

# TEAMSTERS' NATIONAL BENEFIT PLAN

1610 KEBET WAY, PORT COQUITLAM BC V3C 5W9 TEL: (604) 552-2650 FAX: (604) 552-2653

## CHANGE OF BENEFICIARY FORM FOR GROUP LIFE INSURANCE AND ACCIDENTAL DEATH INSURANCE

### MEMBER DATA

Name of Employee _____			Sex _____		
(Print)	Last Name	First	Middle	M or F	
Address _____					
Street			Postal Code _____		
City		Province		Phone (____) _____	
Date of Birth _____			Social Insurance Number _____		
Day		Month		Year	
Employment Status:	<input type="checkbox"/> Regular Employee	<input type="checkbox"/> Dependent Contractor	<input type="checkbox"/> Other		
Teamsters Local 31 Member:	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

### BENEFICIARY APPOINTMENT

I hereby revoke any previous beneficiary designations made by me in respect of any benefits payable upon my death under the provisions of the Teamsters' National Benefit Plan (and any group insurance contract the Trustees may select from time to time to underwrite these benefits). I hereby designate the following beneficiary under the Teamsters' National Benefit Plan (and any group insurance contract the trustees may select from time to time to underwrite these benefits) to receive any benefits payable upon my death, and I reserve the right to change this designation at a later date.

..... Name of Beneficiary (Please print clearly)	..... Relationship to you	..... Beneficiary's date of birth
Contact Information .....		
..... Name of Beneficiary (Please print clearly)	..... Relationship to you	..... Beneficiary's date of birth
Contact Information .....		

If more than one beneficiary is named, settlement will be made in equal shares to the beneficiary or beneficiaries that survive the insured, unless otherwise provided by the Plan's terms, the group insurance contract or as required by law. If no designated beneficiary survives the insured, settlement will be made to the estate of the insured.

I certify that the persons listed as dependents on this form are dependents as defined by the Teamsters' National Benefit Plan (the Plan). I further certify that all information provided on this form is true and correct to the best of my knowledge. I authorize the Plan to use the above information for record keeping purposes and for the administration of the Plan. In addition, I authorize that my Social Insurance Number may be used as my personal identification number for claims information and contributions for me and all other purposes of the Teamsters' National Benefit Plan. I further understand and agree that any and all information provided to the Plan may be used or disclosed by the Plan to agents of the Plan as necessary for the administration of the Plan and/or to determine eligibility for benefits. I understand that benefits are determined by the Board of Trustees in accordance with the Plan Text and the Agreement and Declaration of Trust. A photocopy of this authorization is as valid as the original.

Dated: \_\_\_\_\_ Member Signature: \_\_\_\_\_