Beneficiary Designation Application

CPA INSURANCE PLANS WEST

Please print clearly and complete all pages of this form, in INK. Kindly keep a copy of the completed form for your records and send the original to CPAIPW 9918A 102 Street, Fort Saskatchewan, AB T8L 2C3

Section A. (Required)

Surname:_____ Given Name: _____ Phone Number: _____

Email: _____ Certificate Number: _____

Section B. (Required)

Original signed, dated and witnessed form must be mailed to CPAIPW.

Note: Section D must also be filled out if designating a minor as beneficiary.

Beneficiary Names(s) **Percent Allocated** **Relationship to Insured**

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

To Be Divided as Follows: As Per the Percentage Indicated Above, or ☐ In Equal Shares to Survivor(s) ☐

Section C. Contingent Beneficiary (Optional)

Complete this section to designate contingent beneficiaries in the event that there are no surviving beneficiaries at the time of your death.

Beneficiary Names(s) **Percent Allocated** **Relationship to Insured**

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

Last Name:_____ First Name:_____ Middle Initial:____ _____ _____

To Be Divided as Follows: As Per the Percentage Indicated Above, or ☐ In Equal Shares to Survivor(s) ☐

Section D. Trustee Appointment

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

Do not complete this section if you have made another trustee/administrator appointment.

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 plan where, at the time of payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. 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 Contact Information

Last Name:_____ First Name:_____ Middle Initial:____ Phone Number: _____

Email:_____ Relationship to Insured: _____

Section E. Commitment to Privacy

Protecting Your Personal Information

At CPA Insurance Plans West, 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 office of CPA Insurance Plans West or the offices of an organization authorized by CPA Insurance Plans West. We are committed to meeting or exceeding the privacy standard established by federal and provincial legislations and industry bodies.

The employees of CPA Insurance Plans West play an important role in protecting personal information. Our employees are required to adhere to this policy and take all reasonable steps to ensure that personal information is protected. The personal information that is collected is used to administer an individual's participation in the Plan and to pay benefits as defined by the Plan.

In administering an individual's participation in the Plan, personal information may also be collected from, or disclosed to, insurance companies or other companies that insure the benefits or provide administration and claims handling services; licensed physicians or other healthcare professionals or institutions; and government or regulatory authorities.

We only keep personal information for as long as is necessary for the purpose outlined previously in this policy. We are also required by law to maintain certain information for set periods of time. We have appropriate safeguards in place to protect personal information and when we no longer need the information, it is destroyed.

Section F. Authorization and Declaration

I have read and understand and agree with the contents of the section titled "Protecting Your Personal Information".

I authorize: CPA Insurance Plans West, insurance companies or reinsurance companies, healthcare providers, administrators of government benefits or other benefit programs, other organizations or service providers working with CPA Insurance Plans West or the above to exchange personal information, when relevant and necessary to determine my eligibility for coverage and to administer the plan. I certify that the information given is true, correct and complete to the best of my knowledge.

Insured Signature _____ Date _____

Witness Signature _____ Date _____

An email copy of this application will be accepted to begin the application process, however, insurance will not be activated until we have received the original application signed and dated with original ink.