

Beneficiary designation

In this application, “we”, “us”, and “our” refer to the Manufacturers Life Insurance Company. “You” and “your” refer to the person to be insured. Doctors of BC may be reached toll-free at 1-800-665-2262 ext. 2904 or on their website at doctorsofbc.ca.

1. General information

By completing this form, you are asking us to change the information you previously provided. Any previous beneficiary designation or trustee appointment is revoked.

Certificate(s) #	Doctors of BC #
Last Name:	First Name:
Middle Initial:	Date of Birth: (dd-mm-yyyy):

2. Beneficiary designation

This designation supercedes any previous beneficiary designation and will apply to the entire amount of your Doctors of BC Life insurance coverage.

I hereby designate the individual named as beneficiary on this application to receive any death benefit payable with respect to the coverage applied for. If all the primary beneficiaries are no longer alive, any death benefit payable will become payable to the secondary beneficiary. If no beneficiary is designated, benefits will be payable to the Estate.

If you designate a beneficiary who is a minor when benefits become payable, benefits will be paid into court or to the Public Trustee, unless a trustee is appointed. By appointing a trustee below, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Complete this section if a beneficiary named on this form is a minor. If so, you agree that if the beneficiary is a minor on the date that benefits become payable, the benefits will be paid to the trustee to hold in trust for the minor until the minor comes of age.

Member beneficiary designation

Primary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 18

Secondary beneficiary (share of benefits must add up to 100%)

Last name	First name	Middle initial	Relationship to life insured	Amount %	Age if under 18

Trustee for minor children

Last name	First name	Middle initial	Relationship to life insured

3. Signatures

By signing below, you authorize us to act on the changes provided in this form.

Signed at (city or town): _____ Date (dd-mm-yyyy): _____

Signature of insured: _____

Return completed application to:
Doctors of BC Insurance Department or Fax: 1-604-638-2909 or scan and email to: insurance@doctorsofbc.ca
115-1665 West Broadway
Vancouver BC V6J 5A4

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