



Allendale Centre East  
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 Phone: 1-877-431-4786  
 www.asebp.ca

# CHANGE APPLICATION

## INSTRUCTIONS:

Please return to your employer within 31 days.

## A. PERSONAL INFORMATION

Employer name: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ ASEBP ID: \_\_\_\_\_

Employee status:  Working  Leave of absence  Disabled  Other: \_\_\_\_\_

Previous name (if applicable): \_\_\_\_\_

Apt./suite no: \_\_\_\_\_ Street address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal code: \_\_\_\_\_

Phone number (incl. area code): \_\_\_\_\_ Date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 YYYY MM DD

Email (optional): \_\_\_\_\_

## B. REASON FOR CHANGE

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

Address change  
 Change date (YYYY/MM/DD): \_\_\_\_\_

Change in marital status  
 Change date (YYYY/MM/DD): \_\_\_\_\_  
 Type of change:  Marriage/divorce  Other: \_\_\_\_\_

Are any of your dependants on active duty in any military, naval or air force of any country or peace keeping force?  Yes  No  
*Note: If yes, they are not eligible for coverage under this plan.*

Add common-law spouse/partner  
 Cohabitation date (YYYY/MM/DD): \_\_\_\_\_

Birth/adoption/guardianship  
 Birth/adoption/guardianship date (YYYY/MM/DD): \_\_\_\_\_  
*Note: If change is adoption or guardianship, you'll need to provide a copy of the legal guardianship papers to your employer.*

Loss of spousal/alternative coverage  
 Loss date (YYYY/MM/DD): \_\_\_\_\_  
*Note: Please include a letter from the employer providing coverage indicating date and reason for termination of benefits.*

Other (please explain below)  
 Event date (YYYY/MM/DD): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**C. CHANGES IN BENEFITS**

**Do not complete this section if your reason for change above was an address change.**

Select which benefits you need to **either add or remove** by checking off the appropriate box(es) below. Ensure that you're only selecting one box per row.

Benefit	Add		Remove	
	For myself	For myself and my dependant(s)	Covered under spouse/alternative coverage	Waived/declined
Life, Accidental Death & Dismemberment and Extended Disability Benefits	<input type="checkbox"/> <sup>1</sup>	n/a	n/a	<input type="checkbox"/> <sup>2</sup>
Extended Health Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<sup>1</sup> If selected, you'll be required to complete the *Appointment of Beneficiary(ies)* form as well.

<sup>2</sup> You cannot waive Life, Accidental Death & Dismemberment or Extended Disability Benefits if they are a condition of employment. These benefits are mandatory if you wish to participate in Extended Health Care, Dental Care or Vision Care coverage.

I understand that if any benefits are cancelled for reasons other than spousal/alternative coverage under another Group Plan, any future application for benefits may, in whole or part, be rejected or restricted for a period of time and subject to late applicant restrictions. 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 dependants for whom application for coverage is made. If approved, deductibles will apply to dental and vision coverage and remain in effect for one year from the effective date of coverage or until the deductibles are satisfied, whichever occurs first.

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

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

**Complete the following only if you wish to terminate all of your benefits with ASEBP.**

Termination date (YYYY/MM/DD): \_\_\_\_\_ at 11:59 p.m.

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: \_\_\_\_\_

**D. DEPENDANT INFORMATION**

Last name	First name	Relationship	Sex	Date of birth (YYYY/MM/DD)	Benefits (add or remove)

## E. DECLARATION OF CONSENT AND AUTHORIZATION

The personal information contained herein is required for the purpose of 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: \_\_\_\_\_

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. 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/privacy](http://www.asebp.ca/privacy), or contact the privacy officer at 780-438-5300.

## F. FOR OFFICE USE ONLY

Date change application received in office	Date of employment	Date eligible for benefits