



Suite 700 Weber Centre,  
5555 Calgary Trail,  
Edmonton, AB T6H 5P9  
Phone: 1 877-431-4786  
Website: www.asebp.ab.ca

# EXTENDED HEALTH CARE and VISION CARE CLAIM

**FAXED CLAIMS NOT ACCEPTED**

*Please answer all questions to support timely processing of your claim (see back for specific instructions).*

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/privacy.html](http://www.asebp.ab.ca/privacy.html), or contact the Privacy Officer at 780-431-4786.

## COVERED MEMBER'S INFORMATION *(Please print)*

Covered member's (employee's) name: \_\_\_\_\_

Mailing address: \_\_\_\_\_

GROUP	SECTION	MEMBER'S ASEBP ID NO.
1 9 9 3 0		

Postal code: \_\_\_\_\_ Phone number: \_\_\_\_\_

## CLAIM DETAILS *(Attach original receipts and invoices OR the Explanation of Benefits (EOB) from the other health benefit plan)*

PATIENT'S NAME	ASEBP ID NO.	BIRTH DATE (YYYY/MM/DD)	SERVICE DESCRIPTION OR PRESCRIPTION NUMBER	DATE OF SERVICE (YYYY/MM/DD)	D.I.N. (Prescriptions only)	CLAIM AMOUNT
1.						\$
2.						\$
3.						\$
4.						\$
5.						\$

## OTHER HEALTH BENEFIT COVERAGE

If you or your dependents have health benefit coverage through another health benefits company, insurance company or another ASEBP plan, please complete below. *If you claimed through the health benefit plan listed below first, please attach the EOB to this claim form.*

Name of other health benefits company or insurance company: \_\_\_\_\_

Dental     Vision     EHC/Prescription

Effective date of other coverage (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of person holding coverage: \_\_\_\_\_ Birth date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

## CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

I understand that the personal information contained in this claim form (with supporting documentation) and other personal information held by the Alberta School Employee Benefit Plan (ASEBP) is used to determine eligibility for this benefit, verify, assess and pay claims and administer my benefit plan. By submitting this claim form, I am requesting payment for the listed expenses based on my benefit plan guidelines.

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 dependents eligibility to receive group benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, my dependents 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 agree to the above and declare that my statements in this expense reimbursement request are complete, accurate and true.

Covered member's signature: \_\_\_\_\_ Date: \_\_\_\_\_

<b>ASEBP OFFICE USE ONLY</b>	<b>ASSIGNMENT OF BENEFITS: <i>(To pay the service provider directly)</i></b>  I hereby assign benefits payable for this claim to _____ and authorize payment directly to him/her/them. <span style="float: right;"><i>(Service Provider Name)</i></span>  Address: _____  Covered member's signature: _____
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