

# APPOINTMENT OF BENEFICIARY

CINUP Group Insurance & Pension Plan



Employer Name <b>ABC COMPANY</b>	Pension Policy # <b>33333</b>
Employee Name <b>BOBBY SMITH</b>	Pension Certificate# <b>12345</b>
Group Insurance Certificate # <b>12345</b>	

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In accordance with the terms and conditions of the Contract between the employer indicated above and the Insurance Company, I hereby revoke all previous appointment of beneficiary and hereby appoint the following as beneficiary to receive the proceeds arising by reason of my death. I reserve the right to change the beneficiary at any time.

**TRUSTEE FOR CHILD OF MINORITY (please print)**

I hereby name EDNA SMITH my SPOUSE (relationship) if living, as Trustee to receive and disburse any monies payable to any child listed below of minority. Any payment made to said trustee shall discharge the company to the extent of such payment

**PRIMARY BENEFICIARY (please print)**

Please indicate relationship to beneficiary. If a minor, indicate date of birth and assign a trustee below. If additional space is required, please attach a separate page.

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Full Name	Birthdate MM/DD/YYYY	Relationship	Proportion (must equal 100%)
EDNA SMITH	11/30/1953	SPOUSE	25%
MARY SMITH	11/30/1991	CHILD	25%
BOBBY SMITH JR.	11/30/1978	CHILD	50%

\*Only whole percentages are accepted for the pension beneficiary proportion

ADDITIONAL BENEFICIARIES

CONTINGENT BENEFICIARIES (Secondary beneficiary if the above Beneficiary is deceased)

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Full Name	Birthdate MM/DD/YYYY	Relationship	Proportion (must equal 100%)
MARKUS SMITH	11/30/1952	BROTHER	100%

\*Only whole percentages are accepted for the pension beneficiary proportion

These beneficiaries are applicable to my:

Group Insurance Benefits

Pension Benefits

(Note: If the Employee has a spouse - the spouse will be appointed beneficiary - if your pension plan is with Great-West Life, please complete the Designation of revocable beneficiary/trustee appointment form.)

Signature of Employee Bobby Smith

Date Sept 30/2011

## **Authorization and Consent**

I understand that the personal information provided herein as well as any other personal information currently held or collected in the future by MGI Financial Inc. and the insurance carriers of my group insurance policy may be collected, used, or disclosed to administer the terms of the group policy of which I am an eligible member, to develop and recommend suitable products and service to me and my employer, and to manage the organization's business

Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These include the insurance carriers of my group insurance policy, licensed physicians and/or any other health care professionals or institutions, health and life insurers, government and regulatory authorities, and other third parties when required to administer the benefits outlined in the group policy of which I am an eligible member.

I understand that the personal information will be kept confidential and secure. I understand that I may revoke my consent at any time; however, if consent is withheld or revoked, the coverage may be declined or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. (For additional information regarding MGI Financial Inc.'s Group Benefits privacy policy I can contact MGI Financial at 204-786-0324 or [privacy@mgiwealth.com](mailto:privacy@mgiwealth.com) should I have questions as to the collection, use or disclosure of my personal information)