Chambers Plan
Employee Benefits

J G 2 5 - C H

Employee Statement of Health

Please print your Firm & Certificate #

Firm #	Certificate #

EMPLOYEE INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

Employee's Name _____ Date of Birth (Y/M/D) _____

Company Name _____ Phone (_____) _____

Height _____ ❑ ft/in ❑ cm Weight _____ ❑ lbs ❑ kg

Weight changes in the past 12 months ❑ gain ❑ loss _____ ❑ lbs ❑ kg

Reason for weight change _____

HEALTH QUESTIONNAIRE (PLEASE ANSWER ALL QUESTIONS IN FULL. 'N/A' AND LINES THROUGH THE RESPONSE SECTION ARE NOT ACCEPTABLE.)

Date you last consulted a physician (Y/M/D) _____ Reason _____

Findings, treatment and any medication(s) prescribed and current status ❑ None OR _____

Name and address of personal physician (IF NONE, PLEASE STATE "NONE") _____

	Yes	No
1) Have you ever consulted a doctor because of, suffered from, been treated for, or had any indication of the following medical conditions?		
a) Lung disorder (asthma, bronchitis, tuberculosis)?	❑	❑
b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmur)?	❑	❑
c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)?	❑	❑
d) Diabetes, kidney disease or urine abnormality?	❑	❑
e) Cancer, tumour or growth, or blood disorder?	❑	❑
f) Positive test results or pretest counselling for, or diagnosis of AIDS, antibodies to HIV or any other immunological disorder?	❑	❑
g) Epilepsy, paralysis, nervous, mental or emotional disorder?	❑	❑
h) Back, spine, neck or muscle pain/disorders, neuritis, arthritis, rheumatism, or fibromyalgia/chronic fatigue syndrome?	❑	❑
i) Any disease, impairment or deformity not named?	❑	❑

	Yes	No
2) Are you currently taking any prescription medication? If "Yes", provide details below.	❑	❑
3) In the past 5 years, have you been attended to by a physician or other health professional (such as a chiropractor, massage therapist, psychologist) and/or had medical or surgical treatments other than stated above?	❑	❑
4) Have you ever been unable to work for your employer on a full-time basis for more than three days?	❑	❑
5) In the past 12 months, have you used any form of tobacco, including e-cigarettes or other tobacco substitutes?	❑	❑
6) Have you ever used narcotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce your consumption of alcohol or taken treatment for alcoholism or drug abuse?	❑	❑

IF YOU ANSWER "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS BELOW.

Question Number	Nature of Disorder	Date of Onset (Y/M/D)	Date of Recovery (Y/M/D)	Medication and/or Treatment	Approximate Monthly Cost	Attending Physician or Hospital

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 agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively engaged in my occupation of a full-time basis. 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 or from the administrator of my benefit program.

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

Employee's signature _____ Date (Y/M/D) _____

Information about your insurability and your dependents will be treated as confidential.