



## Confirmation of Health Insurance Coverage

Comprehensive health insurance is mandatory as a condition of your acceptance and participation in a program. **Please complete and return this form to Community Services.** Non-Canadians who have not presented proof of valid health insurance seven (7) calendar days prior to their first day of residency will be automatically be enrolled in The Banff Centre's guard.me International Insurance group plan for the duration of their stay (including arrival and departure days) and charged the applicable fees. **There will be no exceptions or extensions.**

Name: \_\_\_\_\_ Program Name: \_\_\_\_\_  
Last First

Banff Centre ID#: \_\_\_\_\_ Program Dates: \_\_\_\_\_  
Year/Month/Day to Year/Month/Day

### Please check ONE of the following:

I am Canadian (or a permanent resident) and live in Canada and I have provincial health care coverage.

Province: \_\_\_\_\_ Provincial Healthcare #: \_\_\_\_\_

I have private health insurance for the length of my program *(including days of travel)*.

*This includes Canadian citizens residing in a foreign country.*

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Emergency Assistance Number: \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_ Maximum Benefit Coverage: \$ \_\_\_\_\_

Including days of travel: Year/Month/Day to Year/Month/Day

Enrol me in The Banff Centre's guard.me International Insurance group plan *(for international participants)*.

*Enrolment is \$2.00 Canadian per day. If you are 65 or older- different rates apply. Contact Community Services directly or email [medicalform@banffcentre.ca](mailto:medicalform@banffcentre.ca).*

Coverage Start Date: \_\_\_\_\_ Coverage End Date: \_\_\_\_\_  
Including day of travel: Year/Month/Day Including day of travel: Year/Month/Day

Date of Birth: \_\_\_\_\_ Sex: F / M Home Country: \_\_\_\_\_  
Year/Month/Day

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Credit card details:**  Visa  MasterCard  American Express (charges are in Canadian dollars)

Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Name on Card Please print: \_\_\_\_\_ Signature: \_\_\_\_\_

Fax to 1-403-762-6236 or Email [medicalform@banffcentre.ca](mailto:medicalform@banffcentre.ca)  
Or mail to: The Banff Centre, Community Services, PO Box 1020, Station # 34, Banff, Alberta, Canada T1L 1H5