Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
www.asebp.ca

# GROUP INSURANCE ENROLMENT

*(To be returned to your employer within 31 days and provided to ASEBP upon request)*

## A. PERSONAL

Name of school jurisdiction: _____ Employee no.: _____

Employee's last name: _____ First name: _____ ASEBP ID: _____

Apt./Suite no.: _____ Street address: _____ Gender: ☐ Male ☐ Female

City: _____ Province: _____ Postal code: _____ FTE: _____ Salary: _____

Phone number (including area code): _____ Birth date:

Email address (optional): _____ _____ / _____ / _____
YYYY MM DD

Marital status: ☐ Single ☐ Married ☐ Common-law spouse/partner
Date of relationship (YYYY-MM-DD): _____

## B. BENEFITS

Do you have provincial health care coverage? ☐ Yes ☐ No

Are any of your dependants on active duty in any military, naval or air force of any country or peace keeping force?

☐ Yes ☐ No

Note: If yes, they are not eligible for coverage under this plan.

**Please check off which benefits you require and the level of coverage:**

| | | |
|---|---|---|
| ☐ Life, Accidental Death & Dismemberment and Extended Disability Benefits | ☐ For myself – **(Please complete required Appointment of Beneficiary(ies) form(s))** | |
| ☐ Extended Health Care | ☐ For myself | ☐ For myself and my dependant(s) |
| ☐ Dental Care | ☐ For myself | ☐ For myself and my dependant(s) |
| ☐ Vision Care | ☐ For myself | ☐ For myself and my dependant(s) |

## C. DEPENDANT INFORMATION

| *Last name* | *First name* | *Relationship (spouse/partner, son, daughter)* | *Birth date (YYYY/MM/DD)* |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## D. OTHER HEALTH BENEFIT COVERAGE *(Complete **only** if your spouse/partner or dependants have coverage through another group plan)*

**Please check off which benefits you or your dependant(s) already have through another group plan and the level of coverage:**

| | | | |
|---|---|---|---|
| ☐ Extended Health Care | ☐ For myself | ☐ For my spouse/partner | ☐ For my children |
| ☐ Dental Care | ☐ For myself | ☐ For my spouse/partner | ☐ For my children |
| ☐ Vision Care | ☐ For myself | ☐ For my spouse/partner | ☐ For my children |

Name of other insurance company: _____

Effective date of coverage (YYYY-MM-DD): _____

Name of person holding coverage: _____

Coverage holder's birthdate (YYYY-MM-DD): _____



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## E. REFUSAL OF BENEFIT COVERAGE *(Complete **only** if you are declining one or more benefits)*

**I understand the plan of group insurance offered to me, but I decline to participate in (check the applicable categories):**

| | | |
|---|---|---|
| ☐ Life, Accidental Death & Dismemberment and Extended Disability Benefits | | ☐ Waived (**declined**)* |
| ☐ Extended Health Care | ☐ Covered under spouse/ Alternative plan | ☐ Waived (**declined**) |
| ☐ Dental Care | ☐ Covered under spouse/ Alternative plan | ☐ Waived (**declined**) |
| ☐ Vision Care | ☐ Covered under spouse/ Alternative plan | ☐ Waived (**declined**) |

***You cannot waive Life, Accidental Death & Dismemberment or Extended Disability Benefits if they are a condition of employment. These benefits are mandatory if you wish to participate in Extended Health Care, Dental or Vision Care coverage.***

I agree that if at a later date I wish to participate in the insurance hereby declined, I must submit, at my own expense, satisfactory evidence of insurability for myself and my dependants for whom application for coverage is made. Such evidence of insurability will not be required if my spouse's/partner's coverage terminates and I apply for coverage under this group plan within 31 days of the termination date.

I also recognize that if any benefits are declined, any future application for benefits may, in whole or in part, be rejected or restricted for a period of time.

**Please sign here only if you are declining or waiving coverage.**

Signature: _____ Date: _____

## F. DECLARATION OF CONSENT AND AUTHORIZATION

The personal information contained herein is required for the purpose of enrolment in and coverage under the selected ASEBP benefit 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 dependants' eligibility to receive group benefits.

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

Your employer and/or ASEBP may elect to copy and/or store this document by secure and reliable digital or other electronic means. By signing this document you agree that this document, including your signature, may be recorded and stored electronically and that any electronic copy of same will be binding upon you to the same extent as the original version.

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

Signature: _____ Date: _____

## G. FOR OFFICE USE ONLY

| Date enrolment form received in office: | Date of employment: | Date eligible for benefits: |
|---|---|---|
| | | |