CG | INSURANCE

BENEFICIARY DESIGNATION FORM

Basic Life, Supplemental Life and Accidental Death & Dismemberment Insurance

Premier Health

PART 1 PRIMARY INSURED INFORMATION

Employer Name: _____

Employee Name (First name/Family name):_____

PART 2 IMPORTANT INSTRUCTIONS

Please complete this form immediately, sign and return it to Coralisle Medical, retaining a copy for yourself.

Subject to applicable legislation, you designate the beneficiary(ies) named below to receive your coverage in the event of your death.

If the beneficiary(ies) predeceases you, or if a beneficiary has not been named, amounts will be payable in accordance with the terms and provisions of the policy (described over).

State full name, family relationship and address (if possible) for each person named.

If the benefit is to be shared between two or more persons, specify in what proportion each is to receive (must total 100%).

When designating a minor child (under the age of 18) as beneficiary you must also name the legal guardian/trustee of the minor to which the benefit will be paid on his/her behalf. Failure to do so may result in delays in the payment of benefits.

PART 3 BENEFICIARY DESIGNATION

I direct that upon my death my lump sum **Basic Life Insurance/Accidental Death** benefits should be paid to:

Beneficiary First Name/Last Name	Relationship	D.O.B	%	Address

If a Beneficiary named above is a minor (under the age of 18), please provide details on the legal guardian/trustee:

_____

If the above beneficiary(ies) fails to survive me, the lump sum **Basic Life Insurance** benefits should be paid to:

Beneficiary First Name/Last Name	Relationship	D.O.B	%	Address

If a Beneficiary named above is a minor (under the age of 18), please provide details on the legal guardian/trustee:

_____

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PART 4 DECLARATION

I understand that I can change my beneficiaries at any time without their consent. I agree that if a beneficiary has not been named, or if the named beneficiaries predecease me, the death benefit in the case of my death will be made as per the rules of the Policy.

Data Protection Declaration:

By signing this form, I confirm/understand that:

- In order to administer the policy and plan Coralisle Medical Insurance Company Ltd. may process any and all of the personal data provided.
- I consent to Coralisle Medical Insurance Company Ltd. processing my personal data, in accordance with Coralisle Medical Insurance Company Ltd.'s Privacy Policy (https://international.cgcoralisle.com/privacy-policy/). For additional information on your rights and how to exercise them, please access or request this Policy.
- I confirm that any personal data I provide to Coralisle Medical Insurance Company Ltd. in respect of any third party, is done with that third party's consent and knowledge of Coralisle Medical Insurance Company Ltd. processing of their personal data.
- I have the right for my personal data to be processed in accordance with the rights of Data Subjects under the relevant jurisdictional privacy legislation.
- I understand that this form shall be incorporated into and shall constitute a part of the policy contract between me/us and the Company.

Employee's Signature: _____ Date:_____