



GROUP INSURANCE BENEFIT CHANGE FORM

COMPANY INFORMATION

Firm # \_\_\_\_\_ Has any of the following information changed? Yes  No 
Company Name \_\_\_\_\_
Full Mailing Address \_\_\_\_\_
Postal Code \_\_\_\_\_
Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Fax \_\_\_\_\_
Contact Name  Mr.  Mrs.  Ms.  Other \_\_\_\_\_
Alternate Contact  Mr.  Mrs.  Ms.  Other \_\_\_\_\_
Company Email \_\_\_\_\_ Language Preference  English  French
Member of \_\_\_\_\_ Chamber or Board Date Joined Chamber \_\_\_\_\_

COVERAGE REQUESTED

Effective \_\_\_\_\_ please amend our current benefits as follows:
Please change benefits from 1-4 to 5 or more enrolled employees Yes  No 
Please "cap" our benefits at the following benefit level Life/AD&D \_\_\_\_\_ W.I. \_\_\_\_\_ L.T.D. \_\_\_\_\_
Rates are to be Blended  Not Blended

Delete the following benefits entirely:

- Dependent Life  Weekly Indemnity  Long Term Disability  Posaction  Business Overhead  Critical Illness  Health Care  Dental Care

Add or change our current coverage to the following:

Firms with 1 to 4 5 or more Enrolled Employees

Basic Life Insurance / Accidental Death & Dismemberment
Age 65 reduction
50% 75%
1X 2X 3X LVA LEV 50 75 100
1X 2X 3X LVA LEV 50 75 100
1 times annual salary
2 times annual salary
3 times annual salary
Level \$25,000 benefit
Level \$35,000 benefit for managers/\$20,000 for employees
Level \$50,000 benefit
Level \$75,000 benefit
Level \$100,000 benefit

Dependents Group Life
D1 D2 D3
D1 D2 D3
Spousal coverage of \$5,000 plus \$2,500/child
Spousal coverage of \$10,000 plus \$5,000/child
Spousal coverage of \$15,000 plus \$7,500/child

Weekly Indemnity
W1 W2 W3 W4 W6\*
W1 W2 W3 W4 W6\*
Benefits from the 15th day of disability for up to 15 weeks
Benefits from the 31st day of disability for up to 13 weeks
Benefits from the 61st day of disability for up to 9 weeks
Benefits from the 1st day of an accident, 1st day of a hospital stay, 8th day of illness, for up to 17 weeks
Benefits from the 1st day of an accident, 1st day of a hospital stay, 8th day of illness, for up to 26 weeks
\*LTD is not available with this option

Long Term Disability
L1 L2 L3 L4 L5
L1 L2 L3 L4 L5
Benefits from the 121st day of disability for up to 2 years
Benefits from the 121st day of disability for up to 5 years
Benefits from the 121st day of disability up to age 65
With 24-month "own occupation" definition of disability
With "any occupation" definition of disability
Benefits from the 121st day of disability for up to 5 years
Benefits from the 121st day of disability up to age 65



## COVERAGE REQUESTED (CONT'D)

Add or change our current coverage to the following:

Firms with  
1 to 4 : 5 or more  
Enrolled Employees

Posaction	<input type="checkbox"/> A1	<input type="checkbox"/> A1	Employee Assistance Benefits
Business Overhead	\$ _____ of monthly benefit (units of \$100 up to \$2,000)		
Critical Illness	<input type="checkbox"/> C11	<input type="checkbox"/> C11	\$30,000/employee

Firms with  
1 & 2 : 3 to 9 : 10 or more  
Enrolled Employees

Dental Care			
			<i>\$1,500 Overall Maximum (per person/per year)</i> <i>\$1,000 Orthodontic Maximum (per dependent/per lifetime)</i>
	<input type="checkbox"/> D1	<input type="checkbox"/> D1	\$25/\$50, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal
	<input type="checkbox"/> D2	<input type="checkbox"/> D2	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal
	<input type="checkbox"/> D3	<input type="checkbox"/> D3	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D4	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontics
	<input type="checkbox"/> D5	<input type="checkbox"/> D5	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal
	<input type="checkbox"/> D6	<input type="checkbox"/> D6	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D7	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontics
<input type="checkbox"/> D8	<input type="checkbox"/> D8	<input type="checkbox"/> D8	\$25/\$50, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal
	<input type="checkbox"/> D9	<input type="checkbox"/> D9	\$25/\$50, <b>100%</b> Basic
	<input type="checkbox"/> D10	<input type="checkbox"/> D10	\$0, <b>100%</b> Basic
	<input type="checkbox"/> D11	<input type="checkbox"/> D11	\$0, <b>100%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D12	\$0, <b>100%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontic
<input type="checkbox"/> D13	<input type="checkbox"/> D13	<input type="checkbox"/> D13	\$25/\$50, <b>80%</b> Basic
<input type="checkbox"/> D14	<input type="checkbox"/> D14	<input type="checkbox"/> D14	\$0, <b>80%</b> Basic
	<input type="checkbox"/> D15	<input type="checkbox"/> D15	\$0, <b>80%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D16	\$0, <b>80%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontic
			<i>\$2,000 Overall Maximum (per person/per year)</i> <i>\$2,000 Orthodontic Maximum (per dependent/per lifetime)</i>
	<input type="checkbox"/> D17	<input type="checkbox"/> D17	\$25/\$50, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal
	<input type="checkbox"/> D18	<input type="checkbox"/> D18	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal
	<input type="checkbox"/> D19	<input type="checkbox"/> D19	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D20	\$0, <b>100%</b> Basic, <b>100%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontics
	<input type="checkbox"/> D21	<input type="checkbox"/> D21	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal
	<input type="checkbox"/> D22	<input type="checkbox"/> D22	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D23	\$0, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontics
<input type="checkbox"/> D24	<input type="checkbox"/> D24	<input type="checkbox"/> D24	\$25/\$50, <b>80%</b> Basic, <b>80%</b> Endodontic/Periodontal
			<i>\$700 Overall Maximum (per person/per year)</i> <i>\$500 Orthodontic Maximum (per dependent/per lifetime)</i>
	<input type="checkbox"/> D25	<input type="checkbox"/> D25	\$25/\$50, <b>100%</b> Basic
	<input type="checkbox"/> D26	<input type="checkbox"/> D26	\$0, <b>100%</b> Basic
	<input type="checkbox"/> D27	<input type="checkbox"/> D27	\$0, <b>100%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D28	\$0, <b>100%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontic
	<input type="checkbox"/> D29	<input type="checkbox"/> D29	\$0, <b>80%</b> Basic
	<input type="checkbox"/> D30	<input type="checkbox"/> D30	\$0, <b>80%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major
		<input type="checkbox"/> D31	\$0, <b>80%</b> Basic, <b>50%</b> Endodontic/Periodontal, <b>50%</b> Major, <b>50%</b> Orthodontic
<input type="checkbox"/> D32	<input type="checkbox"/> D32	<input type="checkbox"/> D32	\$25/\$50, <b>80%</b> Basic



## COVERAGE REQUESTED (CONT'D)

Add or change our current coverage to the following:

Firms with  
1 & 2 : 3 or more  
Enrolled Employees

<b>Health Care</b>	<input type="checkbox"/> E00	<input type="checkbox"/> E00	<i>Basic Extended Health / Medical Emergency Assistance / Travel Health Benefits</i> \$0 deductible, all benefits paid at 100% <i>Add prescription drug coverage on a reimbursement basis</i>
	<input type="checkbox"/> E1	<input type="checkbox"/> E1	\$25/\$50, 80% RX, 100% all other benefits
	<input type="checkbox"/> E10	<input type="checkbox"/> E10	\$0, 80% RX, 100% all other benefits
	<input type="checkbox"/> E35	<input type="checkbox"/> E35	\$250/\$500, 80% RX, 100% all other benefits
	<input type="checkbox"/> E37	<input type="checkbox"/> E37	\$500/\$1,000, 80% RX, 100% all other benefits <i>Add prescription drug coverage on a drug card</i>
	<input type="checkbox"/> E11	<input type="checkbox"/> E11	\$0, 80% RX, 100% all other benefits
	<input type="checkbox"/> E13	<input type="checkbox"/> E13	\$0, 70% RX, 100% all other benefits
	<input type="checkbox"/> E21	<input type="checkbox"/> E21	\$50/\$100 on RX, 80% all benefits <i>Add prescription drug coverage on a drug card using the Assure National Formulary (non-formulary prescriptions are paid at 50%)</i>
	<input type="checkbox"/> E17	<input type="checkbox"/> E17	\$0, 80% / 50% RX, 100% all other benefits
	<input type="checkbox"/> E19	<input type="checkbox"/> E19	\$0, 70% / 50% RX, 100% all other benefits <i>Add prescription drug coverage on a drug card using the Assure National Formulary (non-formulary prescriptions are paid at 50%) "Other benefits" may have limitations</i>
	<input type="checkbox"/> E40	<input type="checkbox"/> E40	\$0, 80% / 50% RX, 80% all other benefits except Out of Country and Hospital coverage which are paid at 100% <i>Add Vision Care to any of the above options</i>
	<input type="checkbox"/>	<input type="checkbox"/>	\$100 per adult every 24 months (every 12 months for children)
		<input type="checkbox"/>	\$200 per adult every 24 months (every 12 months for children)



## CHAMBER MONTHLY MEMBERSHIP FEE AUTHORIZATION

I authorize the Chambers of Commerce Group Insurance Plan administrator to collect monthly Chamber of Commerce / Board of Trade membership fees from this company, on the same billing as our group benefit plan premium.

Our Chamber membership fees, as set by the Chamber / Board, will be \$ \_\_\_\_\_ per month including GST. I understand that this amount is subject to change when the Chamber / Board sets a new fee schedule.

This payment authorization continues as long as our group coverage remains in effect with the Plan. In the event our company cancels our Chamber group coverage, this authorization ceases. At that time, the company must apply directly with their local Chamber or Board to maintain membership.

Date \_\_\_\_\_ Signature \_\_\_\_\_



## DECLARATION

All statements, representations and answers made in this application are consideration for and a basis of the insurance herein requested and whether written or printed are declared to be true, full and complete. I understand that my application cannot be processed until you receive confirmation that I have joined a participating Chamber of Commerce or Board of Trade.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_

Official \_\_\_\_\_ (Signature) \_\_\_\_\_ (Please print your Name and Title)

Witness \_\_\_\_\_ (Signature) Advisor \_\_\_\_\_ (Number and Name)

### CHAMBERS OF COMMERCE GROUP INSURANCE PLAN

582 King Edward Street, Winnipeg, Manitoba R3H 0P1  
Facsimile (204)774-6698 or TOLL FREE 1-800-457-8410  
www.chambers.ca

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



**Chambers of Commerce  
Group Insurance Plan®**

582 King Edward Street, Winnipeg, Manitoba R3H 0P1  
Telephone (204)774-6677 or TOLL FREE 1-800-665-3365  
Facsimile (204)774-6698 or TOLL FREE 1-800-457-8410  
[www.chambers.ca](http://www.chambers.ca)