

E M P L O Y E E A P P L I C A T I O N

EMPLOYEE INFORMATION (to be completed by the Employee in INK)

Last Name _____ Birthdate (YY/MM/DD) _____
 First Name _____ Male Female
 Middle Name _____ Smoker Non-Smoker
 Home Mailing Address _____ Marital Status Single Married
 _____ Widowed Separated Divorced
 _____ Common law (cohabited for at least 12 months)
 City _____ Province _____ Postal Code _____ Language Preference English French

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (YY/MM/DD)	Sex (M/F)	Full-Time Student (age 21-25)	Disabled Dependent (age 21 or over)
Spouse	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Son	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Daughter	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

You may waive Extended Health and/or Dental benefits for yourself and/or your dependents **only** if covered for similar benefits under another plan.

- I **DO NOT** want Extended Health Care for Myself and my dependents My dependents only
 I **DO NOT** want Dental for Myself and my dependents My dependents only

If you have **WAIVED** any benefits, you must provide us with the following information:

Individual(s) Covered _____ Name of Insurer _____

Beneficiary Designation: I hereby name the following revocable beneficiary of any Life Insurance benefits payable as a result of my participation in this Plan. If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Beneficiary's Full Name _____ Relationship to You _____

Trustee's Name (if applicable) _____

Authorization: I hereby apply for Group Insurance for which I am or may become eligible under this plan and authorize any required payroll deductions for administration of my benefits. I certify that the information provided herein is true, accurate and complete; and that I have no other coverage under the Chambers Plan and have not applied for any. I understand I must be covered under my Provincial Health plan in order to be eligible for Extended Health coverage. I authorize the Chambers Plan and its insurance companies, its agents and service providers to use and exchange information needed for underwriting, administration and adjudicating claims under this group contract with any person or organization who has relevant information about me in connection with this Application, including health professionals, institutions, insurers and reinsurers. A photocopy of this authorization is as valid as the original and shall continue to have effect throughout the duration of my coverage under this group contract.

Employee's Signature _____ Date _____

EMPLOYMENT INFORMATION (to be completed by the Employer in INK)

Company Name _____ Date of **full-time** employment YY / MM / DD

Company Address _____ Monthly Earnings _____

Employee's Occupation _____

Employee's Duties _____

I certify this employee has been employed full-time continuously since the date shown and is now working at least 20 hours per week.

Authorized Official's Name **and** Signature _____ and _____
Print Signature

Firm # _____ Date _____