

TRUSTEE/TUTOR

## **Designation/Change of Beneficiary**

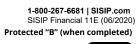
Manulife

Group Policy Number 901102

1. MEMBER IN	FORMATION												
Service Number (SN)			CFOne #						Rank				
Date of Birth (dd-mm-yyyy)		Surname					First Name			Initials		м F	
Date of Enrollment (DOE) (dd-mm-yyyy)					ary/Day hone				Secondary/ Evening Tele	phone			
Apt.	Civic #	Street							City				
Province		Postal Code			Email Addre	ss							
2. APPLICABLE	TO INSURANCE (	COVERAGE:											
a) Optional Group 1 b) Reserve Term Ins c) Coverage After R		Member Member Member Member	Spc	ouse ouse ouse	,		ce for Released M lease specify):	lembers	(IRM)		mber	Spous	
3. MEMBER - E	BENEFICIARY DESI	GNATION											
for the duration of t sign the <u>Release of E</u> <b>Note 2:</b> The membe named, tick PRIMAR are included, the da beneficiary in the ca	the coverage, and a chageneficiary form (Anneser (Block 1) and spouser (Plock 1) and spo	nuse by a member who becange cannot be made with x to 11E) and attach it to the may name any person(s) above and enter the desired pren and the name and additionary beneficiary(ies). The to vious beneficiary designation(s) stated otherwise.	out the is appl and/or ercent ress of otal for which	e spou lication organ age fo f the T r all co	se's written  i.  iization(s) to  r each bene  rustee/Tuto  ntingent be	pe efici er m ene	rmission. If appli e their beneficiary ary in the last col lust be complete ficiary(ies) must a	cable, the y. If more umn. Th d. Tick Co lso equa	e irrevocable than one p e total mus ONTINGENT Il 100%.	e beneficiary  primary bene t equal 100% for the name	must c eficiary b. If mir ning of	omplete a is to be nor childre a seconda	en ery (ies).
PRIMARY								dd	mm	уууу			
☐ PRIMARY ☐ CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
PRIMARY CONTINGENT								dd	mm	уууу			
TRUCTES (TUTOR		·	Add	lress ar	nd								

telephone #:

4. SPOUSAL -	DEINEFICIART D	ESIGNATION								
<b>Note 2:</b> If a primary than one primary be must equal 100%. If	beneficiary, other eneficiary is to be n minor children are	ays the applicant per Block than the applicant (Membe amed, tick PRIMARY in eacl included, the date of birth ary in the case of death of t	er), is to be named, h applicable row ar of the children and	the PRIM nd enter t d the nan	IARY box is to be tick the desired percentag ne and address of the	ed and ir ge for ea Trustee	nformation ch benefici e/Tutor mu	completed ary in the la st be comp	accordir ast colum leted. Tic	in. The total k CONTINGENT
•	•	ficiaries and/or the		or are	exactly the sa	me as	the Me	mber's,	tick h	ere:
As the insured Therehy	revoke any previous	uired to complete to beneficiary designation(s) which		ler the Gro	oun Policy No. 901102 an	d hereby (	designate the	e following he	nefician/li	ac)
This beneficiary design	ation is revocable unle	ss stated otherwise.	Trinay nave made une	ici tile die	oup 1 oney 140. 501 102 am	и петеву (	acsignate tri	c rollowing be	.riericiai y(i	-3).
Beneficiary(ies):	Nam	e (in full) of Persons or O	rganizations		Relationship	,	Date of	Birth	P	ercentage
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
PRIMARY CONTINGENT						dd	mm	уууу		
TRUSTEE/TUTOR			Address and telephone #:							
5. SIGNATURE	<b>BLOCK</b> (to be re-	ad and signed for all submi	issions)							
that any material mis SISIP Financial and M nsurance and claims a) to gather only t any person or c including other Information Bu	srepresentation will lanulife or its reinsu s paying purposes o hat information ne organization that ha insurers, physiciar reau (MIB*), invest organizations likely	ed herein are true and comp render void the insurance. I l rers, for underwriting and ad nly: ecessary for the object of the as personal information release and medical institutions, igation and credit reporting to have personal informati	hereby authorize Iministration of ne file, from lating to me, , the Medical g agencies, and	<ul> <li>b) to disclose only the necessary personal information it has relating to me these same persons and organizations, specified in paragraph (a); or,</li> <li>c) to request a personal investigation report relating to me.</li> <li>A copy of this authorization shall be as valid as the original. This authorization is va for the period required to achieve the ends for which it was requested.</li> <li>The information provided on this form is protected from unauthorized disclosure under Canada's Privacy Act, Personal Information Protection and Electronic Documents (PIPEDA) or equivalent provincial legislation and is available to you upon request.</li> </ul>						
CAF Member's			CAF Member's					dd	mm	уууу
Name Printed:					to being notified or con				ncial	
MIB - to review informa	ition on your file, or ha	ve it corrected, visit www.mib.co		•	or services: Initial:	r c	.5 01	NO		
6. MAILING IN	ISTRUCTIONS									
Regular Force	Members:	Primary Reserve Force 8	& Released Memb	ers:						
Please return to SISIP Financial 4210 Labelle Stre Ottawa, ON K1A	et	Please return to: SISIP Life Insurance – Manulif P.O. Box 1030 2727 Joseph Howe Drive Halifax, NS B3J 2X5								
7. SISIP FINAN	CIAL REVIEW V	erified and reviewed by (H	(Q staff only):							
Name Printed			Signature					dd m	ım	уууу



SN:

