709-758-1600 Toll Free: 1-866-449-4459 Facsimile: 709-758-1694

www.gov.nl.ca/mcp