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|  | | | | SUPPLEMENTAL PACKAGE CHANGE APPLICATION | | | |
| **INSTRUCTIONS:**  Please send the completed form to ASEBP by fax (780-438-5304) or email ([benefits@asebp.ca](mailto:benefits@asebp.ca)). | | | | | |
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| **PART 1: Applicant Information and Benefits Selection** | | | | | |
| A. Personal Information | | | | | |
| Name: | | | | ASEBP ID number: | |
| Mailing address (incl. postal code): | | | | | |
| Date of birth:      /    /    YYYY MM DD | Employer name: | | | | |
| Phone number (incl. area code):    -   - | | | Email: | | |
| B. Reason for Change | | | | | |
| Effective date of change (YYYY/MM/DD):      /    / Please check off the reason(s) you are requesting a change in your benefits: | | | | | |
| Reinstate Supplemental Package benefits upon temporary contract ending  Date eligible for benefits, if different from start date (YYYY/MM/DD):      /    /  Suspend Supplemental benefits. Temporary contract with group benefits with a non-participating employer group  Effective date of new benefit coverage (YYYY/MM/DD):      /    / | | | | | |
| Cancel all supplemental coverage currently participating in (please proceed to section D) | | | | | |
| Cancel Dental Care coverage | | | | | |
| Add ***Single***Dental Care coverage | | | | | |
| Add ***Family*** Dental Care coverage | | | | | |
| Remove dependant and maintain my ***Family*** EHC and, where applicable, Dental Care coverage (please proceed to section C) | | | | | |
| Remove dependant and reduce EHC and, where applicable, Dental Care coverage from ***Family*** to ***Single*** | | | | | |
| Add a new dependant and change my EHC and, where applicable, Dental Care coverage from ***Single*** to ***Family*** (please proceed to section C)  **Reason for change:**  Marriage  Birth/Adoption/Guardianship  Loss of spousal/alternative coverage (please include a letter from the employer providing coverage   indicating the date and reason for termination of benefits) | | | | | |
| Add a new dependant and maintain my ***Family*** EHC and, if applicable, Dental Care coverage (please proceed to section C) | | | | | |
| Reduce Life and Accidental Death & Dismemberment (AD&D) insurance coverage from $50,000 to $25,000 | | | | | |
| Increase Life and AD&D insurance coverage from $25,000 to $50,000 (increases can only be made after a 180-day waiting period) | | | | | |

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| **Reason for Change - Continued** | | | | | | |
| Change in name Previous name: | | | | | | |
| Change in address New mailing address: | | | | | | |
| No longer employed by ASEBP-participating employer Final day of employment (YYYY/MM/DD):      /    / | | | | | | |
| Change in employer Employer name:       Employment start date (YYYY/MM/DD):      /    / | | | | | | |
| Other (please specify): | | | | | | |
| C. Dependant Information | | | | | | |
| Last Name | First Name | Birth Date(YYYY/MM/DD) | **Sex** | Relationship (spouse, partner, son, daughter) | Check One | |
| Add | Remove |
|  |  | /    / |  |  |  |  |
|  |  | /    / |  |  |  |  |
|  |  | /    / |  |  |  |  |
| I declare that these dependants are eligible as described above. I agree to notify ASEBP of any changes to their eligibility and enrolment information as described above. | | | | | | |
| D. Termination of Coverage | | | | | | |
| At my request, my benefit coverage with ASEBP will terminate effective midnight on (YYYY/MM/DD):      /    /  Reason:  Signature: “First name Last name” Date: | | | | | | |
| **PART 2: Terms and Conditions** | | | | | | |
| E. Premiums | | | | | | |
| **Personal Pre-Authorized Debit (PAD) Agreement** (ASEBP does not accept credit card payments).  I understand that the following conditions apply:   1. I’ll pay the monthly premium amount noted in my approval letter 2. A monthly statement won’t be issued 3. I’ll receive notification of changes in the monthly amount payable due to:  * Premium rate adjustments, which typically occur in September as authorized by ASEBP Trustees * A change in benefit coverage (e.g., from “single” to “family” coverage)  1. My premium payment will be automatically withdrawn from my bank account on the 15th of each month until the amount owning has been paid in full.  If the 15th falls on a weekend, the withdrawal will occur on the next business day 2. Premiums are billed in complete months and if my benefits terminate prior to the last day of the month, I will remain responsible for the full month’s premium 3. If there is a change in coverage that takes effect partway through a month (e.g., a change from “family” to “single” status), the premium and coverage in effect at the beginning of the month will remain in effect until the end of that month. On the first day of the following month, the new coverage will come into effect and ASEBP will charge me the new premium 4. I will not receive credits or refunds for premiums already paid 5. If needed, I will update my banking information by logging into My ASEBP.   My authorization will remain in effect until 30 days written notification of cancellation is issued by either myself or ASEBP. To obtain a sample cancellation form or for more information on my right to cancel this PAD agreement, I may contact my financial institution or visit [payments.ca](https://www.payments.ca/).  If ASEBP makes a withdrawal in error or for the incorrect amount, I will notify ASEBP as soon as possible. If ASEBP is aware of an error, ASEBP will correct the error and notify me as soon as possible. I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. I may contact my financial institution or visit payments.ca to obtain more information on my recourse rights. | | | | | | |
| If you have any questions about this PAD Agreement, please contact ASEBP. You can find our contact information on our website, [www.asebp.ca](http://www.asebp.ca/).  **I authorize ASEBP to begin automated withdrawals** for payment of my benefit premiums for the bank account currently on file  (please log in to your My ASEBP account to confirm) OR  A **blank personalized cheque marked “VOID”** is attached OR  **I authorize ASEBP to begin automated withdrawals** for payment for my benefit premiums from the account provided below:  Withdrawal account number ([seven to 12 digits](https://www.asebp.ca/media/1887)):       Branch transit number ([five-digit number](https://www.asebp.ca/media/1889)):  Financial institution number ([three-digit number](https://www.asebp.ca/media/1888)):     Financial institution name:  Branch address (including city and postal code):  **Non-Payment of Premiums**  If my benefits are terminated due to non-payment of premiums, coverage will end and I will not be able to re-enrol in benefits until I make restitution, which may include payment of premiums, interest, NSF charges and claims paid after termination. I understand that ASEBP retains the right to deny re-enrolment should coverage be terminated due to non-payment of premiums. | | | | | | |
| F. Declaration of Consent and Authorization (must be signed) | | | | | | |
| ASEBP requires 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 your employer and 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’ 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.  Signature: “First name Last name” 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. | | | | | | |