



Application for Alberta Blue Cross Non-Group Premium Subsidy

Protected B (when completed)

Retroactive and Current Years - Based on 2023, 2024, 2025 Taxation Year(s)

Please read the eligibility and program information in the information brochure before you complete this application. Your application is only required if you have Alberta Blue Cross Non-Group Coverage. This form can only be used for 2023, 2024 and 2025 tax information.

Section A - Account Holder's Personal Information (Please print)

Personal Health Number

Last Name

First Name

Middle Name

Mailing Address

City/Town

Province/Territory

Country

Postal code

I am applying for subsidy for a previous account.

Yes No

If yes, indicate the account number from the premium statement

Section B - Account Holder's Income Information

2023

subsidy for
Apr 1, 2024 - Mar 31, 2025

Yes No

2024

subsidy for
Apr 1, 2025 - Mar 31, 2026

Yes No

2025

subsidy for
Apr 1, 2026 - Mar 31, 2027

Yes No

I filed an income tax return for the year ▶

a. If yes, my taxable income for that year was
(line 26000 from your income tax return) ▶

\$ _____

\$ _____

\$ _____

b. If no, I was claimed as a spouse, partner or
dependant that year ▶

Yes No

Yes No

Yes 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 C - Primary and Preventative Health Services 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 Primary and Preventative Health Services 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 subsidy periods, also for each account during these periods, 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 account holder

Date

Phone Number

Alternate Phone Number

Y Y Y Y | M M | D D

Section D - 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 Primary and Preventative Health Services 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 taxation year(s) and each subsequent consecutive year for which I may be eligible to receive a premium subsidy under the *Health Insurance Premiums Regulations*.

Signature of account holder

Date

Social Insurance Number

Y Y Y Y | M M | D D


Unsigned forms (Sections C and D) will be returned.

If you have a spouse or partner, they must complete and sign (Sections G and H) on reverse.

Section E - Spouse's or Partner's Personal Information (Please print)			Personal Health Number			
Last Name						
First Name			Middle Name			
Mailing Address (if different than account holder's address on reverse)						
City/Town		Province/Territory		Country		Postal code
I am applying for subsidy for a previous account. <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes , indicate the account number from the premium statement						

Section F - Spouse's or Partner's Income Information

	2023 subsidy for Apr 1, 2024 - Mar 31, 2025	2024 subsidy for Apr 1, 2025 - Mar 31, 2026	2025 subsidy for Apr 1, 2026 - Mar 31, 2027
I filed an income tax return for the year <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If yes , my taxable income for that year was (line 26000 from your income tax return) <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ <input type="text"/>	\$ <input type="text"/>	\$ <input type="text"/>
b. If no , I was claimed as a spouse, partner or dependant that year <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<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 - Primary and Preventative Health Services 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 Primary and Preventative Health Services 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 subsidy periods, also for each account during these periods, 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	Phone Number	Alternate Phone Number
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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 Primary and Preventative Health Services 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 taxation year(s) 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	Social Insurance Number
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Contact information

Mailing Address

Primary and Preventative Health Services
PO Box 1360 Stn Main
Edmonton AB T5J 2N3

Participating Registry Agents

alberta.ca/ahcip-registry-locations

Contact

AHCIP Contact Centre
780-427-1432 in Edmonton
Toll-free within Alberta at
310-0000 then 780-427-1432

Website alberta.ca/ahcip

The information on this form is being collected and used by Primary and Preventative Health Services pursuant to sections 20(a), 20(b), 21(1)(a), and 27(1)(2) of the *Health Information Act* and section 4(c) of the *Protection of Privacy Act (POPA)* for the purpose of determining and verifying eligibility to receive a premium subsidy under the Alberta Health Care Insurance Plan, the Alberta Blue Cross Non-Group Plan, or both, 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 a Primary and Preventative Health Services representative toll-free within Alberta at 310-0000 then 780-427-1432.