alberta benefits ltd.

CHANGE TO BENEFICIARY FORM

PART 1 | YOUR INFORMATION

PLAN SPONSOR/GROUP NAME					
PLAN MEMBER NAME (Last Name, First Name)				DATE OF BIRTH (dd/mm/yyyy)	
GROUP #				MEMBER ID #	
MAILING ADDRESS					
CITY		PROVINCE		POSTAL CODE	
PRIMARY PHONE		EMAIL			

PART 2 | BENEFICIARY DESIGNATION

This section is to be completed by the Plan Member to designate a beneficiary for your life benefits. The original copy of this form will be required for a life claim. If you do not designate a beneficiary, for benefits payable upon death, the beneficiary will be the ESTATE. ***Do not scratch-out or white-out any information in this section.***

Beneficiary's Names

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (mm/dd/yyyy)	PERCENT ALLOCATED *	RELATIONSHIP TO PLAN MEMBER

**** The above percentages must total 100% to be valid***

Contingent Beneficiary (If all my beneficiaries pre-decease me, I designate the following as my beneficiary).

LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (mm/dd/yyyy)	PERCENT ALLOCATED *	RELATIONSHIP TO PLAN MEMBER

Where Québec law applies and you have designated your married spouse or civil union spouse as beneficiary, the designation will be irrevocable. In all other provinces: the beneficiary is revocable.

PART 3 | AUTHORIZATION AND DECLARATIONS

Whereas the "Company" refers to Alberta Benefits Ltd. and its partner Canadian Benefits Providers Inc., ***I certify*** *that the information in this form is true and complete to the best of my knowledge.* ***I acknowledge*** *and agree that this Coverage or any portion of this Coverage, and future claims thereunder may be denied or terminated as a result of the provision of false, incomplete, or misleading information.* ***I authorize*** *the collection, use, maintenance and disclosure of personal information relevant to this application ("Information") for the purposes of Group Benefits plan administration, audit, assessment, investigation, claim management, underwriting and for determining plan eligibility ("Purposes").* ***I authorize*** *any person or organization with Information, including any medical and health professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrators of other benefits programs to collect, use, maintain and exchange this information with each other and with my Plan Advisor, its reinsurers and/or its service providers, for the Purposes.* ***I understand*** *that any Information provided to or collected in accordance with this authorization, will be kept in a Group Benefits life, health or disability file. Access to my Information will be limited to: Plan Advisor employees, representatives, reinsurers, and service providers in the performance of their jobs; Persons to whom I have granted access; and Persons authorized by law.* ***I designate*** *the person(s) named under the Beneficiary Designation as my beneficiary. I agree that a photocopy or electronic version of this authorization is valid.*

PLAN MEMBER'S SIGNATURE	DATE SIGNED (dd/mm/yyyy)

Send completed and original forms to your Plan Administrator; retain a copy for your files.

Alberta Benefits Ltd., #202, 10235-124th Street NW, Edmonton, Alberta, T5N 1P9, Canada
TEL: (780) 944 9167, FAX: (780) 944 9168, TOLL FREE: (866) 944 9167, www.albertabenefits.com