

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

SUPPLEMENTAL PACKAGE APPLICATION

INSTRUCTIONS:

- 1. Please send the completed application form to our office by mail, fax (780-438-5304) or scan and email to benefits@asebp.ca.
- 2. Attach the following documents:
 - □ Blank personalized cheque marked "VOID" or bank account information obtained from your financial institution
 - □ Copy of your birth certificate or government-issued proof of age, and
 - □ Completed original Appointment of Beneficiary form (located in the Forms section of our website, asebp.ca).
- 3. ASEBP must receive your completed application within 31 days of your most recent employment start date. If you return the completed application after the 31-day period, you'll need to provide ASEBP with satisfactory medical evidence of good health. Dental Care deductibles will apply until the full deductible amount is reached or 12 months have elapsed from the effective date of coverage. See the Applying Late section of the Managing your Coverage page on our website, asebp.ca, for details.
- 4. For more information about the benefit plans offered, please refer to the My Benefits section of our website, asebp.ca.

Eligibility to Participate in Benefits

I declare that I am:

- under 70,
- · actively working for an ASEBP-participating employer
- ineligible to participate in benefits offered by an ASEBP-participating employer or serving a waiting period of at least one day for ASEBP group benefits,
- · a resident of Canada and
- covered under a provincial health care insurance plan.

Applicant Information and Benefits Selection

A. Applicant Information	Description of the second seco
Most recent employment start date:	///
School jurisdiction employed by:	
Select one: Teacher Non-te	eacher
Select one: Substitute teacher/Ca	isual staff Part-time employee Probationary Over 65, under 70
Last name:	First name:
Sex at birth: Female Male	Birth date:///
Mailing address:	
City: Pos	stal code: Primary phone #: ()
Email address:	

fi yes, are these other benefits with a school jurisdiction? □ Yes □ No C. Package Selection You must participate in the benefits as listed within each package. Dental Care coverage is optional and can be added for an additional premium. Please refer to the hyperlinks below for premium package rates. If you wish to add Dental Care to your selected package, please check the Add Dental Care (Plan 2) box. If you choose to participate in Dental Care at a later date, you and your dependants will be considered late applicants and will be subject to deductibles for the first 12 months. Please select your package below and make sure to refer to the hyperlinks for information on additional charges. You can visit the applicable benefit area (found under My Benefits) of our website, asebp.ca, for additional information on each benefit package: □ Package 1 Life Insurance (Plan 2) \$25,000 ADAD (Plan 2) \$25,000 Extended Health Care (Plan 2) Single Click here for additional rate cost. □ Package 2 Life Insurance (Plan 2) \$50,000 Extended Health Care (Plan 2) Family Add: □ Dental Care (Plan 2) Family Click here for additional rate cost. □ Package 4 Life Insurance (Plan 2) Family Add: □ Dental Care (Plan 2) Family Click here for additional rate cost. □ Package 4 Life Insurance (Plan 2) Family Add: □ Dental Care (Plan 2) Family Add: □ Dental Care (Plan 2) Family Click here for additional rate cost. □ Package 4 Life Insurance (Plan 2) Family Add: □ Dental Care (Plan 2) Family Add: □ Dental Care (Plan 2) Family Click here for additional rate cost. □ Package 4 Life Insurance (Plan 2) Family Add: □ Dental Care (Plan 2) Family Click here for additional rate cost. □ Single children under 25 was of a package of the family	o you have other group employment benefits coverag	e? 🗌 Yes 🔲 No		
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Last name Sey Pelationship Birth date	or physical disability. Please contact a Bene			
	ease list all your dependants.			
	Last name First name			
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E. Consent and Authorization for the Use of Personal Information

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' ability 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.

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 application are complete, accurate and true.

Signature:	Date:	

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 asebp.ca/privacy or contact the privacy officer at 780-438-5300.



APPOINTMENT OF BENEFICIARY(IES)

Life and Accidental Death & Dismemberment Insurance

HARD COPY ORIGINAL OF COMPLETED FORM TO BE MAINTAINED BY EMPLOYER OR ASEBP

INSTRUCTIONS:

- 1. Please complete required sections A, B and F, along with sections C and D if applicable. Failure to complete this form in its entirety may result in proceeds being paid to your estate.
- Return the *original* completed form to your employer unless you are an Early Retiree or are participating in ASEBP's Supplemental Package, in which case return the *original* completed form directly to ASEBP.

A. Applicant in	nformation					
Last name:		First nan	First name: ASEBP ID #:			
Mailing address: _						
City:			P	rovince:	Postal code:	
Daytime phone:			M	1obile/Alternate phone:		
Employer's name (i	f applicable):			8		
Email address (opti	onal):			Birth da	te:/	/
B. Beneficiary	(ies) for Life a	nd Accident	al Death & D	ismemberment Insurar		
I appoint the following previous appointme the beneficiaries pre	ng beneficiary(ies) ents I may have mad decease me, I und	for my Life and A de for these proce erstand their port	ccidental Death of eeds and I reservion will be divide	& Dismemberment Insurance. The the right to change the benefied equally among any surviving	is appointment supe ciary(ies) named be	ersedes any low. If any of
Select one T	o the person(s) list	ed below	□ To r	ny estate	-	
Last Name	First Name	Relationship	Birthdate (YYYY/MM/DD)	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov, Postal Code)	Phone number (including area code)	% payable to each (must equal 100%)
	2	÷				
						-
					TOTAL	100%

C. Contingent	Beneficiary(i	es) for Life ar	nd Acciden	tal Death & Dismemberr	ment Insurance	9
Your contingent bendereased at the time		ceive the proceed	ds of your policy	r if your primary beneficiary(ies), a	s indicated in Secti	on B, is
		e deceased at the	time of your de	ath, the amount payable to your o	contingent beneficia	ary(ies) shall
	o the person(s) lis	ted <u>below</u>				
Last Name	o my estate First Name	Relationship	Birthdate	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov., Postal	Phone number	% payable to each
Lastivaine	riistitairie	Reduction	(YYYY/MM/DD)	Code)	(including area code)	(must equal 100%)
	-					
				4		
		9, 1				
					TOTAL	100%
D. Appointme				beneficiaries is under the age o	of majority.)	
lappoint		of				
reached at	(Name)	Trustee and auth	norize ASEBP to	(Suite/Apt/Unit no., Street, P.O. Box pay any amount payable to an		er 18 years of
(Pho	one number)			rance proceeds and manage th		
				ary once he/she reaches the ag		
E. Consent an	d Authorizati	on				
Accidental Death a information contain	nd Dismemberme ed herein to your	nt Insurance police employer or the	ies. It may be no third party servi	al information contained herein in ecessary for ASEBP to disclose so ice provider for these purposes. personal information.	ome or all of the pe	ersonal
<u></u>				s and benefits of providing this in	formation. I conser	nt to the
collection, use, and	disclosure of my	personal informat	tion for the purp	poses identified above. I understa gibility to receive Life and Accider	and that I may revo	ke my
	or benefit plan (th	ne beneficiaries na	amed herein) ar	n Protection Act of Alberta, indiving the deemed to consent to the collings		
Your employer and	l/or ASEBP is requ	ired to keep a ha	rd copy origina	l version of your completed ben ing your signature, which it conta		gning below
F. Acknowled	lgement					
l agree to the abov	T	at my statements	are complete,	accurate and true.		
Signatura				Date		
Signature:	tained in accordance	a with eactions 7 0	0 and 61 af th - 5	Date: Personal Information Protection Act of	- f All 10 /	1.1-1-6:
federal Personal Info	rmation Protection I	Electronic Documer	nts Act. If you hav	ersonal information Protection Act of the any questions regarding the colle <u>ca/privacy</u> or contact the privacy of	ection, use and disclo	uie i of the sure of your