Suite 700 Weber Centre
5555 Calgary Trail
Edmonton | Alberta | T6H 5P9
Phone: 1-877-431-4786
www.asebp.ab.ca

CHANGE APPLICATION

(To be maintained on file by the employer and surrendered to ASEBP upon request)

A. Personal Information

Employer's name: _____ School jurisdiction: _____

Employee's name: _____ ASEBP ID no.: _____

Employee status: ❑ Working ❑ Leave of absence ❑ Disabled ❑ Other: _____

Previous name (if applicable): _____ Email (optional): _____

Mailing address (incl. postal code): _____

Phone number (incl. area code): _____ Date of birth: Year_____ Month_____ Day_____

B. Reason for change

Life event date _____ Year _____ Month _____ Day

Please check off the reason(s) you are requesting a change in your benefits:

Change in marital status: ❑ Marriage ❑ Separation ❑ Divorce ❑ Other: _____

❑ Add common-law spouse/partner (whom I have lived with since _____) (Please proceed to Section C)

❑ Birth/adoption/guardianship: (Please provide a copy of the legal guardianship papers to your employer)

Day of birth/adoption/guardianship: _____ Year _____ Month _____ Day (Please proceed to Section C)

❑ Loss of spousal/alternative coverage (Please include a letter from the employer providing coverage indicating date and reason for termination of benefits.)

❑ Other (Please explain) _____

C. Benefits Selection

Please check off which benefits you require:

Life, Accidental Death & Dismemberment and Extended Disability Benefits	❑ For myself – (Please complete the required Appointment of Beneficiary form(s))	
Extended Health Care	❑ For myself	❑ For myself and my dependant(s) (Please proceed to Section E)
Dental Care	❑ For myself	❑ For myself and my dependant(s) (Please proceed to Section E)
Vision Care	❑ For myself	❑ For myself and my dependant(s) (Please proceed to Section E)

D. Changes in Benefit Coverage

I decline to participate in (check the applicable category):

Life, Accidental Death & Dismemberment and Extended Disability Benefits*		☐ Waived (**declined**)*
Extended Health Care	☐ Covered under spouse/alternative coverage	☐ Waived (**declined**)
Dental Care	☐ Covered under spouse/alternative coverage	☐ Waived (**declined**)
Vision Care	☐ Covered under spouse/alternative coverage	☐ Waived (**declined**)

You cannot waive Life, Accidental Death & Dismemberment or Extended Disability if they are a condition of employment. These benefits are mandatory if you wish to participate in Extended Health Care, Dental or Vision coverage.

I understand that if any benefits are cancelled for reasons other than spousal/partner coverage under another Group Plan, any future application for benefits may, in whole or in part, be rejected or restricted for a period of time and subject to late applicant restrictions. I agree that, if at a later date I wish to participate in the insurance hereby cancelled, I must submit, at my own expense, satisfactory evidence of insurability for myself and my dependants for whom application for coverage is made. If approved, deductibles will apply to Dental and Vision coverage and remain in effect for one year from the effective date of coverage or until the deductibles are satisfied, whichever occurs first.

Please sign here only if you are declining or waiving coverage.

Signature: _____ Date: _____

Continued →

E. Dependant information

Last name	*First name*	*Initial*	*Birth date* (yyyy/mm/dd)	*Relationship* (i.e. spouse, partner, son, daughter)	*Check one*	
					Add	*Delete*

F. Termination of Coverage During a Leave of Absence

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: _____

G. Declaration of consent and authorization (must be signed)

The personal information contained herein is required for the purpose of enrolment in and coverage under the selected ASEBP benefit plans. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to third party service providers or your employer for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information. Personal information disclosed to your employer is restricted to information necessary for administering each group benefit plan you enrolled in.

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.

Your employer and/or ASEBP may elect to copy and/or store this document by secure and reliable digital or other electronic means. By signing this document you agree that this document, including your signature, may be recorded and stored electronically and that any electronic copy of same will be binding upon you to the same extent as the original version.

I agree to the above and declare that my statements in this enrolment application are complete, accurate and true.

Signature: _____ Date: _____

H. For office use only

Date change application received in office *(Date Stamp)*	Date of employment	Date eligible for benefits