BENEFICIARY DESIGNATION
The City of Winnipeg Employees' Group Life Insurance Plan

For CL Head Office Use Only
CL Certificate Number

Please print clearly and complete this form in INK. Return the completed original form to The Winnipeg Civic Employees' Benefits Program.

1. General Enrolment Information

Plan number: 31394 Division number: _____ Plan member ID: _____

Plan sponsor: The City of Winnipeg

Plan member name (print): _____
last name first name middle initial

2. Beneficiary Designation

This section must be completed to designate a beneficiary for your life benefits, if applicable.

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

Crossed out beneficiary designations must be initialed.

Please print clearly in INK.

I hereby revoke all previous beneficiary designations and designate the following as beneficiary(ies).

Primary Beneficiary

last name	first name	middle initial	Percent allocated	Relationship to plan member

To be divided as follows: ☐ As per the percentage indicated above, or
☐ In equal shares to the survivor(s)

3. Contingent Beneficiary Designation

If you wish to appoint a contingent beneficiary in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

If there are no surviving beneficiaries at the time of my death, I declare that the following Contingent Beneficiaries shall receive the proceeds. If there are no surviving Contingent Beneficiaries at the time of my death, the proceeds shall be paid to my estate.

Contingent Beneficiary

last name	first name	middle initial	Percent allocated	Relationship to plan member

To be divided as follows: ☐ As per the percentage indicated above, or
☐ In equal shares to the survivor(s)

You may change this beneficiary designation at any time upon notice to The Winnipeg Civic Employees' Benefits Program. If you wish to make the beneficiary designation irrevocable (meaning you may not change the designation or make certain changes to your coverage under the plan without the written consent of the beneficiary) please complete form #M6348 BIL.

4. Trustee Appointment

You may wish to appoint a trustee/administrator by completing this section

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

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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.

Plan member signature: _____ **Date:** _____

For Office Use Only	
Checked and Coded	
Initial: _____ Date: _____	

Clear