Chambers of Commerce Group Insurance Plan®

J G 1 0 - C H

EMPLOYEE APPLICATION

Firm #	Certificate #	

EMPLOYMENT INFORMATION (to be completed by the Employer in INK)

Company Name _____ Date of **full-time** employment (YYYY/MM/DD) _____

Company Address _____ Monthly Earnings _____

_____ Employee's Occupation _____

Employee's Duties _____

I certify this employee has been employed full-time continuously since the date shown and is now working at least 20 hours per week.

Authorized Official's Name **and** Signature _____ (Print) and _____ (Signature)

Date (YYYY/MM/DD) _____

EMPLOYEE INFORMATION (to be completed by the Employee in INK)

Last Name _____ Birthdate (YYYY/MM/DD) _____

First Name _____ Middle Name _____ ❑ Male ❑ Female ❑ Smoker ❑ Non-Smoker

Home Mailing Address _____ Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Common law (cohabited for at least 12 months)

City _____ Province _____ Postal Code _____ Date of Cohabitation (YYYY/MM/DD) _____

Province of Employment (if different) _____ Home Phone _____ Language Preference ❑ English ❑ French

DIRECT DEPOSIT

❑ I authorize the Chambers of Commerce Group Insurance Plan to deposit my health and/or dental benefit payments into my account. (**Must include a VOID cheque** or a statement/letter from your financial institution showing its name, number, and your account number.)

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (YYYY/MM/DD)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse					❑	❑
❑ Son ❑ Daughter					❑	❑
❑ Son ❑ Daughter					❑	❑
❑ Son ❑ Daughter					❑	❑

You may waive Extended Health and/or Dental benefits for yourself and/or your dependents **only** if covered for similar benefits under another plan.

I **DO NOT** want Extended Health Care for ❑ Myself and my dependents ❑ My dependents only

I **DO NOT** want Dental for ❑ Myself and my dependents ❑ My dependents only

If you have **WAIVED** any benefits, you must provide Coordination of Benefits information.

Coordination of Benefits

Spouse has other coverage: Extended Health ❑ Family ❑ Single ❑ None

Dental ❑ Family ❑ Single ❑ None

Name of other insuring company currently providing Health and/or Dental benefits _____

Policy Number _____ Coordination of Benefits notes _____

CONTINUED

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EMPLOYEE APPLICATION (CONTINUED)

Firm #	Certificate #

Beneficiary Designation: I hereby name the following beneficiary of any Life Insurance benefits payable as a result of my participation in this plan.

Last Name	First Name and Initial	% of Benefit	Relationship to Employee	Birthdate (YYYY/MM/DD)

Divided: ❑ As per percentages above (must total 100%) ❑ In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here:
❑ **Revocable**, I may change this designation at any time

Trustee/Administrator Designation: If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name	Relationship to Employee

If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.

For Quebec Only: The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

Declaration and Authorization for the Collection and Communication of Personal Information

I hereby apply for Group Insurance for which I am, or may become, eligible under this plan and authorize any required payroll deductions for administration of my benefits. All the information I have provided on the form is accurate and complete, to the best of my knowledge, and I certify that I have no other coverage under the Chambers Plan and have not applied for any. **I understand that I, and my dependents, must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage.** 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 authorize the Chambers of Commerce Group Insurance Plan to email a copy of any requests for additional medical information and/or questionnaires required to process any application for coverage under this plan, including any correspondence relating to a medical underwriting decision. This authorization extends to my dependents, if applicable.

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 the authorization is as valid as the original.

Employee Name _____ Email Address _____

Signature of Employee _____ Date (YYYY/MM/DD) _____