

BENEFICIARY DESIGNATION CHANGE FORM



Please print clearly and complete this form in INK. Plan Member should return the completed form to your Plan Administrator. If you use GroupNet for Plan Administrator. completed form should be maintained by the Plan Administrator.

General Enrolment Information	Plan number:	168000	Memb	er ID #: (found on d	rug card):	
	Plan sponsor:	(GOVERNME	NT OF NEWFO	JNDLAND AND LA	BRADOR
	Plan member name (pri					
		last nam			first name	middle initial
	Date of birth: Month	Day	Year	Employee #: (a	ssigned by employer): _	
I hereby revoke all previous bene as indicated below: Basic Life Insurance and Basic Optional Employee Life Insur Optional Accidental Death & I If you wish to designate a separat	C Accidental Death & Di ance (Policy No. 16800) Dismemberment Insura	ismemberm 2) ance (Policy	ent Insuran No. 168002	ce (Policy No. 16	58000)	
2. Primary Beneficiary Designation This section must be completed to designations must be init	ignate a beneficiary for your lif		plicable. An ori į	ginal or copy of this fo	orm will be required for a	life claim. Crossed out
Primary Beneficiary					Percent allocated	Relationship to plan member
last name	first name			middle initial		
last name	first name			middle initial		
last name	first name			middle initial		
To be divided as follows: As per the large the qual s You may change this beneficiary design change the designation or make certain Note: Where Quebec law applies and you check the box marked Revocabl I hereby make the above beneficiary Revocable, I may change this ben	ation at any time upon notic changes to your coverage to you have designated your e", below. designation:	ce to Canada L under the plan r married spor				
For Quebec Applicants Only - Benefits to their tutor(s) or curator(s), unless a v and Canada Life has been provided not Before designating a trust, you should	payable under this plan to a alid trust has been establisl ice of the trust. If a valid tru seek legal advice.	a beneficiary w ned for the bei ist has already	who, at the tim nefit of the be been establis	e payment is to be neficiary, by Will or hed, designate the	made, is a minor or lac by separate contract, t trust as the beneficiary	ks legal capacity, will be paid o receive any such payment in this section.
3. Contingent Beneficiary De If you wish to appoint a contingent bei	· ·	e are no survivir	ig primary bene	ficiaries at the time of	your death, please compl	ete this section.
If there are no surviving benficiaries at Contingent Beneficiaries at the time of				ingent Beneficiarie	s shall receive the proc	ceeds. If there are no surviving
Contigent Beneficiary					Percent allocated	Relationship to plan member
last name	first name			middle initial		
last name	first name			middle initial		
last name	first name			middle initial		
To be divided as follows: ☐ As per the ☐ In equal s You may change this beneficiary design. change the designation or make certain			ife. If you wish	n to make the benef vritten consent of th	iciary designation irrevo ne beneficiary) please co	ocable (meaning you may not omplete form #M6348 BIL.
Note: Where Quebec law applies and you check the box marked "Revocabl I hereby make the above beneficiary Revocable, I may change this ben	you have designated your e", below. designation:	r married spo				

For Quebec Applicants Only - Benefits payable under this plan to a beneficiary who, at the time payment is to be made, is a minor or lacks legal capacity, will be paid to their tutor(s) or curator(s), unless a valid trust has been established for the benefit of the beneficiary, by Will or by separate contract, to receive any such payment and Canada Life has been provided notice of the trust. If a valid trust has already been established, designate the trust as the beneficiary in this section.

Before designating a trust, you should seek legal advice.

4. Trustee appointmentYou may wish to appoint a trustee/ administrator by completing this

An original or copy of this form will be required for a life claim.

Please print clearly, in INK.

DO NOT COMPLETE THIS SECTION IF YOU ARE A QUEBEC RESIDENT

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee/administrator by completing this form. This appointment may not be suitable for all purposes.

If you are designating a trustee/administrator, 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 benefits plan 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 Canada Life Assurance Company 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.

Trustee last name	first name	middle initial	Relationship to plan member

5. Privacy

This section explains Canada Life's commitment to privacy.

At The Canada Life Assurance Company we recognize and respect the importance of privacy.

Your personal information:

When you apply for coverage, we establish a confidential file that contains your personal information like your name, contact information, and products and coverage you have with us. Depending on the products or services you apply for and are provided with, this may also include financial or health information. Your information is kept in the offices of Canada Life or the offices of an organization authorized by Canada Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Canada Life.

Who has access to your information:

We limit access to personal information in your file to Canada Life staff or persons authorized by Canada Life who require it to perform their duties and to persons to whom you have granted access. In order to assist in fulfilling the purposes identified below, we may use service providers located within or outside Canada. Your personal information may also be subject to disclosure to public authorities or others authorized under applicable law within or outside Canada.

What your information is used for:

Personal information that we collect will be used for the purposes of determining your eligibility for products, services or coverage for which you apply, providing, administering or servicing products or coverage you have with us, and for Canada Life's and its affiliates' internal data management and analytics purposes. This may include investigating and assessing claims, paying benefits, and creating and maintaining records concerning our relationship. The consent given in this form will be valid until we receive written notice that you have withdrawn it, subject to legal and contractual restrictions. For example, if you withdraw your consent, we may not be able to continue to adjudicate or administer a claim for benefits.

If you want to know more:

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Canada Life's Chief Compliance Officer or refer to www.canadalife.com.

6. Authorizations and Declarations

This section must be signed and dated in INK by the plan member.

I have read and understand and agree with the contents of the section on this form entitled "Privacy".

I authorize:

Canada Life, any healthcare provider, my plan administrator, other insurance or reinsurance companies, administrators
of government benefits or other benefits programs, other organizations, or service providers working with Canada Life
or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage
and to administer the plan.

I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.

I certify that the information given is true, correct and complete to the best of my knowledge.

For Quebec applicants: I request that this form be in English.

Je demande que ce formulaire me soit remis en anglais.

Plan member signature:	Date:	