

BENEFICIARY UPDATE

Please print clearly in INK

Firm/Company Name _____ Firm/Division # _____

Employee Name _____ Certificate # _____

THE EMPLOYEE COMPLETES THIS SECTION OF THE FORM:

Please print clearly in INK (crossed out or revised information must be initialed by the employee)

Beneficiary Designation

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

Last Name	First Name	Middle Initial	% of Benefit	Relationship to Employee

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

Where 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

An irrevocable beneficiary must consent to any change by completing the following:

I, _____
Full Name

hereby revoke my designation as the current beneficiary(ies), in accordance with the provisions of this contract.

Signature of revoked beneficiary(ies)

Signature of beneficiary(ies) witness(es)

Date

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 to Employee

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

For Quebec Residents: Where this appointment is governed by Quebec law, "trustee" shall be read as "administrator", and all terms interpreted accordingly. 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 Maximum Benefit 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.maximumbenefit.ca or from the administrator of my benefit program.

A photocopy or electronic version of this form is **not valid** for recording beneficiary designations.

Signature of Employee _____ Date _____