TEAMSTERS' NATIONAL BENEFIT PLAN

1610 KEBET WAY, PORT COQUITLAM BC V3C 5W9 TEL: (604) 552-2650 FAX: (604) 552-2653

CHANGE OF BENEFICIARY FORM FOR GROUP LIFE INSURANCE AND ACCIDENTAL DEATH INSURANCE

MEMBER DATA

Name of Employee _____ **Sex** _____
(Print) Last Name First Middle M or F

Address _____
Street

_____ **Postal Code** _____ **Phone (___)**_____
City Province

Date of Birth _____ **Social Insurance Number** _____
Day Month Year

Employment Status: ☐ **Regular Employee** ☐ **Dependent Contractor** ☐ **Other**

BENEFICIARY APPOINTMENT

I hereby revoke any previous beneficiary designations made by me in respect of any benefits payable upon my death under the provisions of the Teamsters' National Benefit Plan (and any group insurance contract the Trustees may select from time to time to underwrite these benefits). I hereby designate the following beneficiary under the Teamsters' National Benefit Plan (and any group insurance contract the trustees may select from time to time to underwrite these benefits) to receive any benefits payable upon my death, and I reserve the right to change this designation at a later date.

....
Name of Beneficiary (Please print clearly) Relationship to you Beneficiary's date of birth

Contact Information (Telephone Number/Address) .....

.....
(If you wish to appoint more than one beneficiary, please list on the reverse side of this form (signed/dated) with detailed information.)

If beneficiary listed above is <u>under age 19 or lacks legal capacity</u>, please appoint a trustee:

....
Name of Trustee (Please print clearly) Relationship to you Trustee's date of birth

Contact Information (Telephone Number/Address) .....

.....
If more than one beneficiary is named, settlement will be made in equal shares to the beneficiary or beneficiaries that survive the insured, unless otherwise provided by the Plan's terms, the group insurance contract or as required by law. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured.

I certify that all information provided on this form is true and correct to the best of my knowledge. I authorize the Plan to use the above information for record keeping purposes and for the administration of the Plan. In addition, I authorize that my Social Insurance Number may be used as my personal identification number for claims information and contributions for me and all other purposes of the Teamsters' National Benefit Plan. I further understand and agree that any and all information provided to the Plan may be used or disclosed by the Plan to agents of the Plan as necessary for the administration of the Plan and/or to determine eligibility for benefits. I understand that benefits are determined by the Board of Trustees in accordance with the Plan Text and the Agreement and Declaration of Trust. A photocopy of this authorization is as valid as the original.

Dated: _____ **Member Signature:** _____

<u>OUR OFFICE MUST RECEIVE THIS ORIGINAL FORM BY MAIL (No photocopies or faxes)</u> 22/08/17