Employee's Release of
Disability Claim Information

I hereby authorize the Chambers of Commerce Group Insurance Plan® and/or Desjardins Insurance, to release any information it has in connection with my claim for disability benefits to the following individual(s).

☐ _____, my insurance advisor

☐ _____, my spouse

☐ _____, my child

☐ _____, my _____

Signed this _____ of _____, _____.
Day Month Year

_____ _____
Employee's Name (Please print) Employee's Signature

Return the completed form, "Attn: Disability Claims Department", by toll-free FAX to **1-800-457-8410** or mail it to:

Chambers of Commerce Group Insurance Plan
Attn: Disability Claims Department
1051 King Edward Street,
Winnipeg, MB R3H 0R4

Chambers Plan
Employee Benefits

If you have any questions, please contact our office at
1.800.665.3365 – choose Option #3
or email chdisability@johnstongroup.ca