Optional Life Insurance

Chambers Plan Employee Benefits

STATEMENT OF HEALTH (To be completed for each applicant.)

In the case of dependent coverage, the Statement of Health must be completed by the Employee on behalf of dependent children. All information will be treated confidentially.

Name of Applicant _____ ❑ Employee ❑ Spouse ❑ Dependent

Height _____ ❑ ft/in ❑ cm Weight _____ ❑ lbs ❑ kg Weight changes in the past 12 months ❑ gain ❑ loss _____ ❑ lbs ❑ kg

Reason for weight change _____

Regular doctor's name and mailing address _____

Date you last consulted a physician (YYYY/MM/DD) _____

Reason _____

Describe any treatment or medication in #5 below.

	Yes	No
1) Have you ever consulted a doctor for, suffered from, been treated for any of the following medical conditions?		
a) Lung disorder (e.g. asthma, bronchitis, tuberculosis)?	❑	❑
b) Heart trouble (e.g. chest pain, shortness of breath, high blood pressure or heart murmur)?	❑	❑
c) Stomach trouble (e.g. 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, or muscle pain/disorders, neuritis, arthritis, rheumatism, or chronic fatigue syndrome?	❑	❑
i) Any disease, impairment or deformity not named?	❑	❑
2) Do you have a physical or mental health problem or any physical defect or any symptom of illness or disease?	❑	❑
3) In the past 5 years, have you been hospitalized or under medical observation, taken any medication of any kind, or had medical or surgical advice or treatment other than stated above?	❑	❑
4) Have you ever taken drugs (other than for medical purposes), been advised to drink less alcohol, or received treatment for drug addiction or alcoholism?	❑	❑

5) DETAILS – If you answer "Yes" to any of the above questions, please give details below.

Question Number	Please describe the medical condition	Date of Onset / Recovery	Medication and/or Treatments	Approximate Monthly Cost	Attending Physician or Hospital

DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION
(To be completed by the Employee and, if Spouse is applying for coverage, Spouse)

I declare that the answers and statements I have provided in this form are complete and true. I agree that no insurance shall take effect until the insurance company approves my application. I agree that any employee coverage issued because of this application shall not come into effect unless the employee is actively engaged, full-time, in his or her own occupation on the date the coverage would normally begin. I understand that any coverage requested on dependent children can only be issued if the employee's or spouse's request for coverage is approved. I understand that the employee may cancel this coverage at any time by writing to the Chambers of Commerce Group Insurance Plan.

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 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.

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.

Signature of employee _____ Email address _____

Signature of spouse _____ Signature of dependent child age 16 and over to be insured (aged 14 and over for Quebec) _____

Date _____