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Alberta AlbertaWorks

Request for Reassessment of Eligibility for Health Benefits

The information you provide on this form is collected under the authority of the *Income and Employment Supports Act*, and is in accordance with the *Freedom of Information and Protection of Privacy Act*. The information will be used solely for the purpose of determining and verifying eligibility for health benefits and will be matched and shared with any agency, institution, government department (federal or provincial), or other sources for this purpose. If you have questions about the collection of this information, contact the Health Benefits Contact Centre at 780-427-6848 or toll free outside of Edmonton at 1-877-469-5437.

Provide your estimated current annual income and/or medical expenses information and **attach supporting documents to this form**. **This request will NOT be processed without supporting documentation.** Complete only the income questions that are applicable to you and your spouse.

Send the completed form to: **Alberta Human Services**
Health Benefits Contact Centre
P.O. Box 2222 Station Main
Edmonton AB T5J 5H3

PERSONAL INFORMATION

☐ AAHB ☐ ACHB	Last Name	First Name	Middle Name

Birthdate *(mm/dd/yyyy)*	Social Insurance Number	Home Telephone Number *(e.g., 999-999-9999)*	Work Telephone Number *(e.g., 999-999-9999)*

Mailing Address	City/Town/Municipality	Province/Territory	Postal Code

ESTIMATED CURRENT ANNUAL INCOME *(include both your and your spouse's income; attach supporting documentation.)*

Gross employment earnings *(Monthly average times 12; attach pay slips)*	$ _____
Employment Insurance Benefits *(Weekly rate times number of eligible weeks)*	$ _____
Canada Pension Plan Benefits *(Gross monthly rate times 12)*	$ _____
Private Pension Plan Benefits *(Gross monthly rate times 12)*	$ _____
Taxable Student Funding *(Payments as listed on Notice of Assessment, not including tuition fees)*	$ _____
Cashed RRSP's	$ _____
Farm or Business net income *(Gross monthly income minus business expenses)*	$ _____
Workers' Compensation Benefits *(Monthly payments times 12)*	$ _____
Non-Taxable Child Support Payments *(Estimate amount for the year)*	$ _____
Income Support or AISH income received	$ _____
Other Income not listed above	$ _____

MEDICAL EXPENSES

If you believe your current income is insufficient to pay for your family's ongoing health costs, provide the last 12 months of your household's ongoing prescription drug costs for a deduction from your estimated income. Ask your pharmacist to provide you with a printout of these costs and attach the printout to this form.

Signature of Requestor	Printed Name of Requestor	Date *(mm/dd/yyyy)*

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