


Section E - Spouse's or Partner's Personal Information <i>(Please print)</i>			My personal health number is			
My title is (e.g. Mr, Mrs, Dr)		My last name is				
My first name is			My middle name is			
My current mailing address is (if different than account holder's address on page 1)						
City/Town		Province/Territory		Country		Postal code

Section F - Spouse's or Partner's Income Information		2018 subsidy for Apr 1, 2019 - Mar 31, 2020	
I filed an income tax return with the Canada Revenue Agency for the year		<input type="checkbox"/> Yes <input type="checkbox"/> No	
a. If yes , my taxable income was <i>(line 260 from your income tax return)</i>		\$ <input type="text"/>	
b. If no , I was claimed as a spouse, partner or dependant		<input type="checkbox"/> Yes <input type="checkbox"/> No	
 Unless you file an income tax return or are claimed on your spouse's, partner's or parent's return, you may not qualify for subsidy.			

Section G - Alberta Health Certification and Authorization

I have read the information on this form and certify that the information given by me is true and correct.

I authorize Alberta Health to disclose my registration information to the Canada Revenue Agency for the purpose of verifying my eligibility for a premium subsidy under the *Health Insurance Premiums Regulations*. I understand why I have been asked to consent to the disclosure of this information and I am aware of the risks and benefits of consenting or refusing to consent. I also understand that this authorization is in effect for the current period, and for each subsequent subsidy period for which I may be eligible to receive a premium subsidy under the *Health Insurance Premiums Regulations*. I may revoke this consent in writing at any time.

Signature of spouse or partner 		Date Y Y Y Y M M D D	My home phone number is	My work phone number is
---	--	-----------------------------	-------------------------	-------------------------

Section H - Canada Revenue Agency Authorization

I authorize the Canada Revenue Agency to release information from my income tax return, and, if applicable, other required tax information about me, whether supplied by me or a third party, to the Minister of Health of the Province of Alberta. The information will be relevant to determining my eligibility for a reduced premium rate under the *Health Insurance Premiums Regulations*, and for no other purpose. I acknowledge that this authority is in effect for the 2018 taxation year and each subsequent consecutive year for which I may be eligible to receive a premium subsidy under the *Health Insurance Premiums Regulations*.

Signature of spouse or partner 		Date Y Y Y Y M M D D	My Social Insurance Number is
---	--	-----------------------------	-------------------------------

Contact information Mailing Address

Alberta Health
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

In Person

To locate the office nearest you,
please telephone our office or visit
our website.

Telephone

780-427-1432 Edmonton
Toll-free within Alberta at
310-0000 then 780-427-1432

Fax 780-422-0102

Website www.alberta.ca/ahcip.aspx

The information requested on this application is being collected by Alberta Health pursuant to section 20(a) and (b) of the *Health Information Act* and section 33 of the *Freedom of Information and Protection of Privacy Act* for the sole purpose of determining or verifying your eligibility to receive a premium subsidy under the *Health Insurance Premiums Regulations* and will not be disclosed to any other person or organization without your approval. If you have any questions regarding the collection of this information, please contact an Alberta Health representative at the address or telephone numbers provided above.