



EMAIL AND FAX AUTHORIZATION REQUEST



Employee Information

Employee's Name _____ Firm # _____ Certificate # _____

Firm Name _____



Authorization to Email or Fax Personal Medical Information

I authorize the Chambers of Commerce Group Insurance Plan to email or fax a copy of any requests for additional medical information and/or questionnaires required to process any application for coverage under this plan, including any correspondence relating to a medical underwriting decision. This authorization extends to my dependents, if applicable. A photocopy of this authorization is as valid as the original.

Email address _____

Fax number _____

Signature of Employee _____ Date (YY/MM/DD) _____



Declaration and Authorization for the Collection and Communication of Personal Information

All the information I have provided on the form is accurate and complete, to the best of my knowledge.

I authorize Chambers of Commerce Group Insurance Plan to collect, use, maintain and disclose personal information relevant to this application for the purposes of benefit plan administration, assessment, investigation, claim management, underwriting and for determining Plan eligibility. The non-exhaustive list of sources from which information can be collected includes medical and health professionals, facilities or providers, insurance companies, or other organizations/persons. This authorization is also valid for the collection, use and communication of personal information concerning my dependents, insofar as applicable to the administration of benefits under this plan.

I acknowledge that more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.chambers.ca or from the administrator of my benefit program. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date (YY/MM/DD) _____

Please return this form to our office.

Fax
204-774-6698
or 1-800-457-8410

Email
chambers@johnstongroup.ca

Mail
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