



Life Insurance Plan Beneficiary Change Form

HEB Manitoba Use Only



All applicable sections on this form must be completed. If the form is incorrect or incomplete, the form will be returned to the employee. All corrections made to Section 3 of this form must be initialled by the employee. **Please print clearly in BLUE INK.**

Section 1: Employee Information

Employee Name: _____
Last name First name Middle initial

Address: _____
Mailing Address City/Town Province Postal code

Employee SIN: _____ Birth Date: ____ | ____ | ____ Gender: Male Female
For identification purposes DD MMM YYYY

Section 2: Employment Information

Employer Name: _____ Employer Number: _____

Section 3: Change in Beneficiary Designation

By signing this form below, I, the above named employee, hereby revoke any previous beneficiary designation(s) under the HEB Manitoba Life Insurance Plan and appoint the following as the beneficiary(ies) of any monies payable upon my death under the HEB Manitoba Life Insurance Plan. **Crossed out, white out and/or corrections to primary and/or contingent beneficiary designations must be initialled. Failure to do so may result in the designation reverting to your Estate. Please print clearly in BLUE INK.**

Primary Beneficiary(ies) In equal shares, unless otherwise provided below (indicate % for each beneficiary = 100%)

Last name	First name	Middle initial	Relationship to employee	Percentage

Total = 100%

If you wish to appoint contingent beneficiary(ies), in case there are no surviving Primary beneficiaries at the time of your death, please complete the following section:

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 beneficiary(ies) at the time of my death, the proceeds shall be paid to my Estate.

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

Contingent Beneficiary(ies) In equal shares, unless otherwise provided below (indicate % for each beneficiary = 100%)

Last name	First name	Middle initial	Relationship to employee	Percentage

Total = 100%

Please sign on page 2...

NOTE: Unless the law requires otherwise, the entitlement of any beneficiary who predeceases me will revert to my surviving primary beneficiary(ies) in equal shares, or if there is no surviving primary beneficiary(ies), to my contingent beneficiary(ies). If there is no appointed or surviving contingent beneficiary(ies), the entitlement will revert to my Estate.

*If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a Trustee. Do not complete the following Trustee information if you have already appointed a Trustee in any legal document. **If you are designating a Trustee, we recommend you first consult with the proposed Trustee and a legal advisor.***

If any beneficiary is under 18 or lacks legal capacity at the time of my death, I appoint the individual named below as Trustee to receive and hold in trust all benefits payable to any beneficiary designated hereunder who at the time benefits are paid is a minor or lacks legal capacity to give a valid discharge. Payment of the benefits to the Trustee discharges HEB Manitoba to the extent of payment. The trust will terminate when the beneficiary is of the age of majority and has legal capacity.

Trustee Name: _____ Relationship to Employee: _____

Section 4: Employee Authorization and Signature

CAUTION: Your beneficiary designation by means of a designation form will not be revoked or changed automatically by any future marriage or divorce. Should you wish to change your beneficiary in the event of a future marriage or divorce, you will have to do so by means of a new designation.

I hereby:

1. Acknowledge that I have read and understand the terms and conditions of the Life Insurance Plan as outlined in the *Understanding Your Life Insurance Benefits* brochure. **All corrections have been initialled.**
2. Authorize the administrators of HEB Manitoba, and the individuals and organizations authorized to act on their behalf, to collect, use and disclose my personal information and my personal health information for the purpose of administering the Plans. (For a copy of HEB Manitoba's *Privacy Policy* or for further information about our privacy practices, please visit the *Privacy* section of our website at www.hebmanitoba.ca.)

Employee Signature: _____ Date Signed: _____ | _____ | _____
DD MMM YYYY

Employee Name: _____
Please print

Form Return

Employee

Please submit signed, dated, and completed form to HEB Manitoba, 900-200 Graham Avenue, Winnipeg MB R3C 4L5.