



Employee Statement of Health

Please print your Firm & Certificate #

Firm #	Certificate #

treated for, or had any indication of the following medical conditions? a) Lung disorder (asthma, bronchitis, tuberculosis)? b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmun)? c) Stomach trouble (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? g) Epilepsy, paralysis, nervous, mental or emotional disorder? g) Any disease, impairment or deformity not named? d) Have you ever used narotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce your consumption of alcohol or taken treatment for alcoholism or drug abuse? IF YOU ANSWER "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS BELOW. PLEASE INITIAL ANY CORRECTIONS. Question Number Nature of Disorder Date of Onset (Y/M/D) Date of Recovery (Y/M/D) Date of Recovery Medication and/or Treatment Monthly Cost Altending Physician or Hospital Altending Physician or Hospital 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. lagree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively engaged in my occupation of a permanent basis." I acknowledge that no benefits will be payable until the insurer approves this application. Lauthorize 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 c	EMPLOYEE IN	NFORMATION (PLEASE ANSWER	ALL QUESTIONS IN IN	IK)									
Height													
Reason for weight change HEALTH QUESTIONNAIRE (PLEASE ANSWER ALL QUESTIONS IN FULL. "N/A" AND LINES THROUGH THE RESPONSE SECTION ARE NOT ACCEPTABLE.) Date you last consulted a physician ("MyD")													
HEALTH QUESTIONNAIRE (PLEASE ANSWER ALL QUESTIONS IN FULL "N/A" AND LINES THROUGH THE RESPONSE SECTION ARE NOT ACCEPTABLE.) Date you last consulted a physician (V/M/D) Reason Findings, treatment and any medication(s) prescribed and current status None OR Name and address of personal physician (IF NONE, PLEASE STATE "NONE") Have you ever consulted a doctor because of suffered from, been treated for or had any indication of the following medical conditions? Ves No 22	Height	□ ft/in □ cm Weig	.□lbs □	lkg	Weig	Weight changes in the past 12 months ☐ gain ☐ loss					□kg		
Date you last consulted a physician (Y/M/D)	Reason for we	ight change											
Name and address of personal physician (IF NONE, PLEASE STATE "NONE")	HEALTH QUE	STIONNAIRE (PLEASE ANSWER A	ALL QUESTIONS IN FU	LL. 'N/A'	AND I	LINES	S THROUGH THE RE	SPONSE SEC	CTION ARE NOT	ACCEPTABLE.)			
Name and address of personal physician (IF NONE, PLEASE STATE "NONE") Have you ever consulted a doctor because of, suffered from, been treated for, or had any indication of the following medical conditions?	Date you last o	consulted a physician (Y/M/D)	Rea	son									
1) Have you ever consulted a doctor because of, suffered from, been treated for, or had any indication of the following medical conditions? a) Lung disorder (asthma, bronchist, bibervulosis)? b) Heart trouble (cheet pain, shortness of breath, high blood pressure or heart murmur? c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? d) Diabetes, kidney disease or urine abnormality? e) Cancer, turnour or growth, or blood disorder? f) Positive test results or pretest courselling for, or diagnosis of AIDS, antibloids to HIV or any other immunological disorder? g) Epilepsy, paralysis, nervous, mental or emotional disorder? g) Epilepsy, paralysis, nervous, mental or emotional disorder? h) Back, spine, neck or muscle pain/disorders, muritis, arthmitis, hereumatism, or bitromysligic/kironic latigue syndrome? h) Any disease, impairment or deformity not named? i) Any disease, impairment or deformity not named? b) Any disease, impairment or deformity not named? Date of Onset W/M/D) Date of Onset W/M/D) Date of Onset Recovery Medication and Or Approximate Attending Physician or Hospital Attending Physician or the payable until the insurer approves this application. All the information in have provided on the form is accurate and complete, to the best of my knowledge. I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, a macrively engaged in my occupation of a permanent basis. I acknowledge that no benefits will be payable until the insurer approves this application. Law marked the insurance is to become effective, a macrively engaged in my occupation of a permanent basis. I acknowledge that no benefits will be payable until the insurer approves this application. Law marked the insurance is to be	Findings, treat	ment and any medication(s) prescrib	oed and current status	☐ None(OR								
treated for, or had any indication of the following medical conditions? a) Lung disorder (astima, bronchitis, tuberculosis)? b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmur)? c) Stomach trouble (ucler, indigestion, or gall bladder disorders)? c) Stomach trouble (ucler, indigestion, or gall bladder disorders)? c) Cancer, turnour or growth, or blood disorder? d) Diabetes, kidney disease or urine abnormality? e) Cancer, turnour 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? g) Epilepsy, paralysis, nervous, mental or emotional disorder? g) Epilepsy, paralysis, nervous, mental or emotional disorder? g) Any disease, impairment or deformity not named? i) Any disease, impairment or deformity not named? i) Any disease, impairment or deformity not named? Declaration and Authorization for the Collection and Communication of Personal Information Nature of Disorder Date of Onset (Y/M/D) Date of Genes between the best of my knowledge. I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively ergaged in my occupation of a permanent basis. I acknowledge that no benefits will be payable until the insurance of compulsorance 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 administration of personal information concerning my dependents, incolar as applicable to the	Name and add	ress of personal physician (IF NONE	, PLEASE STATE "NONE	")									
AIDS, antibodies to HIV or any other immunological disorder? g) Epilepsy, paralysis, nervous, mental or emotional disorder? h) Back, spine, neck or muscle pain/disorders, neuritis, arthritis, has, spine, neck or muscle pain/disorders, neuritis, arthritis, has described by a physician, or been advised to reduce your consumption of alcohol or taken treatment for alcoholism or drug abuse? IF YOU ANSWER "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE GIVE DETAILS BELOW. PLEASE INITIAL ANY CORRECTIONS. Question Number Nature of Disorder Date of Onset (Y/M/D) Date of Recovery (Y/M/D) Presonal Information All the information I have provided on the form is accurate and complete, to the best of my knowledge. I agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively engaged in my occupation of a permanent basis. 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, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insurance companies, or other organizations/persons. T	 treated for, or had any indication of the following medical conditions? a) Lung disorder (asthma, bronchitis, tuberculosis)? b) Heart trouble (chest pain, shortness of breath, high blood pressure or heart murmur)? c) Stomach trouble (ulcer, indigestion, or gall bladder disorders)? d) Diabetes, kidney disease or urine abnormality? e) Cancer, tumour or growth, or blood disorder? 			? e		3)	provide details below (no receipts). In the past 5 years, have you been attended to by a physician or other health professional (such as a chiropractor, massage therapist, psychologist) and/or had medical or surgical treatments other than stated above? Have you ever been unable to work for your employer on a full-time basis for more than three days?						
Question Number Nature of Disorder	 g) Epilepsy, paralysis, nervous, mental or emotional disorder? h) Back, spine, neck or muscle pain/disorders, neuritis, arthritis, rheumatism, or fibromyalgia/chronic fatigue syndrome? i) Any disease, impairment or deformity not named? 						Have you ever used narcotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce your consumption of alcohol or taken treatment for alcoholism or drug abuse?						
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 agree that any coverage issued in consequence of this application shall not take effect unless, on the date the insurance is to become effective, I am actively engaged in my occupation of a permanent basis.* 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 authorize 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. Digital signatures are not acceptable. Employee's signature	-	Nature of Disorder		(Y/M/D)			Treatment	ent	Monthly Cost	or Hospita			
Email address	All the informatake effect unluntil the insure I authorize Chaadministration collected incluand communic I authorize Chaapplication for I acknowledge administrator of A photocopy of	and Authorization for the Collection It have provided on the form is a less, on the date the insurance is to be a approves this application. It is application. It is application, claim makes medical and health professional leation of personal information concertainty and coverage under this Plan, including that more specific information about of my benefit program.	n and Communication accurate and complete, recome effective, I am a ce Plan to collect, use, no anagement, underwriting, facilities or providers, rring my dependents, in the Plan to email a copy any correspondence related collection and use of original. Digital signature.	of Perso to the besoctively entaintain and g and for insurance asofar as a of any requiting to a my persor	nal Int t of my gaged nd disco determ comp ppplica uests t medica al info	forma y kno in my close nining anies ble to for ad al uno rmat	ation wledge. I agree that a y occupation of a peri personal information g Plan eligibility. The r , or other organizatio o the administration of ditional medical infor derwriting decision. T ion can be found in the	any coverage manent basis. relevant to th non-exhaustiv ns/persons. T if benefits und mation and/c his authorizat ne Privacy Pol	issued in conseque * I acknowledge the sis application for the re list of sources fre his authorization in der this Plan. or questionnaires re tion extends to my licy on www.chame	that no benefits will be the purposes of beneform which information is also valid for the co- required to process and y dependents, if appliaberplan.ca or from the	efit Pla on can ollection ny icable.	able in be on, use	
	Employee's sig	nature						Date (Y/M/D))				
	Email address												

*For firms that have an onset date prior to March 1, 2024, and have opted not to include their part-time employees, employees must be full time and working no less than 20 hours per week to be eligible.