Chambers of Commerce
Group Insurance Plan®

APPLICATION TO INSURE A DEPENDENT WHO IS OVER AGE 21

The insured employee completes this form. It is to be used when the employee wants coverage for an overage dependent. They would have coverage from their 21st birthday to their 25th birthday (26th Birthday in Québec) provided that:

- the dependent is unmarried;
- the dependent is wholly dependent upon the insured member
- the dependent is in full-time attendance, or on vacation from, an accredited school.

Employee's Name ______________________________ Firm # __________ Certificate # __________

Dependent's Name ______________________________ Employee's relation to the dependent __________________

Dependent's Present Age ______________________________ Dependent's date of birth (YYYY/MM/DD) __________________

1) Is the overage dependent wholly dependent upon you? ______________________________

2) Is the dependent working full or part time? ____________________ # of hours per week ____________________

3) Is the dependent in full-time attendance at an accredited school? ______________________________

If so, what is the name and address of the school? ______________________________

____

What school year is he/she presently enrolled for? ______________________________

Date the current school term is expected to end ______________________________

If the student plans to return to school on a full time basis after this date, please indicate when ____________________

____

How many classes per day? ____________________ # of hours per day? ____________________

***** School Information must be completed on every claim form.**

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge. I acknowledge that no benefits will be payable until the insurer approves this application.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.chambers.ca or from the administrator of my benefit program.

A photocopy of this authorization is as valid as the original.

Signature of Employee ______________________________ Date ______________________________

Desjardins Insurance, ACE INA Insurance and Western Life Assurance Company are the primary insurers for the Plan.

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company