Chambers Plan
Employee Benefits

Group Benefit Plan Waiver

I, _____, have been offered the opportunity to participate in my employer's
(Name)
employee benefit program. I understand the benefits offered and I do not wish to enroll in the program.

I understand that by refusing these benefits, my heirs / beneficiaries and I have no claim, now or in the future, for benefits under the program. I hold my employer, its representatives and the insuring company(ies) harmless from all future claims.

I also understand that if I wish to participate in the employee benefit program at a later date, participation will be subject to the insurer's approval. I may be required to provide evidence of my good health and/or my dependents' good health. Any dental benefits will be limited to $250 per employee or dependent in the first twelve months of coverage.

Dated at _____ in _____, this _____ of _____ 20_____.
Town/City Province Day Month Year

_____ _____
Firm Name Firm Number

_____ _____
Employee's Signature Plan Administrator's Signature (if applicable)

Desjardins Insurance, Chubb Life Insurance Company of Canada and Western Life Assurance Company are the primary insurers for the Plan.
Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company