Chambers Plan
Employee Benefits

JG11-CH

Employee Change Request

TO BE COMPLETED BY THE EMPLOYER/EMPLOYEE (IN INK)

Please complete the section below indicating the reason for the change in coverage

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____

❑ **ADD** ❑ Health ❑ Dental

Were you or your dependents currently covered under a spousal plan?

❑ No ❑ Yes, until (YYYY/MM/DD) _____

If 'No', or if your coverage ended more than 60 days ago, you must complete a Statement of Health/Statement of Dependent's Health

❑ **CANCEL** Health and/or Dental benefits can only be cancelled if you and/or your dependents are covered by similar benefits through your spouse's employer. Is there other coverage?

❑ Yes Name of other insuring company _____

Policy# _____ Effective (YYYY/MM/DD) _____

Health EXEMPTION for ❑ myself and my dependents ❑ my dependents only

Dental EXEMPTION for ❑ myself and my dependents ❑ my dependents only

❑ **CHANGE to** ❑ Single coverage ❑ Family coverage ❑ Couple coverage (if applicable)

Reason for change: ❑ Birth/adoption ❑ Marriage ❑ Widowed ❑ Separation ❑ Divorce } **Date (YYYY/MM/DD)** _____

❑ Common Law* – provide date you **began** living together (YYYY/MM/DD) _____

*A Common Law spouse is only eligible for coverage after 12 consecutive months of co-habitation.

❑ Loss of duplicate coverage (YYYY/MM/DD) _____

❑ Other (please specify) _____

What benefit coverage do your spouse/dependents have through another insurer?

HEALTH ❑ Single ❑ Family ❑ None Are you coordinating benefits? ❑ Yes ❑ No

DENTAL ❑ Single ❑ Family ❑ None Are you coordinating benefits? ❑ Yes ❑ No

Name of insurer _____

SPOUSE/DEPENDENT INFORMATION

	First Name	Last Name	Date of Birth (YYYY/MM/DD)	Gender (Female/Male/ Other Expression/ Undisclosed)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 & over)
❑ Add Spouse ❑ Remove Spouse						
❑ Add Child ❑ Remove Child					❑	❑
❑ Add Child ❑ Remove Child					❑	❑
❑ Add Child ❑ Remove Child					❑	❑

I understand that I, and my dependents, must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage.

Signature of Employee _____ Date _____

Plan Administrator's Name _____ Signature _____ Date _____

Chambers Plan
Employee Benefits

JG10-CH

Employee Change Request

TO BE COMPLETED BY THE EMPLOYEE (IN INK)

Company Name _____ Firm # _____

Employee Name _____ Certificate # _____

❑ **Name Change** Previous Name _____

New Name _____

❑ **Address Change** New Address _____

_____ Province of Employment (if different) _____

Authorization to Email Personal Medical Information ❑ **Yes** ❑ **No**

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

Email address _____

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 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.

Signature of Employee _____ Date (YYYY/MM/DD) _____