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**EARLY REFILL REQUEST FORM**

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| **Instructions:**1. If you or one of your dependants have had to **prepay** for medication(s) required in excess of the 100-day supply eligible under your ASEBP plan, please complete all applicable sections of this form.
2. **Remember to include your** **receipts**. **Note**: If this is for a previously submitted claim, please include a copy of the *Explanation of Benefits* statement you received.
3. Please fax or email this **signed and dated** form, together with the Explanation of Benefits statement, to ASEBP at 780-438-5304 or benefits@asebp.ca.
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| **A. ASEBP Covered Member Information** |
| Plan member’s full name:       GROUP SECTION ASEBP ID |
| Mailing address:       | 1 | 9 | 9 | 3 | 0 |   |   |   |   |   |   |   |   |   |   |  |
| Phone number:    -   -     | Birth date (YYYY/MM/DD):      /    /    |
| Email address:       |
| **B. Travel Details****Note:** If travelling as a family, complete onlyone *Early Refill Request* form per trip. |
| Name of patient(s) travelling: |
| Patient name:      Patient name:       | ASEBP ID:      ASEBP ID:       |
| Departure date (YYYY/MM/DD):      /    /    Return date (YYYY/MM/DD):      /    /    Destination (YYYY/MM/DD):      /    /   Optional out-of-country contact information (email or phone number):       |
| **C. Other Circumstances** |
| If you required more than a 100-day supply of medication for reasons other than travel outside of Canada, please provide an explanation of the circumstance(s) that warranted the early refill of your prescription drugs, for ASEBP’s consideration. |
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| **D. Consent for the Collection, Use and Disclosure of Personal Information** |
| I understand that the personal information contained in this claim form (with supporting documentation) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, verify, assess and pay claims and administer my benefit plan. 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/our 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 agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.**Covered member/spouse’s signature:** “First name Last name”  **Date:**      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. |