Equitable Life of Canada®

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PLAN MEMBER GROUP SPOUSAL OPTIONAL LIFE BENEFICIARY DESIGNATION

Name of Policyholder: Association of Ontario Midwives Benefits Trust

Group Policy Number: 812178 Division Number: _____

Plan Member's Name: _____ Plan Member's Certificate #: _____
First, Middle, Last

Plan Member's Date of Birth: _____ Plan Member's Class: _____
mm/dd/yyyy

Beneficiary Designation for Group Spousal Optional Life: If no beneficiary is appointed, the proceeds shall be paid to the Plan Member. If more than one beneficiary is appointed, proceeds will be payable in equal shares, unless otherwise indicated. The insured Plan Member can change the appointed beneficiaries at any time unless the designation is made irrevocable, in which case, the irrevocable beneficiaries' written consent is required.

I revoke any previous designated beneficiaries and designate the following beneficiaries to receive the proceeds:

Name of Primary Beneficiary (First, Middle, Last)	Relationship to Plan Member	% Share

If the above Primary Beneficiaries pre-decease me, I designate the following contingent beneficiaries to receive the proceeds:

Name of Contingent Beneficiary (First, Middle, Last)	Relationship to Plan Member	% Share

NOTE: If both the Primary Beneficiaries and Contingent Beneficiaries predecease the insured Plan Member, the proceeds will be paid as required by provincial law. If there are additional Primary and/or Contingent Beneficiaries, please sign, date and attach a note to this form with the beneficiary information.

NOTE: For Quebec residents, designating your spouse as beneficiary is irrevocable unless you make the designation revocable. An irrevocable beneficiary designation cannot be changed without the written consent of the irrevocable beneficiary. A revocable beneficiary designation can be changed at any time without the consent of the revocable beneficiary.
I elect to make my spouse designation: ☐ Revocable

If a beneficiary is under the age of majority at the time of my death, proceeds shall be payable to the following trustee in trust for the minor beneficiary:

Name of Trustee (First, Middle, Last)	Relationship to Plan Member

The personal information willingly provided by me to my Plan Sponsor, the independent broker/sales advisor and Equitable Life, collected on this form and held in their files, will be used by Equitable Life for the purposes of servicing, administration, claims processing and adjudication related to this form, the Group Insurance Policy and all benefits thereunder, and any supplementary documents. I understand and authorize that for the above purposes the personal information on file is accessible to, and may be exchanged with, authorized employees of, and relevant third parties retained by Equitable Life, participating reinsurer(s), other insurance companies, investigative organizations, health care providers, including, but not limited to pharmacies, physicians and dentists and any other person or party whom I authorize.

I CERTIFY THAT ALL OF THE INFORMATION GIVEN ON THIS FORM IS TRUE, CORRECT AND COMPLETE AND I DESIGNATE THE BENEFICIARIES STATED ABOVE.

Date: _____ Signature of Plan Member (Employee) : _____
mm/dd/yyyy

Signature of Plan Member's Spouse : _____