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

SUPPLEMENTAL PACKAGE CHANGE APPLICATION

INSTRUCTIONS:

1. Please send the completed form to ASEBP by mail or fax (780-438-5304), or scan and email to benefits@asebp.ca.
2. If you previously declined coverage or are requesting a change reported after 31 days, you'll need to provide satisfactory medical evidence of good health to be eligible for Extended Health Care (EHC). A deductible will apply to Dental Care and remain in effect for one year from the effective date or until the deductible is satisfied, whichever comes first. For more information on deductibles, please visit our website, asebp.ca.

A. Personal Information

Name: _____ ASEBP ID number: _____

Mailing address (incl. postal code): _____

Date of birth: _____ / _____ / _____ Employer name: _____
YYYY MM DD

Phone number (incl. area code): _____ Email: _____

B. Reason for Change

Effective date of change: Year _____ Month _____ Day _____

Please check off the reason(s) you are requesting a change in your benefits:

❑ Temporary contract with group benefits accepted

Start date: Year _____ Month _____ Day _____ End date: Year _____ Month _____ Day _____

❑ Reinstate Supplemental Package benefits upon temporary contract ending

Date eligible for benefits, if different from start date: Year _____ Month _____ Day _____

❑ Temporary contract with group benefits extended

Start date: Year _____ Month _____ Day _____ End date: Year _____ Month _____ Day _____

❑ Cancel all 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, where 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 (satisfactory medical evidence of good health is required)

Reason for Change - Continued

❑ Change in name Previous name: _____

❑ Change in address New mailing address: _____

❑ No longer employed by ASEBP-participating employer

❑ 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:

Year _____ Month _____ Day _____ Reason: _____

I understand that if I request coverage to be reinstated at a later date, I may be subject to late applicant restrictions and be required to provide medical evidence of good health. I further understand that coverage may be declined or subject to deductibles.

Signature: _____ Date: _____

E. 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: _____ 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.