|  |  |
| --- | --- |
|   | SUPPLEMENTAL PACKAGE APPLICATION |
| **INSTRUCTIONS:**1. **Your completed application can be submitted to our office by fax (780-438-5304) or email (****benefits@asebp.ca****). The *Appointment of Beneficiary(ies)* form included in this application package is only required if selecting Life Insurance, and Accidental Death & Dismemberment (AD&D) Benefits. If applicable, it must include either a digital signature or ‘print and sign’; typed names aren’t accepted. Please refer to the instructions section of that form for details on how to submit. PLEASE PRINT SINGLE SIDED.**
2. Attach the following documents:

[ ]  **Blank personalized cheque marked** ***“VOID”*** or bank account information obtained from your financial institution[ ]  Copy of your **birth certificate** or **government-issued proof of age**, andIf applicable:[ ]  If applicable, completed ***Appointment of Beneficiary(ies)*** form. A copy of this form is included for your convenience.1. For more information about the benefit plans offered, please refer to the Supplemental section of our website, [Supplemental Package (asebp.ca)](https://www.asebp.ca/my-benefits/supplemental-package)
 |

|  |
| --- |
| **Eligibility to Participate in Benefits** |
| I declare that I am:* actively working for an ASEBP-participating employer
* ineligible to participate in benefits offered by an ASEBP-participating employer or, receiving partial benefits from an ASEBP-participating employer
* a resident of Canada, and
* covered under a provincial health care insurance plan.
 |

**PART 1: Applicant Information and Benefits Selection**

|  |
| --- |
| A. Applicant Information |
| Most recent employment start date:      /    /    ASEBP ID:        *YYYY MM DD*Name of employer (required):        |
| Select one: [ ]  Teacher [ ]  Other  |
| Last name:       First name:        |
| Sex at birth: [ ]  Female [ ]  Male | Birth date      /    /     *YYYY MM DD* |
| Mailing address:       |
| City:       | Postal code:       | Primary phone #:    -   -      |
| Email address (please use personal email address):       |
|  |
| B. Declaration of Other Benefits Coverage and Supplemental Selection |
| Are you currently participating in benefits offered by an ASEBP participating employer? [ ]  Yes [ ]  No if yes, please indicate below which benefits you are participating in:Life Insurance ---------------------------------- [ ]  AD&D -------------------------------------------- [ ]  Extended Health Care (EHC) --------------- [ ]  Dental ------------------------------------------- [ ]  Spending Account (HSA/WSA) ------------- [ ] Please be advised that this package is designed to complement, not replicate, your existing benefits. You are not eligible to participate in benefits that your employer already covers.**Dental Care:** Enrolment in Dental Care is optional and can be added for an additional premium. If you wish to include Dental Care in your coverage, please check Dental Single, or Dental Family. For detailed information about premiums, please visit our [Supplemental Rates Page](https://asebp.ca/sites/default/files/forms/Supplemental%20Package%20Monthly%20Premium%20Rates.pdf?cb=1724851535). Additional information on each benefit can be found on the [Supplemental Information Page](https://www.asebp.ca/my-benefits/supplemental-package) on our website, asebp.ca.**Important: If you have indicated that you are already receiving certain benefits through your employer, please do not select those benefits again in the section below. Ensure you only select those benefits that are not covered by your employer****Benefit Selection:****Please note, Extended Health Care and Dental Care coverage levels must match****Mandatory Coverage:**If you are **not** receiving Life and AD&D, and Extended Health Care (EHC) coverage through an ASEBP participating employer, you **must** enroll in these benefits under this plan. Please select options below.Life $25,000 / AD&D $25,000 [ ]  EHC Single [ ]  Dental Single[ ]  (Optional) [ ]   OR Life $50,000 / AD&D $50,000[ ]  [ ]  EHC Family [ ]  [ ]  Dental Family (Optional) [ ]  **Reminder – If applicable, please complete the beneficiary form below.**  |

|  |
| --- |
| C. Eligibility for Dependants – *only required if family coverage is selected* |
| The definition of a dependant is as follows:**Spouse** legally married to, or in an adult interdependent relationship with, the covered member.**Child** ASEBP requires that children be registered on a parent’s provincial health care plan. Child dependant provisions are as follows:* Single children under 21 who are wholly dependent on a parent, including adopted children, foster children (if an income tax deduction was claimed), and wards of the court.
* Single children under 25 years of age who are enrolled in three or more courses at an accredited educational institute.
* Single and unemployed dependant over the age of 21, dependent on the covered member by reason of mental or physical disability.  Please contact a Benefit Specialist for more information on eligibility and how to apply.

 Please list all your dependants.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Last name** | **First name** | **Sex** | **Relationship** | **Birth date***(YYYY/MM/DD)* |
|       |       |       |       |      /    /    |
|       |       |       |       |      /    /    |
|       |       |       |       |      /    /    |
|       |       |       |       |      /    /    |

 |

|  |
| --- |
| **E. Consent and Authorization for the Use of Personal Information** |
| 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’ ability 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.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 application are complete, accurate and true.Signature:                           Date:      Consent is 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 [asebp.ca/privacy](https://www.asebp.ca/privacy) or contact the privacy officer at 780-438-5300. |

Page 3 of 3

|  |  |
| --- | --- |
| G:\Communications - CHRS\zLogos\ASEBP\JPG\ASEBP (Grayscale).jpg | APPOINTMENT OF BENEFICIARY(IES)Life and Accidental Death &Dismemberment Insurance |
| **INSTRUCTIONS:**1. Please complete required sections A, B and F, along with sections C and D if applicable. Failure to complete this form in its entirety may result in proceeds being paid to your estate.
2. If you are currently working or on a leave of absence, please return your form to your employer either in person or by email.
3. If you are currently participating in ASEBP’s Supplemental, MyRetiree, or Early Retirement Benefits, please return your form to ASEBP by email (benefits@asebp.ca), either as a scanned document or a photo attachment (content in photo must be readable). Digital signature or ‘print and sign’ are accepted; however, typed names are not.
 |
| A. Applicant information  |
| Last name:       | First name:       | ASEBP ID #:       |
| Mailing address:       |
| City:       | Province:       | Postal code:       |
| Daytime phone:    -   -     | Mobile/Alternate phone:    -   -     |
| Employer’s name (if applicable):        |
| Email address (optional):        | Birth date:      /    /    *YYYY MM DD*  |
| B. Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance |
| I appoint the following beneficiary(ies) for my Life and Accidental Death & Dismemberment Insurance. This appointment supersedes any previous appointments I may have made for these proceeds and I reserve the right to change the beneficiary(ies) named below. If any of the beneficiaries predecease me, I understand their portion will be divided equally among any surviving beneficiaries.***Select one*** [ ]  To the person(s) listed below  [ ]  To my estate

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **Relationship** | **Birthdate**(YYYY/MM/DD) | **Complete Mailing Address** (Apt., Street, P.O. Box, City, Prov, Postal Code) | **Phone number**(including area code) | **% payable to each** (must equal 100%) |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|  |  |  |  |  | **TOTAL** | **100%** |

 |
|  |

|  |
| --- |
| **C. Contingent Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance** |
| Your contingent beneficiary(ies) will receive the proceeds of your policy if your primary beneficiary(ies), as indicated in Section B, is deceased at the time of your death.If all beneficiaries listed in Section B are deceased at the time of your death, the amount payable to your contingent beneficiary(ies) shall be paid as follows.***Select one*** [ ]  To the person(s) listed below [ ]  To my estate

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **Relationship** | **Birthdate**(YYYY/MM/DD) | **Complete Mailing Address** (Apt., Street, P.O. Box, City, Prov, Postal Code) | **Phone number**(including area code) | **% payable to each** (must equal 100%) |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|       |       |       |      /    /    |       |       |       |
|  |  |  |  |  | **TOTAL** | **100%** |

 |
| D. Appointment of Trustee *(Complete only if one or more beneficiaries is under the age of majority.)*  |
| I appoint       of        (Name) (Suite/Apt/Unit no., Street, P.O. Box, City, Prov, Postal Code) reached at       as Trustee and authorize ASEBP to pay any amount payable to any beneficiary under 18 years of (Phone number) age to the Trustee. I authorize the Trustee to have access to the insurance proceeds and manage the funds as directed in my last will and testament and to pay the remaining balance to the beneficiary once he/she reaches the age of majority. |
| E. Consent and Authorization |
| I understand that the ASEBP must collect, use and disclose the personal information contained herein in order to administer the Life and Accidental Death and Dismemberment Insurance policies. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to your employer or the third party service provider 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 eligibility to receive Life and Accidental Death and Dismemberment Insurance benefits. I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, individuals who derive a benefit from an insurance policy or benefit plan (the beneficiaries named herein) are deemed to consent to the collection, use, and disclosure of their personal information for the purpose of coverage under those plans. Your employer and/or ASEBP is required to keep a hard copy original version of your completed beneficiary form. By signing below you agree to the storage of this document and the information, including your signature, which it contains.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. |
| F. Acknowledgement |
| I agree to the above and declare that my statements are complete, accurate and true.Signature:       Date:      **Note:** Digital signatures or ‘print and sign’ are accepted; however, typed names are not. |