CINUP

APPOINTMENT OF BENEFICIARY

1

Employer Name ____________________

Employee Name ____________________

Group Insurance Certificate # ____________________

In accordance with the terms and conditions of the Contract between the employer indicated above and the Insurance Company, I hereby revoke all previous appointment of beneficiary and hereby appoint the following as beneficiary to receive the proceeds arising by reason of my death. I reserve the right to change the beneficiary at any time.

To submit a beneficiary change for your pension plan you will need to complete the appropriate beneficiary change form with your pension provider.

2

PRIMARY BENEFICIARY (please print)

Please indicate relationship to beneficiary. If a minor, indicate date of birth and assign a trustee below.

If additional space is required, please attach a separate page.

Full Name	Birthdate (YYYY/MM/DD)	Relationship	Proportion (must equal 100%)

TRUSTEE FOR CHILD OF MINORITY (please print)

I hereby name ____________________, my ____________________ (relationship) if living, as Trustee to receive and disburse any monies payable to any child listed below of minority. Any payment made to said trustee shall discharge the company to the extent of such payment.

3

☐ **ADDITIONAL BENEFICIARIES** ☐ **CONTINGENT BENEFICIARIES** (Secondary beneficiary if the above beneficiary is deceased)

Full Name	Birthdate (YYYY/MM/DD)	Relationship	Proportion (must equal 100%)

4

Authorization and Consent

I understand the personal information provided herein as well as any other personal information currently held or collected in the future by JG Benefits Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and service to me and my employer, and to manage the organization's business.

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand the personal information will be kept confidential and secure. I understand I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I acknowledge more specific information about collection and use of my personal information can be found in the Privacy and Terms of Use section of www.cinup.ca or from the administrator of my benefit program.

Employee Signature ____________________ **Date** ____________________

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