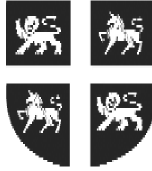

GOVERNMENT OF
NEWFOUNDLAND AND LABRADOR

Department of Health
HOSPITAL SERVICES DIVISION
P.O. Box 8700
St. John's, Newfoundland, A1B 4J6

APPLICATION FOR NEWFOUNDLAND HOSPITAL INSURANCE BENEFITS

1. Patient ____________________ Address ____________________
   Hospital ____________________ Address ____________________
   Admitted ____________________ 20____ Discharged ____________________ 20____

2. Patient left Newfoundland on ____________________ 20____
   Arrived in ____________________ (province or other country) on ____________________ 20____
   Returned (or intends to return) to Newfoundland on ____________________ 20____

3. Reason for absence from Newfoundland ____________________

4. MCP Number ____________________
   Residence in Newfoundland may be verified by:
   Name: ____________________ Address: ____________________
   Name: ____________________ Address: ____________________

5. Is treatment required because of an accident?...................... ________ (yes) ________ (no)
   (a) If illness or accident incurred during employment,
   Name of employer ____________________ Address: ____________________
   (b) Do you intend to make a claim for damages? ____________________

6. If application approved, payment should be forwarded to: ____________________

7. I hereby certify that to the best of my knowledge, the information given in this application is true and correct.
   (Applicant) ____________________ 20____

   (If applicant other than patient, state relationship ____________________)

NOTE: If payment is to be made to applicant, receipt covering payment to hospital MUST be included.