

Beneficiary Designation

July 2011



Print clearly using black ink. See the Instructions page for details on how to complete this form.

This form must be printed on 8½" x 14" (legal size) paper.

- Use this form to report:
- the name of your qualifying spouse, who is by law the primary beneficiary of your HOOPP benefits
 - any other beneficiary or beneficiaries you want to designate
 - a change in spousal status and to remove the name of a former spouse as your primary beneficiary

Any beneficiary designation you make using this form will revoke any previous beneficiary designation you may have made, including those at other HOOPP participating employers.

1. Member Information Name: Miss Mrs. Ms. Mr. Sister Dr. _____
first name last name middle initial(s)

Social insurance number (SIN): Tel: _____

2. Spousal Information

I have a qualifying spouse (If you don't have a qualifying spouse, proceed to Section 3)

Name of qualifying spouse: Miss Mrs. Ms. Mr. Dr. _____
first name last name middle initial(s)

Social insurance number (SIN): Date of birth: |_____| |_____| |_____|
month day year

Only a surviving spouse is eligible to receive spousal benefits upon your death. This entitlement can only be waived through the signing of a prescribed provincial waiver form. NOTE: The social insurance number for your spouse is optional; however, HOOPP may require your spouse's SIN in the future.

Spouse's mailing address: (Check here if the same as member's; if not, please provide below.)

number street apt.

city province postal code

3. Removal of Former Qualifying Spouse

I no longer have a qualifying spouse – please remove my former qualifying spouse. (The effective date of this change is the date in Section 5.)

Name of former spouse: _____

4. Non-Spouse Beneficiary Designation (See Instructions page. Only a member can change a non-spouse beneficiary. A person with power of attorney for a member cannot make a beneficiary change.)

- I have no qualifying spouse Spousal benefits have been waived
- BENEFICIARY: Individual(s) Organization (i.e., a charity) Estate

See Instructions page before filling out this section.

Name (first, last) or Organization	Relationship to member (if beneficiary is an individual) and gender	Social insurance number	Percentage of benefit I would like any benefits payable upon my death (check one): <input type="checkbox"/> divided equally among all surviving non-spouse beneficiaries, or <input type="checkbox"/> divided as shown below; see Instructions page for details	Mailing address Provide for each beneficiary.	Date of birth (mm/dd/yr)
	<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female				
	<input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female				

5. Declaration (Member completes if reporting new information in sections 2,3,4.)

I certify that the information I have provided on this form is accurate and complete. I also consent to the use of all information contained on this form and any and all additional personal information which I may hereafter provide to the administrators of the Plan, including my social insurance number, plus information related to my salary and employment record, as may be required to administer the Plan. My consent extends to any disclosures by the Plan administrators to the Plan's auditors, actuaries and/or other professional advisors for the purposes of administering the Plan. I understand that any death benefits from the Plan are payable to my surviving qualifying spouse (primary beneficiary) or to my non-spouse beneficiary (if there is no qualifying spouse) as designated above. I also understand that any information collected or requested via this document is solely for the purpose of administering the Plan and will not be disclosed to any other party, except as previously indicated, without my consent. I certify that the information contained in this form is correct to the best of my knowledge.

Member's signature: _____ Date: |_____| |_____| |_____|
month day year

Healthcare of Ontario Pension Plan

1 Toronto St., Suite 1400 Toronto, ON M5C 3B2 Website: hoopp.com
 Tel: 416-646-6445 Toll-free: 1-877-43HOOPP(46677) Fax: 416-369-0225 E-mail: clientservices@hoopp.com

- Send this form to HOOPP
- Keep a copy for your files



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Instructions

The following instructions are designed to help you complete the Beneficiary Designation form for the Healthcare of Ontario Pension Plan (HOOPP).

1. Member Information

- Please print your name and social insurance number and provide a contact telephone number.

2. Spousal Information

- Under provincial pension legislation, your surviving qualifying spouse is your primary beneficiary for HOOPP benefits, and will receive spousal benefits upon your death. If you have no spouse, or spousal benefits have been waived, you can name any person, persons, organization, or your estate as your primary beneficiary. Please enter your spouse's name and other information in the space provided.

Your qualifying spouse is someone who, at the time a determination is needed:

- is legally married to you, but not separated from the member; or
- has been living with you continuously in a conjugal relationship for at least a year; or
- is the mother or father (natural or adoptive) of your child, and lives with you in a relationship of some permanence.
- If your spouse is your primary beneficiary, you can name a secondary beneficiary. Your secondary beneficiary – a person, persons, organization, or estate – will receive any death benefit payable from HOOPP after both you and your spouse have died. To name a non-spouse beneficiary, complete Section 4 of this form.

3. Removal of former qualifying spouse

- If you no longer have a qualifying spouse, and wish to remove a former spouse's name from your pension record, tick the box, provide the former spouse's name, and indicate the date that your spousal relationship changed.

4. Non-Spouse Beneficiary Designation

- If you have no spouse, or if spousal benefits have been waived, you can name any persons, organization, or your estate as your non-spouse beneficiary. Indicate, by ticking the appropriate box, if you have no qualifying spouse or if spousal benefits have been waived. If your spouse is your primary beneficiary, use this section to name a non-spouse secondary beneficiary.
- This beneficiary (or beneficiaries) will receive any benefits payable after you (and if applicable, your qualifying spouse) have died.
- Provide full name of each beneficiary.
- If any of your beneficiaries are individuals, indicate by ticking the box if they are your child, or "other." Other can include a spouse (if spousal benefits have been waived), a former spouse, or anyone else you wish to name. Also indicate if the person is male or female.
- If you name more than one non-spouse beneficiary, you can specify what percentage of any benefit payable each beneficiary is to receive in the space provided. If you don't specify a percentage, any benefits payable on your death will be divided equally among all surviving beneficiaries you name. For example, you could leave 75% of any benefit to a daughter, and 25% to a granddaughter.
- If you are naming a minor as a non-spouse beneficiary, you may want to obtain legal advice before proceeding.
- HOOPP cannot process the changes reported on this form unless it is requested by the member or pensioner.

5. Declaration

- You agree to provide HOOPP with the information it needs to administer your pension benefits.
- As well, you acknowledge HOOPP's rules for the privacy of personal information.

6. Returning this form

- Return this form to HOOPP. Barcodes cannot be read if the form is sent by fax. If you are printing this form, please do not reduce it in size or fold it.