Chambers Plan
Employee Benefits

JG11-CH

Employee Change Request

TO BE COMPLETED BY THE EMPLOYER/EMPLOYEE (IN INK)
Please complete the section below indicating the reason for the change in coverage

Company Name ________________________ Firm # ____________

Employee Name ________________________ Certificate # ____________

❑ **ADD**

❑ Health ❑ Dental

Were you or your dependents currently covered under a spousal plan?

❑ No ❑ Yes, until (YYYY/MM/DD) ____________

If 'No', or if your coverage ended more than 60 days ago, you must complete a Statement of Health/Statement of Dependent's Health

❑ **WAIVE HEALTH AND/OR DENTAL**

Health and/or Dental benefits can only be waived if you and/or your dependents are covered by similar benefits through your spouse's employer. Is there other coverage?

❑ Yes Name of other insuring company ____________

Policy# ____________ Effective (YYYY/MM/DD) ____________

Health waiver for ❑ myself and my dependents ❑ my dependents only

Dental waiver for ❑ myself and my dependents ❑ my dependents only

❑ **CHANGE to**

❑ Single coverage ❑ Family coverage ❑ Couple coverage (if applicable)

Reason for change:

❑ Birth/adoption ❑ Marriage
❑ Widowed ❑ Separation ❑ Divorce
} **Date (YYYY/MM/DD)** ____________

❑ Common Law* – provide date you **began** living together (YYYY/MM/DD) ____________
*A Common Law spouse is only eligible for coverage after 12 consecutive months of co-habitation.

❑ Date coverage ended under other plan (YYYY/MM/DD) ____________

❑ Other (please specify) ____________

What benefit coverage do your spouse/dependents have through another insurer?

HEALTH ❑ Single ❑ Family ❑ None Are you coordinating benefits? ❑ Yes ❑ No

DENTAL ❑ Single ❑ Family ❑ None Are you coordinating benefits? ❑ Yes ❑ No

Name of insurer ____________

SPOUSE/DEPENDENT INFORMATION

	First Name	Last Name	Date of Birth (YYYY/MM/DD)	Gender (Female/Male/ Other Expression/ Undisclosed)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 & over)
❑ Add Spouse ❑ Remove Spouse						
❑ Add Child ❑ Remove Child					❑	❑
❑ Add Child ❑ Remove Child					❑	❑
❑ Add Child ❑ Remove Child					❑	❑

I understand that I, and my dependents, must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage.

Signature of Employee ________________________ Date ____________

Plan Administrator's Name ____________ Signature ____________ Date ____________

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Employee Change Request

TO BE COMPLETED BY THE EMPLOYEE (IN INK)

Company Name ______________________ Firm # ______________

Employee Name ______________________ Certificate # ______________

❑ **Name Change** Previous Name ______________________

New Name ______________________

❑ **Address Change** New Address ______________________

______________________ Province of Employment (if different) ______________

Authorization to Email Personal Medical Information ❑ **Yes** ❑ **No**

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. Any copy of this authorization shall be as valid as the original.

Email address ______________________

Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

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 or from the administrator of my benefit program.

Any copy of this authorization shall be as valid as the original.

Signature of Employee ______________________ Date (YYYY/MM/DD) ______________