Manitoba Public School Employees Group Life Insurance Plan
Application for Plan Members

Please complete this form clearly on both sides and return to your employer within 31 calendar days from your date of employment. Otherwise you will be required to provide medical evidence of insurability for coverage above the minimum level of Group Life Insurance.

Plan Member Last Name | Plan Member First Name and Initial

Date of Birth (Day / Month / Year)

Gender: Male | Female | Undisclosed | Other

Were you covered under this plan in another school division within 6 months prior to your current date of hire? Yes | No

If **Yes**, what was your previous school division? _____

(If you wish to elect a higher Group Life option than you were previously insured for, or add Family Life, you must apply and provide medical evidence of insurability to the insurer.)

1. **GROUP LIFE INSURANCE**
   I hereby apply for Group Life Insurance coverage equal to: *(Maximum $1,000,000)*
   - 2x annual salary (minimum)
   - 3x annual salary
   - 4x annual salary
   - 5x annual salary

2. **FAMILY LIFE INSURANCE**
   I hereby apply for optional Family Life Insurance: Yes | No

3. **ACCIDENT INSURANCE**
   I hereby apply for optional Accident Insurance: Yes | No

   If yes, number of units applied for, each unit worth $18,000: _____
   (Maximum 20 units or $360,000)

   Type of coverage applied for: Single | Family

For more information on plan design, options and cost please visit the plan website at www.mpsebp.ca

Beneficiary Designations *(the plan member is the beneficiary for dependent benefits)*

In naming the beneficiaries shown below, I hereby revoke all previous beneficiary designations I may have made under this plan. For multiple beneficiaries, the percent allocated must total 100%. In the absence of that, all beneficiaries will receive equal proportions.

For Group Life and Accident Insurance:

Primary Beneficiary(ies)

Name of revocable beneficiary	Relationship to plan member	Percent allocated

Contingent Beneficiary(ies) - if you wish to appoint a contingent beneficiary(ies) in the event that there are no surviving primary beneficiaries at the time of your death, please complete this section.

Name of revocable beneficiary	Relationship to plan member	Percent allocated

Note: Unless the law requires otherwise, the entitlement of any beneficiary who predeceases me will revert to my surviving Primary Beneficiary(ies) in equal shares, or if there is no surviving Primary Beneficiary(ies), to my Contingent Beneficiary(ies). If there is no appointed or surviving Contingent Beneficiary(ies), the entitlement will revert to my Estate.

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.

Please check one of the following two boxes:

1. ☐ You have already designated a trustee pursuant to your will. The date of your will is _____. OR,
2. ☐ 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.
   I acknowledge that any payment under this policy made to the appointed trustee, acting on behalf of my designated beneficiary, will release the insurer from further liability. If you are designating a trustee, we recommend you consult with a legal advisor, and with any proposed trustee. 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 Plan Member

I hereby authorize the necessary deduction from my earnings of premium contributions for insurance for which I have applied. I also waive my rights to any insurance to which I may not be entitled or that I have not specifically applied for, as indicated above. I understand that any subsequent application for insurance (except Accident Insurance) will be subject to satisfactory evidence of insurability.

Date	***Signature of Plan Member***

Protecting Your Privacy

The Manitoba Public School Employees Group Life Insurance Plan, in conjunction with your employer, is working to ensure compliance with applicable privacy laws, and, as always, maintains security, privacy and confidentiality over all private employee information. We are continually working with our insurer, plan administrators, auditors, consultants and others to make sure that no information is collected, reviewed or transferred beyond what is necessary for effective plan enrolment, benefit processing and payment. We require all insurers and group benefit service providers to confirm their compliance with applicable privacy laws and the employer's general privacy policies and procedures for group benefit plan information management. Plan audit and design reviews are conducted based on sanitized data which excludes the use of names or other means of identification.

For Office Use Only

Plan Member Name		