



Allendale Centre East
 Suite 301, 6104-104 Street NW
 Edmonton | Alberta | T6H 2K7
 Phone: 1-877-431-4786
 Fax: 1-780-438-5304
 www.asebp.ca

LATE APPLICANT MEDICAL INFORMATION SUPPLEMENTAL PACKAGE EMPLOYEES

PLEASE PRINT

INSTRUCTIONS:

Please complete all applicable sections below and return to ASEBP. Faxed copies are acceptable. Any charges incurred for completing this form are the member's responsibility. The information on this form will remain current for no longer than 90 days.

- If requesting coverage for yourself, please complete sections A and B.
- If requesting coverage for yourself and dependants, please complete sections A, B and C.
- If applying for Life Insurance, Accidental Death & Dismemberment Insurance and Extended Disability Benefits, **please have your physician or nurse practitioner complete the Health Assessment form.**

A. To be completed by employee

First name: _____ ASEBP ID number: _____
 Last name: _____ Phone number: (____) _____
 Mailing address: _____ Date of birth: Year ____ Month ____ Day ____

B. To be completed by employee (if requesting coverage for self)

Physician name: _____ Physician phone number: (____) _____

Height (inches): _____ Weight (lbs.): _____ Waist circumference (inches): _____ Smoker: Yes No

1. Have you:	Yes	No		Yes	No
a. been absent from work, applied for benefits or received benefit or pension compensation because of sickness or injury during the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	c. been treated for alcoholism or use illicit substances (i.e. heroin, cocaine)	<input type="checkbox"/>	<input type="checkbox"/>
b. been in any hospital or other institution for observation, rest, diagnosis or treatment during the past five years?	<input type="checkbox"/>	<input type="checkbox"/>	d. been examined by a doctor for a regular physical examination within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>

2. Please indicate "yes" or "no" if you, at any time, have been treated for or told you had difficulty with any of the following:

	Yes	No		Yes	No		Yes	No
a. Neurological disease (e.g. multiple sclerosis)	<input type="checkbox"/>	<input type="checkbox"/>	f. Inflammatory bowel disease (e.g. Crohn's, ulcerative colitis)	<input type="checkbox"/>	<input type="checkbox"/>	k. Autoimmune disease (e.g. Lupus, psoriasis, ankylosing spondylitis)	<input type="checkbox"/>	<input type="checkbox"/>
b. Lung function (e.g. COPD, asthma)	<input type="checkbox"/>	<input type="checkbox"/>	g. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	l. Diabetes or glucose intolerant	<input type="checkbox"/>	<input type="checkbox"/>
c. Rheumatoid or psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	h. Chronic liver disease or infection (e.g. hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please check:</i> <input type="checkbox"/> insulin dependant <input type="checkbox"/> non-insulin dependant		
d. Cancer or tumours	<input type="checkbox"/>	<input type="checkbox"/>	i. Mental health (e.g. anxiety, depression)	<input type="checkbox"/>	<input type="checkbox"/>			
e. Gastrointestinal disease (e.g. ulcers, reflux)	<input type="checkbox"/>	<input type="checkbox"/>	j. Cardiovascular disease, heart failure, angina (chest pain) and/or high blood pressure or abnormal pulse	<input type="checkbox"/>	<input type="checkbox"/>			

3. Do you have any known awareness of any physical or mental health condition or illness not disclosed in the answers to questions 1 and 2?
 Yes No
 If yes, please explain: _____

4. What are the complete details to all the "yes" answers to questions 1, 2 and 3? Attach a separate sheet if more room is required.

Question number	Illness or other reason. Reason for any check-up, doctor's advice, treatment and medication.	Date treatment began (MM/YYYY)	Time lost from normal activity	Treatment plans, outcomes or current status

5. Are you currently taking any prescription or over-the-counter medication?

Yes No

If yes, please provide the drug name(s) and the reason you are taking it. Attach a separate sheet if more room is required.

Drug name(s)	Reason(s)

C. To be completed by employee (if requesting coverage for dependants)

Last name	First name	Relationship (spouse, partner, son, daughter, etc.)	Birth date (YYYY/MM/DD)	Height (inches)	Weight (lbs)	Waist circumference (inches)	Smoker (Y/N)

1. Have any of the persons named above at any time been treated for or been told such person had trouble with any of the following:

	Yes	No		Yes	No		Yes	No
a. Neurological disease (e.g. multiple sclerosis)	<input type="checkbox"/>	<input type="checkbox"/>	f. Inflammatory bowel disease (e.g. Crohn's, ulcerative colitis)	<input type="checkbox"/>	<input type="checkbox"/>	k. Autoimmune disease (e.g. Lupus, psoriasis, ankylosing spondylitis)	<input type="checkbox"/>	<input type="checkbox"/>
b. Lung function (e.g. COPD, asthma)	<input type="checkbox"/>	<input type="checkbox"/>	g. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	l. Diabetes or glucose intolerant	<input type="checkbox"/>	<input type="checkbox"/>
c. Rheumatoid or psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>	h. Chronic liver disease or infection (e.g. hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	<i>Please check:</i>		
d. Cancer or tumours	<input type="checkbox"/>	<input type="checkbox"/>	i. Mental health (e.g. anxiety, depression)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> insulin dependant		
e. Gastrointestinal disease (e.g. ulcers, reflux)	<input type="checkbox"/>	<input type="checkbox"/>	j. Cardiovascular disease, heart failure, angina (chest pain) and/or high blood pressure or abnormal pulse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> non-insulin dependant		

Have any of the persons named above at any time:

r. Been in any hospital or other institution for observation, rest, diagnosis or treatment during the past three years?	<input type="checkbox"/>	<input type="checkbox"/>
s. Been examined by a doctor for a regular physical examination within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
t. Been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	<input type="checkbox"/>	<input type="checkbox"/>
u. Been advised to have a surgical operation or procedure but did not do so?	<input type="checkbox"/>	<input type="checkbox"/>
v. Had any known physical impairments, mental health condition or ill health not covered above?	<input type="checkbox"/>	<input type="checkbox"/>

2. What are the complete details to all the "yes" answers in question 1? Attach a separate sheet if more room is required.

Question number	Dependant's first name	Illness or other reason. Reason for any check-up, doctor's advice, treatment and medication.	Date treatment began (MM/YYYY)	Time lost from normal activity	Treatment plans, outcomes or current status

3. Are any dependants listed above currently taking any prescription or over-the-counter medication?
 Yes No
 If yes, please provide the drug name(s) and the reason they are taking it. Attach a separate sheet if more room is required.

First	Name Last	Drug name(s)	Reason(s)

Consent for the collection, use and disclosure of personal information

The Alberta School Employee Benefit Plan (ASEBP) must collect, use and disclose the personal information contained herein to verify eligibility for benefit coverage for you and/or your dependants.

I understand that my and/or my dependants' personal information will be kept confidential and secure. 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 of determining my and/or my dependants' medical evidence of insurability. I understand that I may revoke my consent at any time and acknowledge that should I do so, benefit coverage may not be available to me.

If indicated above that my treating physician or nurse practitioner will be completing the health assessment below, I authorize said physician or nurse practitioner to disclose to ASEBP my and/or my dependants' personal information as requested by ASEBP for the purpose of determining medical evidence of insurability.

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 plan, through me as an applicant.

I agree to the above and declare that my statements are complete, accurate and true. I agree this authorization shall be in effect from the date below and shall be valid until such time as a decision regarding my and/or my dependants' insurability is determined by ASEBP. A photocopy of this form shall have the same force and effect as the original.

Date: _____ Signature: _____

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 Policy at www.asebp.ca, or contact the privacy officer at 780-438-5300.

HEALTH ASSESSMENT

To be completed by your treating physician or nurse practitioner

PLEASE PRINT

INSTRUCTIONS:

To be completed upon request or if applying for Life Insurance, Accidental Death & Dismemberment (AD&D) and Extended Disability Benefits (EDB). This assessment must be completed in its entirety to be considered for coverage. Faxed copies are acceptable. **Any charges incurred for completing this form are the member's responsibility.** The information on this form will remain current for no longer than 90 days.

A. Patient information

Patient name: _____ ASEBP ID: _____

Mailing address: _____

Date of birth: Year ____ Month ____ Day ____ Date of assessment (visit): Year ____ Month ____ Day ____

Initial date of care for patient: Year ____ Month ____ Day ____ Last annual physical assessment: Year ____ Month ____ Day ____

B. Family medical history

1. Describe family medical history. If history is unattainable, please indicate N/A.

C. Current medical conditions and treatment plans

1. Body Mass Index (BMI): _____

2. Please indicate the following required attachments are included:

Objective findings and lab results or supporting documentation (i.e. psychiatrist, cardiologist, etc.) Net care or prescription history for the previous two years

3. List of medical conditions

Condition(s)	Medication(s) and/or treatment(s)	Status and/or response to treatment(s)

Additional comments (optional):

Signatures are required on the second page.

D. To be completed by a physician or nurse practitioner

OFFICE STAMP

Signature: _____

Print name: _____

Phone number: _____

Fax: _____

E. Consent for the collection, use and disclosure of personal information – To be completed by patient

I, _____, authorize any physician, healthcare provider, hospital or other healthcare facility to disclose to the Alberta School Employee Benefit Plan (ASEBP), any diagnostic, treatment or care information requested by ASEBP necessary for the assessment of my late application for benefit coverage under the provisions of the ASEBP benefit plan.

I understand that my personal information will be kept confidential and secure. I consent to the collection, use, and disclosure of my personal information as described above.

I understand that I may revoke my consent at any time and acknowledge that should I do so, coverage under the ASEBP benefit plans may not be available to me. I understand the reasons why the information requested is required and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I agree this authorization shall be in effect from the date below and shall be valid until such time as a decision regarding my late application for benefit coverage is made. A photocopy of this form shall have the same force and effect as the original.

Date: _____ Signature: _____

Patient/Parent/Guardian

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. This consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and, in relation to personal health information, section 34 of the Health Information Act of Alberta.