THE UNIVERSITY OF LETHBRIDGE

Accidental Death & Dismemberment Form

Please complete this form, sign and return to Pension and Benefits. You may wish to retain a copy for your record. Please keep Pension & Benefits informed of any changes in your family status (i.e. change of beneficiary, new dependents, etc.)

☐ Initial Enrollment ☐ Change

_____
Effective Date (HR use only)

1. Employee Information

Last Name	First Name	Middle Initial	Date of Birth	Province

Employee ID	Employee Group	Type of Contract	Gender

2. Accidental Death and Dismemberment – Beneficiary Information

If you have additional beneficiaries, please list **all of your beneficiaries** on the Multiple Beneficiary Form.

Primary Beneficiary (it is required to assign at least one Primary Beneficiary)

Last Name	First Name	Middle Initial	Percent allocated	Relationship to employee
			%	
			%	
			%	
			Total 100 %	

Contingent Beneficiary (in the event of the Primary Beneficiary's death)

Last Name	First Name	Middle Initial	Percent allocated	Relationship to employee
			%	
			%	
			%	
			Total 100 %	

If living, otherwise to my estate, except that, if more than one beneficiary is named, the proceeds shall be paid in equal shares to the surviving beneficiaries or beneficiary.

If designating a beneficiary who is a **minor** or who lacks legal capacity you may wish to appoint a trustee/administrator.

TRUSTEE CLAUSE: I hereby appoint the following trustee to receive and to hold in trust, on behalf of any beneficiary, money payable to the beneficiary under this group benefits plan where, at the time payment is to be made, the beneficiary is a minor or otherwise lacks legal capacity. Any such payment, to its extent, will release the University of Lethbridge Carrier from further liability.

Trustee Last Name	First Name	Middle Initial	Relationship to employee

3. Employee Authorization

I hereby apply for insurance under the group policy carried by the University of Lethbridge subject to all the terms, conditions and provisions of said policy. The foregoing answers are, to the best of my knowledge and belief, true, complete and correctly recorded. If a contribution towards the premium is required, I authorize the necessary deductions from my earning.

Employee Signature _____ Date

The personal information collected on this form is subject to the provisions of the Alberta Freedom of Information and Protection of Privacy Act 9FOIPP) and is collected for the purpose of administering benefit/pension programs for employees. Information collected may be forwarded to the corresponding institutions for the purpose of administering the programs. If you have any questions about the collection of this information, contact Human Resources, University of Lethbridge, 4401 University Drive, Lethbridge. Alberta, T1K 3M4, phone 329-2274