ALBERTA SCHOOL EMPLOYEE BENEFIT PLAN

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

CHANGE APPLICATION FOR PART-TIME EMPLOYEES

INSTRUCTIONS:

1. Please send the completed form to our office by mail, fax (780-438-5304), or scan and email to benefits@asebp.ca.
2. If you previously declined coverage, you will need to provide satisfactory medical evidence of good health to be eligible for Extended Health Care (EHC) coverage. Deductibles, the amount of money a person has to pay before benefit coverage begins, will apply to applicable Dental Care coverage during the first 12 months.

A. Covered member information

Last name: _____ First name: _____

ASEBP ID: _____ Home phone: (___) _____ Work phone: (___) _____

B. Reason for change

Effective date of change *(YYYY/MM/DD)*: _____/_____/_____

Please check off the reason(s) you are requesting a change. If reported after 31 days, satisfactory evidence of good health will be required and deductibles* will apply to Dental Care coverage.

- ☐ Add ***Single*** Dental Care coverage
- ☐ Add ***Family*** Dental Care coverage ***(Complete section C)***
- ☐ Cancel Dental Care coverage
- ☐ Change in dependant information ***(Complete section C)***
- ☐ Add a new dependant and change my EHC and, where applicable, Dental Care coverage from ***Single*** to ***Family*** ***(Complete section C)***
- ☐ Add a new dependant and maintain my ***Family*** EHC and, where applicable, Dental Care coverage ***(Complete section C)***
- ☐ Remove dependant and maintain my ***Family*** EHC and, where applicable, Dental Care coverage ***(Complete section C)***
- ☐ Remove dependant and reduce EHC and, where applicable, Dental Care coverage from ***Family*** to ***Single*** ***(Complete section C)***
- ☐ Loss of spousal/partner coverage, change my EHC and, where applicable, Dental Care coverage from ***Single*** to ***Family*** ***(Complete section C).*** Please include a letter from your spouse's/partner's employer indicating the date and reason for termination of benefit coverage.
- ☐ Reduce Life and Accidental Death & Dismemberment (AD&D) insurance coverage from $50,000 to $25,000
- ☐ Increase Life and AD&D insurance coverage from $25,000 to $50,000 ***(Satisfactory medical evidence of good health is required)***
- ☐ Change in beneficiary (please complete the required *Appointment of Beneficiary(ies)* form)
- ☐ Change in name Previous name: _____
- ☐ Change in address New mailing address: _____
- ☐ No longer eligible for part-time employee benefits
- ☐ Other ***(Please explain)*** _____

_____

Please Turn Over →

C. List of dependants

Last name	First name	Relationship *(spouse, partner, son, daughter)*	Birth date *(YYYY/MM/DD)*

I declare that these dependants are eligible as described above. I agree to notify ASEBP of any changes to their eligibility and enrolment information as described above.

D. Termination of Coverage

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

Year_____ Month _____ Day _____

I understand that if I request coverage to be reinstated at a later date, I may be subject to late applicant restrictions and be required to provide medical evidence of good health. I further understand that coverage may be declined or subject to deductibles.

Signature_____ Date: _____

E. Consent

The ASEBP requires the personal information contained herein in order to administer the group benefit plans that you are enrolled in. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to your employer and third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

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' ability 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.

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.