Alberta AlbertaWorks

Alberta Child Health Benefit Application

The information you have provided on this application is collected under the authority of the *Income and Employment Supports Act*, and is managed in accordance with the *Freedom of Information and Protection of Privacy Act*. The information will be used solely for the purpose of determining and verifying eligibility for benefits under the Alberta Child Health Benefit (ACHB) program, and will be matched and shared with any agency, institution, government department (federal or provincial), or other sources for this purpose. If you have questions about the collection of this information, contact the Health Benefits Contact Centre at 780-427-6848 or toll-free outside of Edmonton at 1-877-469-5437. **Applications can be faxed toll-free to: 1-855-415-8386.**

- **Complete this form in pen. Do not use pencil. Please PRINT clearly.**
- **The application will be sent back to you if information is missing.**
- **Ensure you, and your spouse if applicable, read and sign the Declaration and the Consent on page 2 of this application.**

My Personal Information

Last Name	First Name	Middle initial	Gender	Social Insurance Number

Mailing Address		
City/Town/Municipality	Province/Territory 1	Postal Code

Home phone number	Work phone number	Extension	Birth date (yyyy-mm-dd)

My Spouse/Partner's Information **(If you are divorced or separated from your spouse/partner, do not complete this section.)**

Last Name	First Name	Middle initial	Gender	Social Insurance Number

Birth date (yyyy-mm-dd)

My Child(ren) *(List all children under 18 years of age and 18 and 19-year-olds attending high school.)*

Complete All sections for each child. Please note that all children MUST have ALBERTA Personal Health Numbers before they can be enrolled in this program.

	Child's last name	First name	Gender
1			
2			
3			
4			

Birth date (yyyy-mm-dd)	**Alberta** Personal Health Number	Does this child have health coverage other than standard Alberta Health Care Insurance?	Does this child have Indian or Inuit status?
		☐ Yes ☐ No	☐ Yes ☐ No

If you have more than four children, please attach another sheet listing the same information for them.

Applicant's Last name	Social Insurance Number

If you or your children have any other health coverage *(other than standard Alberta Health Care Insurance)* please provide:

1	Type(s) of coverage provided in policy ☐ Dental ☐ Prescription Drugs ☐ Optical ☐ Ambulance	Name of Insurer *(i.e. Clarica, Alberta Blue Cross)*	
	Name of Policy Holder *(if different from you)*		Policy Number/Identification Number
2	Type(s) of coverage provided in policy ☐ Dental ☐ Prescription Drugs ☐ Optical ☐ Ambulance	Name of Insurer *(i.e. Clarica, Alberta Blue Cross)*	
	Name of Policy Holder *(if different from you)*		Policy Number/Identification Number

- If you have more than two other health insurers, please attach another sheet providing the same information for that coverage and who is covered under each plan.
- Please note if you have existing health coverage Alberta Child Health Benefit may provide top up to 100% of Alberta Government agreement rates.

My Declaration

1. I declare that I am a resident of Alberta and that the information on this application is true and complete to the best of my knowledge.
2. I will report any changes in this information to the Health Benefits Contact Centre.
3. I understand that giving false or incomplete information, or not advising of changes in my situation may result in termination or suspension of benefits, criminal charges and repayment of benefits I have received.
4. I understand that to be eligible for this program I must consent to Canada Revenue Agency providing tax information for the head of household and spouse/partner (if applicable).
5. I understand my eligibility for the Alberta Child Health Benefit program will be assessed automatically each year, unless I inform the Health Benefits Contact Centre that I no longer wish to receive this benefit.

My signature	Date (yyyy-mm-dd)	Spouse/Partner's signature (if applicable)	Date (yyyy-mm-dd)
X		X	

Consent for Canada Revenue Agency to Verify Income

I consent to Canada Revenue Agency giving Alberta Government information from my income tax return(s) and other taxpayer information about me, whether supplied by me or a third party. The information will be relevant to, and will be used solely for the purpose of determining, verifying and/or auditing my/our eligibility, and for the general administration and enforcement of the Alberta Child Health Benefit under the *Income and Employment Supports Act*. This consent is valid for the taxation year in which I sign this consent, the previous tax year, and for each taxation year that I receive this benefit.

My signature	Date (yyyy-mm-dd)	Spouse/Partner's signature (if applicable)	Date (yyyy-mm-dd)
X		X	

NOTE:

If you have a Notice of Assessment from Canada Revenue Agency for the most recent tax year, please include a copy with this application as this will reduce the processing time. However, your continued eligibility in future years will be based on tax information from Canada Revenue Agency, and does require that you sign the above consent.

For Office Use Only Date application received

The Alberta Child Health Benefit program pays for:

Prescription Drugs and some Over-the-Counter Products
Dental/Denturist Services
Optical Services
Emergency Ambulance Services
Diabetic Supplies

Just fill out this application form and mail or fax your completed application to:

Alberta Human Services
Health Benefits Contact Centre
P.O. Box 2222 Station Main
Edmonton, AB T5J 5H3
Fax: 780-415-8386 in Edmonton
or 1-855-415-8386 toll-free outside Edmonton

Call if you have questions: 780-427-6848 in Edmonton or 1-877-469-5437 toll-free.