Northwest Territories Health and Social Services

MÉTIS HEALTH BENEFITS
APPLICATION

IMPORTANT INFORMATION *(Please Print)*

This personal information is being collected under the authority of the Government of the Northwest Territories Extended Health Benefits Policy and Directive and will be used to determine program benefit entitlement. This information is protected by the privacy provisions of the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, contact the Department of Health and Social Services (see contact information provided on this form).

In order to apply for the Métis Health Benefits Program, you must have a valid NWT Health Care Plan No.

NOTE: If more space is required, enter additional information on a separate sheet of paper and attach it to this application.

1. You must access employer or similar plans first.
2. If employer information should change, please notify: Benefits Co-ordinator, Health Benefits, Health Services Administration, Department of Health and Social Services, GNWT, Bag #9, Inuvik, NT X0E 0T0. Fax (867) 777-3197, Tel (867) 777-7400, Toll Free 1-800-661-0830.
3. You are responsible for providing proof of descendency. You may be required to provide the following: (a) Birth Registration, (b) Marriage Certificate, (c) Other supporting documentation.

REASON FOR APPLICATION

❑ New ❑ Change	**I request that** ❑ Applicant, ❑ Spouse, and ❑ Dependants, if eligible, be registered for the Métis Health Benefits Program. **OR** ❑ I make this application as guardian on behalf of the applicant who is under the age of 18 or is incapacitated.

APPLICANT'S INFORMATION

Surname	Given Name(s)	Init.	Sex ❑ M ❑ F
Mailing Address	City/ Community		Postal Code
Telephone Number ( )	NWT Health Care Plan No.	Date of Birth (y/m/d)	Place of Birth

Indigenous Descendent of which NWT Group

❑ Métis and: ❑ Cree ❑ Hare ❑ Slavey ❑ Chipewyan ❑ Dogrib ❑ Gwich'in ❑ Other (specify):

Name of Father and Ethnic Origin		Maiden Name of Mother and Ethnic Origin	
Date of Birth (y/m/d)	Place of Birth	Date of Birth (y/m/d)	Place of Birth
Name of Paternal Grandfather and Ethnic Origin		Name of Maternal Grandfather and Ethnic Origin	
Name of Paternal Grandmother and Ethnic Origin		Name of Maternal Grandmother and Ethnic Origin	

SPOUSE'S INFORMATION (Note: If spouse is non-aboriginal he/she is not required to fill out this section)

Family Name	Given Name(s)		Sex ❑ M ❑ F
Mailing Address			Postal Code
Telephone Number ( )	NWT Health Care Plan No.	Date of Birth (y/m/d)	Place of Birth

Indigenous Descendent of which NWT Group

❑ Métis and: ❑ Cree ❑ Hare ❑ Slavey ❑ Chipewyan ❑ Dogrib ❑ Gwich'in ❑ Other (specify):

OTHER INFORMATION

Please indicate if you are:

❑ Indigenous Métis of the NWT ❑ Non-indigenous Métis of the NWT ❑ Métis Bill C-31

❑ Community Acceptance Member, Name of Community:

Please indicate if you are:

❑ On the General Membership List, Name of Community: ____________________

❑ A Member of a Métis Local, Name of Community: ____________________

Please indicate if you qualify as a Land Claims Beneficiary in:

❑ Gwich'in Region ❑ Sahtu Region ❑ Dehcho Region ❑ North Slave Region ❑ South Slave Region

Translation into other NWT official languages will be provided upon reasonable request. La traduction dans une autre langue officielle des T.N.-O. sera fournie sur demande raisonnable.

Northwest Territories Health and Social Services

LIST OF ALL APPLICANT'S CHILDREN (Note: Individuals who are over 18 must complete their own application form.)

Surname	Given Name(s)	Sex	Date of Birth (y/m/d)	NWT Health Care Plan No.

EMPLOYMENT STATUS

Description	Applicant or parent or guardian if applicant is a dependant		Spouse or second parent or guardian if applicant is a dependant	
Are you Employed?	❑ Yes ❑ No		❑ Yes ❑ No	
Is your Employment Seasonal?	❑ Yes ❑ No		❑ Yes ❑ No	
If 'Yes', Specify:	From	To	From	To
Employer's Name and Department:				
Employer's Address:				
Employer's Phone Number:	( )		( )	
Are you eligible for any Benefits under your Employer's Insurance Plan?	❑ Yes ❑ No		❑ Yes ❑ No	
If 'Yes', Specify:	Name of Employer's Insurance Plan		Name of Employer's Insurance Plan	
	Medical Plan No.	Dental Plan No.	Medical Plan No.	Dental Plan No.
Are you eligible for any Benefits under a Private Insurance Plan?	❑ Yes ❑ No		❑ Yes ❑ No	
If 'Yes', Specify:	Name of Employer's Insurance Plan		Name of Employer's Insurance Plan	
	Medical Plan No.	Dental Plan No.	Medical Plan No.	Dental Plan No.

APPLICANT'S DECLARATION

I consent to the release of my personal information to the Métis Health Benefits program for the purposes of determining mine, my spouse and/or my family's initial and continued eligibility for health benefits coverage.

x ______________________________ Applicant's Signature (Parent / Guardian)

______________ Date (y/m/d)

RETURN COMPLETED FORM TO:

Department of Health and Social Services
HEALTH BENEFIT PROGRAMS
BAG #9, INUVIK NT X0E 0T0

Phone: (867) 777-7400
Toll Free: 1-800-661-0830