Chambers Plan
Employee Benefits

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 _____

Waive Waiting Period? ❑ No ❑ Yes, for the following reason _____

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

_____ and _____ _____

Authorized Official's Name | Signature | Date (YYYY/MM/DD)

EMPLOYEE INFORMATION (TO BE COMPLETED BY THE EMPLOYEE IN INK)

Last Name _____

First Name _____ Middle Name _____

Home Mailing Address _____

City _____ Province _____ Postal Code _____

Province of Employment (if different) _____ Phone (_____)_____

Birthdate _____ (YYYY/MM/DD)

❑ Male ❑ Female

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

Date of Cohabitation _____ (YYYY/MM/DD)

Language Preference ❑ English ❑ French

DIRECT DEPOSIT

By completing the banking information below, I authorize Chambers of Commerce Group Insurance Plan to deposit my Health and/or Dental benefit payments into this account.

Branch/Transit Number _____ Bank Number _____ Account Number _____

List all your dependents, including your spouse: (required for coverages such as Dependent Life, Health and Dental) Dependents must be covered under your Provincial Health plan in order to be eligible for Extended Health coverage.

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					❑	❑

If your Chambers Plan coverage has Health and/or Dental benefits, you or your dependents may waive these benefits **only if you have coverage under another plan**.

Do you or your dependents have other coverage ❑ No ❑ Yes, please provide the name of insurance company and the coverage held:

Name of insuring company _____ Policy Number _____

Other plan includes coverage for:
- Extended Health ❑ Family ❑ Couple ❑ Single ❑ None
- Dental ❑ Family ❑ Couple ❑ Single ❑ None

Are you waiving coverage for:
- Extended Health ❑ No ❑ Yes, for myself and my dependents ❑ Yes, for my dependents only
- Dental ❑ No ❑ Yes, for myself and my dependents ❑ Yes, for my dependents only

Notes/ Comments _____

CONTINUED

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Employee Application (continued)

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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 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 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 Policy on www.chamberplan.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 signed _____
(YYYY/MM/DD)