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

CHANGE APPLICATION

INSTRUCTIONS:
Please return to your employer within 31 days.

A. PERSONAL INFORMATION

Employer name: _____

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

Employee status: ❑ Working ❑ Leave of absence ❑ Disabled ❑ Other: _____

Previous name (if applicable): _____

Apt./suite no: _____ Street address: _____

City: _____ Province: _____ Postal code: _____

Phone number (incl. area code): _____

Email (optional): _____

Date of birth: _____ / _____ / _____
YYYY MM DD

B. REASON FOR CHANGE

Check off the reason(s) you are requesting a change in your benefits:

❑ Address change
Change date (YYYY/MM/DD): _____

❑ Change in marital status
Change date (YYYY/MM/DD): _____

Type of change: ❑ Marriage/divorce ❑ Other: _____

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.*

❑ Add common-law spouse/partner
Cohabitation date (YYYY/MM/DD): _____

❑ Birth/adoption/guardianship
Birth/adoption/guardianship date (YYYY/MM/DD): _____

Note: *If change is adoption or guardianship, you'll need to provide a copy of the legal guardianship papers to your employer.*

❑ Loss of spousal/alternative coverage
Loss date (YYYY/MM/DD): _____

Note: *Please include a letter from the employer providing coverage indicating date and reason for termination of benefits.*

❑ Other (please explain below)
Event date (YYYY/MM/DD): _____

_____

_____

C. CHANGES IN BENEFITS

Do not complete this section if your reason for change above was an address change.

Select which benefits you need to **either add or remove** by checking off the appropriate box(es) below. Ensure that you're only selecting one box per row.

Benefit	Add		Remove	
	For myself	For myself and my dependant(s)	Covered under spouse/alternative coverage	Waived/declined
Life, Accidental Death & Dismemberment and Extended Disability Benefits	☐ [1]	n/a	n/a	☐ [2]
Extended Health Care	☐	☐	☐	☐
Dental Care	☐	☐	☐	☐
Vision Care	☐	☐	☐	☐

[1] If selected, you'll be required to complete the *Appointment of Beneficiary(ies)* form as well.

[2] 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 Care or Vision Care coverage.

I understand that if any benefits are cancelled for reasons other than spousal/alternative coverage under another Group Plan, any future application for benefits may, in whole or part, be rejected or restricted for a period of time and subject to late applicant restrictions. 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 dependants for whom application for coverage is made. If approved, deductibles will apply to dental and vision coverage and remain in effect for one year from the effective date of coverage or until the deductibles are satisfied, whichever occurs first.

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

Signature: _____ Date: _____

Complete the following only if you wish to terminate all of your benefits with ASEBP.

Termination date (YYYY/MM/DD): _____ at 11:59 p.m.

I understand that if I request coverage to be reinstated at a later date, I may be subject to late applicant restrictions and be required to provide medical evidence of good health. I further understand that coverage may be declined or subject to deductibles.

Signature: _____ Date: _____

D. DEPENDANT INFORMATION

Last name	First name	Relationship	Sex	Date of birth (YYYY/MM/DD)	Benefits (add or remove)

E. 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 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.

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: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Policy at www.asebp.ca/privacy, or contact the privacy officer at 780-438-5300.

F. FOR OFFICE USE ONLY

Date change application received in office	Date of employment	Date eligible for benefits