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

GREATER THAN 100 DAY SUPPLY OF PRESCRIPTION DRUGS REQUEST

OUTSIDE CANADA ONLY

This form should be submitted to ASEBP at least **five business days** before your scheduled departure date; however, if sent well in advance of your departure, it will be processed no earlier than **seven business days** prior. Fax completed form to 780-438-5304.

COVERED MEMBER'S INFORMATION *(Please print)*

Covered member's name: Last: _____ First: _____

Mailing address: _____

_____

GROUP	SECTION	ASEBP ID NO.
1 9 9 3 0		

Postal code: _____ Phone number: _____ Gender: ❑ M ❑ F

TRAVEL DETAILS

❑ **Personal** Optional out-of-country contact information (email or phone number): _____

Departure date: _____ Return date: _____ Destination: _____

❑ **Teacher Exchange/Secondment** Optional out-of-country contact information (email or phone number): _____

Departure date: _____ Secondment/Teacher exchange for an approved period starting: _____ to _____

Secondment/Teacher exchange location _____

PRESCRIPTION DETAILS

PATIENT'S NAME	ASEBP ID NO.	DRUG NAME	DRUG IDENTIFICATION NUMBER (DIN)	QUANTITY	DAYS SUPPLY
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

PHARMACY CONTACT

Pharmacy Licence number: _____ Pharmacy name: _____

Pharmacist/Contact name: _____ Phone number: _____

CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

In order to assess and verify eligibility for you and your dependants to purchase prescription drug supplies for greater than 100 days under the Alberta School Employee Benefit Plan (ASEBP) group benefit plans, ASEBP will need to collect, use and disclose the personal information contained herein.

I understand that in order to qualify for a "*Greater than 100 day supply,*" I must be outside Canada and must maintain Extended Health Care coverage through the ASEBP and provincial health care coverage for the duration of this request. If I should terminate my coverage or my coverage is terminated for any reason during the term of this request, I will reimburse ASEBP in part or in full for the costs related to the prescription drugs indicated above. I authorize ASEBP to monitor my coverage for the duration of this request.

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 should I do so, my request may not be considered.

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 agree to the above and declare that my statements in this application are complete, accurate and true.

Signature: _____ Date: _____