BIGSTONE HEALTH BENEFITS PROGRAM CONSENT FORM

(This form is to be completed by the Applicant who would like to access benefits under the Bigstone Health Benefits Program.)

APPLICANT INFORMATION

Last name		Given name(s)		Date of Birth MM / DD / YYYY	Gender
Treaty Status No.		**Health Care No.**		**Telephone No.** ( )	
Address	**Box No.**	**City/Town**	**Province**	**Postal Code**	

DEPENDENT(S) INFORMATION

Last name	Given name(s)	Date of Birth MM / DD / YYYY
Treaty Status No.	**Health Care No.**	**Gender**
Last name	**Given name(s)**	**Date of Birth MM / DD / YYYY**
Treaty Status No.	**Health Care No.**	**Gender**
Last name	**Given name(s)**	**Date of Birth MM / DD / YYYY**
Treaty Status No.	**Health Care No.**	**Gender**

I have read and understand that:

- Bigstone Health Commission operates, provides and otherwise facilitates the provision of various health related and other benefits, items, goods and services ("benefits") under its Bigstone Health Benefits Program ("Bigstone Health Benefits Program"). Further particulars of the Bigstone Health Benefits Program may be found on the Bigstone Health Commission website: www.bigstonehealth.ca.

- Bigstone Health Benefits Program is collecting my personal information including health information, individually identifying information, and health related and claims processing information ("personal information") and the personal information of my dependent(s) (if any) which will be used to confirm eligibility and to process claims for benefits and for purposes related to the administration, delivery and management of my benefits under the Bigstone Health Benefits Program and otherwise as authorized herein.

- Bigstone Health Benefits Program may collect, use, disclose, exchange and share my personal information and that of any dependent(s) with any party as may be required for any purpose relating to the administration, delivery and management of my benefits under the Bigstone Health Benefits Program or otherwise as authorized herein. This includes but is not limited to the Government of Canada, the Government of Alberta, Alberta Health Services, any federal, provincial or territorial government agencies involved as well as any federal, provincial, territorial or other third party plans or private insurers or any goods and services providers involved in the provision of benefits hereunder and the Non-Insured Health Benefits Program ("NIHB Program") operated by Health Canada. Further particulars of the NIHB Program may be found on the Health Canada website.

- The personal information may also be disclosed to the contractors administering the claims system for payment, parties involved with claim assessment and verification, quality assurance and audit purposes; information may be exchanged with benefit providers to verify eligibility with provincially or territorially registered practitioners; pharmacists, medical doctors, dentists, other healthcare professionals and their respective professional licensing bodies to ensure compliance with professional standards, applicable legislation and regulations and program management policies on medical necessity; and with provincial or territorial health facilities; Indian and Northern Affairs Canada (INAC) and Health Canada for purposes of confirming my eligibility or any of my dependent(s) under the NIHB Program and Status Verification System (SVS); provincial or territorial medical insurance plans; and provincial, territorial or municipal public assistance plans to verify eligibility; and to compile statistics. The personal information collected herein may be acquired from me or any of my

dependent(s) and other sources including but not limited to claims from benefit prescribers or health care service providers such as pharmacists, medical doctors, dentists, nurses, registered psychologists, registered social workers and vision, dental, medical supply and equipment specialists or anyone else that is required.

- Bigstone Health Benefits Program is authorized to use the personal information collected for statistical purposes, quality assurance, planning and program development. For such purposes, said personal information shall be used only in generic and statistical manner, without any reference to any material that may identify the recipient of benefits or result in personal information specifically about the recipient of benefits included in the dissemination or gathering of such information.

- Bigstone Health Benefits Program and any duly authorized employees of Bigstone Health Commission may disclose and share my personal information and that of any dependent(s) with Alberta as represented by the Minister of Health and link to Alberta Health databases, registries and administrative health datasets for the purpose of participating in immunization information sharing and adverse events following immunization, improving vaccine safety and monitoring, increasing the accuracy of province wide information, assessing health status and determinants of health of the Bigstone population, trends and issues for planning, prioritizing health services, education and advocacy. Bigstone Health Benefits Program will ensure that any collection, use and disclosure of information for this purpose is to be carried out in the most limited manner and with the highest degree of anonymity that is possible in the circumstances.

- This consent will not affect any aboriginal or Treaty Rights or any rights of the Applicant or the dependent(s) (if any) under the land claim agreements of Bigstone Cree Nation.

- This consent is valid for as long as it is needed for purposes of the Bigstone Health Benefits Program as amended from time to time and any benefits provided to the Applicant or any dependent(s) thereunder. The Applicant may withdraw consent at any time on giving written notice to Bigstone Health Benefits Program. If the Applicant withdraws or fails to provide consent hereunder, Bigstone Health Benefits Program will not be able to process any requests or claims for benefits.

I, the Applicant, hereby confirm that:

(A) I have read and understand this Consent Form, and hereby consent and agree to the contents thereof on my behalf and on behalf of my dependent(s) (if any) noted above;

(B) I authorize and give my consent to Bigstone Health Benefits Program, its agents and duly authorized employees, the claims administrator(s) or anyone who acts for or on its behalf including prescribers, health care or service professionals or providers and First Nations, Inuit or Innu organizations providing benefits on behalf of the Bigstone Health Benefits Program to collect, use and disclose my personal information and that of any dependent(s) noted above for purposes related to the administration, delivery and management of my benefits under the Bigstone Health Benefits Program and for other purposes as described herein.

(C) All information provided by me in completing this Consent Form is true and accurate and any false answer or declaration may lead to a denial of benefits.

(D) I am the parent or guardian of the dependent(s), (if any) noted above, such dependent(s) being under the age of 18 years and/or incompetent, and I am duly authorized to provide this consent in my personal capacity and on behalf of each of my dependent(s) noted above.

Signature of Applicant	**Print Name of Applicant**	**Date** MM / DD / YYYY

TRANSLATOR'S DECLARATION: (if applicable)

I declare that prior to consent being given, I have faithfully interpreted the Consent Form in the language of _____ for the benefit of all interested parties.

Print Name of Translator	**Street Address**	**Box No.**

City/Town	**Postal Code**	**Telephone No.** ( )

Signature of Translator	**Date** MM / DD / YYYY