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

MEDICAL EVIDENCE OF GOOD HEALTH

SUBSTITUTE TEACHERS AND CASUAL STAFF

INSTRUCTIONS:

1. Please complete sections A, B and D if you selected ***Single*** coverage.
2. Please complete sections A, C, and D if medical evidence is being provided for a dependant.
3. Please return the completed form to Alberta School Employee Benefit Plan (ASEBP) or fax to 780-438-5304.
4. If you have any questions regarding the collection, use and disclosure of your personal information in **Section D**, please refer to our website at www.asebp.ca or contact our Privacy Officer at 780-438-5300 or by email at po@asebp.ca.

NOTE: Upon review of this completed form, additional medical information may be required from your (or your dependants') treating physician(s). If so, Alberta School Employee Benefit Plan (ASEBP) will contact you to obtain this information. You are responsible for any costs associated with producing the appropriate medical evidence.

A. Applicant information

School jurisdiction employed by: _____
If you are on more than one roster, please identify the jurisdiction you would like to be affiliated with for benefit coverage purposes.

Name: _____ Birth date: YYYY MM DD

Mailing address: _____ _____ / _____ / _____

Home phone #: (____) _____ Work phone #: (____) _____

E-mail address *(Optional)*: _____

☐ Substitute Teacher ☐ Casual staff _____
(*Name of employee group – e.g.: Maintenance, Clerical, Custodian, etc)*

B. Complete if requesting coverage on self (applicant)

☐ Male ☐ Female Height _____ Weight _____

1. Have you

	YES	NO
a) been absent from work because of sickness or injury during the last six months?	☐	☐
b) been in any hospital or other institution for observation, rest, diagnosis or treatment during the past five years?	☐	☐
c) ever used barbiturates, heroin, opiates or other narcotics except as prescribed by a physician, or ever been treated for alcoholism?	☐	☐
d) had any sickness or injury within the past 5 years resulting in your being away from work 10 days or more?	☐	☐
e) had or received advice or treatment for Acquired Immune Deficiency Syndrome (AIDS), hepatitis, unexplained persistent lymph gland enlargement, unusual infections or any other immune system abnormalities?	☐	☐
f) tested positive for antibodies to the AIDS (Type H-IV) virus?	☐	☐
g) been examined by or consulted a doctor or other practitioner during the past five years?	☐	☐
h) ever applied for or received benefits, compensation or pension on account of sickness or injury?	☐	☐
i) ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions?	☐	☐
j) any condition which may require any medication or medical/surgical attention now or in the future?	☐	☐
k) had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams?	☐	☐

2. Have you at any time been treated for or told you had any trouble with any of the following:

	YES	NO		YES	NO		YES	NO
a) Heart, chest pain	☐	☐	g) Nervous or mental disorders	☐	☐	m) Urinary system	☐	☐
b) High blood pressure	☐	☐	h) Arthritis or rheumatism	☐	☐	n) Goitre or glands	☐	☐
c) Abnormal pulse	☐	☐	i) Ulcers, stomach disorders	☐	☐	o) Pleurisy or asthma	☐	☐
d) Cancer or tumors	☐	☐	j) Intestines or kidney	☐	☐	p) Chronic diarrhea	☐	☐
e) Diabetes	☐	☐	k) Liver or gallstones	☐	☐	q) Neuritis or sciatica	☐	☐
f) Lungs	☐	☐	l) Sexually Transmitted Diseases	☐	☐	r) Back or spinal disorder	☐	☐

B. Complete if requesting coverage on self (applicant) - Continued

3. Have you any known indication of any physical disorder, deformity, defect or abnormality not disclosed in the answers to questions 1 and 2.
   ☐ Yes ☐ No

4. Please provide complete details to all the "yes" answers to questions 1, 2, and 3? *(If more space required, go to last page)*

Question no.	*Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment, and medication.*	*Began MM YYYY*	*Time lost from normal activities*	*Full Recovery MM YYYY*	*Doctors and hospitals Provide full name and addresses*

5. Are you currently taking any medication prescribed by a doctor? If yes, please provide the drug names, frequency, and dosage.

Drug name	Frequency	Dosage

6. Have you ever been declined or postponed for life or health insurance or had a policy rated up or waived or issued for a smaller amount than applied for? Yes ☐ No ☐

C. Complete only if requesting Extended Health Care coverage for dependant(s) - List dependant(s) below.

Name Last	First	Address *(same or)*	Relationship *(Spouse/partner, son, daughter)*	Birth date YYYY/MM/ DD	Height	Weight	**ASEBP use only**

1. Have any of the dependants named above at any time been treated for or been told such person had trouble with any of the following:

		YES	NO			YES	NO			YES	NO
a)	Heart	☐	☐	e)	Diabetes	☐	☐	i)	Cancer	☐	☐
b)	Lungs	☐	☐	f)	Nervous or mental disorder	☐	☐	j)	Back or joints	☐	☐
c)	Urinary system	☐	☐	g)	High blood pressure	☐	☐	k)	Stomach or intestines	☐	☐
d)	Tumors	☐	☐	h)	Kidney	☐	☐	l)	Hernia	☐	☐

m)	been in any hospital or other institution for observation, rest, diagnosis or treatment during the past three years?	☐	☐
n)	been examined by, or consulted a doctor or other practitioner during the past three years?	☐	☐
o)	been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	☐	☐
p)	been advised to have a surgical operation or procedure but did not do so?	☐	☐
q)	any known physical impairments, deformities or ill health not covered by 1 a) through 1 p)?	☐	☐
r)	had or received advice or treatment for Acquired Immune Deficiency Syndrome (AIDS), hepatitis, unexplained persistent lymph gland enlargement, unusual infections or any other immune system abnormalities?	☐	☐
s)	tested positive for antibodies to the AIDS (Type H-IV) virus?	☐	☐
t)	ever had epilepsy, paralysis, dizziness, mental illness, fibromyalgia, chronic fatigue, alcoholism, or drug addictions?	☐	☐
u)	any condition which may require any medication or medical/surgical attention now or in the future?	☐	☐
v)	had or been advised to have electrocardiogram, x-ray, blood or any other related diagnostic test other than routine exams?	☐	☐

C - Complete only if requesting Extended Health Care coverage for dependant(s) - Continued

2. Please provide complete details to all the "yes" answers to questions 1 a) through 1 v)? *(If more space required, go to last page)*

Dependant's name	*Question no.*	*Illness or other reason. If operated, so state. Reason for any check-up, doctor's advice, treatment, and medication.*	*Began MM YYYY*	*Time lost from normal activities*	*Full Recovery MM YYYY*	*Doctors and hospitals Provide full name and addresses*

3. For each dependant named, please provide a list of medications currently taken. Please include the drug name, frequency, and dosage. If none, please indicate.

Dependant's name	*Drug name*	*Frequency*	*Dosage*

D. Consent for the collection, use and disclosure of personal information

The Alberta School Employee Benefit Plan (ASEBP) must collect, use and disclose the personal information contained herein in order to verify eligibility coverage for you and your dependants under the group benefit plans.

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: _____

Please go to next page if additional space is required.

Additional information