Newfoundland & Labrador
Health and Community Services

RENEWAL OF COVERAGE / CARD REPLACEMENT / INFORMATION UPDATE FORM

mcp Medical Care Plan

PLEASE INDICATE YOUR REASON FOR **COMPLETING** THIS FORM (**C**heck 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. **International Students** must also provide a letter from their Educational Institution, dated within 30 days of the submission of this form, verifying full-time enrolment for one year. **International Workers** must also provide a current letter from their Employer verifying full-time employment.

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/Gender M / F / X	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 I am the person named on the form, the information given is correct, and the person(s) listed on this form are residents of Newfoundland and Labrador. In lieu of a written signature, my typed name on the form shall be considered my electronic signature.

Electronic or Written 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.*

Electronic or Written Signature	Electronic or Written Signature
Electronic or Written Signature	Electronic or Written 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

www.gov.nl.ca/mcp