Ontario **ServiceOntario**

# Seasonal Agricultural Workers Registration for Ontario Health Insurance Coverage

Microfilm Use Only

For use only when registering Migrant Farm Workers through the Seasonal Agricultural Worker Program. Please fill in the form and print or print the form and fill out using a blue or black pen.

## Section A - Personal Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Date of Birth (year/month/day) | Sex | Have you ever had an Ontario Health Number? | If yes, what was the number? |
|---|---|---|---|
| | ☐ Male ☐ Female | ☐ Yes ☐ No | |

| Home Telephone Number | Work Telephone Number |
|---|---|
| ( ) | ( ) Ext. _____ |

## Section B - Farm Mailing Address

Street number and name, or P.O Box number, R.R. or General Delivery

| City | Province | Postal Code | Country |
|---|---|---|---|
| | ON | | Canada |

## Section C - Farm Residence Address - if different from Mailing Address

Street number and name, or P.O Box number, R.R. or General Delivery

| City | Province | Postal Code | Country |
|---|---|---|---|
| | ON | | Canada |

## Section D - Agreement

I confirm and understand that:

- The Ministry of Health and Long-Term Care or its agent, ServiceOntario, may attempt to verify my residence status and any information I have given on this form and in the documents I have provided.
- In support of this verification, my personal information may be collected from, and disclosed to, government and non-government organizations, as lawfully permitted.
- If there is a change in my name, address, citizenship or immigration status, ServiceOntario must be notified within 30 days of the change.
- All of the information I have given in this application, and in the documents I have provided, is true and accurate.

| Signature of Applicant | Date |
|---|---|
| | |

Collection of the personal health information on this form is for assessment and verification of eligibility for Ontario health insurance coverage, or related programs, health planning and research, and the administration of the *Health Insurance Act* and the *Ontario Drug Benefit Act*. The information may be used and disclosed in accordance with the *Personal Health Information Protection Act*, *2004*, and as set out by the "Ministry of Health and Long-Term Care Statement of Information Practices" which may be accessed at www.health.gov.on.ca. I understand that I may withhold my consent to the collection of this information; but that in doing so may interfere with the provision of my Ontario health insurance coverage. For more information, please call ServiceOntario INFOline at 1-800-268-1154.

| **Ministry use only** | Health Number | Version Code | Processing Clerk | | |
|---|---|---|---|---|---|
| | | | Date | Number | Initials |

**Citizenship**

| Name on Document | Cit Type | Effective Date | End Date |
|---|---|---|---|
| | **MFW** | | |

| Document Type | Issue Date | End Date | Issued by | Document Number | Client I.D. |
|---|---|---|---|---|---|
| | | | **CAN** | | |


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