HEALTH ASSOCIATION NOVA SCOTIA

BENEFICIARY DESIGNATION FORM

BFOR

Last Name	First Name	Middle Initial	SIN
			- -

Please PRINT clearly. You must initial any changes or deletions. Correction fluid CANNOT be used. Complete the form in ink, sign and date the form and return to your benefit administrator for handling.

Subject to applicable legislation, I hereby designate the following to receive any benefits payable from the plans checked below in the event of my death. I reserve the right to change my beneficiary designation. I understand that, if I do not designate a beneficiary, my estate will receive any benefits payable in the event of my death, in accordance with the laws of the area in which I reside. My employer and Health Association Nova Scotia assume no responsibility for the validity or effect of this designation. By completing a new Beneficiary form, I revoke all previously designated beneficiary (ies) and make the following designations, where permitted by law.

☐ **Basic Life Insurance for Myself**

LAST NAME	FIRST NAME	RELATIONSHIP	DOB: (MM/DD/YYYY)	Percentage:
If any primary beneficiary is under age 18, please name a **trustee:**				**100%**
In the event of my death, the above listed beneficiaries will receive any benefits payable from the Basic Life Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries.				
LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any contingent beneficiary is under age 18, please name a **trustee:**				**100%**

☐ **Optional Life Insurance for Myself**

LAST NAME	FIRST NAME	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any primary beneficiary is under age 18, please name a **trustee:**				**100%**
In the event of my death, the above listed beneficiaries will receive any benefits payable from the Optional Life Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries.				
LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any contingent beneficiary is under age 18, please name a **trustee:**				**100%**

☐ **Optional Accidental Death & Dismemberment Insurance**

LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any primary beneficiary is under age 18, please name a **trustee:**				**100%**
In the event of my death, the above listed beneficiaries will receive any benefits payable from the Optional Accidental Death & Dismemberment Insurance Plan, if living. Otherwise, the following are my contingent beneficiaries.				
LAST NAME	FIRST NAME:	RELATIONSHIP:	DOB: (MM/DD/YYYY)	Percentage:
If any contingent beneficiary is under age 18, please name a **trustee:**				**100%**

DECLARATION AND AUTHORIZATION

I hereby consent to the information provided in this form being collected, used or disclosed by Health Association Nova Scotia and/or any of its agents and service providers, including but not limited to insurers, benefits providers or administrators, benefits consultants and medical professionals, and shared between these parties for purposes of assessing eligibility for benefits to which I may be entitled, administering changes to benefits coverage, adjudicating any claims, auditing/reviewing the benefit plan as necessary for the proper and efficient design and administration of the plan, assessing, developing and administering related programs, and maintaining an effective claims management process.

I have verified the information on this form and declare that it is accurate and complete. I authorize the use of my social insurance number for group insurance identification purposes and as required by law for income tax reporting. I authorize my employer to deduct from my earnings any required contributions for coverage under these plans.

Date (MM/DD/YYYY) _____ Employee Signature _____

TO BE COMPLETED BY EMPLOYER ONLY

Employee name	Division name	Division number

Date (MM/DD/YYYY) _____ Name of Authorized Benefits Administrator _____ Signature of Authorized Benefits Administrator _____