Chambers Plan
Employee Benefits

JG10-CH

Beneficiary Designation

EMPLOYEE INFORMATION

Employee's Name _____ Firm # _____ Certificate # _____

Firm Name _____

PRIMARY DESIGNATION

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 to 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.

CONTINGENT DESIGNATION

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). Should there not be any surviving beneficiary(ies) at the time of your death, the proceeds will be paid to your estate.

Last Name	First Name and Initial	% of Benefit	Relationship to Employee	Birthdate

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

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_____ _____

Full Name **Relationship with Employee**

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Continued...

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Employee's Name _____ Firm # _____ Certificate # _____

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 Policy on www.chamberplan.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
chambers@johnstongroup.ca

Mail
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Winnipeg, MB R3H 0R4