Chambers of Commerce
Group Insurance Plan®

B E N E F I T I N C R E A S E W A I V E R

Firm Name _____ Firm # _____

Employee Name _____ Certificate # _____

My employer has made me aware that upon completion and submission of the *Statement of Health* form to the Chambers of Commerce Group Insurance Plan administrators, I may qualify for additional coverage under the program. The required forms have been provided to me and it is my responsibility to complete and submit such forms in a timely manner to Chambers of Commerce Group Insurance Plan administrators for consideration.

I understand that by not applying for the additional coverage, my heirs / beneficiaries and I have no claim, now or in the future, for benefits I may have been approved for under the program.

Dated at _____ in _____, this _____ of _____20 _____.
town/city province day month year

_____ _____

Employee's Signature Printed Name

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