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

DECLARATION AND BENEFITS APPLICATION FOR PART-TIME EMPLOYEES

INSTRUCTIONS:

1. Please send the completed application form to our office by mail, fax (780-438-5304) or scan and email to benefits@asebp.ca.
2. Attach the following documents:
   - ☐ **Blank personalized cheque marked** ***"VOID"*** or bank account information obtained from your financial institution, **and**
   - ☐ Completed original **Appointment of Beneficiary(ies)** forms (located under the Forms tab on our website).
3. ASEBP must receive your completed application **within 31 days of obtaining a part-time contract.** If you return the completed application after the 31 day period, you will need to provide ASEBP with satisfactory medical evidence of good health. Dental Care deductibles will apply until the full deductible amount is reached or 12 months have elapsed from the effective date of coverage.
4. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's privacy statement at **www.asebp.ab.ca/about/privacy.html** or contact the Privacy Officer at 780-438-5300.
5. For more information, please refer to the *Part-time Employee Benefits online guide*, under the Benefits and Services tab on our website.

PART 1 – Eligibility (to be completed by employer)

A. Declaration of Eligibility to Participate in Benefits

I declare that this employee is:

- currently working a minimum of 0.2 FTE;
- associated with an employee group that is participating in ASEBP benefits;
- under age 65;
- a resident of Canada;
- ineligible for group employment benefits through an ASEBP participating employer or other school jurisdiction; and
- not participating in ASEBP early retirement benefits.

As such, this employee is eligible to participate in ASEBP *Benefits for Part-time Employees*.

This employee obtained a part-time contract with ______________________________
(Name of ASEBP participating employer)

as of ______________________________.
(Date (YYYY/MM/DD) employee obtained part-time contract)

☐ Teacher ☐ Non-Teacher FTE Level: ________ Group: ______________________________
(name of employee group, e.g., Educational Assistant)

Name of employer representative______________________________ Phone #: ______________________

Employer signature: ______________________________

PART 2 – Applicant Information and Benefits Selection (to be completed by employee)

A. Applicant Information

Last name: ______________________________ First name: ______________________________

Mailing address: ______________________________ Gender: ☐ Female ☐ Male

City: ______________________ Postal code: ______________________ Birth date:

Home phone #: __________________ Work phone #:______________________________ _____/ _____/ _____

Email address: ____ YYYY MM DD

B. Declaration of Other Benefits Coverage

1. Are you enrolled in provincial health care coverage (e.g. the Alberta Health Care Insurance Plan)? ☐ Yes ☐ No
2. Do you have other group employment benefits coverage? ☐ Yes ☐ No

   If yes, are these other benefits with a school jurisdiction? ☐ Yes ☐ No

C. Benefits Selection

You must participate in the benefits as listed within each package. **Dental Care coverage is optional and can be added for an additional premium.** Please refer to the premium sheet for package rates. Click here to access the premium rate sheet. **If you wish to add Dental Care to your selected package, please check the Add Dental Care (*Plan 2*) box. If you choose to participate in Dental Care at a later date, you and your dependants will be considered late applicants and will be subject to deductibles for the first 12 months.**

Please select your package below:

☐ **Package 1**
Life Insurance *(Plan 2)* $25,000
AD&D *(Plan 2)* $25,000
Extended Health Care *(Plan 2)* Single
Add: ☐ Dental Care *(Plan 2)* Single

☐ **Package 2**
Life Insurance *(Plan 2)* $25,000
AD&D *(Plan 2)* $25,000
Extended Health Care *(Plan 2)* Family
Add: ☐ Dental Care *(Plan 2)* Family

☐ **Package 3**
Life Insurance *(Plan 2)* $50,000
AD&D *(Plan 2)* $50,000
Extended Health Care *(Plan 2)* Single
Add: ☐ Dental Care *(Plan 2)* Single

☐ **Package 4**
Life Insurance *(Plan 2)* $50,000
AD&D *(Plan 2)* $50,000
Extended Health Care *(Plan 2)* Family
Add: ☐ Dental Care *(Plan 2)* Family

PART 3 – Dependants' Information

A. Declaration of Eligibility for Dependants

The definition of a dependant is as follows:

Spouse legally married to, or in an adult interdependent relationship with, the covered member.

Child ASEBP requires that children be registered on a parent's provincial health care plan. Child dependant provisions are as follows:

- Single children under 21 who are wholly dependent on a parent, including adopted children, foster children (if an income tax deduction was claimed), and wards of the court.
- Single children 21 years of age or older and wholly dependent on a parent because of physical or mental disabilities.
- Single children under 25 years of age who are enrolled in three or more courses at an accredited educational institute.
- Single and unemployed dependant over the age of 21, dependent on the covered member by reason of mental or physical disability. Please contact a Benefit Specialist for more information on eligibility and how to apply.

Based on the definitions above, do you have dependants?

☐ Yes. Please list your dependants in the table below.
☐ No. Please proceed to **Part 4.**

Please list all your dependants.

Last name	First name	Relationship *(spouse, partner, son, daughter)*	Birth date *(YYYY/MM/DD)*

PART 4 – Consent and Declaration

A. Consent and Authorization for the Use of Personal Information

ASEBP requires the personal information contained herein in order to enrol you and any dependants you may have, in and administer the group benefit plans. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to your employer and third party service providers 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, and my dependants' ability 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.

Signature: ______________________________ Date: ______________________