Chambers Plan
Employee Benefits

Benefit Increase Waiver

Firm Name _____ Firm # _____

Employee Name _____ Certificate # _____

My employer has made me aware that upon completion and submission of the *Statement of Health* form to the Chambers of Commerce Group Insurance Plan administrators, I may qualify for additional coverage under the program. The required forms have been provided to me and it is my responsibility to complete and submit such forms in a timely manner to Chambers of Commerce Group Insurance Plan administrators for consideration.

I understand that by not applying for the additional coverage, my heirs / beneficiaries and I have no claim, now or in the future, for benefits I may have been approved for under the program.

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

_____ Employee's Signature

_____ Printed Name

Desjardins Insurance and Sutton Special Risk/Lloyd's are the primary insurers for the Plan.
Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company