ONTARIO MEDICAL SERVICES INSURANCE PLAN

APPLICATION FORM

PLEASE READ INSTRUCTIONS ON BA BEFORE COMPLETING

[redacted]

1. Do you have a Social Insurance Number? If yes, ins[redacted] No

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2. Your Name Please print	Last or Family Name [redacted]	3. Given Names (First) [redacted]	(Second)	Other
4. Your Address Please print	RR # or P.O. Box or Street & Number C/O THE PUBLIC TRUSTEE, 145 QUEEN STR. W. Ontario Hospital School	City or Town or Village or Post Office Orillia TORONTO 1	County or District Simcoe YORK	

5. Birth Date Day / Month [redacted]	Year 49	6. Sex ☒ Male ☐ Female	7. Marital Status ☒ Single ☐ Married Other (specify)	8. Occupation & Nature of Business or Industry PATIENT

9. LIST DEPENDANTS Spouse and/or children (children must be under 21 and unmarried). Other dependants and fully employed children must apply for separate coverage.

	Given Names Only	Birth Date Day	Month	Year	Sex M or F		Given Names Only	Birth Date Day	Month	Year	Sex M or F
Spouse						3rd child					
1st child (oldest eligible)	[redacted]					4th child					
2nd child						5th child					

List additional dependant children on back of this form.

10. In appli[redacted]surance Act, 19[redacted]0 days, I am n[redacted]hat the inform[redacted]

FOR PUBLIC TRUSTEE, STATUTORY COMMITTEE JUN 15 1966

Signature of Applicant

Date _____ 19__

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APPLICATION FOR PREMIUM ASSISTANCE

11. I have lived in Ontario for the past 12 months. I am not covered for total medical care by government. I agree to allow the Medical Services Insurance Division to verify all statements made by me on this application.

[redacted]

[redacted]nce [redacted]axable in- [redacted]r 31st last. [redacted]is correct.

FOR PUBLIC TRUSTEE, STATUTORY COMMITTEE

Signature of Applicant

Date JUN 15 1966 19 _____

B. TAXABLE INCOME OF $1,300.00 OR LESS

I hereby apply for partial premium assistance
My taxable income and the taxable income of my eligible dependants was in total $_____ for the 12 months ended December 31st last.
I state that the information given by me is correct.

Signature of Applicant

Date _____ 19 _____