Newfoundland Labrador
Health and Community Services

CARD REPLACEMENT / INFORMATION UPDATE

mcp
Medical Care Plan

PLEASE INDICATE YOUR REASON FOR COMPLETING THIS FORM (check all that apply)

☐ LOST / STOLEN CARD ☐ NAME CHANGE ☑ RENEWAL OF COVERAGE ☐ ADDRESS CHANGE
☐ TERMINATION OF COVERAGE ☐ EXTENSION OF COVERAGE FOR NON-CANADIANS ☐ INTENT FOR ORGAN/TISSUE DONATION

DOCUMENTS YOU MUST SUBMIT WITH THIS FORM

- For name change due to marriage - a clear copy of the marriage certificate is required.
- For other legal name changes - a clear copy of the legal name change document or Government issued Birth Certificate in the new legal name is required.
- For correction to date of birth - a Government issued Birth Certificate is required. Baptismal Certificates are not acceptable.
- For gender change - a Government issued Birth Certificate in the new gender is required.
- For extension of coverage for non-Canadians - updated Immigration documents are required as well as a recent letter from University or Employer verifying full-time enrolment or employment for at least one year.

SECTIONS 1, 2 AND 5 MUST BE COMPLETED BY ALL APPLICANTS

SECTION 1 GENERAL INFORMATION (please print)

MCP Card Number	Surname	All Given Names (in full) First Name	Middle Name	Sex/Gender M / F / X	Birth Date YYYY	MM	DD
5 7 9 9 9 1 8 6 0 5 0 6	NOOR	SM FAIYEZ		M	1999	04	07

SECTION 2 HOME MAILING ADDRESS

Street / P.O. Box	City / Town	Province	Postal Code
4 oxenpond road	ST JOHN's	NL	A 1 B 3 J 1

Home Telephone Number	Cell Number	E-mail Address
	7092190975	noorfaiyez@gmail.com

SECTION 3 NAME CHANGE

Reason for Change	New Surname (if applicable)	New Given Name(s) (if applicable)

SECTION 4 TERMINATION OF COVERAGE

Reason for Termination	Date of Termination/Departure	Country/Province of Relocation

SECTION 5 DECLARATION (to be signed by parent/legal guardian if applicant(s) under 16 years of age)

IT IS AN OFFENCE TO GIVE FALSE INFORMATION FOR THE PURPOSE OF OBTAINING COVERAGE UNDER THE NEWFOUNDLAND & LABRADOR MEDICAL CARE PLAN

I Faiyez hereby declare that I am the person named on the form, the information given is correct, and the person(s) listed on this form are residents of Newfoundland and Labrador. In lieu of a written signature, my typed name on the form shall be considered my electronic signature.

Electronic or Written Signature of Applicant: _____ Date: _____

INTENT FOR ORGAN/TISSUE DONATION - If anyone named on this form wishes to become an organ/tissue donor, please sign in one of the spaces below. Your intent to donate is supported by the *Human Tissue Act.* **(If signing below, please also print your name)**

Electronic or Written Signature and Printed Name	Electronic or Written Signature and Printed Name
Electronic or Written Signature and Printed Name	Electronic or Written Signature and Printed Name

PRIVACY NOTICE: The Newfoundland and Labrador Medical Care Plan (MCP) collects personal health information under the authority of the *Medical Care and Hospital Insurance Act.* Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office.

Grand Falls-Windsor Office:
MCP, 22 High Street, PO Box 5000, Grand Falls-Windsor, NL, A2A 2Y4
Telephone: 709-292-4000 Toll Free: 1-800-563-1557 Facsimile: 709-292-4052

St. John's Office:
MCP, 45 Major's Path, PO Box 8700, St. John's, NL, A1B 4J6
Telephone: 709-758-1600 Toll Free: 1-866-449-4459 Facsimile: 709-758-1694

www.gov.nl.ca/mcp