



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

# MyRETIREE PLAN CHANGE APPLICATION

## INSTRUCTIONS:

1. Complete all applicable sections of this form.
2. Return the completed form to ASEBP by fax (780-438-5304) or email [benefits@asebp.ca](mailto:benefits@asebp.ca).

## A. Personal Information

Name: \_\_\_\_\_ ASEBP ID number: \_\_\_\_\_

Previous name (if applicable): \_\_\_\_\_ Date of birth (YYYY/MM/DD): \_\_\_\_\_

Mailing address (incl. postal code): \_\_\_\_\_ Phone number (incl. area code): \_\_\_\_\_

Personal email address:

Please **do not** use your work email. Your personal email ensures uninterrupted access to your personal benefits information in your My ASEBP account and ID card download/print.

## B. Reason for Change

Life event/Change date (YYYY/MM/DD): \_\_\_\_\_

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

Change in marital status:  Marriage/Common Law  Separation/Divorce  Deceased Spouse  Other: \_\_\_\_\_

If Common Law, indicate date of start of cohabitation (YYYY / MM/ DD): \_\_\_\_\_ (Please proceed to Section C & D)

Birth/adoption/guardianship (Please attach a copy of the legal guardianship papers to this form.) (Please proceed to Section C & D)

Loss of partner/alternate coverage (Include a letter from employer/carrier providing coverage noting the date and reason for termination of benefits.)

\*Terminate coordination of benefits (\*applies to all Extended Health, Vision, and Dental Care benefits on file).

Name of insurance carrier: \_\_\_\_\_

Effective date of loss (YYYY/MM/DD): \_\_\_\_\_

Reinstatement of MyRetiree Plan benefits

Terminate **all** MyRetiree Plan coverage currently participating in (Please proceed to Section E)

Change in name. New name: \_\_\_\_\_

Change in mailing address to (include postal code): \_\_\_\_\_

Other (Please explain): \_\_\_\_\_

**C. Changes in Benefit Coverage**

Please check off which benefits you require.

Also, please note the following **restrictions** or visit [MyRetireePlan.ca](http://MyRetireePlan.ca) for more information.

- You may increase your coverage from Core to Enhanced at any time.
- You may only reduce your coverage from Enhanced to Core after two years of participation.
- You may terminate Core Dental at any time or Enhanced Dental after two years. However, you won't be able to participate in Dental at a later date.

<p><b>Extended Health Care and Vision Care: Mandatory</b></p> <p><input type="checkbox"/> Enhanced Extended Health and Vision</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Core Extended Health and Vision</p> <p style="background-color: #cccccc; padding: 2px;"><b>Choose Single, Couple or Family for both EHC and Vision Coverage</b></p> <table style="width:100%; text-align: center;"> <tr> <td></td> <td><b>Single</b></td> <td><b>Couple</b></td> <td><b>Family</b></td> </tr> <tr> <td><b>EHC Coverage</b></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>Vision Coverage</b></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		<b>Single</b>	<b>Couple</b>	<b>Family</b>	<b>EHC Coverage</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vision Coverage</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Dental Care: Optional</b></p> <p><input type="checkbox"/> Terminate my Dental Care coverage</p> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Add Enhanced Dental Care (choose one option and one level):</p> <p style="text-align: center;"><b>Option 1</b> <input type="checkbox"/> <b>OR</b> <b>Option 2</b> <input type="checkbox"/></p> <table style="width:100%; text-align: center;"> <tr> <td></td> <td><b>Single</b></td> <td><b>Couple</b></td> <td><b>Family</b></td> </tr> <tr> <td><b>Level:</b></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p style="text-align: center;"><b>OR</b></p> <p><input type="checkbox"/> Add Core Dental (choose one level):</p> <table style="width:100%; text-align: center;"> <tr> <td></td> <td><b>Single</b></td> <td><b>Couple</b></td> <td><b>Family</b></td> </tr> <tr> <td><b>Level:</b></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		<b>Single</b>	<b>Couple</b>	<b>Family</b>	<b>Level:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<b>Single</b>	<b>Couple</b>	<b>Family</b>	<b>Level:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Coordination of Benefits</b></p> <p>If this section is applicable to you, please read each statement carefully and check all boxes.</p> <p><i>I have benefits under my partner/alternative provider, and I acknowledge and understand that:</i></p> <p><input type="checkbox"/> By selecting this option, I am choosing to terminate EHC/Vision and or Dental currently.</p> <p><input type="checkbox"/> I will need to provide ASEBP with proof of loss of coverage and complete a MyRetiree Plan Change Application form to reinstate these benefits.</p> <p><input type="checkbox"/> Failure to provide proof of loss of coverage will result in these benefits remaining terminated.</p>
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**D. Dependant Information**

First Name	Last Name	Sex	Birth Date (YYYY/MM/DD)	Relationship (i.e. spouse, son, etc.)	Check One	
					Add	Remove

**E. Termination of Coverage**

- I would like to terminate my ASEBP MyRetiree Plan benefits coverage because (please choose all that apply):
- The ASEBP plan is not comprehensive enough
  - The ASEBP plan is too expensive
  - I've moved to a private-sponsored plan or my spouse's/partner's plan (plan carrier name): \_\_\_\_\_
  - Other (please specify): \_\_\_\_\_

At my request, I would like my benefits terminated effective midnight on (YYYY/MM/DD): \_\_\_\_\_

I understand that I will not be eligible to reapply for ASEBP MyRetiree Plan benefits at a later date:

Signature: \_\_\_\_\_ Date (YYYY/MM/DD): \_\_\_\_\_

**F. Declaration of Consent and Authorization (must be signed)**

The personal information contained herein is required for 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' 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.

Your employer and/or 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 enrolment application are complete, accurate and true.

Signature: \_\_\_\_\_

Date (YYYY/MM/DD): \_\_\_\_\_

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 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](http://www.asebp.ca) or contact the privacy officer at 780-438-5300.