THE Great-West Life ASSURANCE COMPANY

BENEFICIARY DESIGNATION
FOR SELF-ADMINISTERED PLANS
(GROUP ONLY)

Please print clearly and complete this form in INK. Return completed form to your employer. If you are a retired member, please return completed form directly to the Civil Service Superannuation Board.

Group Policy Number: **330780** Division Number(s): _____ Employee Number: _____

Name of Insured: _____ Certificate Number/SIN: _____
last name first name middle initial

The undersigned life insured, revokes any beneficiary designations and requests, respecting payment of proceeds payable on the death of the life insured and directs that such proceeds be paid to my Estate unless otherwise provided below:

Primary Beneficiary(ies):	Percent allocated:	Relationship to insured:	Birthdate: (if under 18)
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			

in equal shares or as allocated above who may survive the life insured.

Contingent Beneficiary(ies):	Percent allocated:	Relationship to insured:	Birthdate: (if under 18)
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			
last name first name middle initial			

in equal shares or as allocated above who may survive the life insured.

Trustee Appointment:

If designating a beneficiary who is a minor or who lacks legal capacity you may wish to appoint a trustee by completing this section.

If you are designating a trustee, we recommend you consult with a legal advisor, and with any proposed trustee.

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 benefits plan 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 Great-West Life Assurance Company 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.

Trustee last name first name middle initial _____ Relationship to insured

Privacy (This section explains Great-West Life's commitment to privacy)**:**

Protecting Your Personal Information

At **The Great-West Life Assurance Company (Great-West Life),** we recognize and respect the importance of privacy. When you apply for coverage, we establish a confidential file that contains your personal information. This file is kept in the offices of Great-West Life or the offices of an organization authorized by Great-West Life. You may exercise certain rights of access and rectification with respect to the personal information in your file by sending a request in writing to Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims, and creating and maintaining records concerning our relationship.

Authorizations and Declarations (This section must be signed and dated in INK by the plan member)**:**

I have read and understand and agree with the contents of the section on this form entitled "Protecting Your Personal Information" on this form.
I reserve the right to change this designation of beneficiary within the legal restrictions.
The company assumes no responsibility for the validity or effect of this designation.
I agree that a photocopy or electronic copy of the Authorizations and Declarations section is as valid as the original.
I certify that the information given is true, correct and complete to the best of my knowledge.

Plan member signature: _____ **Date:** _____