VESTCOR

Shared Risk Plan for Certain Bargaining Employees of New Brunswick Hospitals
Shared Risk Plan for CUPE Employees of New Brunswick Hospitals

DESIGNATION / CHANGE OF BENEFICIARY

EMPLOYER INFORMATION

EMPLOYER:

EMPLOYEE INFORMATION

NAME:	SOCIAL INSURANCE NO. - -

PLAN (Please indicate which plan applies):

☐ **Shared Risk Plan for Certain Bargaining Employees of NB Hospitals**

☐ **Shared Risk Plan for CUPE Employees of NB Hospitals**

In accordance with the terms and conditions of the pension plan mentioned above, I revoke all previous designations of beneficiaries made by me and I hereby appoint the individual(s) named in the Beneficiary Information section below as beneficiary (beneficiaries) entitled to receive the proceeds arising under the said Plan by reason of my death when they become due.

Note: If you have a spouse or common-law partner as defined in the *Pension Benefits Act*, the entitlement of your spouse or common-law partner shall supersede the entitlement of your beneficiary to a death benefit under the Plan, except where your spouse or common-law partner has waived their rights (fully or partially) by signing a "Pre-retirement Death Benefit Waiver" form (Form 9 of the *Pension Benefits Act*). The waiver form can be signed at any time prior to your death.

BENEFICIARY INFORMATION

NAME	ADDRESS	DATE OF BIRTH	SEX	RELATIONSHIP
		______/______/______ year month day	☐ Male ☐ Female	
		______/______/______ year month day	☐ Male ☐ Female	
		______/______/______ year month day	☐ Male ☐ Female	
		______/______/______ year month day	☐ Male ☐ Female	

If any beneficiary named above dies before me, the interest of such beneficiary (if any) shall, unless otherwise provided above, accrue to the surviving beneficiary (beneficiaries) or, if none, to my estate.

I reserve the right to revoke the appointment of any beneficiary designated by me hereunder at any time.

AUTHORIZATION

SIGNATURE OF MEMBER: MEMBER'S ADDRESS:	DATE ______/______/______ year month day
SIGNATURE OF WITNESS*:	DATE ______/______/______ year month day

* **Witness must have attained full age of majority and must not be a beneficiary**.

Please forward completed form to: Vestcor Pension Services Corporation
P.O. Box 6000, Fredericton NB E3B 5H1

06/2017