INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

doctors of bc
British Columbia Medical Association

Accidental Death and Dismemberment Beneficiary Designation

POLICY INFORMATION	
Name of Insured:	Policy #: **119-1015**
Doctors of BC ID Number:	Certificate #:

I REVOKE THE BENEFICIARY PRESENTLY NOMINATED TO RECEIVE THE PROCEEDS THAT BECOME DUE ON MY DEATH AND NAME INSTEAD THE FOLLOWING:

PRIMARY BENEFICIARY OR BENEFICIARIES – IN EQUAL SHARES UNLESS OTHERWISE PROVIDED BELOW

	Full Name	Relationship to Insured	%	Indicate if under age 19
1.				
2.				
3.				
4.				

If you are designating a minor as a beneficiary, please complete the Trustee Section below.

CONTINGENT BENEFICIARY OR BENEFICIARIES – IN EQUAL SHARES UNLESS OTHERWISE PROVIDED BELOW

If all of my primary beneficiaries predecease me, I designate the following individual(s) as by beneficiary(ies).

	Full Name	Relationship to Insured	%	Indicate if under age 19
1.				
2.				
3.				
4.				

DECLARATION APPOINTING TRUSTEE – APPLIES WHEN BENEFICIARY IS UNDER AGE 19

I authorize the trustee to receive any payments on behalf of the beneficiary while under the age of 19 and to apply the proceeds solely for the support, maintenance, education and benefit of such beneficiary at the discretion of the trustee.

Full Name ____________________ Relationship to Insured ____________________

AUTHORIZATION

If more than one beneficiary is designated and if one of the beneficiaries dies before the Insured, his/her share will be divided equally among the other designated beneficiaries. In the event of death of all designated beneficiaries, the proceeds will be paid to my estate, unless otherwise provided in the policy or required by law.

To the extent permitted by law, I reserve the right to alter or revoke the beneficiary designation. The beneficiary designation stated on this form will supersede all prior dated designations and will apply to all coverage in force under this policy unless specific instructions to the contrary have been received by Industrial Alliance Insurance and Financial Services Inc.

Signature of Applicant: ____________________ Date ____ ____ ____
Month Day Year

Submit your completed form via email to insurance@doctorsofbc.ca, or via fax or mail to the number or address below.

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