

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

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EMPLOYEE INFORMATION (to be completed by the Employee)

Last Name _____ Birthdate (DD/MM/YY) _____
 First Name _____ Male Female
 Middle Name _____ Smoker Non-Smoker
 Home 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 (DD/MM/YY)	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 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.

Employee's Signature _____ Date _____

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EMPLOYMENT INFORMATION (to be completed by the Employer)

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

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 _____