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

CHANGE APPLICATION FOR SUBSTITUTE TEACHERS AND CASUAL STAFF

INSTRUCTIONS:

1. Please return the completed form to Alberta School Employee Benefit Plan (ASEBP) at the address above.
2. If you previously declined coverage, you will need to provide ASEBP with satisfactory medical evidence of good health to be eligible to receive benefits for Extended Health Care (EHC) coverage and deductibles will apply to applicable Dental Care coverage during the first 12 months of coverage.
3. If you have any questions regarding the collection, use and disclosure of your personal information in Part D, please refer to our website at www.asebp.ab.ca or contact our Privacy Officer at 780-438-4545.

A. Covered member information

Name: ______________________________ ASEBP ID No.: ______________

Home phone: (_____) ______________ Work phone: (_____) ______________

Email *(Optional)*: ______________________________

☐ Substitute Teacher ☐ Casual staff ______________________________
(*Name of employee group – e.g.: Maintenance, Clerical, Custodian, etc.)*

B. Reason for change

Effective date of change *(YYYY/MM/DD)*: _______/_____ / _____

Please check off the reason(s) you are requesting a change. If reported after 31 days, satisfactory evidence of good health will be required and deductibles will apply to Dental Care coverage.

☐ Add *Single* Dental Care coverage

☐ Add *Family* Dental Care coverage ***(Complete section C)***

☐ Drop Dental Care coverage

☐ Add a new dependent and change my EHC and, where applicable, Dental Care coverage from *Single* to *Family* ***(Complete section C)***

☐ Add a new dependent and maintain my *Family* EHC and, where applicable, Dental Care coverage ***(Complete section C)***

☐ Remove dependent and maintain my *Family* EHC and, where applicable, Dental Care coverage ***(Complete section C)***

☐ Remove dependent and reduce EHC and, where applicable, Dental Care coverage from *Family* to *Single* ***(Complete section C)***

☐ Loss of spousal/partner coverage, change my EHC and, where applicable, Dental Care coverage from *Single* to *Family* ***(Complete section C).*** Please include a letter from your spouse's/partner's employer indicating the date and reason for termination of benefit coverage.

☐ Change in dependent information ***(Complete section C)***

☐ Temporary contract with group benefits accepted

Start date: *(YYYY/MM/DD)* _______ / _____ / _____ End date: *(YYYY/MM/DD)* _______ / _____ / _____

Date eligible for benefits if different from start date: *(YYYY/MM/DD)* _______ / _____ / _____

School jurisdiction employed by: ______________________________

☐ Temporary contract with group benefits extended

Start date: *(YYYY/MM/DD)* _______ / _____ / _____ End date: *(YYYY/MM/DD)* _______ / _____ / _____

☐ Reduce Life and Accidental Death & Dismemberment (AD&D) insurance coverage from $50,000 to $25,000

☐ Increase Life and AD&D insurance coverage from $25,000 to $50,000 ***(Satisfactory medical evidence of good health is required)***

Reason for change - continued

☐ Change in name Previous name: ______________________________

☐ Change in address New mailing address: ______________________________

____

☐ No longer on substitute teacher / casual staff roster

☐ Other *(Please explain)* ______________________________

____

C. Declaration of eligibility for dependents

Do you have dependents? ☐ Yes, please complete below.

The following persons qualify as eligible dependents:

1. Spouse – legally married to the covered member or in an adult interdependent relationship.
2. Child – ASEBP requires that children be registered on a parent's Alberta health plan. Their provisions are as follows:
   - Single children under 21 who are wholly dependent on a parent, including adopted children, foster children (if an income tax deduction was claimed), and wards of the court
   - Single children 21 years of age or older and wholly dependent on a parent because of physical or mental disabilities
   - Single children under 25 years of age who are enrolled in three or more courses at an accredited educational institute.

Please list all your dependents below.

Last name	First name	Relationship *(spouse, partner, son, daughter)*	Birth date *(YYYY/MM/DD)*

D. Dependents' other benefit coverage information

Complete this section if you selected family coverage for Extended Health Care, Dental Care and/or Vision Care.

Please list all eligible dependents and other coverage.

Please provide the date of your common-law spouse or partner relationship (YYYY/MM/DD): ____________ /_____ / _____.

First name *(as shown above)*	Other benefit coverage information				
	Benefit coverage through another plan *(spouse or dependent child's plan)*				
	No	Yes	ASEBP Plan **or** other insurance company	*EHC	*DC
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐
	☐	☐	☐ ASEBP ID # __________ or ☐ other	☐	☐

* Legend: EHC – Extended Health Care DC – Dental Care

I declare that these dependents are eligible as described above. I agree to notify ASEBP of any changes to their eligibility and enrolment information as described above.

E. Consent and authorization for use of personal information - *To be completed by dependents 16 years of age and over (spouse/partner, children)*

I understand that my ability to enroll in group benefits is a result of my relationship with the applicant (my spouse / partner / parent) and that group benefit coverage is not extended to me unless the applicant is enrolled in the group benefits.

I acknowledge that any change in the applicant's eligibility to receive group benefits including withdrawal of consent to collect, use and disclose his/her personal information will affect my eligibility to receive group benefits.

I understand that in order for ASEBP to administer the group benefit plans, ASEBP will have to collect and use my personal information and that it may be necessary for ASEBP to disclose some or all personal information to its staff and any consultants hired by ASEBP for these purposes.

I consent to the disclosure of my personal information including benefit utilization, to the applicant (my spouse / partner / parent) for the purpose of providing information regarding benefit coverage.

I consent to the collection, use and disclosure of my personal information for the above purposes. I understand that my personal information may be disclosed to government and regulatory authorities without consent under the provisions of relevant privacy legislation.

I may revoke my consent at any time and acknowledge that doing so will affect my eligibility to receive group benefits.

Full name *(last name, first name)*	Birth date *(YYYY/MM/DD)*	Relationship *(spouse, partner, son, daughter)*	Signature

I understand that if my dependents 16 years of age and over do not provide written consent on this application; they will not be eligible to receive benefit coverage under my employee group plans.

F. Consent and authorization for use of personal information - Applicant

I understand that in order for ASEBP to administer the group benefit plans and Health Spending Account, deposit payments to and withdraw premium payments from my bank account, ASEBP must collect and use my personal information, and the personal information of any dependents under the age of 16 years, and that it may be necessary for ASEBP to disclose some or all personal information to its staff and any consultants hired by ASEBP for these purposes.

On behalf of myself and my dependents under the age of 16 years, I consent to the collection, use and disclosure of my/their personal information for the above purposes. I understand that my/their personal information may be disclosed to government and regulatory authorities without consent under the provisions of relevant privacy legislation.

I may revoke my consent at any time and acknowledge that doing so will affect my and my dependents eligibility to receive group benefits.

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

Signature: ______________________________ Date: ____________________