Life & Accident Insurance Beneficiary Designation Form

The purpose of this beneficiary designation form is to provide necessary information for payment of Life and Accident Insurance benefits. If this form is not completed in full and submitted to the Plan Administrator all payable benefits will be paid to the Plan Member's Estate.

Please Sign in Ink and return to:
AGA Benefit Solutions.
#301E-675 Cochrane Dr, Markham, ON L3R 0B8
Fax: 905-477-2249 Email: studenthealthbc@aga.ca

Name of Student Union:	Selkirk College Students' Union			Policy No.:	GRE1002
Student ID:				Class:	A
Student Name	Last:		First:		
Student Address	Street:		Apt #:	City:	
	Province:	Postal:			
Date of Birth (MM/DD/YY):		Language Preference:	English French	Gender:	if Male < Female < [ls
E-Mail Address:				Phone No.:	

Primary Beneficiary

Unless otherwise designated or prohibited by law, the designation of any beneficiary is "Revocable". If no beneficiary is designated, the beneficiary will be the Estate. If naming a minor as a Beneficiary, please appoint a Trustee in the section below. Without completion of this section, the insurer may hold proceeds until the minor reaches age of majority. For Province of Quebec Residents, the appointment of a spouse as beneficiary is considered "Irrevocable" unless the wording "Revocable" is actually selected after the spouse's name. If you are a resident of Quebec please indicate Revocable or Irrevocable.

Full First and Last Name of Beneficiary (ies)	Benefit Name	Percentage	Relationship to Insured	Date of Birth	Revocable	Irrevocable

Note: Percentages above must total 100% to be valid.

Contingent Beneficiary

Full First and Last Name of Beneficiary (ies)	Relationship to Insured	Date of Birth

I appoint _____ as **Trustee** to receive any payment payable to a minor beneficiary under this policy. The trustee shall discharge the Insurer for the amount paid. Note: Trustee appointment is not available in the Province of Quebec.

~ Declaration and Authorization for the Collection and Communication of Personal Information to Third Parties ~

I HEREBY CONFIRM that the information contained in this form is true and complete to the best of my knowledge.
I hereby revoke any previous beneficiary designations in relation to my forgoing coverage(s) and designate the person(s) named above.
If my social insurance number is used as my identification number, I authorize its use for the administration of my group benefits.
On behalf of myself and my dependents, I CONSENT TO THE RELEASE of the information contained in this form to my policyholder and AGA Benefit Solutions., its employees, agents, reinsurers and service providers for the purposes of underwriting, administration, claims processing and determining coverage for myself and my dependents in my policyholder's group insurance plan.
I AGREE that a photocopy of this authorization shall be as valid as the original.

Signature of Participant	Signature of Witness	Date Signed (MM/DD/YYYY)

Internal Use Only

Received On:		Processed By:		Date Processed:	