GROUP INSURANCE ENROLMENT

INSTRUCTIONS:
Please return to your employer within 31 days.

A. PERSONAL

Employer name: _____ Employee no.: _____

Last name: _____ First name: _____ ASEBP ID (if available): _____

Mailing address (PO Box/RR/suite/apt #/street): _____ Sex at birth: ☐ Male ☐ Female

City: _____ Province: _____ Postal code: _____ FTE: _____ Salary: _____

Phone number (including area code): _____ Date of birth: _____ / _____ / _____ (YYYY/MM/DD)

Email address: _____
(A personal email is recommended to receive timely information on how to access your benefits.)

Marital status: ☐ Single ☐ Common-law spouse/partner

☐ Married Date of cohabitation YYYY/MM/DD): _____

B. BENEFITS

Do you have provincial health care coverage? ☐ Yes ☐ No

Are you or any of your dependants on active duty in any military, naval, air force, including as a member of the reserves of any country or peacekeeping force? ***Note:*** *If yes, coverage under this plan will exclude expenses or claims if incurred when on active duty.*

☐ Yes ☐ No

Select which benefits you require by checking off the level of coverage:

Benefit	For myself	For myself and my dependant(s)
Life, Accidental Death & Dismemberment and Extended Disability Benefits	☐ ***Note:*** *If selected, you'll be required to complete the Appointment of Beneficiary(ies) form as well.*	n/a
Extended Health Care	☐	☐
Dental Care	☐	☐
Vision Care	☐	☐

C. DEPENDANT INFORMATION

Last name	First name	Relationship	Sex	Date of birth (YYYY/MM/DD)

D. REFUSAL OF BENEFITS

Complete only if you are declining one or more benefits.

I understand the group insurance plan being offered to me, but decline to participate in (check the applicable categories):
Note: *You cannot waive Life, Accidental Death & Dismemberment or Extended Disability Benefits if they're a condition of employment. These benefits are mandatory if you wish to participate in Extended Health Care, Dental Care or Vision Care coverage.*

Life, Accidental Death & Dismemberment and Extended Disability Benefits		☐ Waived/declined
Extended Health Care	☐ Covered under spouse/alternative plan	☐ Waived/declined
Dental Care	☐ Covered under spouse/alternative plan	☐ Waived/declined
Vision Care	☐ Covered under spouse/alternative plan	☐ Waived/declined

I agree that if at a later date I wish to participate in the insurance hereby declined, I must submit a change application to my employer requesting to participate. Coverage will be effective the first of the month following the date the change application form is received.

Please sign here only if you are declining or waiving coverage.

Signature: _____ Date: _____

E. DECLARATION OF CONSENT AND AUTHORIZATION

I understand that the Alberta School Employee Benefit Plan (ASEBP) must collect, use, maintain and disclose personal information for the purposes of enrolling myself and my dependants, if any, in the ASEBP benefit plans and services and for determining eligibility for coverage, assessment, paying claims, audit, investigation, and administering the benefit plan. I understand that it may be necessary for the ASEBP to disclose some or all of my personal information to third party service providers or my employer for some of these purposes as is reasonable. I acknowledge that where third-party service providers are retained, ASEBP ensures that appropriate contracts or terms of service are in place to protect personal information.

By providing my email address, I understand that ASEBP may use my email address to notify me of transactions on my account, changes or information related to ASEBP and its various benefit plans and services, to provide information specifically related to my benefit coverage/utilization/experience or to conduct surveys regarding my experience with ASEBP.

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.

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.

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: _____

Consent is obtained in accordance with sections 7, 8, 9 and 61 of the *Personal Information Protection Act* (PIPA) 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 or contact the privacy officer at 780-438-5300.

F. FOR OFFICE USE ONLY

Date enrolment form received in office:	Date of employment:	Date eligible for benefits: