Chambers of Commerce
Group Insurance Plan®

Firm # Certificate #

Effective Date

E M P L O Y E E A P P L I C A T I O N

EMPLOYEE INFORMATION (to be completed by the Employee)

Last Name _____ Birthdate (D/M/Y) _____

First Name _____ ❑ Male ❑ Female

❑ Smoker ❑ Non-Smoker

Middle Name _____ Marital Status ❑ Single ❑ Married

❑ Widowed ❑ Separated ❑ Divorced

Home Address _____ ❑ Common law (cohabited for at least 12 months)

City _____ Province _____ Postal Code _____ Language Preference ❑ English ❑ French

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (D/M/Y)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse					❑	❑
Child					❑	❑
Child					❑	❑
Child					❑	❑
Child					❑	❑

You may waive Extended Health 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 us with the following information:

Individual(s) Covered _____ Name of Insurer _____

Beneficiary Designation: I hereby name the following revocable beneficiary of any Life Insurance benefits payable as a result of my participation in this Plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Beneficiary's Full Name _____ Relationship to You _____

Trustee's Name (if applicable) _____

Authorization: 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. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under the Chambers Plan and have not applied for any. I understand I must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage.

Employee's Signature _____ Date _____

EMPLOYMENT INFORMATION (to be completed by the Employer)

Company Name _____ Date of **full-time** employment (D/M/Y) _____

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.

Firm # _____ Authorized Official's Signature _____ Date _____

Chambers of Commerce
Group Insurance Plan®

Firm # Certificate #

Effective Date

EMPLOYEE CHANGE REQUEST

TO BE COMPLETED BY THE EMPLOYER

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____

❑ **Terminate Employee's Coverage** ❑ Employee Left Employment Last Day of Work (D/M/Y) _____

❑ Other Reason (please specify) _____

❑ **Reinstate Employee's Coverage** Date of Return to Work (D/M/Y) _____

Employer's Signature _____ Date _____

TO BE COMPLETED BY THE EMPLOYEE

Check the changes you are making and provide ALL the information requested for EACH section you check.

❑ **Add Benefits** ❑ Health ❑ Dental (Complete *Dependent Status* if requesting family coverage)

Previously covered under another plan? ❑ No ❑ Yes, up to (D/M/Y) _____

❑ **Cancel Duplicate Coverage** ❑ Health ❑ Dental Other Insurer's Name _____

Date your coverage began in the above plan (D/M/Y) _____

❑ **New Marital Status** ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced Date (D/M/Y) _____

❑ Common Law (Please provide date you began living together) _____

❑ **Employee Name Change** Previous Name _____ Date of Change (D/M/Y) _____

Reason for Change _____

❑ **Dependent Status**

❑ Add new dependent(s) listed below _____ (Reason) _____ (Date of Change (D/M/Y))

❑ Delete dependent(s) listed below _____ (Reason) _____ (Date of Change (D/M/Y))

❑ Change from family to single coverage _____ (Reason) _____ (Date of Change (D/M/Y))

❑ Change from single to family coverage _____ (Reason) _____ (Date of Change (D/M/Y))

List all your dependents affected by the change, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (D/M/Y)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse					❑	❑
Child					❑	❑
Child					❑	❑
Child					❑	❑
Child					❑	❑

❑ **New Beneficiary:** I hereby name the following revocable beneficiary of any Life Insurance benefits payable as a result of my participation in this Plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Beneficiary's Full Name _____ Relationship to You _____

Trustee's Name (if applicable) _____ Date (D/M/Y) _____

PLEASE SIGN HERE Employee's Signature _____ Date _____

Coverage changes are subject to the terms of the group insurance plan and any applicable legislation. Return the completed form to your Employer who will send it to the Plan Administrator.