



CMAW TARGET PENSION PLAN

Plan Administrator: **BG BENEFIT ADMINISTRATORS**
1000-4445 Lougheed Highway Burnaby BC V5C 0E4
Toll Free: 1-844-366-2629 Fax: 604-433-8894
Email: cmaw@bgbenefitsadmin.com

Check as Applicable:

- Original
 Replacement
 Change to Beneficiary Information

POST-RETIREMENT DEATH BENEFIT BENEFICIARY CHANGE CARD

Please **PRINT** clearly in ink and ensure that you and a witness have signed and dated this form.

1. MEMBER INFORMATION

LAST NAME	FIRST NAME	SOCIAL INSURANCE NUMBER	
ADDRESS (No. and Street)	CITY	PROVINCE	POSTAL CODE
TELEPHONE NO.	EMAIL ADDRESS		

2. BENEFICIARY DESIGNATION

If you name more than one beneficiary, specify percentages. Otherwise, proceeds will be divided equally among all surviving beneficiaries.

If any person identified in this section 2 predeceases me, I direct that their Percentage of Entitlement (as indicated in this section 2) be divided equally among the surviving beneficiaries. For greater certainty, the share of a deceased beneficiary will go in equal portions to the surviving beneficiary (ies) listed in section 2.

For purposes of any benefits that may become payable on my death, I revoke any previous beneficiary designations and appoint the following individual(s) as my beneficiary(ies):

LAST NAME	MIDDLE INITIAL	FIRST NAME	RELATIONSHIP TO YOU	PERCENT
				%
				%

3. CONTINGENT BENEFICIARY DESIGNATION

A contingent beneficiary(ies) will only become a primary beneficiary if ALL of the primary beneficiary(ies) (identified in section 2) have pre-deceased me. If there is no surviving contingent beneficiary at the time of my death, the benefit shall be paid to my estate. I hereby revoke any prior contingent beneficiary designations.

LAST NAME	MIDDLE INITIAL	FIRST NAME	RELATIONSHIP TO YOU	PERCENT
				%
				%

4. APPOINTMENT OF TRUSTEE FOR MINOR BENEFICIARY

If your beneficiary and/or contingent beneficiary is a minor (under 19 years of age), please name an adult Trustee here. If we cannot pay to the Trustee identified or you fail to name a Trustee, the plan will pay the benefits to the Public Guardian and Trustee's Office.

LAST NAME OF TRUSTEE	MIDDLE INITIAL	FIRST NAME OF TRUSTEE	CONTACT INFORMATION

PAYMENT TO THE TRUSTEE SHALL DISCHARGE THE CMAW TARGET PENSION PLAN. THE CMAW TARGET PENSION PLAN CANNOT BE RESPONSIBLE FOR THE EFFECT OF THE SUFFICIENCY OF APPOINTMENT.

5. SIGNATURE OF MEMBER

- (a) I certify that the information provided on this Form is correct and can be relied upon by the Plan.
(b) I agree to promptly update the Plan Administrator of any changes to my marital status or the beneficiaries to be designated.
(c) I agree that I am liable for benefits paid out incorrectly due to the Form including my failure to update my marital status.
(d) I agree to the collection, use and disclosure of my personal information as is reasonably required to administer my entitlements and obligations under the Plan.
(e) If I am entitled to receive documents or information from the Plan I consent to receiving electronic copies of those documents.
(f) I understand that I may change my beneficiaries at any time by completing a new form which may be obtained from the Plan Administrator at 1-844-366-2629.

Signature of Member X	Date (dd-mm-yyyy)
Signature of Witness (any person over age 19 but cannot be Beneficiary or Trustee) X	Name of Witness