Chambers of Commerce
Group Insurance Plan®

OPTIONAL LIFE INSURANCE

You have a basic level of life insurance under your current group benefits, through the Chambers of Commerce Group Insurance Plan.® Now **Chambers Plan Optional Life Insurance** lets you top up that coverage, and it lets you insure your spouse and dependent children, too. It's a benefit designed to bring you low group prices combined with a high degree of individual flexibility. You can build the program you need at a price you can afford.

Select coverage in units of $10,000 for yourself and your spouse, up to a maximum benefit of $500,000 each. For your dependent children, you can choose $5,000 of coverage each, so long as you or your spouse take part in the program.

HERE'S HOW YOU APPLY…

Complete a Chambers Plan Optional Life application for each individual you want to cover – yourself, your spouse, your children. All your dependent children are eligible to apply up to age 21, while those who are full-time students can be covered up to age 25.

As you're completing the form, there will be slight differences for each type of applicant.

FOR YOU, THE EMPLOYEE

Fill in the *GENERAL INFORMATION* and *BENEFICIARY DESIGNATION* sections naming the beneficiary who would receive the policy's benefits. Complete the ***STATEMENT OF HEALTH*** section and sign the *APPLICANT'S DECLARATION*.

FOR YOUR SPOUSE

You can complete the *GENERAL INFORMATION* section. Your spouse completes the *SPOUSE INFORMATION* and a **separate *STATEMENT OF HEALTH***. Both you and your spouse must sign the *APPLICANT'S DECLARATION*. *

FOR DEPENDENT CHILDREN

You fill in the *GENERAL INFORMATION* and *DEPENDENT INFORMATION* section. Complete a **separate *STATEMENT OF HEALTH*** on behalf of your child for **each** child you are applying for and sign the *APPLICANT'S DECLARATION*. *

* You (the employee) are automatically designated as the beneficiary for your spouse's and dependent children's coverage.

Return the completed application(s) to your employer to be forwarded to:
Chambers of Commerce Group Insurance Plan
582 King Edward Street
Winnipeg, Manitoba R3H 0P1

The Plan is underwritten by Desjardins Financial Security and administered by Johnston Group Inc. If you have any questions, please call our Service Center at **1-800-665-3365**

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CHAMBERS PLAN OPTIONAL LIFE RATES

Age	Male		Female	
	Smoker	Non-Smoker	Smoker	Non-Smoker
< 30	$ 1.08	$ 0.54	$ 0.70	$ 0.37
30 – 34	1.41	0.64	0.95	0.40
35 – 39	1.45	0.71	1.10	0.58
40 – 44	2.97	1.27	2.01	0.85
45 – 49	5.24	2.21	3.03	1.49
50 – 54	8.25	3.92	4.95	2.51
55 – 59	14.02	6.25	8.57	3.93
60 – 64	18.12	9.01	11.32	6.45
65 – 69	30.97	13.70	18.71	10.73

The chart above shows monthly premiums per ***$10,000*** of coverage for employees and spouses. Dependent coverage is $0.24 per month per dependent. To estimate your monthly premium, look under "Male" or "Female" in the column that matches your smoking status. Find the row that includes your age. Multiply the cost shown by the units of coverage you are requesting.

OPTIONAL LIFE RATE WORKSHEET

	Name	Rate	Units of $10,000	Monthly Premium
Employee	_____	_____	_____	$_____
Spouse	_____	_____	_____	$_____
	Name	**Rate**	**Units of $5,000**	**Monthly Premium**
Dependent	_____	0.24 x	1	$_____
Dependent	_____	0.24 x	1	$_____
Dependent	_____	0.24 x	1	$_____
			Total	**$**_____

Chambers of Commerce Group Insurance Plan®

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APPLICATION FOR OPTIONAL LIFE INSURANCE

Firm Name _____ Firm # _____ Employee Certificate # _____

GENERAL INFORMATION (To be completed by the Employee)

Last Name _____ Daytime Phone Number (____) _____

Given Name(s) _____ Date of Birth (YYYY/MM/DD) _____

Home Address _____ ❑ Female ❑ Male

City _____ Province _____ Postal Code _____ ❑ Smoker ❑ Non-Smoker (at least 12 consecutive months)

This is a:
- ❑ New application
- ❑ Application for change in coverage
- ❑ Beneficiary change

Applying for coverage for:
- ❑ Myself
- ❑ Spouse
- ❑ Dependent children ($5,000 per Dependent Child)

Amount of coverage (Units of $10,000 up to $500,000)
- A. Current Optional Life Held $_____
- B. Additional Amount Requested $_____
- Total (A + B) $_____

SPOUSE INFORMATION (To be completed if applying for Spousal coverage. Separate Statement of Health required.)

Last Name _____ Date of Birth (YYYY/MM/DD) _____

Given Name(s) _____ ❑ Female ❑ Male

❑ Smoker ❑ Non-Smoker (at least 12 consecutive months)

DEPENDENT INFORMATION (To be completed if applying for coverage for dependent children. Separate Statements of Health required.)

Last Name _____ Date of Birth (YYYY/MM/DD) _____

Given Name(s) _____ ❑ Female ❑ Male

Child is ❑ Under 21 ❑ Student under 25

Last Name _____ Date of Birth (YYYY/MM/DD) _____

Given Name(s) _____ ❑ Female ❑ Male

Child is ❑ Under 21 ❑ Student under 25

Last Name _____ Date of Birth (YYYY/MM/DD) _____

Given Name(s) _____ ❑ Female ❑ Male

Child is ❑ Under 21 ❑ Student under 25

BENEFICIARY DESIGNATION (To be completed by the Employee)

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

Last Name	First Name and Initial	% of Benefit	Relationship to Employee	Date of Birth (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.

PLEASE SEE OTHER SIDE

STATEMENT OF HEALTH

To be completed for EACH applicant. In the case of dependent coverage, the Statement of Health must be completed by the Employee on behalf of dependent children. All information will be treated confidentially.

Name of Applicant _____ ❑ Employee ❑ Spouse ❑ Dependent

Height _____ ❑ ft/in ❑ cm Weight _____ ❑ lbs ❑ kg Weight changes in the past 12 months ❑ gain ❑ loss _____ ❑ lbs ❑ kg

Reason for weight change _____

Regular doctor's name and mailing address _____

Date you last consulted a physician (YYYY/MM/DD) _____

Reason _____

Describe any treatment or medication in #5 below.

	Yes	No
1) Have you ever consulted a doctor for, suffered from, been treated for any of the following medical conditions?		
a) Lung disorder (e.g. asthma, bronchitis, tuberculosis)?	❑	❑
b) Heart trouble (e.g. chest pain, shortness of breath, high blood pressure or heart murmur)?	❑	❑
c) Stomach trouble (e.g. ulcer, indigestion, or gall bladder disorders)?	❑	❑
d) Diabetes, kidney disease or urine abnormality?	❑	❑
e) Cancer, tumour or growth, or blood disorder?	❑	❑
f) Positive test results or pretest counselling for, or diagnosis of AIDS, antibodies to HIV or any other immunological disorder?	❑	❑
g) Epilepsy, paralysis, nervous, mental or emotional disorder?	❑	❑
h) Back, spine, or muscle pain/disorders, neuritis, arthritis, rheumatism, or chronic fatigue syndrome?	❑	❑
i) Any disease, impairment or deformity not named?	❑	❑
2) Do you have a physical or mental health problem or any physical defect or any symptom of illness or disease?	❑	❑
3) In the past 5 years, have you been hospitalized or under medical observation, taken any medication of any kind, or had medical or surgical advice or treatment other than stated above?	❑	❑
4) Have you ever taken drugs (other than for medical purposes), been advised to drink less alcohol, or received treatment for drug addiction or alcoholism?	❑	❑

5) DETAILS – If you answer "Yes" to any of the above questions, please give details below.

Question Number	Please describe the medical condition	Date of Onset / Recovery	Medication and/or Treatments	Approximate Monthly Cost	Attending Physician or Hospital

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION
(To be completed by the Employee and, if Spouse is applying for coverage, Spouse)

I declare that the answers and statements I have provided in this form are complete and true. I agree that no insurance shall take effect until the insurance company approves my application. I agree that any employee coverage issued because of this application shall not come into effect unless the employee is actively engaged, full-time, in his or her own occupation on the date the coverage would normally begin. I understand that any coverage requested on dependent children can only be issued if the employee's or spouse's request for coverage is approved. I understand that the employee may cancel this coverage at any time by writing to the Chambers of Commerce Group Insurance Plan.

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 this authorization is as valid as the original.

Signature of employee _____ Email address _____

Signature of spouse _____ Signature of dependent child age 16 and over to be insured (aged 14 and over for Québec) _____

Date _____