ALBERTA SCHOOL EMPLOYEE BENEFIT PLAN
Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton | Alberta | T6H 2K7

CONSENT TO DISCLOSE PERSONAL INFORMATION

INSTRUCTIONS:

1. Complete each section below. Incomplete forms will not be accepted.
2. Please read the acknowledgement in Part 4 and sign and date the bottom of the page. If you have any questions regarding the collection, use and disclosure of your personal information, 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.
3. Return this form to the address above or fax to 780-438-5304.
4. This consent is being obtained in accordance with sections 7, 8, 9, and 61 of Alberta's *Personal Information Protection Act* and section 5 of the federal *Personal Information Protection Electronic Documents Act*.

Part 1 - Identification*

**Who the information is about*

First name: _____ Last name: _____ ASEBP ID #: _____

Mailing address: _____ Birth date (YYYY/MM/DD): _____ / _____ / _____

City: _____ Province: _____ Postal Code : _____

Home phone #: _____ Work or Mobile phone #: _____

Email: _____

Part 2 – Type of Information (Please check all that apply)

Select the type of information ASEBP has consent to release. Benefit utilization is a record of the claims submitted and paid for each benefit type, this includes claims submitted by a covered member or a dependant, as well as a service provider (e.g. pharmacist).

☐ Extended Health Care utilization ☐ Dental Care utilization ☐ Vision Care utilization ☐ Spending Account

☐ Extended Disability Benefits information:

☐ Current claim file ☐ Past claim file(s); claim time period: From _____ To _____

☐ Other: _____

_____

_____

Why is the release of information indicated above being requested?

☐ To Answer questions about the plan ☐ Benefit administration ☐ Income tax ☐ Litigation

☐ Other: _____

_____

_____

Please turn over and complete.

Part 3 - Release of Information

Indicate to whom ASEBP should release the requested information. This could be a person or an organization (e.g. lawyer). In the case of an organization, please provide a contact name. Please complete all fields below.

1. Name: _____ ☐ Person ☐ Organization

Contact Name (if information is being sent to an organization): _____

Mailing address: _____

Home phone #: _____ Work phone #: _____ Email: _____

Method of release: ☐ By phone ☐ In person ☐ In writing ☐ By fax ☐ By email

2. Name: _____ ☐ Person ☐ Organization

Contact Name (if information is being sent to an organization): _____

Mailing address: _____

Home phone #: _____ Work phone #: _____ Email: _____

Method of release: ☐ By phone ☐ In person ☐ In writing ☐ By fax ☐ By email

Part 4 - Acknowledgement

I understand that my consent is effective on the date I sign this document and shall continue indefinitely or until ____/__/__ (YYYY/MM/DD). I understand why I have been asked to provide this information to the requestor. I am aware of the risks and benefits of consenting to or refusing to consent to the disclosure of this information. I am aware that I may withdraw this consent at any time by notifying ASEBP in writing through contact information provided herein.

_____ _____ / _____ / _____

Signature of Person Identified in Part 1 or Parent/ Guardian** Date (YYYY/MM/DD)

** Signature of Parent or Guardian is only required if the person identified in Part 1 is under the age of 16.