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

EARLY REFILL REQUEST FORM

Instructions:

Complete this form if you, or one of your dependants, have had to prepay for medication(s) required in excess of the 100 day supply eligible under your ASEBP's prescription drug plan for the purpose of travel outside Canada.

Please complete all applicable sections of this form, then sign and date the form.

1. We require a **completed** *Extended Health Care and Vision Care Claim* form as well as the **original receipts**.
2. **If there is a claim to be reprocessed**, please complete this form **and** attach a copy of the Explanation of Benefits form you received.
3. 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.

A. ASEBP covered member information

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

Mailing address: _____ Gender: ☐ Female ☐ Male

City: _____ Postal code: _____ Birth date (YYYY/MM/DD):

Home phone #: _____ Daytime phone #: _____ _____ / _____ / _____

Email address: _____

B. Travel details (If travelling as a family, only **one** Early Refill Request form needs to be filled out per trip)

Name of patient(s) travelling:

Last name: _____ First name: _____

Last name: _____ First name: _____

Last name: _____ First name: _____

Destination of travel: _____

Expected departure date (YYYY/MM/DD): Expected return date (YYYY/MM/DD):

_____ / _____ / _____ _____ / _____ / _____

Optional out of country contact information (email address or phone number): _____

Continued →

C. Other circumstances

If you required more than a 100 day supply of medication for reasons other than travel, please provide an explanation of the circumstance(s) that warranted the early refill of your prescription drugs to be considered by ASEBP.

_____

_____

_____

_____

_____

D. Consent and authorization

The ASEBP must collect, use and disclose the personal information contained herein in order to administer the group benefit plans that you are enrolled in. It may be necessary for the ASEBP to disclose some or all of the personal information contained herein to third party service providers for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

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', eligibility 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.

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

Signature: _____ Date signed: _____

ASEBP OFFICE USE ONLY

❑ Approved ❑ Declined If declined, reason: _____

Approved by: _____ Date: _____

COMMENTS

Please forward the completed form to ASEBP at the address below.

Alberta School Employee Benefit Plan
Allendale Centre East
Suite 301, 6104-104 Street NW
Edmonton, AB T6H 2K7