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Edmonton | Alberta | T6H 2K7
Phone: 1-877-431-4786
Fax: 1-780-438-5304
www.asebp.ca

MyRETIREE PLAN
BENEFIT APPLICATION

INSTRUCTIONS

1. Fully complete the Eligibility Requirements and Parts 1, 2, 3 and 4.
2. Sign the application.
3. If you are under 65 and eligible for our Life and AD&D insurance, please complete the *Appointment of Beneficiary(ies)* form and submit it with the completed application.
4. If you currently have or previously had benefits through another provider, please complete the *Coordination of Benefits* form and submit it with the completed application.

Forward the completed application, along with the *Appointment of Beneficiary* and *Coordination of Benefits* forms (if applicable), by **email** to benefits@asebp.ca, **mail** (address above), or **fax** to 780-438-5304.

ELIGIBILITY REQUIREMENTS

I declare that I am/have:

- ☐ A current or previous employee of an eligible Alberta public school board
- ☐ Age 50 or older at the time of retirement
- ☐ A Canadian resident (excluding Quebec residents)
- ☐ Provincial health care coverage
- ☐ A surviving partner who meets eligibility or whose deceased partner meets eligibility and was an employee of a qualifying Alberta public school board. Deceased's First Name Last Name

Also, please indicate your understanding and acceptance of the following statement:

- ☐ I am enrolled, or I will enrol (prior to turning 65), in my provincial or territorial healthcare plan (i.e. Alberta Coverage for Seniors program), which will become the first payor.

PART 1 – APPLICANT and BENEFITS INFORMATION

A. Applicant Information

Name First Name Last Name	ASEBP ID (if available)	Date of birth YYYY/MM/DD
Mailing address (PO Box/RR/suite /apt #, street)		Daytime phone no. (area code-xxx-xxxx)
City/town	Province	Postal code
Please email my benefits information and ID card to: A personal email is recommended to easily create and access your My ASEBP account. You can view your benefit information and print or download your ID card there. Alternatively, contact ASEBP for a mailed copy.	Name of current or former Alberta public school board employer: Retirement date: YYYY/MM/DD	
Termination date of any current benefits: YYYY/MM/DD **Note:** benefits will start the day after your current benefits terminate (if your application is received within 31 days of termination) or the 1st of the month following termination if you don't currently have benefits.	If you are in receipt of or will receive benefits through a contract position that starts immediately after your retirement date, indicate the contract start YYYY/MM/DD and end dates YYYY/MM/DD . ☐ N/A	

B. Benefit Plan Choices

Choose Enhanced or Core under the **Extended Health Care and Vision Care** column, including level (single, couple or family) and the **Dental Care** column (if chosen). **Note: ***while dental coverage is optional, if you decline coverage now, you cannot opt-in later unless you are currently participating in a dental plan through another carrier and can provide ASEBP with proof of loss of coverage. **If you choose an Enhanced plan, including Dental Care Option 1 or 2, you must maintain a minimum level of Single coverage for two years before choosing the Core Plan. You can change from Core to Enhanced at any time.

In addition, if you are coordinating benefits through your partner or another carrier, you will also need to provide ASEBP with proof of loss of coverage. You can find more information at www.MyRetireePlan.ca.

Extended Health Care and Vision Care:
Mandatory

☐ **Enhanced****
Extended Health + Vision Care

	Single	Couple	Family
EHC Coverage	☐	☐	☐
Vision Coverage	☐	☐	☐

OR

☐ **Core**
Extended Health + Vision Care

	Single	Couple	Family
EHC Coverage	☐	☐	☐
Vision Coverage	☐	☐	☐

***Dental Care:**
Optional

☐☐ I decline dental coverage (*see note above)

OR (choose one of the following plans)

	Single	Couple	Family
☐ Enhanced** Option 1	☐	☐	☐

OR

	Single	Couple	Family
☐ Enhanced** Option 2	☐	☐	☐

OR

	Single	Couple	Family
☐ Core	☐	☐	☐

Coordination of Benefits

If this section is applicable to you, please read each statement carefully and check all boxes.

I have benefits under my partner/alternative provider, and I acknowledge and understand that:

☐ By selecting this option, I am currently choosing to waive/terminate EHC/Vision and/or Dental.

☐ I will need to provide ASEBP with proof of loss of coverage and complete a MyRetiree Plan Change Application form to reinstate these benefits.

☐ Failure to provide proof of loss of coverage will result in these benefits remaining terminated.

Life and AD&D Insurance
If you are under 65 at the time of your retirement, and you currently or previously had Life and AD&D insurance with ASEBP, this insurance is mandatory and is 2x your pre-retirement employer salary. You benefit from retaining a group rate and are encouraged to visit our MyRetiree Plan site and request a quote for premium calculations.

C. Eligibility for Dependants (required if couple or family coverage selected)

The definition of a dependant is:
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-dependent 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 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.

Please list all your dependants:

First name	Last name	Sex	Birth Date (YYYY/MM/DD)	Relationship (i.e. spouse, son, etc.)
			/ /	
			/ /	
			/ /	
			/ /	

PART 2 – TERMS and CONDITIONS

A. Termination of Benefits

I understand that once enrolled, my coverage will remain in place until the earliest of the following dates:

- the date the policy or plan expires
- the first of the month in which the first premium payment is not made
- the date I request termination of coverage

I understand that once my dependants are enrolled, their coverage will remain in place until the earliest of the following:

- the date my coverage expires or changes (i.e. drug maximums)
- the date my spouse or partner 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 (ASEBP does not accept credit card payments).

I understand that the following conditions apply:

a) I'll pay the monthly premium amount noted in my approval letter
b) A monthly statement won't be issued
c) 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)
d) My premium payment will be automatically withdrawn from my bank account on the 15th of each month until the amount owning has been paid in full. If the 15th falls on a weekend, the withdrawal will occur on the next business day
e) 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
f) If there is a change in coverage that takes effect partway 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 remain 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
g) I will not receive credits or refunds for premiums already paid
h) If needed, I will update my banking information by logging into My ASEBP.

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 payments.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. I may contact my financial institution or visit payments.ca to obtain more information on my recourse rights.

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

☐ **I authorize ASEBP to begin automated withdrawals** for payment of my benefit premiums for the bank account currently on file (please log in to your My ASEBP account to confirm) OR
☐ A **blank personalized cheque marked "VOID"** is attached OR
☐ **I authorize ASEBP to begin automated withdrawals** for payment for my benefit premiums from the account provided below:

Withdrawal account number (seven to 12 digits):
Branch transit number (five-digit number):
Financial institution number (three-digit number):
Financial institution name:
Branch address (including city and postal code):

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.

C. Claim Payments

Direct deposit will be used for general health benefit claims payments (if applicable) made to you by ASEBP. Direct deposit ensures that payment is made directly into your bank account and provides:

- Faster and safer service than mailing a cheque to you
- Protection from delays during postal disruptions
- Automatic deposits to your bank account if you are away from home

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 and provided in the future while coverage is maintained to administer the group benefit plans that I am enrolled in, and to deposit payments to or withdraw premium payments from my bank account. It may be necessary for ASEBP to disclose some, or all the personal information contained herein to 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' 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.

I also confirm that I:

- ☐ Have signed the application.
- ☐ Have completed the *Appointment of Beneficiary(ies)* form (if under 65 and eligible) and submitted it with the completed application.
- ☐ Have completed the *Coordination of Benefits* form (if applicable) and submitted it with the completed application.
- ☐ Have kept a copy of this completed application form (plus all other applicable forms) for my records.
- ☐ Will advise ASEBP within 31 days of any changes to my eligibility.
- ☐ Understand that dental coverage is optional and if I decline coverage now, I cannot opt-in later unless I currently have dental coverage through another carrier and provide ASEBP with proof of loss of coverage within 31 days of losing coverage.
- ☐☐ Understand that, as the plan member, I alone am fully responsible for all claims made under my membership by myself and my dependants, and that I am answerable to any errors, abuse or fraud stemming from these claims.

Signature: First name Last Name Date: YYYY/MM/DD

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 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.

PART 4 – HOW DID YOU HEAR ABOUT THE MYRETIREE PLAN?

Choose all that apply:

ASEBP:

- ☐ Website
- ☐ Social media post
- ☐ News article
- ☐ Staff (i.e., benefit specialist)
- ☐ Through my employer
- ☐ Online search (i.e., Google search)
- ☐ Teachers' Convention

An ad in/on:

- ☐ Google
- ☐ Cineplex theatre
- ☐ Facebook ad
- ☐ CASS Magazine
- ☐ ATA Magazine
- ☐ ATA News
- ☐ Ever Active Schools Magazine
- ☐ Other ASEBP ad online