

# FEDERAL INSURANCE COMPANY (the "Company")

## BENEFICIARY DESIGNATION REQUEST

**INSTRUCTIONS: Complete this form and retain a copy with your important papers.**

Indicate: \_\_\_\_\_ Original Designation  
                  \_\_\_\_\_ Change of Beneficiary

Policyholder: \_\_\_\_\_

Policy Number: \_\_\_\_\_

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

*Hereby revoking any and all previous designations, I designate the person(s) on this form as my Beneficiary(ies) to receive any payment from the policy or certificate number shown above. I fully understand that this designation of Beneficiary(ies) applies to the full Accidental Loss of Life Benefit Amount that is in force.*

Date: \_\_\_\_\_

Insured's Signature: \_\_\_\_\_

\_\_\_\_\_%

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_%

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_%

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_%

\_\_\_\_\_  
Name of Beneficiary

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code