Ontario

ONTARIO TEMPORARY HEALTH PROGRAM
CONSENT FORM

INSTRUCTIONS: To be completed with Claimant on initial claim submission.

CONSENT (ALL FIELDS ARE REQUIRED)

I, _____ consent to the Ministry of Health and Long-Term Care ("ministry"), its agent Medavie Blue Cross ("Medavie") and my health care provider(s) collecting my personal information from Citizenship and Immigration Canada, and from this form, to use in administering the Ontario Temporary Health Program ("OTHP").

I also consent to the Ministry, its agent Medavie and my health care provider(s) collecting and using my personal information, and disclosing it to each other, for the purpose of administering the OTHP.

I understand that this consent will remain in effect until I am no longer eligible for Interim Federal Health Program (IFHP) coverage. I understand that I am not required to give this consent, and that I may withdraw my consent at any time by providing notice in writing to Medavie Blue Cross at:

OTHP
Medavie Blue Cross
644 Main St. PO Box 6000
Moncton, NB, E1C 0P9

The individual signing this form must indicate if s/he is consenting for him/herself as the Claimant, or for another individual, as described below:

- ❑ I am the claimant consenting for myself
- ❑ I am a parent consenting for my child who is under 12 years of age
- ❑ I am an adult, consenting for an incapable adult who is:
  - ❑ My spouse/partner ❑ My parent ❑ My brother/sister ❑ My relative _____

Signature: _____ Date: _____

Witness (print): _____ Witness Signature: _____

CLAIMANT INFORMATION (ALL FIELDS ARE REQUIRED)

Certificate Number	Language Preference ❑ English ❑ French ❑ Other (specify) _____	
Last Name	First Name	Initial
Birth Date (dd/mm/yy)	Sex ❑ Male ❑ Female	Telephone Number (with area code)
Address Street & No.		
City or Town	Province	Postal Code

PROVIDER INFORMATION (ALL FIELDS ARE REQUIRED)

Provider Name	Provider Number	Telephone Number

MEDAVIE BLUE CROSS™