

**BENEFICIARY DESIGNATION**  
**(FOR GROUP PLANS ONLY)**

Please print clearly and complete this form, in INK. Please return to Pension & Benefit & Advisory Service, 2 - 60 University Terrace.

**1. General Enrollment Information**

Plan number: \_\_\_\_\_ Division No.(s): \_\_\_\_\_ ID No.: \_\_\_\_\_

Plan sponsor: **UNIVERSITY OF ALBERTA**

Plan member name: \_\_\_\_\_  
last name first name middle initial

**2. Beneficiary Appointment-Employee Basic Life and Employee Optional Life Insurance**

The original or copy of this original form will be required for a Life claim.

Please print clearly, in INK.

I hereby appoint the beneficiary of my insurance to be paid in the event of my death. Where I have named more than one beneficiary, each is allocated an equal share of my insurance unless I have indicated otherwise.

Primary Beneficiary	Percent allocated	Relationship to plan member	Basic Life	Opt Life
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
last name first name middle initial				
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
last name first name middle initial				
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
last name first name middle initial				
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
last name first name middle initial				

**Appointing Contingent Beneficiaries**

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

Please print clearly, in INK.

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.

Unless I specify otherwise, my contingent beneficiary will apply to all benefits for which I have coverage. I revoke all previous contingent beneficiary appointments.

Name (first, last)	Relationship to plan member	Percentage	Basic Life	Opt Life
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Name (first, last)	Relationship to plan member	Percentage	Basic Life	Opt Life
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

**3. Trustee Appointment**

**MINOR CLAUSE** - check (✓) if necessary

TRUSTEE FOR CHILDREN

Full Name (please print) \_\_\_\_\_ Relationship to Life Insured \_\_\_\_\_

is hereby appointed Trustee to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED in this form who is a minor on the date such payment falls due.

**4. Privacy**

This section explains Great-West Life's commitment to privacy.

**Protecting Your Personal Information**

At The Great-West Life Assurance Company (Great-West Life), we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West 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 Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship. 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 Great-West Life's Chief Compliance Officer or refer to [www.greatwestlife.com](http://www.greatwestlife.com).

**5. Authorization and Declaration**

This section must be signed by the employee.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information".

I authorize:

- Great-West Life, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with Great-West Life to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

It agrees that a photocopy or electronic copy of this 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: \_\_\_\_\_