TK'EMLÚPS TE SECWÉPEMC
MEDICAL/DENTAL FINANCIAL
ASSISTANCE APPLICATION FORM

As per the Tk'emlúps te Secwépemc Medical/Dental Assistance Policy this application must be completed in order to receive assistance. It is the individual TteS band member's responsibility to read and understand the TteS Medical/Dental Policy.

Date of Application: _____

Name of Applicant: _____ D.O.B.:_____

Address:_____

Phone Number:_____

If applicable, name of parent/guardian: _____

Status Number: 688_____

Note: All requests must include a physician's referral or prescription and/or original invoices or receipts.

Do you have any extended dental or health insurance coverage: Yes____ No____

If yes, please attach proof of denial of ineligibility, service carrier name and number:_____

Failure to inform TteS of alternate medical/dental coverage will jeopardize future funding.

I agree any reimbursable funds will be made payable directly to: Tk'emlúps te Secwépemc, c/o Social Development Department.

_____ _____
Signature of Applicant or Parent/Guardian **Date Signed**

_____
Print Name