MOVING OUT OF MANITOBA

Please provide correct information as it appears on your Health Card

Cardholder's Information

Registration Number:	Personal Health Identification Number:	
Primary Phone Number:	Email Address:	
Last Name:	First Name:	Middle Name:
Sex: ○ Male ○ Female ○ Non-Binary		
Date of birth:		

Current Address (the address that is on your Manitoba Health card)

Note: Please ensure the accuracy of your residential and/or mailing address as typed on this form. The information you are providing will be used to confirm your information in our database. If a mistake is made it can result in mail from Manitoba Health being returned to sender as undeliverable which could result in the suspension of your health benefits.

Current Address*

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Moving Out of Manitoba

Only complete one section below based on the following criteria:

Complete **Section A** if:

a) you are a single persons.
b) you are a family leaving Manitoba together.

Complete **Section B** if:

a) one spouse is leaving Manitoba before their spouse and/or dependants.

Complete **Section C** if:

a) one spouse is leaving Manitoba and the remainder of the family is staying in Manitoba.

Section A: Single persons, or families leaving Manitoba together

By completing this section, I am certifying that I and my dependants, if any, are leaving Manitoba permanently, as indicated below:

Date of Departure from Manitoba:
Date of Arrival in New Place of Residence:

Note: Please ensure the accuracy of your residential and/or mailing address as typed on this form. The information you are providing will be used to confirm your information in our database. If a mistake is made it can result in mail from Manitoba Health being returned to sender as undeliverable which could result in the suspension of your health benefits.

Section A Continued

New Residential Address

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Mailing address (if different from above)

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Section B: One spouse is leaving Manitoba before their spouse and/or dependants

By completing this section, I am certifying that I am leaving Manitoba permanently and my dependant(s) are moving at a later date, as indicated below:

Date of Departure from Manitoba:
Date of Arrival in New Place of Residence:
Dependants Date of Departure from Manitoba:
Dependants Date of Arrival in New Place of Residence:

Note: Please ensure the accuracy of your residential and/or mailing address as typed on this form. The information you are providing will be used to confirm your information in our database. If a mistake is made it can result in mail from Manitoba Health being returned to sender as undeliverable which could result in the suspension of your health benefits.

New Residential Address

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Mailing address (if different from above)

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Section C: One spouse is leaving Manitoba and the remainder of the family is staying in Manitoba

By completing this section, I am certifying that I am leaving Manitoba permanently as indicated below, and my dependant(s) will remain in Manitoba:

Date of Departure from Manitoba:
Date of Arrival in New Place of Residence:

Note: Please ensure the accuracy of your residential and/or mailing address as typed on this form. The information you are providing will be used to confirm your information in our database. If a mistake is made it can result in mail from Manitoba Health being returned to sender as undeliverable which could result in the suspension of your health benefits.

New Residential Address

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Mailing address (if different from above)

Apartment/Unit Number:	Street address/P.O Box:	
City/Town/Municipality:	Province:	Postal Code:

Form Completed By

Last Name:	First Name:
Date:	

Signature:

☐ **By checking this box, I certify that the information contained herein is true. Section 42 of the Health Services Insurance Act provides for a fine of up to $5000 for a person convicted of making false and misleading statements.**