

Employee Statement of Dependents' Health

Please print your Firm & Certificate #

Firm #	Certificate #
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DEPENDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (Y/M/D)	Sex (M/F)	Height	Weight
Spouse	_____	_____	_____	_____	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
Child	_____	_____	_____	_____	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
Child	_____	_____	_____	_____	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
Child	_____	_____	_____	_____	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg
Child	_____	_____	_____	_____	<input type="checkbox"/> ft/in <input type="checkbox"/> cm	_____ <input type="checkbox"/> lbs <input type="checkbox"/> kg

DEPENDENT HEALTH QUESTIONNAIRE

	Yes	No		Yes	No
1) Have any of your dependents ever consulted a doctor, suffered from, been treated for, or had any indication of the following medical conditions?			2) Are any of your dependents currently taking any prescription medication? If "Yes", provide details below (no receipts).	<input type="checkbox"/>	<input type="checkbox"/>
a) Lung disorder (asthma, bronchitis, tuberculosis)?	<input type="checkbox"/>	<input type="checkbox"/>	3) In the past 5 years, have any of your dependents been attended to by a physician or other health professional (such as a chiropractor, massage therapist, psychologist) and/or had medical or surgical treatment other than stated above?	<input type="checkbox"/>	<input type="checkbox"/>
b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmur)?	<input type="checkbox"/>	<input type="checkbox"/>	4) In the past 12 months, have any of your dependents used any form of tobacco, including e-cigarettes or other tobacco substitutes?	<input type="checkbox"/>	<input type="checkbox"/>
c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)?	<input type="checkbox"/>	<input type="checkbox"/>	5) Have any of your dependents ever used narcotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce their consumption of alcohol or taken treatment for alcoholism or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
d) Diabetes, kidney disease or urine abnormality?	<input type="checkbox"/>	<input type="checkbox"/>			
e) Cancer, tumour or growth, or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
f) Positive test results or pretest counselling for, or diagnosis of AIDS, antibodies to HIV or any other immunological disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
g) Epilepsy, paralysis, nervous, mental or emotional disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
h) Back, spine, neck or muscle pain/disorders, neuritis, arthritis, rheumatism, or fibromyalgia/chronic fatigue syndrome?	<input type="checkbox"/>	<input type="checkbox"/>			
i) Any disease, impairment or deformity not named?	<input type="checkbox"/>	<input type="checkbox"/>			

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

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

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 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. Digital signatures are not acceptable.

Signature of Employee _____ Date (Y/M/D) _____

Signature of Dependent _____ Date (Y/M/D) _____

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