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MEDICAL EVIDENCE OF GOOD HEALTH

SUBSTITUTE TEACHERS AND CASUAL STAFF

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) or fax to 780-438-5304.
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: _____ Birth date: _____
YYYY MM DD
Mailing address: _____ / _____ / _____

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

E-mail address (Optional): _____

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

B. Complete if requesting coverage on self (applicant)

Male Female Height _____ Weight _____

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you | YES | NO | | YES | NO |
| a) been absent from work because of sickness or injury during the last six months? | <input type="checkbox"/> | <input type="checkbox"/> | f) tested positive for antibodies to the AIDS (Type H-IV) virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| b) been in any hospital or other institution for observation, rest, diagnosis or treatment during the past five years? | <input type="checkbox"/> | <input type="checkbox"/> | g) been examined by or consulted a doctor or other practitioner during the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) ever used barbiturates, heroin, opiates or other narcotics except as prescribed by a physician, or ever been treated for alcoholism? | <input type="checkbox"/> | <input type="checkbox"/> | h) ever applied for or received benefits, compensation or pension on account of sickness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) had any sickness or injury within the past 5 years resulting in your being away from work 10 days or more? | <input type="checkbox"/> | <input type="checkbox"/> | i) ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | j) any condition which may require any medication or medical/surgical attention now or in the future? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | k) had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams? | <input type="checkbox"/> | <input type="checkbox"/> |
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- | | | | | | | | | |
|---|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| 2. Have you at any time been treated for or told you had any trouble with any of the following: | YES | NO | YES | NO | YES | NO | | |
| a) Heart, chest pain | <input type="checkbox"/> | <input type="checkbox"/> | g) Nervous or mental disorders | <input type="checkbox"/> | <input type="checkbox"/> | m) Urinary system | <input type="checkbox"/> | <input type="checkbox"/> |
| b) High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | h) Arthritis or rheumatism | <input type="checkbox"/> | <input type="checkbox"/> | n) Goitre or glands | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Abnormal pulse | <input type="checkbox"/> | <input type="checkbox"/> | i) Ulcers, stomach disorders | <input type="checkbox"/> | <input type="checkbox"/> | o) Pleurisy or asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Cancer or tumors | <input type="checkbox"/> | <input type="checkbox"/> | j) Intestines or kidney | <input type="checkbox"/> | <input type="checkbox"/> | p) Chronic diarrhea | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | k) Liver or gallstones | <input type="checkbox"/> | <input type="checkbox"/> | q) Neuritis or sciatica | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Lungs | <input type="checkbox"/> | <input type="checkbox"/> | l) Sexually Transmitted Diseases | <input type="checkbox"/> | <input type="checkbox"/> | r) Back or spinal disorder | <input type="checkbox"/> | <input type="checkbox"/> |

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)*

<i>Question no.</i>	<i>Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment, and medication.</i>	<i>Began MM YYYY</i>	<i>Time lost from normal activities</i>	<i>Full Recovery MM YYYY</i>	<i>Doctors and hospitals Provide full name and addresses</i>
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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	<input type="checkbox"/>	<input type="checkbox"/>	e) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	i) Cancer	<input type="checkbox"/>	<input type="checkbox"/>
b) Lungs	<input type="checkbox"/>	<input type="checkbox"/>	f) Nervous or mental disorder	<input type="checkbox"/>	<input type="checkbox"/>	j) Back or joints	<input type="checkbox"/>	<input type="checkbox"/>
c) Urinary system	<input type="checkbox"/>	<input type="checkbox"/>	g) High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	k) Stomach or intestines	<input type="checkbox"/>	<input type="checkbox"/>
d) Tumors	<input type="checkbox"/>	<input type="checkbox"/>	h) Kidney	<input type="checkbox"/>	<input type="checkbox"/>	l) Hernia	<input type="checkbox"/>	<input type="checkbox"/>
m) been in any hospital or other institution for observation, rest, diagnosis or treatment during the past three years?							<input type="checkbox"/>	<input type="checkbox"/>
n) been examined by, or consulted a doctor or other practitioner during the past three years?							<input type="checkbox"/>	<input type="checkbox"/>
o) been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?							<input type="checkbox"/>	<input type="checkbox"/>
p) been advised to have a surgical operation or procedure but did not do so?							<input type="checkbox"/>	<input type="checkbox"/>
q) any known physical impairments, deformities or ill health not covered by 1 a) through 1 p)?							<input type="checkbox"/>	<input type="checkbox"/>
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?							<input type="checkbox"/>	<input type="checkbox"/>
s) tested positive for antibodies to the AIDS (Type H-IV) virus?							<input type="checkbox"/>	<input type="checkbox"/>
t) ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions?							<input type="checkbox"/>	<input type="checkbox"/>
u) any condition which may require any medication or medical/surgical attention now or in the future?							<input type="checkbox"/>	<input type="checkbox"/>
v) had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams?							<input type="checkbox"/>	<input type="checkbox"/>

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)*

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

<i>Dependent's name</i>	<i>Drug name</i>	<i>Frequency</i>	<i>Dosage</i>
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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.

