

# Basic Life Insurance Plan - Beneficiary Designation/Change of Beneficiary

Please print in ink and retain a copy for your records in a secure place

**Status of Employee**  Active Employee  Retired Employee in Receipt of Immediate Pension

**Type of Transaction**  Enrollment  Amendment  Change of Beneficiary  Change of Employee Name

**A - Employee/Retiree Information**

Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initials \_\_\_\_\_ Employee ID No. \_\_\_\_\_ Male  Date of Birth \_\_\_\_\_  
Female  Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_ Telephone No. \_\_\_\_\_

**B - Coverage Options - Retiree only (Please select one)**

Full Amount  Flat \$10,000 (Complete CPC Paid Death Benefit Age 65 and up - Beneficiary Designation/Change of Beneficiary Form).  Decline Coverage - Complete Section E below  
I understand the Retiree Basic Life Insurance coverage offered to me but decline to participate.

**C - Beneficiary Designation/Change of Beneficiary**

**Note** For more than 3 beneficiaries, attach separate sheet. You are responsible to ensure that the beneficiary designation is complete (last name, first name, middle initial). If the beneficiary designation is incomplete or no beneficiary is designated, your estate will be deemed to be the beneficiary. If you designate a beneficiary as irrevocable, or have previously designated a beneficiary as irrevocable, you cannot change your beneficiary designation without the prior written consent of the irrevocable beneficiary.

Where Quebec law applies, a spousal beneficiary (whether married or civil union spouse) is irrevocable unless you make the designation revocable by checking here: Revocable

If more than one beneficiary is designated, ensure that the appropriate % share of benefit is shown below:

1	% of benefit _____ %	Beneficiary's Surname _____	First Name _____	Initials _____	Relationship to Employee _____
		Address _____	City _____	Prov./State _____	Postal/Zip Code _____
		Country _____	Telephone No. _____		
2	% of benefit _____ %	Beneficiary's Surname _____	First Name _____	Initials _____	Relationship to Employee _____
		Address _____	City _____	Prov./State _____	Postal/Zip Code _____
		Country _____	Telephone No. _____		
3	% of benefit _____ %	Beneficiary's Surname _____	First Name _____	Initials _____	Relationship to Employee _____
		Address _____	City _____	Prov./State _____	Postal/Zip Code _____
		Country _____	Telephone No. _____		

**D - Trustee/Administrator Clause**

If designating a beneficiary who is a minor or who otherwise lacks legal capacity, you may wish to appoint a trustee/administrator by completing this section. This appointment may not be suitable for all purposes. **We recommend you consult with a legal advisor, and with any proposed trustee/administrator. Do not complete this section if you have made another trustee/administrator appointment.**

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group policy where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the Insurance Company and Canada Post from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

**FOR QUEBEC ONLY**  
Where this appointment is governed by Quebec law, "trustee" shall be understood as "administrator", and their related terms and concepts understood accordingly. This appointment shall be interpreted in accordance with the provisions governing the administration of the property of others, under the Quebec Civil Code.

Trustee's/Administrator's Surname \_\_\_\_\_ First Name \_\_\_\_\_ Initials \_\_\_\_\_  
Relationship to Employee \_\_\_\_\_  
Address of Trustee \_\_\_\_\_  
City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_  
Country \_\_\_\_\_ Telephone No. \_\_\_\_\_

**E - Cancellation of Insurance - Retiree Only**

I understand the Retiree Basic Life Insurance coverage offered to me but decline to participate. I understand that I cannot rejoin the Plan at a later date.

Retiree's Signature \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Name of Witness (please print) \_\_\_\_\_  
Witness' Signature \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Address of Witness \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_ Telephone No. \_\_\_\_\_

**F - Authorization and Protection of Personal Information**

I hereby apply for coverage under the Basic Life Insurance Plan and authorize the deduction from my pay/my pension of any contributions I must make towards the cost of this benefit. I understand and agree that the personal information that you collect from me will be used to provide the group coverage and to administer the benefits. Access to this personal information is limited to those who require it to administer this benefit in the performance of their duties, those to whom I have granted access, and those authorized by law. I agree that a photocopy or electronic copy of this form is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's/Retiree's Signature \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_  
Witness' Signature - Other than the beneficiary (ies) \_\_\_\_\_ Year \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_

Address of Witness \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_ Country \_\_\_\_\_ Telephone No. \_\_\_\_\_

**G - Office Use Only**

Plan No.	Effective Date of Coverage/Change	Year	Month	Day	Benefits Representative Name	System Updated	Year	Month	Day
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