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|  | | | | MYRETIREE PLANBENEFITS APPLICATION | | | | |
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| **ELIGIBILITY REQUIREMENTS** | | | | | | |
| I declare that I am:  A resident of Alberta  Age 50 or older at time of retirement  Maintaining Alberta Health Care coverage  Current or previous employee of an Alberta School Employee Benefit Plan (ASEBP) participating employer    A surviving dependant of a former ASEBP member who was at least 50 at the time of passing.  Deceased member’s  First Name   Last Name | | | | | | |
| **INSTRUCTIONS** | | | | | | |
| 1. Fully complete Parts 1, 2 3 and 4. 2. Sign the application. 3. If you are under 65 and eligible for our Life and AD&D insurance, please complete the [*Appointment of Beneficiary(ies)*](https://www.asebp.ca/forms) form and submit with the completed application. 4. If you currently have or previously had benefits through another provider, please complete the [*Coordination of Benefits*](https://asebp.ca/sites/default/files/forms/ASEBP111_fillable.docx?cb=1626804910) form and submit with the completed application. 5. Forward the completed application and the *Appointment of Beneficiary* (if applicable) by **email** to [benefits@asebp.ca](mailto:benefits@asebp.ca), **mail** (address above), or **fax** to 780-438-5304. | | | | | | |
| **PART 1 – APPLICANT and BENEFITS INFORMATION** | | | | | | |
| A. Applicant Information | | | | | | |
| Name   First Name   Last Name | | | ASEBP ID (if available) | | Date of birth   YYYY/MM/DD | |
| Mailing address (PO Box/RR/suite /apt #, street) | | | | | Daytime phone no. (area code-xxx-xxxx) | |
| City/town | | | Province | | Postal code | |
| Please send my benefits information and ID card by (*either or both*):  email:        mail (*address above*) | | | | | Name of current or former ASEBP employer: | |
| Retirement date: YYYY/MM/DD | |
| Termination date of current benefits:  YYYY/MM/DD  **Note:** benefits will start the day after your current benefits terminate (if your application is received within 31 days of termination) or the 1st of the month following termination if you don't currently have benefits | | | | If you’ve accepted a contract position (with benefits) that starts immediately after your retirement date, indicate the contract start YYYY/MM/DD  and end YYYY/MM/DD  dates.  N/A | | |
| B. Referral Program | | | | | | |
| *Complete this section only if you were referred to the MyRetiree Plan by a member currently participating in the plan.*  I confirm that the following named individual referred me to the MyRetiree Plan, and he/she is presently enrolled in the plan.   First Name   Last Name   YYYY/MM/DD  Of referring individual Date of birth of referring individual Or ASEBP ID if available | | | | | | |
| C. Benefits Plan Choices (coverage information and rate sheet enclosed) | | | | | | | | |
| Choose either the Enhanced or Core option under the Extended Health Care + Vision Care column, and in the dental column (if you want dental coverage). Plus, indicate your coverage level (single, couple or family) where indicated. **Note: \***while dental coverage is optional, if you decline coverage now, you cannot opt-in at a later date unless you are currently participating in dental through another carrier and can provide ASEBP with proof of loss of coverage. You can find more information in our MyRetiree Plan brochure (included) or on our [website](http://www.asebp.ca/my-benefits/retirement) by choosing MyRetiree Plan under the My Benefits tab. | | | | | | | | |
| **Life and AD&D Insurance**  (*for information only)* | | **Extended Health Care + Vision Care: Mandatory** | | | | | **\*Dental Care: Optional** | |
| If under 65 at the time of your retirement, you may be eligible for Life and AD&D insurance.  You must be currently participating in, or have previously participated in Life and AD&D insurance with ASEBP to be eligible for the following:   * Life Insurance 2x pre-retirement employer salary (Mandatory) * AD&D Insurance 2x pre-retirement employer salary (Mandatory) | | Enhanced Extended Health + Vision Care  **Single** **Couple Family**  **EHC Coverage**  **Vision Coverage**  **OR**  Core Extended Health + Vision Care  **Single Couple Family**  **EHC Coverage**  **Vision Coverage** | | | | | I decline dental coverage (\*see note above)  **OR**  **Single Couple Family**  Add Enhanced    Dental Care  **OR**  Add Core   Dental Care | |
| **D. Eligibility for Dependants – only required if couple or family coverage selected** | | | | | | | | |
| The definition of a dependant is:  **Spouse**: Legally married to, or in an adult interdependent relationship with, the covered member.  **Child**: ASEBP requires that children be registered on a parent’s provincial health care plan. Child dependent provisions are as follows:   * Single children under 21 who are wholly dependent on a parent, including adopted children, foster children (if an income tax deduction was claimed), and wards of the court. * Single children under 25 years of age who are enrolled in three or more courses at an accredited educational institute. * Single and unemployed dependant over the age of 21, dependent on the covered member by reason of mental or physical disability. Please contact a Benefit Specialist for more information on eligibility and how to apply.   Please list all your dependants:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **First name** | **Last name** | **Sex** | **Relationship** | **Birthdate** | |  |  |  |  | YYYY/MM/DD | |  |  |  |  | YYYY/MM/DD | |  |  |  |  | YYYY/MM/DD | |  |  |  |  | YYYY/MM/DD | | | | | | | | | |

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| **PART 2 – TERMS and CONDITIONS** | |
| **A. Termination of Benefits** | | | |
| I understand that once enrolled, my coverage will remain in place until the earliest of the following dates:   * the date the policy or plan expires * the first of the month in which the first premium payment is not made * the date I request termination of coverage | | | |
| I understand that once my dependants are enrolled, their coverage will remain in place until the earliest of the following dates:   * the date my coverage expires * the date my spouse ceases to be eligible under the definition of dependant * the date my dependent child ceases to be eligible under the definition of dependant * the date I request termination of coverage | | | |
| **B. Premiums** | | | |
| **Personal Pre-Authorized Debit (PAD) Agreement** (ASEBP does not accept credit card payments).  I understand that the following conditions apply:   1. I’ll pay the monthly premium amount noted in my approval letter 2. A monthly statement won’t be issued 3. I’ll receive notification of changes in the monthly amount payable due to:    * Premium rate adjustments, which typically occur in September as authorized by ASEBP Trustees    * A change in benefit coverage (e.g., from “single” to “family” coverage) 4. My premium payment will automatically be withdrawn from my bank account on the 15th of each month. If the 15th falls on a weekend, the withdrawal will occur on the next business day 5. Premiums are billed in complete months and if my benefits terminate prior to the last day of the month, I will remain responsible for the full month’s premium 6. If there is a change in coverage that takes effect partway through a month (e.g., a change from “family” to “single” status), the premium and coverage in effect at the beginning of the month will remain in effect until the end of that month. On the first day of the following month, the new coverage will come into effect and ASEBP will charge me the new premium 7. I will not receive credits or refunds for premiums already paid 8. I will notify ASEBP of any changes to my banking information   My authorization will remain in effect until 30 days written notification of cancellation is issued by either myself or ASEBP. To obtain a sample cancellation form or for more information on my right to cancel this PAD agreement, I may contact my financial institution or visit [payments.ca](https://www.payments.ca/).  If ASEBP makes a withdrawal in error or for the incorrect amount, I will notify ASEBP as soon as possible. If ASEBP is aware of an error, ASEBP will correct the error and notify me as soon as possible. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit [payments.ca](https://www.payments.ca/).  If you have any questions about this PAD Agreement, please contact ASEBP. You can find our contact information on our website, [www.asebp.ca](http://www.asebp.ca).  **I authorize ASEBP to begin automated withdrawals** for payment of my benefit premiums for the bank account currently on file (please log in to your My ASEBP account to confirm) OR  A **blank personalized cheque marked “VOID”** is attached OR  **I authorize ASEBP to begin automated withdrawals** for payment for my benefit premiums from the account provided below: | | | |
| Withdrawal account number ([seven to 12 digits](https://www.asebp.ca/media/1887)): | | Branch transit number ([five-digit number](https://www.asebp.ca/media/1889)): | |
| Financial institution number ([three-digit number](https://www.asebp.ca/media/1888)): | | Financial institution name: | |
| Branch address (including city and postal code): | | | |
| **Non-Payment of Premiums**  If my benefits are terminated due to non-payment of premiums, coverage will end and I will not be able to re-enrol in benefits until I make restitution, which may include payment of premiums, interest, NSF charges and claims paid after termination. I understand that ASEBP retains the right to deny re-enrolment should coverage be terminated due to non-payment of premiums. | | | |
| **C. Claim Payments** | | | |
| Direct deposit will be used for general health benefit claims payments (if applicable) made to you by ASEBP. Direct deposit ensures that payment is made directly into your bank account and provides:   * Faster and safer service than mailing a cheque to you * Protection from delays during postal disruptions * Automatic deposits to your bank account if you are away from home | | | |

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| **PART 3 – CONSENT and DECLARATION** |
| **A. Consent and Authorization for Use of Personal Information** |
| I understand that ASEBP must collect, use, and disclose the personal information contained herein and provided in the future while coverage is maintained in order to administer the group benefit plans that I am enrolled in, and to deposit payments to or withdraw premium payments from my bank account.  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. |
| **B. Application Declaration** |
| I have read and agree to the terms and conditions in this application and declare that my statements in this enrolment application are complete, accurate and true.  **I also confirm that I:**  Have signed the application.  Have completed the [*Appointment of Beneficiary(ies)*](https://www.asebp.ca/forms) form (if under 65 and eligible) and submitted it with the completed application.  Have completed the [*Coordination of Benefits*](https://asebp.ca/sites/default/files/forms/ASEBP111_fillable.docx?cb=1626804910) form (if applicable) and submitted it with the completed application.  Have kept a copy of this completed application form (plus all other applicable forms) for my records.  Will advise ASEBP within 31 days of any changes to my eligibility.  Understand that dental coverage is optional and if I decline coverage now, I cannot opt-in at a later date unless I currently have dental coverage through another carrier and provide ASEBP with proof of loss of coverage within 31 days of losing coverage.  Understand that, as the plan member, I alone am fully responsible for all claims made under my membership by myself and my dependants, and that I am answerable to any errors, abuse or fraud stemming from these claims.  Signature:  First name  Last Name   Date:  YYYY/MM/DD  Consent is obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act of Alberta* and section 1 of the federal *Personal Information Protection Electronic Documents Act*. Be advised that in order to optimize the services we provide, we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP’s Privacy Policy at [www.asebp.ca](http://www.asebp.ca) or contact the privacy officer at 780-438-5300. |

**PART 4**

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| How did you hear about the MyRetiree Plan? Choose all that apply: | |
| Through my employer  ASEBP (please note where):  MyRetiree web page  News article  Social media post  I did a Google search | I was referred  An ad  In the ATA, CASS, Ever Active Schools publications  (please circle the publication(s))  Another publication or online ad. Please note where:    Other: |