NAME CHANGE

Please submit 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:		

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 (the address that is on your Manitoba Health card):

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

Mailing address (if different than above)

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

Change of Name (How your new legal name(s) should appear on the Manitoba Health Card)

Last Name:	First Name:	Middle Name:

Documentation

Please supply a copy of **one** of the following documents to Manitoba Health by email, fax, mail or in-person showing the change of name(s) together with your application form:

Manitoba Vital Statistics Branch
Marriage certificate,
Birth certificate,
Legal name change

Immigration, Refugees and Citizenship Canada
Canadian citizenship
Permanent resident card

Other
Divorce certificate

Will you required a change of address?

○ Yes ○ No

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.**