Manulife

ALBERTA MEDICAL ASSOCIATION

Beneficiary Designation form for Policy 4328

1. General Information

In this application, "we", "us", and "our" refer to the Manufacturers Life Insurance Company. "You" and "your" refer to the person to be insured.

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) # AMA #

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 AMA 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 applicant: _____

Return your completed application to:
ADIUM Insurance Services Inc.
Alberta Medical Association
12230 106 Avenue NW
Edmonton AB T5N 3Z1

Fax: 780-488-7558 or 1-877-302-3486
Email: adium@albertadoctors.org

For general information, you may call us toll-free at **1-888-492-3486** or visit our website at **www.albertadoctors.org**.

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