

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