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

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): ____________

Apt./suite no.: ______ Street address: ____________________ Sex at birth: ☐ Male ☐ Female

City: ____________ Province: ________ Postal code: ________ FTE: ______ Salary: ______

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

Email address (optional): ____________________

Marital status: ☐ Single ☐ Married ☐ Common-law spouse/partner
Date of cohabitation (YYYY/MM/DD): ________

B. BENEFITS

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

Are any of your dependants on active duty in any military, naval or air force of any country or peace keeping force?
Note: *If yes, they are not eligible for coverage under this plan.*

☐ 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 are 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, at my own expense, satisfactory evidence of insurability for myself and my dependants for whom application for coverage is made. Such evidence of insurability will not be required if my spouse's/partner's coverage terminates and I apply for coverage under this group plan within 31 days of the termination date.

I also recognize that if any benefits are declined, any future application for benefits may, in whole or in part, be rejected or restricted for a period of time.

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

Signature: ______________________________ Date: ______________________________

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 the 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.

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* 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.

F. FOR OFFICE USE ONLY

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