



# Employee Application

Firm # _____	Certificate # _____	
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## EMPLOYMENT INFORMATION

Company Name \_\_\_\_\_ Date of **Full-Time** Employment \_\_\_\_\_ (YYYY/MM/DD)

Company Address \_\_\_\_\_

Employee's Occupation \_\_\_\_\_

Employee's Duties \_\_\_\_\_

Regular Earnings \_\_\_\_\_ Frequency  Annually  Monthly  Semi-monthly  Bi-Weekly  Weekly  Hourly # Hours/week \_\_\_\_\_

Waive Waiting Period?  No  Yes, for the following reason \_\_\_\_\_

If applicable: Health Spending Account maximum: \$ \_\_\_\_\_ Lifestyle Spending Account maximum: \$ \_\_\_\_\_

I certify this employee has been employed full-time continuously since the date shown and is now working at least 20 hours per week. If the hourly wage is provided but the number of hours per week is not, it will be assumed 40 hours.

\_\_\_\_\_ and \_\_\_\_\_  
Authorized Official's Name Signature Date (YYYY/MM/DD)

## EMPLOYEE INFORMATION

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Home Mailing Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_ Province of Employment (if different) \_\_\_\_\_

Email Address \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ (YYYY/MM/DD)

**Gender**  Female  Male  
 Other Expression  Undisclosed

**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	Last Name (if different)	First Name	Date of Birth (YYYY/MM/DD)	Gender Female/Male/ Other Expression/ Undisclosed	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse	_____	_____	_____	_____		
Child	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Child	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Child	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

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 \_\_\_\_\_



# Employee Application (continued)

Firm #	Certificate #
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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	Date of Birth (YYYY/MM/DD)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

If you wish to designate a contingent beneficiary, please complete and submit the Beneficiary Designation form found on my-benefits.ca

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.

Last Name	First Name	Relationship to Employee
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*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 acknowledge that more specific information about collection and use of my personal information can be found in the Privacy Policy on [www.chamberplan.ca](http://www.chamberplan.ca) or from the administrator of my benefit program.

A photocopy of the authorization is as valid as the original.

Employee Name \_\_\_\_\_

Signature of Employee \_\_\_\_\_ Date signed \_\_\_\_\_

(YYYY/MM/DD)