Chambers Plan
Employee Benefits

J G 2 6 - C H

Employee Statement of Dependents' Health

Please print your Firm & Certificate #

Firm #	Certificate #

DEPENDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Date of Birth (YYYY/MM/DD)	Gender (Female/Male Other Expression/Undisclosed)	Height		Weight	
Spouse						❑ ft/in ❑ cm		❑ lbs ❑ kg
Child						❑ ft/in ❑ cm		❑ lbs ❑ kg
Child						❑ ft/in ❑ cm		❑ lbs ❑ kg
Child						❑ ft/in ❑ cm		❑ lbs ❑ kg
Child						❑ ft/in ❑ cm		❑ lbs ❑ kg

DEPENDENT HEALTH QUESTIONNAIRE

	Yes	No
1) Have any of your dependents ever consulted a doctor, suffered from, been 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?	❑	❑
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, neck or muscle pain/disorders, neuritis, arthritis, rheumatism, or fibromyalgia/chronic fatigue syndrome?	❑	❑
i) Any disease, impairment or deformity not named?	❑	❑
2) Are any of your dependents currently taking any prescription medication? If "Yes", provide details below.	❑	❑
3) In the past 5 years, have any of your dependents been attended to by a physician or other health professional (such as a chiropractor, massage therapist, psychologist) and/or had medical or surgical treatment other than stated above?	❑	❑
4) In the past 12 months, have any of your dependents used any form of tobacco, including e-cigarettes or other tobacco substitutes?	❑	❑
5) Have any of your dependents ever used narcotics, hallucinogens or similar drugs, not prescribed by a physician, or been advised to reduce their 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.

Question Number	Name	Nature of Disorder	Date of Onset (YYYY/MM/DD)	Date of Recovery (YYYY/MM/DD)	Medication and/or Treatment	Approximate Monthly Cost

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 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.

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

Employee's Email _____

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

Information about your insurability and your dependents will be treated as confidential.