



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

CHANGE APPLICATION FOR SUBSTITUTE TEACHERS AND CASUAL STAFF

INSTRUCTIONS:

1. Please send the completed form to our office by mail, fax (780-438-5304), or scan and email to **benefits@asebp.ab.ca**.
2. If you previously declined coverage, you will need to provide satisfactory medical evidence of good health to be eligible for Extended Health Care (EHC) coverage. Deductibles, the amount of money a person has to pay before benefit coverage begins, will apply to applicable Dental Care coverage during the first 12 months.
3. Please note, 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 780-431-4786.

A. Covered member information

Name: _____ ASEBP ID Number: _____

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

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.

- 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) _____ / _____ / _____
- Add **Single** Dental Care coverage
- Add **Family** Dental Care coverage (**Complete section C**)
- Cancel Dental Care coverage
- Change in dependent information (**Complete section C**)
- 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.
- 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. List of dependents

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

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.

D. Applicant's consent and authorization for use of personal information

The ASEBP requires the personal information contained herein in order to administer the group benefit plans to withdraw premiums payments from your bank account. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

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 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.

Signature: _____

Date: _____