Alberta Health Benefit Application (Ukrainian Evacuee)

Protected B (when completed)

Alberta Health Benefits

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 or Alberta Adult Health Benefit (AAHB) 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 1-877-644-9992.

Applications can be faxed toll-free to 1-855-415-8386 or mailed to the Health Benefits Contact Center address listed below.

- **If completing this form by hand, please use pen and print clearly.**
- **You must include a postal mailing address on the Alberta Health Benefits application form. Providing an email address does not fulfill this requirement. Incomplete applications will not be processed and will delay your access to health benefits.**
- **Ensure you, and your spouse if applicable, read and sign the Declaration and the Consent on page 2 of this application.**
- **Please note, all names listed on this application MUST have ALBERTA Personal Health Numbers before they can be enrolled in this program.**

My Personal Information (Applicant)

Last Name | First Name | Middle Initial | Gender | Alberta Personal Health Number

Postal Mailing Address *(do not provide an email address)*

City or Town | Province | Postal Code

Home Phone Number | Cell Phone Number | Extension | Date of Birth: Year | Month | Day

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 | Alberta Personal Health Number

Date of Birth: Year | Month | Day

My Child(ren)

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.

1 Child's Last Name | Child's First Name | Gender

Date of Birth: Year | Month | Day | Alberta Personal Health Number

2 Child's Last Name | Child's First Name | Gender

Date of Birth: Year | Month | Day | Alberta Personal Health Number

3 Child's Last Name | Child's First Name | Gender

Date of Birth: Year | Month | Day | Alberta Personal Health Number

If you have more than three children, please use the "Add Child" button, or attach another sheet listing the same information for them.

Applicant's Last Name	Alberta Personal Health Number

My Declaration

1. I declare that I am a Ukrainian evacuee residing in Alberta and 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.

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

The Alberta Health Benefit program provides coverage for:

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

For Office Use Only
Date application received

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

Alberta Community and Social 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 the Health Benefits Contact Center if you have questions: 1-877-644-9992 toll-free.