Public Service Alliance of Canada
Alliance de la Fonction publique du Canada

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CHANGE OF BENEFICIARY AND NAME FORM

COUGHLIN
employee benefits specialists

Please select the appropriate box

- ☐ PSAC Enhanced Coverage - Policy GL17700
- ☐ PSAC Critical Illness Coverage - Policy C010367302
- ☐ PSAC (Free $10,000) - Policy GL39240

PLAN MEMBER INFORMATION

Please complete this form in INK and print clearly.

MEMBER SURNAME	GIVEN NAME	INITIAL

GENDER	DATE OF BIRTH	STREET ADDRESS
☐ Male ☐ Female	year month day	

CITY	PROVINCE	POSTAL CODE	TELEPHONE

MARITAL STATUS	REFERENCE NUMBER
☐ Single ☐ Married/Common-law	

APPOINTMENT OF NEW BENEFICIARY

This section is to be completed by the plan member.

This section must be completed to designate a beneficiary for your life benefits, if applicable.

The ORIGINAL form must be returned to the address indicated above.

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	% ALLOCATED	RELATIONSHIP TO PLAN MEMBER
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You must make your beneficiary designation revocable or irrevocable by checking one of the boxes below. You may change a revocable beneficiary designation at any time. You may not change an irrevocable beneficiary designation or make certain changes to your plan without the written consent of the irrevocable beneficiary.

Note: Where Quebec law applies and you have designated your married spouse or civil spouse as beneficiary, the designation will be *irrevocable* unless you check the box marked "Revocable".

I hereby make the above beneficiary(ies) designation: ☐ Revocable ☐ Irrevocable

If any of the above beneficiaries predecease me, such beneficiary's share shall:

☐ revert to my estate ☐ be divided equally among my surviving beneficiaries

TRUSTEE CLAUSE

If you are designating a trustee/administrator, we recommend you consult with a legal advisor and any proposed trustee/administrator.

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to complete this Trustee Clause.

I hereby nominate and appoint:

TRUSTEE SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

EMPLOYEE NAME CHANGE

Please provide a copy of one piece of identification confirming your name change.

I hereby request that the plan's records reflect my change of name.

FROM:

EMPLOYEE SURNAME	GIVEN NAME	INITIAL	FORMER SIGNATURE

TO:

EMPLOYEE SURNAME	GIVEN NAME	INITIAL	NEW SIGNATURE

BENEFICIARY'S NAME CHANGE

Please use this section **ONLY** when you are reporting a change in your current beneficiary's name. Use the "Appointment of new beneficiary" section when naming a new beneficiary.

I hereby request that the plan's records reflect my present beneficiary's name change.

FROM:

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

TO:

BENEFICIARY SURNAME	GIVEN NAME	INITIAL	RELATIONSHIP TO PLAN MEMBER

AUTHORIZATIONS & DECLARATIONS

I AUTHORIZE:

- Coughlin to exchange my personal information with the following persons, organizations or parties: Health care providers; financial institutions; government agencies; insurance companies; employers or former employers; my local union or plan trustees and auditors; and
- Coughlin to use the personal information on file to provide me with additional information regarding any benefits to which I am entitled.

When providing personal information for my spouse and/or dependants, **I confirm** that I am authorized to act on their behalf. **I agree** that a photocopy or electronic copy of this Authorizations & 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.

You must print THEN sign this form

Member's Signature **Date**(y/m/d)

Protecting your personal information The administrator of your group benefit plans is Coughlin & Associates Ltd. At Coughlin, we recognize and respect every individual's right to privacy. When personal information is provided to us, we establish a confidential file that is kept in the offices of Coughlin, or the offices of an organization authorized by Coughlin. We use the information to administer the group benefits plan. We limit access to information in your file to Coughlin staff or persons authorized by Coughlin who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law.

THIS IS TO CERTIFY that the above change of beneficiary/name has been noted and placed on file with the group policyholder.

CHECKED BY: **DATE** (y/m/d)**:**