



CHANGE OF BENEFICIARY AND NAME FORM

Please complete this form in INK and print clearly.

PLAN MEMBER INFORMATION



- Policy # 138020
- GSR16046
- Policy # CI10334601

MEMBER SURNAME		GIVEN NAME		INITIAL
GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH year month day		STREET ADDRESS	
CITY	PROVINCE	POSTAL CODE	TELEPHONE ()	
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married/Common-law		REFERENCE NUMBER		

APPOINTMENT OF NEW BENEFICIARY

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

An original copy of this form will be required for a life insurance claim.

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	% ALLOCATED	RELATIONSHIP TO PLAN MEMBER

You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Quebec law applies and you have designated your married spouse or civil spouse as beneficiary, the designation will be *irrevocable* unless you check the box marked "Revocable".

I hereby make the above beneficiary(ies) designation: Revocable Irrevocable

TRUSTEE CLAUSE

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

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to complete this Trustee Clause.

I hereby nominate and appoint:

TRUSTEE SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

If living, to receive and disburse any monies payable under the said group policy to my beneficiary(ies) during minority, and any payments made to the said trustee shall discharge THE GREAT-WEST LIFE ASSURANCE COMPANY / ACE INA to the extent of such payment.

EMPLOYEE NAME CHANGE

I hereby request that the plan's records reflect my change of name.

FROM:

EMPLOYEE SURNAME	GIVEN NAME	INITIAL	FORMER SIGNATURE

TO:

EMPLOYEE SURNAME	GIVEN NAME	INITIAL	NEW SIGNATURE

BENEFICIARY'S NAME CHANGE

Please use this section **ONLY** when you are reporting a change in your current beneficiary's name. Use the "Appointment of new beneficiary" section when naming a new beneficiary.

I hereby request that the plan's records reflect my present beneficiary's name change.

FROM:

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

TO:

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

AUTHORIZATIONS & DECLARATIONS

- I AUTHORIZE:**
- . Coughlin the use of my Social Insurance Number for the purposes of government reporting, identification and administration of my group benefits;
 - . Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and
 - . Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled.
- When providing personal information for my spouse and/or dependants, I confirm that I am authorized to act on their behalf. I agree that a photocopy or electronic copy of this Authorizations & Declarations section is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Member's Signature _____

Date(y/m/d) _____

Protecting your personal information The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

THIS IS TO CERTIFY that the above change of beneficiary/name has been noted and placed on file with the group policyholder.

CHECKED BY: _____

DATE (y/m/d): _____