Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
Fax: 1-780-438-5304
www.asebp.ca

SUPPLEMENTAL PACKAGE APPLICATION

INSTRUCTIONS:

1. Please send the completed application form to our office by mail, fax (780-438-5304) or scan and email to benefits@asebp.ca.
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**, and
   - ☐ Completed *original* ***Appointment of Beneficiary*** form (located in the Forms section of our website, asebp.ca).
3. ASEBP must receive your completed application **within 31 days of your most recent employment start date.**
4. For more information about the benefit plans offered, please refer to the My Benefits section of our website, asebp.ca.

Eligibility to Participate in Benefits

I declare that I am:

- under 70,
- actively working for an ASEBP-participating employer
- ineligible to participate in benefits offered by an ASEBP-participating employer or serving a waiting period of at least one day for ASEBP group benefits,
- a resident of Canada and
- covered under a provincial health care insurance plan.

Applicant Information and Benefits Selection

A. Applicant Information

Most recent employment start date: _____ / _____ / _____
YYYY *MM* *DD*

School jurisdiction employed by: _____

Select one: ☐ Teacher ☐ Non-teacher

Select one: ☐ Substitute teacher/Casual staff ☐ Part-time employee ☐ Probationary ☐ Over 65, under 70

Last name: _____ First name: _____

Sex at birth: ☐ Female ☐ Male

Birth date: _____ / _____ / _____
YYYY *MM* *DD*

Mailing address: _____

City: _____ Postal code: _____ Primary phone #: ( ) _____

Email address: _____

B. Declaration of Other Benefits Coverage

Do you have other group employment benefits coverage? ☐ Yes ☐ No

If yes, are these other benefits with a school jurisdiction? ☐ Yes ☐ No

C. Package Selection

You must participate in the benefits as listed within each package. **Dental Care coverage is optional and can be added for an additional premium. Please refer to the hyperlinks below for premium package rates.** If you wish to add Dental Care to your selected package, please check the Add Dental Care (*Plan 2*) box.

Please select your package below and make sure to refer to the hyperlinks for information on additional charges. You can visit the applicable benefit area (found under My Benefits) of our website, asebp.ca, for additional information on each benefit package:

☐ **Package 1**
Life Insurance *(Plan 2)* $25,000
AD&D *(Plan 2)* $25,000
Extended Health Care *(Plan 2)* Single

Add: ☐ Dental Care *(Plan 2)* Single
Click here for additional rate cost.

☐ **Package 2**
Life Insurance *(Plan 2)* $25,000
AD&D *(Plan 2)* $25,000
Extended Health Care *(Plan 2)* Family

Add: ☐ Dental Care *(Plan 2)* Family
Click here for additional rate cost.

☐ **Package 3**
Life Insurance *(Plan 2)* $50,000
AD&D *(Plan 2)* $50,000
Extended Health Care *(Plan 2)* Single

Add: ☐ Dental Care *(Plan 2)* Single
Click here for additional rate cost.

☐ **Package 4**
Life Insurance *(Plan 2)* $50,000
AD&D *(Plan 2)* $50,000
Extended Health Care *(Plan 2)* Family

Add: ☐ Dental Care *(Plan 2)* Family
Click here for additional rate cost.

D. 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 or contact the privacy officer at 780-438-5300.

APPOINTMENT OF BENEFICIARY(IES)

Life and Accidental Death & Dismemberment Insurance

HARD COPY ORIGINAL OF COMPLETED FORM TO BE MAINTAINED BY EMPLOYER OR ASEBP

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. **Return the *original* completed form to your employer unless you are an Early Retiree or are participating in ASEBP's Supplemental Package, in which case return the *original* completed form directly to ASEBP.**

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: _____ / _____ / _____
MM *DD* *YYYY*

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.)*

Note: Your Trustee cannot be a named beneficiary.

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 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.
(Phone number)

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.

F. Acknowledgement

I agree to the above and declare that my statements 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.