Chambers of Commerce
Group Insurance Plan®

J G 3 9 - C H

BENEFICIARY DESIGNATION

Employee Information

Employee's Name _____ Firm # _____ Certificate # _____

Firm Name _____

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

Last Name	First Name	Middle Name	Relationship with employee	%

For Quebec Residents:

Where Quebec law applies, a spouse beneficiary is irrevocable unless you make the designation revocable by checking here:

❑ **Revocable**

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

I, _____, hereby revoke my designation as the current beneficiary(ies), in
Last and first name of revoked beneficiary(ies)
accordance with the provisions of this contract.

_____ _____ _____
Signature of revoked beneficiary(ies) Signature of beneficiary(ies) witness(es) Date

Trustee Designation (Not applicable in Quebec)

If the beneficiary is under the age of majority, I appoint the trustee named below to receive any amount payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. I authorize the trustee to spend all or part of the amount, or interest earned on it, for the support or education of the minor.

Last Name	First Name	Middle Name	Relationship with Employee

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 Chambers of Commerce Group Insurance Plan 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.chambers.ca or from the administrator of my benefit program. A photocopy of this authorization is as valid as the original.

Signature of Employee _____ Date _____

Please return this form to our office.

Fax
(204) 774-6698
or 1-800-457-8410

Email
chambers@johnstongroup.ca

Mail
Chambers of Commerce Group Insurance Plan
582 King Edward Street
Winnipeg MB R3H 0P1

Desjardins Financial Security, ACE INA Insurance and Western Life Assurance Company are the primary insurers for the Plan.