

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)		Sex/Gender M / F / X	Birth Date		
		First Name	Middle Name		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)
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SECTION 4 TERMINATION OF COVERAGE

Reason for Termination	Date of Termination/Departure	Country/Province of Relocation
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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 and Hospital Insurance Act*. 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.

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