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# CHANGE APPLICATION

## GROUP INSURANCE ENROLMENT

(To be maintained on file by the employer and surrendered to ASEBP upon request)

### A. Personal

Employer's name: \_\_\_\_\_ Participation no.: \_\_\_\_\_  
 Employee's name: \_\_\_\_\_ ASEBP ID no.: \_\_\_\_\_  
 Previous name (if applicable): \_\_\_\_\_  
 Mailing address: \_\_\_\_\_

### 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:**  
 Change in marital status:  Marriage  Separation  Divorce  
 Add common-law spouse/partner (whom I have lived with since \_\_\_\_\_)  
 Birth/adoption/guardianship: (Please provide a copy of the legal guardianship papers to your employer)  
 Day of birth/adoption/guardianship: \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day  
 Loss of spousal/partner coverage (Please include a letter from spouse's/partner's employer indicating date and reason for termination of benefit coverage)  
 Other (Please explain) \_\_\_\_\_

### C. Benefits

**Please check off which benefits you require:**  
 Extended Disability Benefits, Life, and  
 Accidental Death & Dismemberment  For myself  For myself and my dependent(s)  
 Dental Care  For myself  For myself and my dependent(s)  
 Extended Health Care  For myself  For myself and my dependent(s)  
 Vision Care  For myself  For myself and my dependent(s)

### D. Dependent information

Last name	First name	Initial	Birth date (yy/mm/dd)	Relationship (ie. spouse, partner, son, daughter)	Check one	
					Add	Delete

### E. Coordination of benefits (Complete **only** if your spouse/partner or dependents have coverage through another group plan)

**Please check off which benefits you or your dependent(s) already have through another group plan:**  
 Dental Care  For myself  For my spouse/partner  For my children  
 Extended Health Care  For myself  For my spouse/partner  For my children  
 Vision Care  For myself  For my spouse/partner  For my children

### F. Change of benefit coverage (Complete **only** if you wish to cancel benefit coverage you currently have)

**I decline to participate in (check the applicable category):**  
 Extended Disability Benefits, Life, and  
 Accidental Death & Dismemberment  Waived (**declined**)  Covered by spouse's/partner's plan  
 Dental Care  Waived (**declined**)  Covered by spouse's/partner's plan  
 Extended Health Care  Waived (**declined**)  Covered by spouse's/partner's plan  
 Vision Care  Waived (**declined**)  Covered by spouse's/partner's plan

I understand that if any benefits are cancelled for reasons other than spousal/partner coverage under another Group Plan, any future application for benefits may, in whole or in part, be rejected or restricted for a period of time. I agree that, if at a later date I wish to participate in the insurance hereby cancelled, I must submit, at my own expense, satisfactory evidence of insurability for myself and my dependents for whom application for coverage is made.

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

### G. Beneficiary for Life and Basic Accidental Death & Dismemberment Insurance

I appoint the following beneficiary(ies) for my Life and Accidental Death & Dismemberment Insurance. This appointment supercedes any previous appointments I may have made for these monies and I reserve the right to change the beneficiary(ies) named below.

**Select one**     To the person(s) listed below                       To my estate

<i>Last name</i>	<i>First name</i>	<i>Relationship (spouse/partner, son, daughter)</i>	<i>Address</i>	<i>% payable to each</i>

**TOTAL**      **100%**

If any of the individuals (beneficiaries) listed above die before me, the amount payable to him/her shall be paid as follows.

**Select one**     Equally to the persons listed above who survive me                       To my estate  
 To the persons listed below who survive me

<i>Last name</i>	<i>First name</i>	<i>Relationship (spouse/partner, son, daughter)</i>	<i>Address</i>	<i>% payable to each</i>

**TOTAL**      **100%**

### H. Appointment of Trustee *(Complete only if Beneficiary is under the age of majority)*

I do hereby appoint \_\_\_\_\_ as Trustee and authorize the Trustee to receive any amount due to the beneficiary of mine under 18 years of age. The receipt of the Trustee shall be a good discharge to the payer(s) of such monies for the amount paid. The Trustee is hereby authorized and directed to expend all or any portion of such amount and/or the income therefrom solely for the maintenance or education of such beneficiary and to pay the remainder to that beneficiary upon he or she reaching the age of 18 years.

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

### I. Declaration of consent and authorization

In order to administer your Alberta School Employee Benefit Plan (ASEBP) group benefit plans and to adjudicate your claims; ASEBP will have to collect personal and expense reimbursement information (with supporting documentation) for you or any of your dependents claiming benefits under these plans.

It may be necessary for ASEBP to disclose some or all personal information to its staff, any consultants hired by ASEBP and to your employer for these purposes. Personal information disclosed to your employer is restricted to information necessary for administering each group benefit plan you enrolled in.

On behalf of my dependents and myself, I consent to the collection, use and disclosure of personal information as described above or provided on claims I submit. I may revoke my consent at any time and acknowledge that doing so may affect my eligibility to receive group benefits. I understand why the information is required and am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize my employer to regularly deduct from my pay, any contribution to be made by myself for these benefits. Should the information provided change, I understand that it is my responsibility to advise my employer immediately.

I agree to the above and declare that my statements in this enrolment application are complete, accurate and true.

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

### J. For office use only

Date of employment	Date eligible for benefits	Date benefits received