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LATE APPLICANT MEDICAL INFORMATION

SUBSTITUTE/CASUAL STAFF AND PART-TIME EMPLOYEES

PLEASE PRINT

INSTRUCTIONS:

Please complete all applicable sections below and return to ASEBP. Faxed copies are acceptable. Any charges incurred for completing this form are the member's responsibility. The information on this form will remain current for no longer than 90 days.

- If requesting coverage for yourself, please complete sections A and B.
- If requesting coverage for yourself and dependants, please complete sections A, B and C.
- If applying for Life Insurance, Accidental Death & Dismemberment (AD&D) and Extended Disability Benefits (EDB), **please have your physician or nurse practitioner complete the Health Assessment form**.

A. To be completed by employee

First name: _____ ASEBP ID number: _____

Last name: _____ Phone number: (____) _____

Mailing address: _____ Date of birth: Year _____ Month _____ Day _____

B. To be completed by employee (if requesting coverage for self)

Please indicate which category you are a part of:

☐ Substitute/casual staff ☐ Part-time employee _____
Name of employee group (e.g. maintenance, clerical, custodian, etc.)

Physician name: _____ Physician phone number: (____) _____

Height (inches): _____ Weight (lbs.): _____ Waist circumference (inches): _____ Smoker: ☐ Yes ☐ No

1. Have you:

		Yes	No
a.	been absent from work, applied for benefits or received benefit or pension compensation 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.	been treated for alcoholism or use illicit substances (i.e. heroin, cocaine)	☐	☐
d.	been examined by a doctor for a regular physical examination within the past five years?	☐	☐

2. Please indicate "yes" or "no" if you, at any time, have been treated for or told you had difficulty with any of the following:

		Yes	No
a.	Neurological disease (e.g. multiple sclerosis)	☐	☐
b.	Lung function (e.g. COPD, asthma)	☐	☐
c.	Rheumatoid or psoriatic arthritis	☐	☐
d.	Cancer or tumours	☐	☐
e.	Gastrointestinal disease (e.g. ulcers, reflux)	☐	☐
f.	Inflammatory bowel disease (e.g. Crohn's, ulcerative colitis)	☐	☐
g.	High cholesterol	☐	☐
h.	Chronic liver disease or infection (e.g. hepatitis)	☐	☐
i.	Mental health (e.g. anxiety, depression)	☐	☐
j.	Cardiovascular disease, heart failure, angina (chest pain) and/or high blood pressure or abnormal pulse	☐	☐
k.	Autoimmune disease (e.g. Lupus, psoriasis, ankylosing spondylitis)	☐	☐
l.	Diabetes or glucose intolerant *Please check:* *☐ insulin dependant* *☐ non-insulin dependant*	☐	☐

3. Do you have any known awareness of any physical or mental health condition or illness not disclosed in the answers to questions 1 and 2?

☐ Yes ☐ No

If yes, please explain: _____

4. What are the complete details to all the "yes" answers to questions 1, 2 and 3? Attach a separate sheet if more room is required.

Question number	Illness or other reason. Reason for any check-up, doctor's advice, treatment and medication.	Date treatment began (MM/YYYY)	Time lost from normal activity	Treatment plans, outcomes or current status

5. Are you currently taking any prescription or over-the-counter medication?

☐ Yes ☐ No

If yes, please provide the drug name(s) and the reason you are taking it. Attach a separate sheet if more room is required.

Drug name(s)	Reason(s)

C. To be completed by employee (if requesting coverage for dependants)

Last name	First name	Relationship (spouse, partner, son, daughter, etc.)	Birth date (YYYY/MM/DD)	Height (inches)	Weight (lbs)	Waist circumference (inches)	Smoker (Y/N)

1. Have any of the persons 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.	Neurological disease (e.g. multiple sclerosis)	☐	☐	f.	Inflammatory bowel disease (e.g. Crohn's, ulcerative colitis)	☐	☐	k.	Autoimmune disease (e.g. Lupus, psoriasis, ankylosing spondylitis)	☐	☐
b.	Lung function (e.g. COPD, asthma)	☐	☐	g.	High cholesterol	☐	☐	l.	Diabetes or glucose intolerant	☐	☐
c.	Rheumatoid or psoriatic arthritis	☐	☐	h.	Chronic liver disease or infection (e.g. hepatitis)	☐	☐		*Please check:* ☐ *insulin dependant* ☐ *non-insulin dependant*		
d.	Cancer or tumours	☐	☐	i.	Mental health (e.g. anxiety, depression)	☐	☐				
e.	Gastrointestinal disease (e.g. ulcers, reflux)	☐	☐	j.	Cardiovascular disease, heart failure, angina (chest pain) and/or high blood pressure or abnormal pulse	☐	☐				

Have any of the persons named above at any time:

		Yes	No
r.	Been in any hospital or other institution for observation, rest, diagnosis or treatment during the past three years?	☐	☐
s.	Been examined by, or consulted a doctor or other practitioner during the past three years?	☐	☐
t.	Been advised to enter a hospital or other institution for diagnosis, rest or treatment but did not do so?	☐	☐
u.	Been advised to have a surgical operation or procedure but did not do so?	☐	☐
v.	Had any known physical impairments, mental health condition or ill health not covered above?	☐	☐

2. What are the complete details to all the "yes" answers in question 1? Attach a separate sheet if more room is required.

Question number	Illness or other reason. Reason for any check-up, doctor's advice, treatment and medication.	Date treatment began (MM/YYYY)	Time lost from normal activity	Treatment plans, outcomes or current status

3. Are any dependants listed above currently taking any prescription or over-the-counter medication?

☐ Yes ☐ No

If yes, please provide the drug name(s) and the reason they are taking it. Attach a separate sheet if more room is required.

Name First	Name Last	Drug name(s)	Reason(s)

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 to verify eligibility for benefit coverage for you and/or your dependants.

I understand that my and/or my dependants' personal information will be kept confidential and secure. 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 of determining my and/or my dependants' medical evidence of insurability. I understand that I may revoke my consent at any time and acknowledge that should I do so, benefit coverage may not be available to me.

If indicated above that my treating physician or nurse practitioner will be completing the health assessment below, I authorize said physician or nurse practitioner to disclose to ASEBP my and/or my dependants' personal information as requested by ASEBP for the purpose of determining medical evidence of insurability.

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 plan, through me as an applicant.

I agree to the above and declare that my statements are complete, accurate and true. I agree this authorization shall be in effect from the date below and shall be valid until such time as a decision regarding my and/or my dependants' insurability is determined by ASEBP. A photocopy of this form shall have the same force and effect as the original.

Date: _____ Signature: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. 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.ca/privacy.html, or contact the Privacy Officer at 780-438-5300 or by email at po@asebp.ca.