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

CHANGE APPLICATION
GROUP INSURANCE ENROLMENT

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

A. Personal

Employer's name: ______________________ Participation no.: ____________

Employee's name: ______________________ ASEBP ID no.: ____________

Previous name (if applicable): ______________________

Mailing address: ______________________

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

❑ Add common-law spouse/partner (whom I have lived with since ______________________)

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

Day of birth/adoption/guardianship: ________ Year ________ Month ________ Day

❑ Loss of spousal/partner coverage (Please include a letter from spouse's/partner's employer indicating date and reason for termination of benefit coverage)

❑ Other (Please explain) ______________________

C. Benefits

Please check off which benefits you require:

Extended Disability Benefits, Life, and Accidental Death & Dismemberment	❑ For myself	
Dental Care	❑ For myself	❑ For myself and my dependent(s)
Extended Health Care	❑ For myself	❑ For myself and my dependent(s)
Vision Care	❑ For myself	❑ For myself and my dependent(s)

D. Dependent information

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

E. Coordination of benefits *(Complete **only** if your spouse/partner or dependents have coverage through another group plan)*

Please check off which benefits you or your dependent(s) already have through another group plan:

Dental Care	❑ For myself	❑ For my spouse/partner	❑ For my children
Extended Health Care	❑ For myself	❑ For my spouse/partner	❑ For my children
Vision Care	❑ For myself	❑ For my spouse/partner	❑ For my children

Continued →

F. Change of benefit coverage *(Complete **only** if you wish to cancel benefit coverage you currently have)*

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

Extended Disability Benefits, Life, and Accidental Death & Dismemberment		☐ Waived (**declined**)
Dental Care	☐ Covered by spouse's/partner's plan	☐ Waived (**declined**)
Extended Health Care	☐ Covered by spouse's/partner's plan	☐ Waived (**declined**)
Vision Care	☐ Covered by spouse's/partner's plan	☐ Waived (**declined**)

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. 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 dependents for whom application for coverage is made.

Please sign here only if you are waiving coverage.

Date: ______________________ Signature: ______________________

G. Beneficiary for Life and Basic Accidental Death & Dismemberment Insurance

I appoint the following beneficiary(ies) for my Life and Accidental Death & Dismemberment Insurance. This appointment supersedes any previous appointments I may have made for these monies and I reserve the right to change the beneficiary(ies) named below.

Select one ☐ To the person(s) listed below ☐ To my estate

Last name	*First name*	*Relationship (spouse/partner, son, daughter)*	*Address*	*% payable to each*
			TOTAL	**100%**

If any of the individuals (beneficiaries) listed above die before me, the amount payable to him/her shall be paid as follows.

Select one ☐ **Equally to the persons listed <u>above</u> who survive me** ☐ **To my estate**
☐ **To the persons listed <u>below</u> who survive me**

Last name	*First name*	*Relationship (spouse/partner, son, daughter)*	*Address*	*% payable to each*
			TOTAL	**100%**

H. Appointment of Trustee *(Complete **only** if beneficiary is under the age of majority)*

I do hereby appoint ______________________(name) of ______________________(address) as Trustee and authorize the Trustee to receive any amount due to the beneficiary of mine under 18 years of age. The receipt of the Trustee shall be a good discharge to the payer(s) of such monies for the amount paid. The Trustee is hereby authorized and directed to expend all or any portion of such amount and/or the income therefrom solely for the maintenance or education of such beneficiary and to pay the remainder to that beneficiary upon he or she reaching the age of 18 years.

Date: ______________________ Signature: ______________________

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I. Declaration of consent and authorization

In order to administer your Alberta School Employee Benefit Plan (ASEBP) group benefit plans and to adjudicate your claims; ASEBP will have to collect personal and expense reimbursement information (with supporting documentation) for you or any of your dependents claiming benefits under these plans.

It may be necessary for the 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 dependents eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependents/beneficiaries 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.

I authorize my employer to regularly deduct from my pay, any contribution to be made by myself for these benefits. Should the information provided change, I understand that it is my responsibility to advise my employer immediately.

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

Date: ____________________ Signature: ____________________

J. For office use only

Date of employment	Date eligible for benefits	Date benefits received