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

EARLY REFILL REQUEST FORM

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 attach your receipts**. **Note**: If this is for a claim to be reprocessed, please also attach a copy of the *Explanation of Benefits* statement you received.
3. Once this form is complete (signature and date included) with the aforementioned attachments, please forward these documents to ASEBP by mail at the address listed above, fax at 780-438-5304 or email at benefits@asebp.ca.

A. ASEBP Covered Member Information

Plan member's full name: _____

Mailing address: _____

_____

GROUP	SECTION	ASEBP ID
1 9 9 3 0		

Phone number: _____ Birth date (YYYY/MM/DD): _____ / _____ / _____

Email address: _____

B. Travel Details

Note: If travelling as a family, only one *Early Refill Request* form needs to be filled out per trip.

Name of patient(s) travelling:

Patient name: _____ ASEBP ID: _____

Patient name: _____ ASEBP ID: _____

Departure date: _____ Return date: _____ Destination: _____

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 to be considered by ASEBP.

_____

_____

_____

_____

_____

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: _____ **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.html or contact the privacy officer at 780-438-5300.