



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

COORDINATION OF BENEFITS INFORMATION

Instructions:
 Complete this form if you, or one of your dependents, have extended health, dental, or vision coverage through another insurance provider **OR** if you need to make any changes to the information ASEBP currently has on file for your family.

1. Please complete all sections of this form, then sign and date the form on the back page. This form has two sides.
2. You must indicate either an **effective** or **termination** date for the insurance information you specify in this form.
3. **If there is a claim to be reprocessed**, please ensure you complete **Section C**.
4. 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.

A. ASEBP covered member information

Last name: _____ First name: _____ ASEBP ID #: _____

Mailing address: _____ Gender: Female Male

City: _____ Postal code: _____ Birth date (YYYY/MM/DD): _____

Home phone #: _____ Daytime phone #: _____ / _____ / _____

B. Other coverage information *(If your family has coverage under more than one insurance plan, please complete a second form)*

Name of person holding other coverage: _____ Birth date (YYYY/MM/DD): _____

Last name: _____ First name: _____ / _____ / _____

Is update to notify of **start** or **end** of other coverage? Start End

Name of other insurance company: _____

Benefits covered by this plan: EHC* Vision Dental * includes drugs, massage, physiotherapy, psychological services, hospital, etc.

Effective or **termination** date of other coverage (YYYY/MM/DD): _____ / _____ / _____

Please list all individuals who are covered under the plan identified above. Use additional forms if required. For dependents with other/additional coverage (i.e. custody situations), please complete Section D.

Last name	First name	Birth date (YYYY/MM/DD)

C. Rejected claims

Please complete the following information if a claim has been rejected as a result of insurance information previously on file. If applicable, please attach this form along with your **Explanation of Benefits and original receipts**, and forward to ASEBP for processing.

Name of person whose claim was rejected (last name, first name)	Type of claim (EHC, Dental, Vision)	Date of claim	Claim Reference # (located on Explanation of Benefits form, if available)

D. Dependent(s) with other/additional coverage – custody situations

To enable ASEBP to determine the correct order of benefits, please complete the following information regarding your dependents' custody agreement.

- 1) **Joint/shared custody**

Please list all dependent(s) this information applies to:

Dependent name	Name of individual holding other coverage	Relationship (biological parent/ step-parent)	Birth date of coverage holder (YYYY/MM/DD)	Name of insurance plan

- 2) **Sole/custodial custody** Name of custodial parent: _____

Please list all dependent(s) this information applies to:

Dependent name	Name of individual holding other coverage	Relationship (biological parent/ step-parent)	Birth date of coverage holder (YYYY/MM/DD)	Name of insurance plan

E. Consent and authorization

The ASEBP must collect, use and disclose the personal information contained herein in order to administer the group benefit plans that you are enrolled in. 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.

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

Signature: _____ Date signed: _____

Please forward the completed form to ASEBP at the address below or fax to 780-438-5304. If you have any questions about this form, please contact a Benefit Specialist by phone at 1-877-431-4786 (toll-free) or by email at benefits@asebp.ab.ca.

Alberta School Employee Benefit Plan
Suite 700 Weber Centre
5555 Calgary Trail
Edmonton, AB T6H 5P9