Alberta School Employee Benefit Plan
Suite 700 Weber Centre,
5555 Calgary Trail,
Edmonton, AB T6H 5P9
Fax: 780-438-5304
Web site: www.asebp.ab.ca

AUTOMATIC DIRECT DEPOSIT

Direct deposit will be used for Health Spending Account, Extended Disability Benefits, or general health benefit claims payments (if applicable) made to you by ASEBP. Direct deposit ensures that payment is made directly into your bank account and provides:

- faster and safer service than mailing a cheque to you
- protection from delays during postal disruptions
- automatic deposits to your bank account if you are away from home

Most chartered banks, trust companies, credit unions and treasury branches participate in direct deposit. You should check with your financial institution to make sure it can receive payment into the account selected below. The financial institution's personnel will help you complete this form if necessary.

If there is a change in the amount of benefit payment, notification will be sent to your home address.

Please forward the ***completed*** form to Alberta School Employee Benefit Plan to the address below or fax to 780-438-5304.

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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.ab.ca/privacy.html, or contact the Privacy Officer at 780-431-4786.

PERSONAL INFORMATION (Please print)

Last name:	First name:	ASEBP ID number:
Mailing address:		
City/Town:	Province:	Postal code:

Please deposit into: ☐ Chequing account *(attach cheque marked **"VOID"** and continue to "**Declaration of Consent**")*

☐ Non-chequing account *(complete "**Financial Institution Information**" below)*

FINANCIAL INSTITUTION INFORMATION

Name of financial institution:		Branch transit number:
Street address:		Bank number:
City/Town:		Account number:
Province:	Postal code:	Phone number:

DECLARATION OF CONSENT

The Alberta School Employee Benefit Plan (ASEBP) collects and uses the above personal information to set up direct deposit service with your financial institution to deposit Health Spending Account, Extended Disability Benefits, or general health benefit claims payments (if applicable) into your bank account. It is necessary for ASEBP to disclose some or all of the above personal information to your financial institution for these purposes.

I understand why the information is required and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. I hereby consent to the collection, use and disclosure of my personal information as described above. This consent may be revoked at any time. I acknowledge that doing so will affect my ability to receive payments from ASEBP.

I declare that my statements in this application are complete, accurate and true.

Signature: _____ Date: _____