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

GREATER THAN 100 DAY SUPPLY OF PRESCRIPTION DRUGS REQUEST

OUTSIDE CANADA ONLY

Fax the completed form to ASEBP at 780-438-5304 at least **five business days** before your scheduled departure date. However, if sent well in advance of your departure, it will be processed no earlier than **seven business days** prior.

COVERED MEMBER INFORMATION

Plan member's full name: _____

Mailing address: _____

_____

GROUP	SECTION	ASEBP ID
1 9 9 3 0		

Email: _____ Phone number: _____

TRAVEL DETAILS

Optional out-of-country contact information (email or phone number): _____

Departure date: _____ Return date: _____ Destination: _____

Type: ❑ Personal ❑ Approved Teacher Exchange/Secondment

PRESCRIPTION DETAILS

Note[1]: We are unable to approve requests for birth control, erectile dysfunction and fertility medications due to monthly maximums.
Note[2]: 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

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 and your dependants to purchase prescription drug supplies for greater than 100 days 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 *"Greater than 100 day supply,"* I must be outside Canada and must maintain Extended Health Care coverage through the 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/spouse's 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, or contact the Privacy Officer at 780-438-5300 or by email at po@asebp.ca.