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| The completed form can be faxed (780-438-5304) or emailed (benefits@asebp.ca) to ASEBP at least **five business days** before your scheduled departure date. If sent well in advance of your departure, it will be processed no earlier than **seven business days** prior. |
| **COVERED MEMBER INFORMATION** |
| Covered member’s full name:       |
| Mailing address:       |  |
| GROUP |  SECTION | ASEBP ID |
| 1 | 9 | 9 | 3 | 0 |   |   |   |   |   |   |   |   |   |   |  |
| Email:       Phone number:    -   -     |
| **TRAVEL DETAILS** |
| Optional out-of-province contact information (email or phone number):      Departure date (YYYY/MM/DD):      /    /    Return date (YYYY/MM/DD):      /    /    Destination:      Type: [ ]  Personal [ ]  Approved Teacher Exchange/Secondment |
| **PRESCRIPTION DETAILS****Note1:** We are unable to approve requests for birth control, erectile dysfunction and fertility medications due to monthly maximums.**Note2:** The “days supply” amount cannot exceed 212 days for applicants on personal leaves. |
| Patient’s Name | ASEBP ID | Drug Name | Drug Identification Number (DIN) | Quantity | Days Supply |
|       |       |       |       |       |       |
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| **PHARMACY CONTACT** |
| Pharmacy license number:       | Pharmacy name:       |
| Pharmacist/contact name:       | Phone number:    -   -     |
| **CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION** |
| In order to assess and verify eligibility for you or your dependants to purchase prescription drug supplies for out-of-province or country travel under the ASEBP group benefit plans, ASEBP will need to collect, use and disclose the personal information contained herein.I understand that in order to qualify for a *“Travel supply of prescription drugs request,”* I must be travelling outside of my province of residence and must maintain Extended Health Care coverage through ASEBP and provincial health care coverage for the duration of this request. If I should terminate my coverage or my coverage is terminated for any reason during the term of this request, I will reimburse ASEBP in part or in full for the costs related to the prescription drugs indicated above. I authorize ASEBP to monitor my coverage for the duration of this request.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 should I do so, my request may not be considered. 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. I agree to the above and declare that my statements in this application are complete, accurate and true.**Covered member/partner signature:** “First name Last name” Date:      Consent is being 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 or contact the privacy officer at 780-438-5300. |