



1. PERSONAL INFORMATION

LEGAL NAME	SURNAME		GIVEN NAME (FIRST)		GIVEN NAME (SECOND)	
DATE OF BIRTH	MM	DD	YYYY	GENDER <input type="checkbox"/> F <input type="checkbox"/> M	CITIZENSHIP	
<b>BUSINESS</b> MAILING ADDRESS						If non-Canadian, indicate your status in Canada and enclose a copy of your Work Permit and/or Landed Immigrant status papers. CITY POSTAL CODE
PHONE NUMBER		FAX NUMBER		EMAIL ADDRESS		
<b>HOME</b> ADDRESS (NUMBER AND STREET)						CITY POSTAL CODE
PHONE NUMBER		FAX NUMBER		EMAIL ADDRESS		

2. REGISTRATION

NAME OF COLLEGE	DATE OF REGISTRATION (MM / DD / YYYY)	REGISTRATION #
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3. PAYMENT

To apply for Direct Bank Payment from MSP BC, please attach a blank sample cheque.
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4. SIGNATURE

_____ <i>Signature</i>	_____ <i>Date</i>
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Personal information on this form is collected under the authority of the Medicare Protection Act and will be used to process your application for a Medical Services Plan Billing number and for record keeping. This information is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act and may be disclosed only as provided by that Act. If you have any questions about the collection of this information, contact Health Insurance BC at the address or telephone numbers below.