CanAssistance

550 Sherbrooke O/W, suite B9
Montréal, Quebec, Canada
H3A 3S3

SCHEDULE « A »

ASSIGNMENT OF PAYMENT DUE TO INSURED PERSON OR BENEFICIARY UNDER THE MEDICARE PROTECTION ACT OR HOSPITAL INSURANCE ACT

BETWEEN:	_____ _____ _____	Of the first part, Hereinafter referred to As the Assignor
AND:	CanAssistance 550 Sherbrooke O./W., suite B9 Montréal, Quebec, Canada, H3A 3S3	Of the second part Hereinafter referred to As the Assignee
AND:	HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH	Herein referred to As the Minister

WHEREAS the Assignor is a person eligible for insured services and/or benefits under the Province of *British Columbia's Medicare Protection Act* and/or *Hospital Insurance Act*, and as such may receive payment for certain of those services or benefits from the Minister.

And WHEREAS the Assignor is bound by an obligation under a contract or agreement with the Assignee to remit to the Assignee all payments received for such insured services and/or benefits from the Minister.

THEREFORE, in consideration of the obligation to the Assignee, the Assignor hereby assigns to the Assignee all sums of money that shall be owing to the Assignor by the Minister in relation to the insured services and/or benefits referred to above. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address noted above, or at any address the Assignee may from time to time designate, with payment of any such sum to be complete discharge of the Minister from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

By signing this form, you will be assigning your MSP and hospital insurance benefit to the insurance company (Assignee) named above.

DATED this _____ day of _____, _____
(Year)

_____
Signature of the Assignor

WITNESS

_____ Signature

_____ Occupation

ASSIGNMENT

Effective from: ____/ ____/ _____
MO DY YR

To: ____/ ____/ _____
MO DY YR

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SCHEDULE « B »

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

I, _____ - (or I, _____, parent/guardian of

_____, a minor) hereby consent to and authorize the Ministry of Health Services ("the Ministry") to provide to an authorized representative of CanAssistance ("the Insurer"), for the use by the Insurer in assessing entitlement to benefits, any and all records and information in the possession of the Ministry regarding claims for medical or health care services incurred while I had insurance coverage with the Insurer from Month _____ Day _____ Year _____ to Month _____ Day _____ Year _____, including records and information relating to medical history and physical condition both prior and subsequent to receipt of medical or health care services.

DATED this _____ day of _____, _____
(Year)

_____
Personal Health Number

_____
Signature

_____
_____
_____
Address

_____
Telephone number