INTERIM FEDERAL HEALTH CERTIFICATE OF ELIGIBILITY

Family name:

Given name(s):

Date of birth: (yyyy/mm/dd)

Sex:

Citizenship:

UCI:

Application no.:

*****NOT VALID FOR TRAVEL*****
*****DOES NOT CONFER STATUS*****

The above named individual is eligible for the following coverage:

Coverage:	**Effective Date:**	**Valid Until:**

This coverage may cease or be modified without notice if the individual's immigration status changes.

This certificate must be presented to participating health care providers, along with government issued photo ID, before receiving services. If an individual pays for services covered under the Interim Federal Health Program (IFHP), the individual cannot be reimbursed.

I, the undersigned:

- declare that I require coverage under the IFHP. I will notify CIC immediately of any changes to my immigration status, or if I become eligible for or receive other health insurance;

- understand that it is my responsibility to renew this coverage before and annually thereafter, as required;

- understand that my medical and personal information will be shared with CIC, IFHP claims administration and other appropriate third-parties for the administration of the IFHP and that personal information may be shared with other government institutions and other third-parties in accordance with the *Privacy Act* and the *Department of Citizenship and Immigration Act*.

SIGNED at on
(yyyy/mm/dd)

For the health care provider, you **MUST** verify the eligibility of the individual with the IFHP administrator **BEFORE** providing services, via web **https://provider.medavie.bluecross.ca/** phone 1-888-614-1880 or fax 506-867-3824.

Client ID #:
Family name:
Given name(s):
Date of birth: (yyyy/mm/dd)