Public Service Group Insurance Fund
Group Life Insurance and Dependents Insurance Appointment and Election Statement

For New Employees Only - All sections must be completed. Please print.

If you are contributing in a full-time position with a participating employer, you will not be eligible to contribute to the insurance plan with any other participating employers. Contact your employer for further information.

A Personal Information - To be answered in full by employee

Name of Employee _____ Employer _____
Last Name Given Names

Employee Number _____ SIN _____ Date of Birth _____
YYYY MM DD

B Life Insurance — Group Policy 330780

I understand that my insurance benefits will be determined based on my annual salary, age, and Class of Insurance selected in accordance with the terms of the Group Insurance Plans for Employees of the Province of Manitoba and related Boards and Commissions. I further understand that the amount of insurance payable in the event of a claim will be calculated subject to the terms of the policy (age reductions and maximum insurance of $1,000,000). All employees are automatically enrolled at Class 5 (maximum) and are responsible for the payment of premiums, and any accumulated arrears at the maximum, until written notice is received by the employer selecting a lesser Class.

I hereby elect (a Class selection MUST be made by placing an X in the appropriate box)

☐	☐	☐	☐	☐
Class 1 (1x Annual Salary)	**Class 2** (2x Annual Salary)	**Class 3** (3x Annual Salary)	**Class 4** (4x Annual Salary)	**Class 5 - Maximum** (5x Annual Salary)

I understand that if I elect a Class lesser than the maximum Class 5 and want to increase my insurance Class at a later date, I will have to provide my employer with medical evidence of insurability that is satisfactory to The Insurance Company. Any costs incurred in providing evidence of insurability will be at my expense. I acknowledge that the necessary premiums will be deducted from my earnings.

Beneficiary Designation

I hereby appoint the following as revocable beneficiary(ies) of the insurance payable in the event of my death.

Primary Beneficiary(ies) – in equal shares unless otherwise provided below. A Primary Beneficiary must be appointed.

Full Name	Relationship to Life Insured	% to Beneficiary	Birthdate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

who may survive the life insured. YYYY MM DD

Contingent Beneficiary(ies) – in equal shares unless otherwise provided below. Proceeds are payable to Contingent Beneficiary(ies) only if <u>all</u> Primary Beneficiary(ies) predecease the insured.

Full Name	Relationship to Life Insured	% to Beneficiary	Birthdate
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

who may survive the life insured. YYYY MM DD

When naming minors as beneficiaries, a trustee should also be named. For information on naming minors, we recommend you consult with a legal advisor. Should you choose to name a minor, it is necessary to also complete a Beneficiary Designation form (M6697) which provides an area for naming a Trustee.

I reserve the right to change this designation of beneficiary. The Insurance Company assumes no responsibility for the validity or effect of this designation. Any changes to the above must be initialed by the employee.

C Dependents Insurance — Group Policy 330785

I hereby apply for Dependents Life Insurance which insures my eligible dependents as selected below. I understand that the Dependents Insurance Plan does not insure dependents age 70 or over*. I also authorize my employer to make the necessary deductions from my earnings. I understand that the insurance payable on the death of an eligible dependent will be payable to me if living, otherwise to my Estate. Enrollment at four (4) Units (maximum) is automatic and the employee is responsible for the payment of premiums, and any accumulated arrears at the maximum, until written notice is received by the employer selecting lesser Units or No Dependent Coverage.

I hereby elect (a selection MUST be made by placing an X in the appropriate box)

☐	☐	☐	☐	☐
No Dependents Coverage	**1 Unit** (Spouse $17,500* Each Eligible Child $3,500*)	**2 Units** (Spouse $35,000* Each Eligible Child $7,000*)	**3 Units** (Spouse $52,500* Each Eligible Child $10,500*)	**4 Units** (Spouse $70,000* Each Eligible Child $14,000*)

* see the Dependent Insurance section of the Group Insurance Information booklet for the definition of eligible dependents

Coverage is not available if dependents have not met the requirements of eligibility.

Dependents (including spouse) – All eligible dependents must be listed	Relationship to Life Insured	Birthdate
_____	_____	_____
_____	_____	_____
_____	_____	_____

who may survive the life insured. YYYY MM DD

I am aware that if I elect “No Dependents Coverage” at the time of eligibility or if I choose less than the maximum of 4 Units, I will have to provide my employer with medical evidence of insurability pertaining to my dependents that is satisfactory to The Insurance Company if at a later date I wish to insure these eligible dependents or increase the Units. Any costs incurred in providing evidence of insurability will be at my expense. I am also aware that if I presently do not have eligible dependents or I previously opted out of the Dependents Insurance Plan, I may insure newly acquired eligible dependents without providing evidence of insurability if I notify my employer within 90 days of acquiring the eligible dependent. Any changes to the above must be initialled by the employee.

D

_____ Signature of Insured Member — _____ Date

_____ Witness - Other Than Beneficiary — _____ Date