BLUE CROSS®

THE UNIVERSITY OF WINNIPEG

LIFE INSURANCE CHANGE FORM

Please return completed form to Human Resources at the University of Winnipeg

TYPE OF CHANGE

☐ Beneficiary Change ☐ Name Change

EMPLOYEE INFORMATION

Group # 40604 Company: The University of Winnipeg Employee # _____

Employee's Last Name _____ Employee's First Name _____

NAME CHANGE

From _____ To _____

Effective Date of Change _____

CHANGE OF BENEFICIARY

In accordance with the terms and conditions of the Group Life Contract between the employer indicated above and Blue Cross Life Insurance Company of Canada, I revoke all previous appointments of beneficiary and hereby appoint the following as beneficiary entitled to receive the proceeds arising by reason of my death.

Primary Beneficiary(ies) - in equal shares, unless otherwise indicated below

	Last Name	First Name	Initial	Relationship	Percentage
1.					
2.					
3.					

Note: Percentage must equal 100%

Contingent Beneficiary(ies) - in equal shares, unless otherwise indicated below

	Last Name	First Name	Initial	Relationship	Percentage
1.					
2.					
3.					

Note: Percentage must equal 100%

Minor Clause - indicate with an (X) if necessary

☐ Trustee for Children

Full Name (please print) Relationship to Insured Date: _____

_____ _____

is hereby appointed Trustee to receive any payment due on or after the life insured's death to any BENEFICIARY DESIGNATED on this form who is a minor on the date such payment falls due.

I certify that all information contained hereon is correct for the changes specified.

Employee's Signature _____

Date: _____

BLUE CROSS LIFE INSURANCE COMPANY OF CANADA UNDERWRITES ALL LIFE AND DISABILITY BENEFITS