Major's Path
Newfoundland and Labrador Fertility Services (NLFS)
Fertility Subsidy Application

Applicant Information:

First Name: ________________________ Last Name:________________________ DOB: ___________
YY/MM/DD

MCP Number:______________________________ MCP Expiry Date: ____________________ Age: ___
YY/MM/DD

Address: ____

Town/City: ____ Postal Code: _____________

Telephone: ___________ Alternate Telephone:___________ Email: ______________________________

Major's Path NLFS Referring Physician Name____

ART Clinic: ____Province: __________

Indicate Treatment and Date of Treatment:

☐ Embryo transfer _________________________
☐ Fresh ☐ Frozen YY/MM/DD

☐ Donor egg cycles_________________________
YY/MM/DD

☐ Donor embryo cycles_______________________
YY/MM/DD

☐ Oocyte cryopreservation__________________
YY/MM/DD

☐ Intracytoplasmic sperm injection_____________
YY/MM/DD

☐ Gestational carrier cycles_________________
YY/MM/DD

☐ Other_________________________________ ____
Treatment Name YY/MM/DD

Declaration of Eligibility:

I do solemnly declare that:

- I hold a valid MCP card issued by Newfoundland and Labrador (NL)
- I have been assessed by a Major's Path NLFS reproductive endocrinology and infertility specialist for fertility concerns and have received treatment after August 4, 2021.
- The Assisted Reproductive Technology (ART) treatment costs that I am claiming are not eligible for coverage by any other provincial program or private sector insurance plan.
- I acknowledge and understand that I may claim eligible incurred costs of ART procedures and pharmaceutical products up to $5,000 (per treatment) for a maximum of three treatments (max $15,000).
- I acknowledge and understand that costs associated with ART treatment incurred outside of the province of NL will be eligible, only if the specific treatments are unavailable in the province.
- I have attached original receipts or clear copies of original receipts from a Canadian ART clinic which identifies the date the treatment services were rendered.
- I acknowledge and understand that payment of my claim is subject to the availability of government funding.

I, the applicant, hereby declare that the information provided on this application, and in any documents attached, is correct and complete.

Applicant's signature: ____ Date: _________________

Release of Information: The collection of information on this form by Eastern Health is necessary for the purposes of assessing and verifying eligibility of this subsidy and for other purposes related to administration of the program. In accordance with the NL Personal Health Information Act and with your consent, information obtained from this form may be used by or disclosed to appropriate employees for the purposes of evaluation of this subsidy. I consent to the collection and use of my personal health information for the purposes outlined above only for the time period of eligibility for benefits under this subsidy. I understand that if I wish to withdraw this consent I may do so at any time. I understand that by withdrawing my consent I will no longer be eligible for benefits. I consent to the sharing of this information with appropriate employees of Eastern Health and the Government of NL.

Applicant's signature: ____ Date: _________________

Please complete, sign, and submit via email (preferred), mail, or in-person. Illegible or incomplete forms will be returned. It is estimated that it will take 30-60 days for you to receive payment.
Email: fertility.services@easternhealth.ca

Internal Use Only

Approved for: ☐Initial $5,000 ☐Second subsidy of $5,000 ☐Third subsidy of $5,000 ☐Denied (maximum $ provided)
Other Reason for Denial (explain):

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NLFS administrator's name (print): __________________________

NLFS administrator's signature: ___________________________ Date: ______________________