APPOINTMENT OF BENEFICIARY(IES)

Life and Accidental Death & Dismemberment Insurance

HARD COPY ORIGINAL OF COMPLETED FORM TO BE MAINTAINED BY EMPLOYER OR ASEBP

INSTRUCTIONS:

1. Please complete required sections A, B and F, along with sections C and D if applicable. Failure to complete this form in its entirety may result in proceeds being paid to your estate.
2. **Return the *original* completed form to your employer unless you are an Early Retiree, Part-Time Employee or Substitute Teacher or Casual Staff.** If you are an Early Retiree or currently participating under ASEBP's Part-Time or Substitute/Casual Staff Benefits, return the original completed form directly to ASEBP.

A. Applicant information

Last name: _____ First name: _____ ASEBP ID #: _____

Mailing address: _____

City: _____ Province: _____ Postal code: _____

Daytime phone: _____ Mobile/Alternate phone: _____

Employer's name (if applicable): _____

Email address (optional): _____ Birth date: _____ / _____ / _____
MM *DD* *YYYY*

B. Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance

I appoint the following beneficiary(ies) for my Life and Accidental Death & Dismemberment Insurance. This appointment supersedes any previous appointments I may have made for these proceeds and I reserve the right to change the beneficiary(ies) named below. If any of the beneficiaries predecease me, I understand their portion will be divided equally among any surviving beneficiaries.

Select one ☐ To the person(s) listed below ☐ To my estate

Last Name	First Name	Relationship	Birthdate (YYYY/MM/DD)	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov, Postal Code)	Phone number (including area code)	% payable to each (must equal 100%)
					TOTAL	100%

C. Contingent Beneficiary(ies) for Life and Accidental Death & Dismemberment Insurance

Your contingent beneficiary(ies) will receive the proceeds of your policy if your primary beneficiary(ies), as indicated in Section B, is deceased at the time of your death.

If all beneficiaries listed in Section B are deceased at the time of your death, the amount payable to your contingent beneficiary(ies) shall be paid as follows.

Select one ☐ To the person(s) listed below

☐ To my estate

Last Name	First Name	Relationship	Birthdate (YYYY/MM/DD)	Complete Mailing Address (Apt., Street, P.O. Box, City, Prov., Postal Code)	Phone number (including area code)	% payable to each (must equal 100%)
					TOTAL	**100%**

D. Appointment of Trustee *(Complete only if one or more beneficiaries is under the age of majority.)*

Note: Your Trustee cannot be a named beneficiary.

I appoint _____ of _____
(Name) (Suite/Apt/Unit no., Street, P.O. Box, City, Prov, Postal Code)

reached at _____ as Trustee and authorize ASEBP to pay any amount payable to any beneficiary under 18 years of
(Phone number)

age to the Trustee. I authorize the Trustee to have access to the insurance proceeds and manage the funds as directed in my last will and testament and to pay the remaining balance to the beneficiary once he/she reaches the age of majority.

E. Consent and Authorization

I understand that the ASEBP must collect, use and disclose the personal information contained herein in order to administer the Life and Accidental Death and Dismemberment Insurance policies. It may be necessary for ASEBP to disclose some or all of the personal information contained herein to your employer or the third party service provider for these purposes. Where third party service providers are retained, appropriate contracts are in place to protect personal information.

I understand why the information is required and am aware of the risks and benefits of providing this information. I consent to the collection, use, and disclosure of my personal information for the purposes identified above. I understand that I may revoke my consent at any time and acknowledge that doing so will affect my eligibility to receive Life and Accidental Death and Dismemberment Insurance benefits.

I understand that by virtue of the provisions of the *Personal Information Protection Act* of Alberta, individuals who derive a benefit from an insurance policy or benefit plan (the beneficiaries named herein) are deemed to consent to the collection, use, and disclosure of their personal information for the purpose of coverage under those plans.

Your employer and/or ASEBP is required to keep a hard copy original version of your completed beneficiary form. By signing below you agree to the storage of this document and the information, including your signature, which it contains.

F. Acknowledgement

I agree to the above and declare that my statements are complete, accurate and true.

Signature: _____ Date: _____

Consent is being obtained in accordance with sections 7, 8, 9 and 61 of the Personal Information Protection Act of Alberta and Schedule 1 of the federal Personal Information Protection Electronic Documents Act. If you have any questions regarding the collection, use and disclosure of your personal information, please refer to ASEBP's Privacy Policy at www.asebp.ca/privacy or contact the privacy officer at 780-438-5300.