



# BENEFICIARY DESIGNATION

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Complete this form to add to or change the status of your existing Beneficiary information on file. The original of this form is required for a Life Claim. Crossed out Beneficiary Designations must be initialled. Please complete in ink.

## General Information

Plan Sponsor Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Member Name: \_\_\_\_\_ Personal Identification Number: \_\_\_\_\_

I confirm by checking below this applies to the following in-force Benefits:

Group Life & Accidental Death and Dismemberment  Optional Life  Optional Accidental Death and Dismemberment

## Primary Beneficiary

Beneficiaries listed below revoke any Primary Beneficiary previously assigned. Percentage allocation will be deemed equal unless indicated otherwise. Percentages must total 100%.

_____	_____	(YYYY/MM/DD)	_____	_____
First Name	Last Name	Date of Birth	Relationship to Member	Percentage (%)
_____	_____	(YYYY/MM/DD)	_____	_____
First Name	Last Name	Date of Birth	Relationship to Member	Percentage (%)
_____	_____	(YYYY/MM/DD)	_____	_____
First Name	Last Name	Date of Birth	Relationship to Member	Percentage (%)

**In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.**

A revocable nomination can be changed at any time without the beneficiary's consent. You cannot change an irrevocable beneficiary nomination unless certain requirements are met.  Revocable beneficiary

## Contingent Beneficiary

Used when the Primary Beneficiary predeceases the member. Beneficiary listed below revokes any Contingent Beneficiary previously assigned.

_____	_____	(YYYY/MM/DD)	_____	_____
First Name	Last Name	Date of Birth	Relationship to Member	Percentage (%)

**In Quebec, if you name your spouse as the beneficiary, this beneficiary will be irrevocable unless you check the revocable box.**

Revocable beneficiary

## Trustee Assignment

Only to be completed when a named Beneficiary is a minor.

I hereby confirm the Trustee listed below, who is over the age of majority, will receive and disperse monies payable under this group policy for any designated beneficiary who is a minor at the time insurance proceeds are payable. This Trustee Assignment revokes any Trustee previously assigned.

_____	_____	_____
First Name	Last Name	Relationship to Member

## Member Authorization

I declare the information is complete and reflects my intentions of who will receive my Life Insurance Benefits upon my death. If no designated beneficiary survives me, settlement will be made to my Estate. I hereby authorize my Employer, GroupSource, the Insurer, or their Agents to collect, use and disclose relevant information about me to underwrite, administer and pay claims.

Member Signature: \_\_\_\_\_ Date: (YYYY/MM/DD) \_\_\_\_\_

*GroupSource is committed to protecting the confidentiality, accuracy and security of the personal information it collects and uses in the course of conducting business.*