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|  | | | **COORDINATION OF BENEFITS**  **INFORMATION** | | | | | | |
| **Instructions:** Complete this form if you, or one of your dependants, 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.Please complete all sections of this form, then sign and date it. You should return your completed form to ASEBP by email to [benefits@asebp.ca](mailto:benefits@asebp.ca) or fax at 780-438-5304.You must indicate either an effective or termination date for the insurance information you specify in this form. Please also remember to update this information with your health care providers (e.g. dentists, massage therapists, etc.) so they have the most current information on file.  1. **If there is a claim to be reprocessed**, please ensure you complete **Section C.** | | | | | | | |
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| A. ASEBP covered member information | | | | | | | | |
| Last name: | | First name: | | | | ASEBP ID #: | |
| Mailing address: | | | | | | | |
| City: | | | Postal code: | | | Birth date (YYYY/MM/DD):       /    / | |
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| **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:  Remove all external COB / all benefits / all dependants (ASEBP is the only active coverage) | | | | | | | | |
| Benefits affected by this update:  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 dependants with other/additional coverage (i.e. custody situations), please complete Section D. | | | | | | | | |
| **Last name** | | | | | **First name** | | | **Birth date**  (YYYY/MM/DD) |
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| **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 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** (YYYY/MM/DD) | **Claim Reference #**  (located on Explanation of Benefits form, if available) |
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| **D. Dependant(s) with other/additional coverage – custody situations** | | | | |
| To enable ASEBP to determine the correct order of benefits, please complete the following information regarding your dependants’ custody agreement. | | | | |
| 1. **Joint/shared custody**   Please list all dependants this information applies to: | | | | |
| **Dependant name** | **Name of individual**  **holding other coverage** | **Relationship**  (biological parent/  step-parent) | **Birth date of coverage holder**  (YYYY/MM/DD) | **Name of insurance plan** |
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| 1. **Sole/custodial custody**  Name of custodial parent:   Please list all dependants this information applies to: | | | | |
| **Dependant name** | **Name of individual holding other coverage** | **Relationship**  (biological parent/  step-parent) | **Birth date of coverage holder**  (YYYY/MM/DD) | **Name of insurance plan** |
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| **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 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 confirm that I have obtained consent from the individual(s) listed in Part D holding other coverage for the collection, use and disclosure of their personal information for the purpose of administering the coverage provided under the group benefit plans.  I agree to the above and declare that my statements in this notice are complete, accurate and true.  Signature:       Date signed:  Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act* of Alberta and section 1 of the federal *Personal Information Protection Electronic Documents Act*. Be advised that in order to optimize the services we provide we may use service providers outside Canada to carry out certain functions on our behalf. In such situations, we enter into contracts and/or verify that appropriate privacy and security protocols are in place. 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 or contact the privacy officer at 780-438-5300. | | | | |

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| **F. ASEBP COMMENTS ONLY** |
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