

## **Beneficiary Designation**

Please mail original completed form to BBD:

Western Canada

500-2755 Lougheed Highway, Port Coquitlam, BC V3B 5Y9 Fax: 604.464.7997 Toll Free Fax: 800.667.1336

Eastern Canada

107 – 6 Cataraqui Street, Kingston, ON K7K 1Z7
Fax: 613.530.3770 Toll Free Fax: 888.272.0414

Name of Employer:			

- To use this form you must already be insured under your employer's plan.
- ► For a new enrollment complete a Group Insurance Enrollment form. ◀
- ▶ PLEASE PRINT. Submit original form only fax copies or photocopies cannot be accepted.  $\blacktriangleleft$

Employee – Comple	ete for Change	of Beneficiary		
Employee Last Name	First Name		Initial	
Beneficiary Designation (use full legal name – e.g. Mary Jane Doe, not Mrs. John D	<i>'</i>	Trustee Designation		
I revoke all previous beneficiary appointments and designate as revo	cubic	(complete only if beneficiary is under age 18)		
beneficiary in the event of my death:		I appoint as revocable Trustee to receive any amount which may be due my beneficiary, while such beneficiary is a minor:		
	%	iay be due my beneficiary, w	while such behenciary is a minor:	
	70			
	% F1	ıll Legal Name		
Full Legal Name Relationship Sh	are of Proceeds			
▶ Important Note ◀	)	(		
For a Beneficiary Designation, your signature must be witnessed	by someone Si	gnature of Employee	Date	
over the age of 18 who is not related to you and who is not your	•	(		
	Si	gnature of Witness	Date	

05-2010