



Chambers of Commerce
Group Insurance Plan®

GROUP BENEFIT PLAN WAIVER

I, _____, have been offered the opportunity to participate in my employer's
(Name)

employee benefit program. I understand the benefits offered and I do not wish to enroll in the program.

I understand that by refusing these benefits, my heirs / beneficiaries and I have no claim, now or in the future, for benefits under the program. I hold my employer, its representatives and the insuring company(ies) harmless from all future claims.

I also understand that if I wish to participate in the employee benefit program at a later date, participation will be subject to the insurer's approval. I may be required to provide evidence of my good health and/or my dependents' good health. Any dental benefits will be limited to \$250 per employee or dependent in the first twelve months of coverage.

Dated at _____ in _____, this _____ of _____ 20_____.
town/city province day month year

Firm Name

Firm Number

Employee's Signature

Witness

Spouse's Signature (if applicable)

Witness

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