Irrevocable Beneficiary Designation

eSignature Option: Certificate of Completion must accompany this form.
Handwritten Option: Complete in ink, with any corrections initialed. A copy should be kept for your records and is considered as valid as the original.
Send completed form to: csr-groupadmin@rwam.com or mail to RWAM at address noted below.

EMPLOYER DATA

Group		Division		Class		Certificate #	
Name of Employee	First Name			Surname			
Name of Employer							

EMPLOYEE STATEMENT

I revoke all prior beneficiary designations under my group insurance. I hereby designate the following person(s) to receive all group Life insurance benefits payable on my death. If more than one beneficiary is named, the total of my group Life insurance benefits are to be allotted to my beneficiaries by equal percentages, unless otherwise indicated below.

In Quebec, if you do not indicate whether the beneficiary designation is revocable or irrevocable, the designation of the legal spouse is irrevocable, and any other choice is revocable. In all provinces, an irrevocable beneficiary's written consent is required in order to make any change to the beneficiary designation.

The following beneficiary designation applies to the employee's insurance. Dependent Life claims will be payable to the employee.

If no beneficiary designation is provided, the Life insurance benefits will be paid to your estate.

IRREVOCABLE BENEFICIARY

I hereby make the following beneficiary designation irrevocable. I understand that I may not change this beneficiary designation without the written consent of the irrevocable beneficiary(ies).

Beneficiary Name(s) (first name, surname)	Relationship to Employee	% of Share (Total must = 100%)

TRUSTEE

If a beneficiary is under age 18, consider naming a trustee as group Life insurance benefits cannot be paid to a minor and will be issued according to the Insurer's guidelines. In Quebec, such trustee must be a parent or legal guardian.

Trustee Name (first name, surname)	As Trustee for Beneficiary Name(s)	Trustee's Relationship to Beneficiary

AUTHORIZATION TO CHANGE IRREVOCABLE BENEFICIARY

Only complete if you are an irrevocable beneficiary. If you were named as an irrevocable beneficiary, then the employee requires your consent to: (a) replace you as a beneficiary or (b) change the percentage of benefit payable to you upon the employee's death.

Irrevocable Beneficiary (first name, surname)	

I hereby consent to any change of beneficiary under this contract. I hereby declare that I am of legal age.

Irrevocable Beneficiary (first name, surname)		Date	

EMPLOYEE AUTHORIZATION

I understand the information I provide on this form will be used by RWAM Insurance Administrators Inc. (RWAM) and the Insurer. I hereby authorize my employer/plan administrator, the authorized group agent/broker, and the Insurer or Reinsurer to exchange any relevant and necessary information. This authorization is also valid, in the event of my death, regarding any person, beneficiary(ies) or organization including any medical and professionals, facilities or providers, professional regulatory bodies, any employer, group plan administrator, insurer, investigative agency, and any administrator holding information required by the Insurer, or its service providers, that may be required for the processing of my file. I declare that the statements made on this form are complete and true. I understand that if any statement is incomplete or false, any coverage granted may be voided. This authorization (original or photocopy) will remain valid for as long as I am claiming benefits or service, or until revoked by myself.

Employee Signature	Certificate of Completion must accompany this form with eSignatures	Date	

RWAM or the Insurer assumes no responsibility for the validity or sufficiency of this designation.