GOVERNMENT OF
NEWFOUNDLAND AND LABRADOR

Department of Health
HOSPITAL SERVICES DIVISION
P.O. Box 8700
St. John's, Newfoundland, A1B 4J6

APPLICATION FOR NEWFOUNDLAND HOSPITAL INSURANCE BENEFITS

1. Patient _____ Address _____
   Hospital _____ Address _____
   Admitted _____ 20____ Discharged _____ 20____

2. Patient left Newfoundland on _____ 20____
   Arrived in _____ on _____ 20____
   (province or other country)
   Returned (or intends to return) to Newfoundland on _____ 20____

3. Reason for absence from Newfoundland _____

4. MCP Number _____
   Residence in Newfoundland may be verified by:
   Name: _____ Address: _____
   Name: _____ Address: _____

5. Is treatment required because of an accident?..... _____ _____
   (yes) (no)
   (a) If illness or accident incurred during employment,
   Name of employer _____ Address: _____
   (b) Do you intend to make a claim for damages? _____

6. If application approved, payment should be forwarded to: _____

7. I hereby certify that to the best of my knowledge, the information given in this application is true and correct.
   (Applicant) _____ 20____

   (If applicant other than patient, state relationship _____)

NOTE: If payment is to be made to applicant, receipt covering payment to hospital MUST be included.