Chambers of Commerce
Group Insurance Plan®

Firm # Certificate #

EMPLOYEE STATEMENT OF HEALTH

EMPLOYEE INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

Employee's Name _____ Date of Birth (D/M/Y) _____

Company Name _____ Daytime Phone Number _____

Height _____ ❑ ft/in ❑ cm Weight _____ ❑ lbs ❑ kg Monthly Income _____

Weight changes in the past 12 months ❑ gain ❑ loss _____ ❑ lbs ❑ kg

Reason for weight change _____

HEALTH QUESTIONNAIRE

Date you last consulted a physician (D/M/Y) _____ Reason _____

If "Reason" is "checkup", what problems/symptoms did you have? ❑ None OR _____

Findings, treatment and any medication(s) prescribed _____

Name and address of personal physician (if none, please state "none") _____

	Yes	No
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, 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, tumor 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?	❑	❑

	Yes	No
2) Have you used cigarettes or any other tobacco product in the past 12 months?	❑	❑
3) Are you currently taking any prescription medication?	❑	❑
4) Have you ever been unable to work for your employer on a full time basis for more than three days?	❑	❑
5) 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?	❑	❑
6) 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?	❑	❑

If you answer "Yes" to any of the above questions, please give details below.

Question Number	Nature of Disorder	Date of Onset	Date of Recovery	Medication and/or Treatment	Approximate Monthly Cost	Attending Physician or Hospital

I hereby declare that the above answers and statements are complete and true and 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 on a full-time basis. I further agree that the insurance applied for shall not become effective until the application is approved by the Insurance Company. 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 (D/M/Y) _____

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

Desjardins Financial Security, RBC Insurance and Western Life Assurance Company are the primary insurers for the plan.

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EMPLOYEE STATEMENT OF DEPENDENTS' HEALTH

DEPENDENT INFORMATION (PLEASE ANSWER ALL QUESTIONS IN INK)

List all your dependents, including your spouse:

Relation	First Name	Last Name (if different)	Birthdate (D/M/Y)	Sex (M/F)	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, tumor 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?	❑	❑

	Yes	No
2) Have any of your dependents used cigarettes or any other tobacco product in the past 12 months?	❑	❑
3) Are any of your dependents currently taking any prescription medication?	❑	❑
4) 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 treatments other than stated above?	❑	❑
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	Date of Recovery	Medication and/or Treatment	Approximate Monthly Cost

I hereby declare that the above answers and statements are complete and true. 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 (D/M/Y) _____

Spouse's signature _____ Date (D/M/Y) _____

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