Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7

EARLY RETIREE BENEFIT COVERAGE APPLICATION

INSTRUCTIONS:

1. Please make a copy of this completed application form for your records.
2. Check applicable box below to confirm the following (see Part 2, Section B for additional details):
   - ☐ **I authorize ASEBP to begin automated withdrawals** for payment of my benefit premiums from the bank account currently on file (please login to your My ASEBP account to confirm) OR
   - ☐ a **blank personalized cheque marked *"VOID"*** or bank account information obtained from your financial institution is attached
3. Check box to confirm the following documents are attached:
   - ☐ a copy of your **birth certificate, or government issued proof of age**
   - ☐ ***Appointment of Beneficiary(ies)*** form(s)
4. Complete Parts 1, 2 and 3. **Forward the completed application and all the above documents to your employer.**
5. Your application must be received by the Alberta School Employee Benefit Plan (ASEBP) from your employer **within 31 days of your retirement date**. Please ensure you provide the application with your portions completed to your employer in advance of your retirement date to ensure this deadline is met. If your application is received after the application deadline, it will be declined.
6. ASEBP will notify you after reviewing your application to either request additional information or to advise you that your application was approved or declined.

PART 1 – Applicant & Benefits Information

A. Applicant Information

Last name: _____ First name: _____ ASEBP ID #: _____

Mailing address: _____ Gender:

City: _____ Province: _____ Postal code: _____ ☐ Female ☐ Male

Home phone #: _____ Daytime phone #: _____ Birth date:

Email address (optional): _____ _____ / _____ / _____
YYYY MM DD

B. Benefits Selection & Changes

Your benefits selection will be effective on the first day following your last day worked. Any benefits you previously waived cannot be included in your Early Retiree Benefits. Please note that if you are currently participating in Life and Accidental Death & Dismemberment (AD&D), these benefits will continue as mandatory benefits. Extended Disability Benefits and spending accounts are not available under the Early Retiree Benefits plan.

Continuation of Current Coverage (refer to your ASEBP ID card for your current benefit selection)

☐ By checking this box, I confirm that I wish to continue all ASEBP benefits I am currently participating in, excluding Extended Disability Benefits and spending accounts, **with no changes.**

☐ By checking this box, I confirm that I wish to continue all ASEBP benefits that I am currently participating in, excluding Extended Disability Benefits and spending accounts, **with the changes indicated in the Changes to Coverage section**.

Changes to Coverage

** Please confirm with your employer if any of your benefits are a condition of employment. If so, you are unable to select waived.*

If you would like to make changes to your current level of coverage for Extended Health Care, Dental Care and/or Vision Care benefits, please select your new coverage level below. In order for ASEBP to accept the changes you are requesting for your Early Retiree Benefits, you must select the second checkbox in the **Continuation of Current Coverage** section.

Extended Health Care	☐ Single	☐ Family	☐ Covered under spouse/alternative coverage	☐ Waived*
Dental Care	☐ Single	☐ Family	☐ Covered under spouse/alternative coverage	☐ Waived*
Vision Care	☐ Single	☐ Family	☐ Covered under spouse/alternative coverage	☐ Waived*

Note: If you need to make a change that increases your coverage, e.g., going from Single to Family, please complete a *Change Application*, available in the Forms section of our website, www.asebp.ca, and submit it to your employer.

PART 2 – Terms and Conditions

A. General

Eligibility

I declare that I:

- am between the ages of 50 and 64 inclusive;
- am a resident of Canada;
- am maintaining provincial health care coverage;
- completed a minimum of five consecutive years with a participating ASEBP employer(s) immediately preceding my last day of work;
- am enrolled in ASEBP benefits immediately preceding my retirement date; and as such, am eligible to participate in ASEBP's Early Retiree Benefits.

I will advise ASEBP of any changes to the conditions listed above.

Changes to Benefits

Your Early Retiree Benefits are provided as an extension of the group plan provided by your former employer. As such, you are still tied to the group benefits your former employee group is enrolled in. Changes to those benefits will affect you. Changes may include, but are not limited to, adding or removing benefits, changes to maximums, moving between plan options (e.g. EHC plan 2 to plan 1).

Be advised that ASEBP also reserves the right to make changes to its Early Retiree Benefit Plan at any time, including after retirement of Early Retirees. Any changes made (e.g. adding or removing any benefits, reducing or increasing benefits, etc.) may affect the benefits you have enrolled in as a retiree, even if you enrolled in the benefit plan prior to the changes being implemented.

Increasing coverage or adding a dependant

I understand that:

- If I enrol in "single" coverage under Extended Health Care, Dental Care, and/or Vision Care and subsequently wish to apply for "family" coverage after gaining a dependant (e.g., spouse, child, etc.), I must apply **within 31 days** of gaining the dependant
- If I am enrolled under Life and Accidental Death & Dismemberment and covered under spouse/alternative coverage for general health benefits, I may opt up to "single" or "family" coverage **within 31 days** of involuntary loss of spousal/alternative coverage. ASEBP will require written confirmation of the involuntary loss of spousal/alternative coverage from the employer or benefits carrier.
- If I waived or declined benefit coverage, I cannot enrol in those benefits at a later date.

Decreasing coverage or removing a dependant

I understand that:

- If I wish to switch from "family" coverage to "single" coverage for Extended Health Care, Dental Care, and/or Vision Care, I can do so without penalty by notifying ASEBP.
- Once I have retired, I cannot opt out of individual plans.

Other changes affecting coverage for dependants

I understand that if I am enrolled in "family" coverage for Extended Health Care, Dental Care, and/or Vision Care and subsequently wish to add an eligible dependant that is not enrolled, I must apply **within 31 days** of gaining the dependant.

Termination of Benefits

I understand that once I enrol in Life, Accidental Death & Dismemberment, Dental Care, Extended Health Care and/or Vision Care coverage, my coverage will remain in place until the earliest of the following dates:

- the date the policy or plan terminates;
- the date one or more benefits within the early retirement package terminates;
- the date the employee group at my school jurisdiction terminates its participation in ASEBP benefits;
- the first premium due date for which payment is not made;
- the date I am no longer eligible (the last day of the month in which I turn age 65);
- the date I request termination of coverage

I understand that once my dependants are enrolled in Dental Care, Extended Health Care and/or Vision Care coverage, their coverage will remain in place until the earliest of the following dates:

- the date my coverage terminates;
- the date my spouse ceases to be eligible under the definition of dependant;
- the date my dependent child ceases to be eligible under the definition of dependant;
- the date I request termination of coverage.

B. Premiums

Personal Pre-Authorized Debit (PAD) Agreement

I understand that the following conditions apply:

a) I'll pay the monthly premium amount noted in my approval letter and a monthly statement won't be issued
b) I'll receive notification of changes in the monthly amount payable due to:
   - Premium rate adjustments, which typically occur in September as authorized by ASEBP Trustees
   - A change in benefit coverage (e.g., from "single" to "family" coverage)
c) My premium payment will automatically be withdrawn from my bank account on the 15th of each month. If the 15th falls on a weekend, the withdrawal will occur on the next business day
d) Premiums are billed in complete months and if my benefits terminate prior to the last day of the month, I will remain responsible for the full month's premium
e) If there is a change in coverage that takes effect part way through a month (e.g. a change from "family" to "single" status), the premium and coverage in effect at the beginning of the month will stay in effect until the end of that month. On the first day of the following month, the new coverage will come into effect and ASEBP will charge me the new premium
f) I understand that I will not receive credits or refunds for premiums already paid
g) I will notify ASEBP of any changes to my banking information

My authorization will remain in effect until 30 days written notification of cancellation is issued by either myself or ASEBP. To obtain a sample cancellation form or for more information on my right to cancel this PAD agreement I may contact my financial institution or visit www.cdnpay.ca.

If ASEBP makes a withdrawal in error or for the incorrect amount, I will notify ASEBP as soon as possible. If ASEBP is aware of an error, ASEBP will correct the error and notify me as soon as possible.

I have certain recourse rights if any debit does not comply with this agreement. For example, I have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my recourse rights, I may contact my financial institution or visit www.cdnpay.ca.

If you have any questions about this PAD Agreement, please contact ASEBP. You can find our contact information on our website, www.asebp.ca.

Non-Payment of Premiums

If my benefits are terminated due to non-payment of premiums, coverage will end and I will not be able to re-enrol in benefits until I make restitution, which may include payment of premiums, interest, NSF charges and claims paid after termination. I understand that ASEBP retains the right to deny re-enrolment should coverage be terminated due to non-payment of premiums.

PART 3 – Consent and Declaration

A. Consent and Authorization for Use of Personal Information

I understand that ASEBP must collect, use and disclose the personal information contained herein in order to administer the group benefit plans and health spending account that I am enrolled in and to deposit payments to or withdraw premium payments from my bank account.

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.

B. Application Declaration

I have read and agree to the terms and conditions in this application 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 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 www.asebp.ca or contact the privacy officer at 780-438-5300.

Once complete, please return this form to your employer. Your employer will complete Part 4 and submit the completed form to ASEBP on your behalf.

PART 4 – To Be Completed By Employer

Employee name: _____

Employer name: _____

Retirement date (last day of employment) (YYYY/MM/DD) _____ / _____ / _____

Employee's annual salary prior to retirement $_____

☐ All historical ***Group Insurance Enrolment***, original ***Appointment of Beneficiary(ies)*** and ***Change Application*** forms are attached, if available.

Has this employee been offered a contract with benefits immediately after their retirement date?

☐ **If yes, please submit an enrolment transaction for this employee.** Contract start date (YYYY/MM/DD) _____ / ____ / ____

☐ No, ASEBP will terminate their benefits and Health Spending Account.

☐ No, ASEBP will terminate their benefits and leave their Health Spending Account active.

If the employee is retiring and not entering into a contract, are premiums paid by the employer?

☐ Yes, until (YYYY/MM/DD) _____ / _____ / _____

☐ Yes, until age 65

☐ No, the employee will pay them

Please verify which benefits are a condition of employment:

☐ Extended Health Care ☐ Dental Care ☐ Vision Care ☐ N/A

I have confirmed this employee's personal information, names of any dependants and beneficiaries are up-to-date. I certify that according to the records of this organization, the information contained on this application is correct.

Employer's signature: _____ Date: _____

Employer's title: _____ Phone #: _____

APPOINTMENT OF BENEFICIARY(IES)

Life and Accidental Death & Dismemberment Insurance

HARD COPY ORIGINAL OF COMPLETED FORM TO BE MAINTAINED BY EMPLOYER OR ASEBP

INSTRUCTIONS:

1. Please complete required sections A, B and F, along with sections C and D if applicable. Failure to complete this form in its entirety may result in proceeds being paid to your estate.
2. **Return the *original* completed form to your employer unless you are an Early Retiree or are participating in ASEBP's Supplemental Package, in which case return the *original* completed form directly to ASEBP.**

A. Applicant information

Last name: _____ First name: _____ ASEBP ID #: _____

Mailing address: _____

City: _____ Province: _____ Postal code: _____

Daytime phone: _____ Mobile/Alternate phone: _____

Employer's name (if applicable): _____

Email address (optional): _____ Birth date: _____ / _____ / _____
MM *DD* *YYYY*

B. Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance

I appoint the following beneficiary(ies) for my Life and Accidental Death & Dismemberment Insurance. This appointment supersedes any previous appointments I may have made for these proceeds and I reserve the right to change the beneficiary(ies) named below. If any of the beneficiaries predecease me, I understand their portion will be divided equally among any surviving beneficiaries.

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

Last Name	First Name	Relationship	Birthdate (YYYY/MM/DD)	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov, Postal Code)	Phone number (including area code)	% payable to each (must equal 100%)
					TOTAL	100%

C. Contingent Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance

Your contingent beneficiary(ies) will receive the proceeds of your policy if your primary beneficiary(ies), as indicated in Section B, is deceased at the time of your death.

If all beneficiaries listed in Section B are deceased at the time of your death, the amount payable to your contingent beneficiary(ies) shall be paid as follows.

Select one ☐ To the person(s) listed below

☐ To my estate

Last Name	First Name	Relationship	Birthdate (YYYY/MM/DD)	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov., Postal Code)	Phone number (including area code)	% payable to each (must equal 100%)
					TOTAL	100%

D. Appointment of Trustee *(Complete only if one or more beneficiaries is under the age of majority.)*

Note: Your Trustee cannot be a named beneficiary.

I appoint _____ of _____
(Name) (Suite/Apt/Unit no., Street, P.O. Box, City, Prov, Postal Code)

reached at _____ as Trustee and authorize ASEBP to pay any amount payable to any beneficiary under 18 years of age to the Trustee. I authorize the Trustee to have access to the insurance proceeds and manage the funds as directed in my last will and testament and to pay the remaining balance to the beneficiary once he/she reaches the age of majority.
(Phone number)

E. Consent and Authorization

I understand that the ASEBP must collect, use and disclose the personal information contained herein in order to administer the Life and Accidental Death and Dismemberment Insurance policies. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to your employer or the third party service provider 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 eligibility to receive Life and Accidental Death and Dismemberment Insurance benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, individuals who derive a benefit from an insurance policy or benefit plan (the beneficiaries named herein) are deemed to consent to the collection, use, and disclosure of their personal information for the purpose of coverage under those plans.

Your employer and/or ASEBP is required to keep a hard copy original version of your completed beneficiary form. By signing below you agree to the storage of this document and the information, including your signature, which it contains.

F. Acknowledgement

I agree to the above and declare that my statements 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 or contact the privacy officer at 780-438-5300.