FIRST NATIONS INSURANCE SERVICES LIMITED PARTNERSHIP

EMPLOYEE BENEFICIARY ADDENDUM FORM

Please print clearly and complete this form, in INK. Section 1 are to be completed by the plan member.

Plan member name: _____ FNIS Plan ID number: _____

☐ Employee Application for Group Coverage – Section 5 Beneficiary Designation / Trustee appointment dated and signed on _____, _____

☐ Employee Data Change Form – Section 9 Beneficiary Designation / Trustee appointment dated and signed on _____, _____

1. Beneficiary Designation

This section is to be completed by the plan member. This section must be completed to designate a beneficiary for your life benefits. The original of this form will be required for a life claim. Crossed out beneficiary designations must be initialed. If no Percentage is allocated; it will be paid out in equal shares (any rounding will be applied to the first beneficiary) Please print clearly, in INK. **DO NOT USE WHITE OUT**

Listed beneficiary is revocable.

Beneficiary's name(s)			**Percent Allocated**	**Date of birth month/day/year**	**Relationship to plan member**
last name	first name	middle initial			
last name	first name	middle initial			
last name	first name	middle initial			
last name	first name	middle initial			
last name	first name	middle initial			
last name	first name	middle initial			
last name	first name	middle initial			

If designating a beneficiary who is a minor or who lacks legal capacity, you may wish to appoint a trustee/administrator below. If you are designating a trustee/administrator, we recommend you consult with a legal advisor.

Trustee: _____ _____

last name first name middle initial Relationship to plan member

2. Privacy

This section explains First Nations Insurance Services Limited Partnership's commitment to privacy

Protecting Your Personal Information

At First Nations Insurance Services Limited Partnership (hereinafter referred to as FNISLP), 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 offices of FNISLP or the offices of an organization authorized by FNISLP. You may exercise certain right of access and rectification with respect to the personal information in your file by sending a request in writing to FNISLP. We limit access to personal information in your file to FNISLP staff or person(s) authorized by FNISLP who require it to perform their duties, to person(s) to whom access has been granted, and to person(s) authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada. Personal information that we collect will be used for the purposes of determining your eligibility for coverage and administering the group benefits plan. This includes investigating and assessing claims and creating and maintaining records concerning our relationship.

3. Authorization and Declaration

This section must be signed and dated in INK by plan member & witness.

Witness cannot be a beneficiary.

I hereby apply for coverage under the group benefits plan issued by First Nations Insurance Services Limited Partnership.

I have read and understand and agree with the contents of the section entitled "Protecting Your Personal Information" on this form.

I authorize:

- My plan sponsor to deduct from my pay and remit to FNISLP the plan members contributions required under the plan, if applicable;
- FNISLP, any healthcare provider, my plan administrator, other Insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations, or service providers working with FNISLP to exchange personal information, when necessary to determine my eligibility for coverage and to administer the plan.

If applying for coverage for my spouse and/or dependents, I confirm that I am authorized to act on their behalf.

I agree that a photocopy or electronic copy of this Authorization and Declaration section is as valid as the original.

Plan member signature: _____ **Date:** _____

Witness signature: _____