Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

EARLY RETIREE CHANGE APPLICATION

INSTRUCTIONS:

1. Complete all applicable sections of this form.
2. Return the completed form to ASEBP via mail, email at benefits@asebp.ca or fax at 780-438-5304.

A. Personal Information

Employee's name: _____ ASEBP ID no.: _____

Previous name (if applicable): _____ Date of birth *(YYYY / MM / DD)*:

School Jurisdiction: _____ _____ / _____ / _____

Mailing address (incl. postal code): _____

Phone number (incl. area code): _____ Email (optional): _____

B. Reason for Change

Life event date: Year _____ Month _____ Day _____

Please check off the reason(s) you are requesting a change in your benefits:

Change in marital status: ❑ Marriage ❑ Separation ❑ Divorce ❑ Other: _____

❑ Add common-law spouse/partner (whom I have lived with since _____) (Please proceed to Section C)

❑ Birth/adoption/guardianship: (Please attach a copy of the legal guardianship papers to this form)

Day of birth/adoption/guardianship: Year _____ Month _____ Day _____ (Please proceed to Section C)

❑ Loss of spousal/alternate coverage (Please include a letter from the employer providing coverage indicating date and reason for termination of benefits.)

❑ Terminate coordination of benefits on file. Name of insurance carrier: _____

Coverage affected: ❑ EHC ❑ Dental ❑ Vision

Effective date of loss: Year _____ Month _____ Day _____

❑ Reinstate Early Retiree Benefits on: Year _____ Month _____ Day _____

❑ Cancellation of ***all*** coverage currently participating in (Please proceed to Section F)

❑ Change in name. New name: _____

❑ Change in mailing address. New address (including postal code): _____

❑ Other (Please explain) _____

C. Changes in Benefit Coverage

Please check off which benefits you require:

Life and Accidental Death & Dismemberment ❑ Single – (Please complete the required Appointment of Beneficiary(ies) form(s))

Extended Health Care	❑ Single	❑ Family (Please proceed to Section D)	❑ Covered under spouse/alternative coverage
Dental Care	❑ Single	❑ Family (Please proceed to Section D)	❑ Covered under spouse/alternative coverage
Vision Care	❑ Single	❑ Family (Please proceed to Section D)	❑ Covered under spouse/alternative coverage

D. Dependant Information

Last name	*First name*	*Initial*	*Birth date* *(YY/MM/DD)*	*Relationship* *(i.e. spouse, son, daughter)*	*Check one*	
					Add	*Delete*

E. Termination of Coverage

At my request, my benefit coverage with ASEBP will terminate effective midnight on:

Year_____ Month _____ Day _____

I understand that I will be required to requalify for Early Retiree Benefits should I wish to reinstate coverage at a later date.

Signature_____ Date: _____

F. Declaration of Consent and Authorization (must be signed)

The personal information contained herein is required for the purpose of enrolment in and coverage under the selected ASEBP benefit plans. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to third party service providers or your employer for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information. Personal information disclosed to your employer is restricted to information necessary for administering each group benefit plan you enrolled in.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my and my dependants' eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependants are deemed to consent to the collection, use and disclosure of their personal information for the purpose of enrolment in and coverage under the group benefit plans, through me as the applicant.

Your employer and/or ASEBP may elect to copy and/or store this document by secure and reliable digital or other electronic means. By signing this document you agree that this document, including your signature, may be recorded and stored electronically and that any electronic copy of same will be binding upon you to the same extent as the original version.

I agree to the above and declare that my statements in this enrolment application are complete, accurate and true.

Signature_____ Date: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Statement at www.asebp.ca/privacy.html, or contact the Privacy Officer at 780-438-5300 or by email at po@asebp.ca.