



## BENEFICIARY DESIGNATION

### Employee Information

Employee's Name \_\_\_\_\_ Firm # \_\_\_\_\_ Certificate # \_\_\_\_\_  
Firm Name \_\_\_\_\_

I hereby name the following beneficiary(ies) of any Life Insurance benefits payable as a result of my participation in this plan.

Last Name	First Name and Initial	% of Benefit	Relationship with Employee	Birthdate
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Divided:  As per percentages above (must total 100%)  In equal shares to survivor(s)

When Quebec law applies, a spouse beneficiary is irrevocable (an irrevocable beneficiary must consent to any change) unless you make the designation revocable by checking here:  **Revocable**, I may change this designation at any time.

**Trustee/Administrator Designation:** If the beneficiary is under the age of majority, I appoint the trustee/administrator named below to receive any amount payable to a minor beneficiary under this policy. The trustee/administrator shall discharge the Insurer for the amount paid. I authorize the trustee/administrator to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Full Name	Relationship with employee
_____	_____

*If you are designating a trustee/administrator, you should consult with a legal advisor and any proposed trustee/administrator.*

**For Quebec Only:** The appointment will be interpreted in accordance with provisions governing the administration of property of others, under Quebec Civil Code.

### 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](http://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 \_\_\_\_\_

Please return this form to our office.

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

**Email**  
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