Public Service Group Insurance Fund Group Life Insurance and Dependents Insurance Appointment and Election Statement

For New Employees Only - All sections must be completed. Please print. If you are contributing in a full-time position with a participating employer, you will not be eligible to contribute to the insurance plan with any other participating employers. Contact your employer for further information.

A Personal Inform	ation - To be answered in f	ull by employee		
Name of Employee	Last Name	Given Names	Employer	
Employee Number			Date of Birth	,
				YYYY MM DD
B Life Insurance Density of the Province of Manitoba and related Boards and Commissions. I further understand that the amount of insurance with the terms of the Group Insurance Plans for Employees of the Province of Manitoba and related Boards and Commissions. I further understand that the amount of insurance payable in the event of a claim will be calculated subject to the terms of the policy (age reductions and maximum insurance of \$1,000,000). All employees are automatically enrolled at Class 5 (maximum) and are responsible for the payment of premiums, and any accumulated arrears at the maximum, until written notice is received by the employer selecting a lesser Class.				
I hereby elect (a Class selection Class 1 (1x Annual Salary)	MUST be made by placing an X ir Class 2 (2x Annual Salary)	n the appropriate box) Class 3 (3x Annual Salary)	Class 4 (4x Annual Salary)	Class 5 - Maximum (5x Annual Salary)
I understand that if I elect a Class lesser than the maximum Class 5 and want to increase my insurance Class at a later date, I will have to provide my employer with medical evidence of insurability that is satisfactory to The Insurance Company. Any costs incurred in providing evidence of insurability will be at my expense. I acknowledge that the necessary premiums will be deducted from my earnings.				
Beneficiary Designation I hereby appoint the following as revocable beneficiary(ies) of the insurance payable in the event of my death.				
Primary Beneficiary(ies) – in equal shares unless otherwise provided below. A Primary Beneficiary must be appointed.				
Full Name		Relationship to Life Insured	% to Beneficiary	Birthdate
who may survive the life insured				YYYY MM DD
Contingent Beneficiary(ies) -		provided below. Proceeds are pay	vable to Contingent Beneficiary(ies) o	
predecease the insured. Full Name		Relationship to Life Insured	% to Beneficiary	Birthdate
who may survive the life insured				YYYY MM DD
When naming minors as beneficiaries, a trustee should also be named. For information on naming minors, we recommend you consult with a legal advisor. Should you choose				
to name a minor, it is necessary to also complete a Beneficiary Designation form (M6697) which provides an area for naming a Trustee. I reserve the right to change this designation of beneficiary. The Insurance Company assumes no responsibility for the validity or effect of this designation. Any changes to the				
above must be initialed by the employee.				
C Dependents Insurance I hereby apply for Dependents Life Insurance which insures my eligible dependents as selected below. I understand that the Dependents Insurance Plan does not insure dependents age 70 or over*. I also authorize my employer to make the necessary deductions from my earnings. I understand that the insurance payable on the death of an eligible dependent will be payable to me if living, otherwise to my Estate. Enrollment at four (4) Units (maximum) is automatic and the employee is responsible for the payment of premiums, and any accumulated arrears at the maximum, until written notice is received by the employer selecting lesser Units or No Dependent Coverage.				
I hereby elect (a selection MUST be made by placing an X in the appropriate box)				
No Dependents Coverage	1 Unit (Spouse \$17,500* Each Eligible Child \$3,500*)	2 Units (Spouse \$35,000* Each Eligible Child \$7,000*)	3 Units (Spouse \$52,500* Each Eligible Child \$10,500*)	4 Units (Spouse \$70,000* Each Eligible Child \$14,000*)
* see the Dependent Insurance	section of the Group Insurance Info	ormation booklet for the definitior	of eligible dependents	
Coverage is not available if depe	endents have not met the requirem	nents of eligibility.		
Dependents (including spouse)	 All eligible dependents must be li 	isted	Relationship to Life Insured	Birthdate
				V//// 1414 55
who may survive the life insured. YYYY MM DD I am aware that if I elect "No Dependents Coverage" at the time of eligibility or if I choose less than the maximum of 4 Units, I will have to provide my employer with medical				
evidence of insurability pertaining to my dependents that is satisfactory to The Insurance Company if at a later date I wish to insure these eligible dependents or increase the Units. Any costs incurred in providing evidence of insurability will be at my expense. I am also aware that if I presently do not have eligible dependents or I previously opted out of the Dependents Insurance Plan, I may insure newly acquired eligible dependents without providing evidence of insurability if I notify my employer within 90 days of acquiring the eligible dependent. Any changes to the above must be initialled by the employee.				
D				
	Signature of Insured Member		Date	_
				_
W	itness - Other Than Beneficiary		Date	
Civil Service CSSB.8001/2009-01 Superannuation Board				

V