BRITISH COLUMBIA | Health InsuranceBC

SCHEDULE A
ASSIGNMENT OF PAYMENT

Personal Health Number (PHN) of Patient

BETWEEN

Assignor (Adult Patient, or Parent/Guardian of Patient)

AND

Assignee (Insurance Company)	MSP Account Number
CanAssistance	900 32

AND

HER MAJESTY THE QUEEN IN THE RIGHT OF THE PROVINCE OF BRITISH COLUMBIA AS REPRESENTED BY THE MINISTER OF HEALTH SERVICES, hereinafter 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 a complete discharge of the Minister from any indebtedness in the 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.

Payment assignment is effective from: _____ to _____
(YYYY / MM / DD) *(YYYY / MM / DD)*

_____ _____
Signature of Assignor (Patient or Parent/Guardian of Patient) *Date Signed (YYYY / MM / DD)*

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SCHEDULE B
AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

Personal Health Number (PHN) of Patient

Name of Adult Patient, or Parent/Guardian of Patient	Name of Minor-aged Patient (if applicable)

Address	Telephone Number

Insurance Company	
CanAssistance	
Insurance Coverage	
FROM (YYYY / MM / DD)	TO (YYYY / MM / DD)

I, the above-named adult, hereby consent to and authorize the Ministry of Health ("the Ministry") to provide to an authorized representative of the above-named insurance company("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 during the period noted above, including records and information relating to medical history and physical condition both prior and subsequent to receipt of the medical or health care services.

_____ *Signature of Adult (Patient or Parent/Guardian of Patient)*

Date Signed (YYYY / MM / DD)