CANADA POST / POSTES CANADA

Basic Life Insurance Plan -
Beneficiary Designation/Change of Beneficiary

Please print in ink and retain a copy for your records in a secure place

Status of Employee ☐ Active Employee ☐ Retired Employee in Receipt of Immediate Pension

Type of Transaction ☐ Enrollment ☐ Amendment ☐ Change of Beneficiary ☐ Change of Employee Name

A - Employee/Retiree Information

Surname	First Name	Initials	Employee ID No.	Male ☐ Female ☐	Date of Birth (Year / Month / Day)

Address	City	Prov.	Postal Code	Country	Telephone No.

B - Coverage Options - Retiree only (Please select one)

☐ Full Amount

☐ Flat $10,000 (Complete CPC Paid Death Benefit Age 65 and up - Beneficiary Designation/Change of Beneficiary Form).

☐ Decline Coverage - Complete Section E below
I understand the Retiree Basic Life Insurance coverage offered to me but decline to participate.

C - Beneficiary Designation/Change of Beneficiary

Note For more than 3 beneficiaries, attach separate sheet. You are responsible to ensure that the beneficiary designation is complete (last name, first name, middle initial). If the beneficiary designation is incomplete or no beneficiary is designated, your estate will be deemed to be the beneficiary. If you designate a beneficiary as irrevocable, or have previously designated a beneficiary as irrevocable, you cannot change your beneficiary designation without the prior written consent of the irrevocable beneficiary.

Where Quebec law applies, a spousal beneficiary (whether married or civil union spouse) is irrevocable unless you make the designation revocable by checking here: Revocable ☐

If more than one beneficiary is designated, ensure that the appropriate % share of benefit is shown below:

1

% of benefit	Beneficiary's Surname	First Name	Initials	Relationship to Employee
%				

Address	City	Prov./State	Postal/Zip Code	Country	Telephone No.

2

% of benefit	Beneficiary's Surname	First Name	Initials	Relationship to Employee
%				

Address	City	Prov./State	Postal/Zip Code	Country	Telephone No.

3

% of benefit	Beneficiary's Surname	First Name	Initials	Relationship to Employee
%				

Address	City	Prov./State	Postal/Zip Code	Country	Telephone No.

D - Trustee/Administrator Clause

If designating a beneficiary who is a minor or who otherwise lacks legal capacity, you may wish to appoint a trustee/administrator by completing this section. This appointment may not be suitable for all purposes. ***We recommend you consult with a legal advisor, and with any proposed trustee/ administrator.***
Do not complete this section if you have made another trustee/ administrator appointment.

I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group policy where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the Insurance Company and Canada Post from further liability. The trustee shall act prudently and may use the money, including any returns on it or investments made, for the education and/or maintenance of the beneficiary. The trust will terminate once the beneficiary is of the age of majority and has legal capacity. At that time, the trustee shall deliver to the beneficiary all assets held in trust.

FOR QUEBEC ONLY
Where this appointment is governed by Quebec law, "trustee" shall be understood as "administrator", and their related terms and concepts understood accordingly. This appointment shall be interpreted in accordance with the provisions governing the administration of the property of others, under the Quebec Civil Code.

Trustee's/Administrator's Surname	First Name	Initials

Relationship to Employee

Address of Trustee

City	Prov.	Postal Code

Country	Telephone No.

E - Cancellation of Insurance - Retiree Only

I understand the Retiree Basic Life Insurance coverage offered to me but decline to participate. I understand that I cannot rejoin the Plan at a later date.

Retiree's Signature — Year / Month / Day

Name of Witness (please print)

Witness' Signature — Year / Month / Day

Address of Witness	City	Prov.	Postal Code	Country	Telephone No.

F - Authorization and Protection of Personal Information

I hereby apply for coverage under the Basic Life Insurance Plan and authorize the deduction from my pay/my pension of any contributions I must make towards the cost of this benefit. I understand and agree that the personal information that you collect from me will be used to provide the group coverage and to administer the benefits. Access to this personal information is limited to those who require it to administer this benefit in the performance of their duties, those to whom I have granted access, and those authorized by law. I agree that a photocopy or electronic copy of this form is as valid as the original. I certify that the information given is true, correct and complete to the best of my knowledge.

Employee's/Retiree's Signature — Year / Month / Day

Witness' Signature - Other than the beneficiary (ies) — Year / Month / Day

Address of Witness	City	Prov.	Postal Code	Country	Telephone No.

G - Office Use Only

Plan No.	Effective Date of Coverage/Change (Year / Month / Day)	Benefits Representative Name	System Updated (Year / Month / Day)