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

MEDICAL EVIDENCE OF GOOD HEALTH

SUBSTITUTE TEACHERS

INSTRUCTIONS:

1. Please complete sections A, B and D if you selected *Single* coverage.
2. Please complete sections A, C, and D if medical evidence is being provided for a dependent.
3. Please return the completed form to Alberta School Employee Benefit Plan (ASEBP).
4. If you have any questions regarding the collection, use and disclosure of your personal information in **Section D**, please refer to our website at www.asebp.ab.ca or contact our Privacy Officer at 780-438-4545.

NOTE: Upon review of this completed form, additional medical information may be required from your (or your dependents') treating physician(s). If so, Alberta School Employee Benefit Plan (ASEBP) will contact you to obtain this information. You are responsible for any costs associated with producing the appropriate medical evidence.

A. Applicant information

School jurisdiction employed by: ____________________
If you are on more than one roster, please identify the jurisdiction you would like to be affiliated with for benefit coverage purposes.

Name: ____________________

Mailing address: ____________________

____

Birth date: YYYY ______ / MM ______ / DD ______

Home phone #: (____) ____________ Work phone #: (____) ____________

E-mail address *(Optional)*: ____________________

B. Complete if requesting coverage on self (applicant)

☐ Male ☐ Female Height ______ Weight ______

1. Have you

		YES	NO
a)	been absent from work because of sickness or injury during the last six months?	☐	☐
b)	been in any hospital or other institution for observation, rest, diagnosis or treatment during the past five years?	☐	☐
c)	ever used barbiturates, heroin, opiates or other narcotics except as prescribed by a physician, or ever been treated for alcoholism?	☐	☐
d)	had any sickness or injury within the past 5 years resulting in your being away from work 10 days or more?	☐	☐
e)	had or received advice or treatment for Acquired Immune Deficiency Syndrome (AIDS), hepatitis, unexplained persistent lymph gland enlargement, unusual infections or any other immune system abnormalities?	☐	☐
f)	tested positive for antibodies to the AIDS (Type H-IV) virus?	☐	☐
g)	been examined by or consulted a doctor or other practitioner during the past five years?	☐	☐
h)	ever applied for or received benefits, compensation or pension on account of sickness or injury?	☐	☐
i)	ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions?	☐	☐
j)	any condition which may require any medication or medical/surgical attention now or in the future?	☐	☐
k)	had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams?	☐	☐

2. Have you at any time been treated for or told you had any trouble with any of the following:

		YES	NO
a)	Heart, chest pain	☐	☐
b)	High blood pressure	☐	☐
c)	Abnormal pulse	☐	☐
d)	Cancer or tumors	☐	☐
e)	Diabetes	☐	☐
f)	Lungs	☐	☐
g)	Nervous or mental disorders	☐	☐
h)	Arthritis or rheumatism	☐	☐
i)	Ulcers, stomach disorders	☐	☐
j)	Intestines or kidney	☐	☐
k)	Liver or gallstones	☐	☐
l)	Sexually Transmitted Diseases	☐	☐
m)	Urinary system	☐	☐
n)	Goitre or glands	☐	☐
o)	Pleurisy or asthma	☐	☐
p)	Chronic diarrhea	☐	☐
q)	Neuritis or sciatica	☐	☐
r)	Back or spinal disorder	☐	☐

B. Complete if requesting coverage on self (applicant) - Continued

3. Have you any known indication of any physical disorder, deformity, defect or abnormality not disclosed in the answers to questions 1 and 2.
   ☐ Yes ☐ No

4. Please provide complete details to all the "yes" answers to questions 1, 2, and 3? *(If more space required, go to last page)*

Question no.	*Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment, and medication.*	*Began MM YYYY*	*Time lost from normal activities*	*Full Recovery MM YYYY*	*Doctors and hospitals Provide full name and addresses*

5. Are you currently taking any medication prescribed by a doctor? If yes, please provide the drug names, frequency, and dosage.

Drug name	Frequency	Dosage

6. Have you ever been declined or postponed for life or health insurance or had a policy rated up or waived or issued for a smaller amount than applied for? Yes ☐ No ☐

C. Complete only if requesting Extended Health Care coverage for dependent(s) - List dependent(s) below.

Name Last	First	Address *(same or)*	Relationship *(Spouse/partner, son, daughter)*	Birth date YYYY/MM/ DD	Height	Weight	**ASEBP use only**

1. Have any of the dependents 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)	Heart	☐	☐	e)	Diabetes	☐	☐	i)	Cancer	☐	☐
b)	Lungs	☐	☐	f)	Nervous or mental disorder	☐	☐	j)	Back or joints	☐	☐
c)	Urinary system	☐	☐	g)	High blood pressure	☐	☐	k)	Stomach or intestines	☐	☐
d)	Tumors	☐	☐	h)	Kidney	☐	☐	l)	Hernia	☐	☐

		YES	NO
m)	been in any hospital or other institution for observation, rest, diagnosis or treatment during the past three years?	☐	☐
n)	been examined by, or consulted a doctor or other practitioner during the past three years?	☐	☐
o)	been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	☐	☐
p)	been advised to have a surgical operation or procedure but did not do so?	☐	☐
q)	any known physical impairments, deformities or ill health not covered by 1 a) through 1 p)?	☐	☐
r)	had or received advice or treatment for Acquired Immune Deficiency Syndrome (AIDS), hepatitis, unexplained persistent lymph gland enlargement, unusual infections or any other immune system abnormalities?	☐	☐
s)	tested positive for antibodies to the AIDS (Type H-IV) virus?	☐	☐
t)	ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions?	☐	☐
u)	any condition which may require any medication or medical/surgical attention now or in the future?	☐	☐
v)	had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams?	☐	☐

C - Complete only if requesting Extended Health Care coverage for dependent(s) - Continued

2. Please provide complete details to all the "yes" answers to questions 1 a) through 1 v)? *(If more space required, go to last page)*

Dependent's name	*Question no.*	*Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment, and medication.*	*Began MM YYYY*	*Time lost from normal activities*	*Full Recovery MM YYYY*	*Doctors and hospitals Provide full name and addresses*

3. For each dependent named, please provide a list of medications currently taken. Please include the drug name, frequency, and dosage. If none, please indicate.

Dependent's name	*Drug name*	*Frequency*	*Dosage*

D. Consent for the collection, use and disclosure of personal information

In order to assess and verify eligibility of health benefit coverage for you and/or your dependents under the Alberta School Employee Benefit Plan (ASEBP) group benefit plans, ASEBP will need to review the medical history for you and/or your dependents.

It may be necessary for ASEBP to disclose some or all personal information to its staff, any consultants hired by ASEBP, licensed physicians and/or any other health care professional or institutions, health benefit companies or insurance companies for the purposes outlined above.

I represent to ASEBP that I have been authorized by all dependents for whom coverage is applied for through me to consent on their behalf to the collection, use and disclosure of their personal information for the above purposes.

I consent to the collection, use and disclosure of personal information as described above or to government and regulatory authorities where required by law within provisions of the relevant privacy legislation. I understand that the personal information belonging to my dependents and myself will be kept confidential and secure.

I may revoke my consent at any time and acknowledge that doing so may affect my eligibility to receive group benefits. 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 agree to the above and declare that my statements in this document are complete, accurate and true.

Signature: ______________________________ Date: ______________________

Please go to next page if additional space is required.

Additional information